unicef | for every child

Endline
evaluation of
**Space for
Kids to be**
**Kids**
**P R O J E C T**
in Maharashtra & Rajasthan, 2017–2020

**Final Evaluation Report**

**May 2021**

ATHENA
INFONOMICS

Dcor
evelopment Corner

## ACKNOWLEDGEMENTS

**Vijay Bhalaki,**
**Co-Founder and Director**
**Athena Infonomics India Private Limited**

# ABBREVIATIONS

| Abbreviation | Full form |
|---|---|
| ASHA | Accredited Social Health Activist |
| AWW | Anganwadi Worker |
| BF | Breast Feeding |
| CDPO | Child Development Project Officer |
| CF | Complementary Feeding |
| CSO | Civil Society Organisation |
| DD | Deputy Director |
| EBF | Exclusive Breast Feeding |
| ECCE | Early Childhood Care and Education |
| ECD | Early Childhood Development |
| FLW | Front Line Worker |
| GE | Gender Equity |
| GoI | Government of India |
| HBNC | Home Based New-born Care |
| HBYC | Home-Based Care for Young Child |
| HR | Human Rights |
| HV | Home Visit |
| ICDS | Integrated Child Development Services |
| ICT | Information and Communications Technology |
| JSSK | Janani Shishu Suraksha Karyakram |
| KAP | Knowledge, Attitudes and Practices |
| KII | Key Informant Interview |
| M&E | Monitoring and Evaluation |
| MWCD | Ministry of Women and Child Development |
| MLE | Monitoring, Learning and Evaluation |
| MoHFW | Ministry of Health and Family Welfare |
| NBSU | New-born Stabilization Unit |
| NNM | National Nutrition Mission |
| ODK | Open Data Kit |
| OECD | Organisation for Economic Co-operation and Development |
| SDG | Sustainable Development Goals |
| SNCU | Special New-born Care Units |
| ToR | Terms of Reference |
| UNEG | United Nations Evaluation Group |
| UNICEF | United Nations Children's Fund |

## Authors

**Ms. Monisha Singh Diwan**
*Team Leader and ECD Expert*


**Dr. Francis Xavier Rathinam**
*Evaluation Expert*


**Mr. Bilal Afroz**
*Quantitative Expert & Project Manager*


**Ms. Ashmika Gouchwal**
*Research Associate*


**Ms. Saumya Kaul**
*Research Associate*

# CONTENT

# LIST OF TABLES

# LIST OF FIGURES

# EXECUTIVE SUMMARY

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## Context

Early childhood (till 6 years of age)[1] is a critical period that affects the holistic development of an individual and determines their ability to reach their optimum health, social, and economic potential. Comprehensive development and well-being of children in the 0-6 years age group is strongly interconnected with long-term outcomes of completing school education and learning levels, better livelihood opportunities, and mental health.

In India, according to Census 2011 data, there are 164.48 million children in the age group 0-6 years. While significant progress has been made with regard to maternal and child health over the past decade - infant mortality rates (IMR) are down to 28.3 per 1000 live births in 2019[2]; the under-five mortality rates (U5MR) have decreased to 37 deaths per 1,000 live births in 2019[3]; maternal mortality rates have fallen to 145 per 100,000 live births, much more remains to be done. In addition to country wide variations, even within states, some groups are more vulnerable than others; infant mortality rates for rural children are up to 1.5 times higher than their urban counterparts.

In response to the twin challenge of providing pre-school non-formal education and breaking the vicious cycle of malnutrition, morbidity, reduced learning capacity and mortality, the Government of India (GOI) rolled out the Integrated Child Development Services (ICDS) Scheme in 1975, for children in the 0-6 years age group, pregnant women, lactating mothers, and adolescent girls.

## Introduction to the project

"Spaces for kids to be kids" is a project supported by the IKEA Foundation to improve the early development of children in two states of India – Maharashtra, and Rajasthan, initiated in August 2017, in a partnership with the Department of Women and Child Development. The project adopts a 'system-based approach'[4] and utilizes the platforms available within the ICDS system to reach caregivers.

The project's strategic thrust was on building the capacity of the frontline workers primarily the Anganwadi workers (AWWs) and the Accredited Social Health Activists (ASHAs) to effectively support parents/caregivers in improving care of children and to support early learning at the household level. The strategic components of the project included the development of training materials and communication packages on parental care; building the capacity of the frontline functionaries (AWWs and ASHAs), which includes training and on the job support to enhance their knowledge, attitude and perceptions on parenting care; and use of such learning through various platforms for quality counselling and interaction with the parents/caregivers.

The IKEA Foundation funded project aimed that both boy and girl child have equal access to services for early childhood care and education, ensuring all girls and boys survive, thrive and develop to their fullest

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[1] From conception to school entry

[2] Source: https://data.worldbank.org/indicator/SP.DYN.IMRT.IN?locations=IN

[3] Source: Countdown to 2030- Country Profiles on Early Childhood Development (India), UNICEF

[4] System based approach focuses on utilizing existing government structures - for capacity building of frontline workers (AWW and ASHA); as well as the delivery of quality services including counselling of parents through existing platforms of ICDS; leveraging the ongoing government programmes such as Poshan Abhiyaan, Rashtriya Bal Swasthya Karyakram (RBSK), Home Based Young Child Care (HBYC) and strengthening early childhood education under the umbrella of the ICDS programme

potential. The project interventions also emphasized the involvement of fathers and other caregivers in the family (besides mothers) in child-care and learning.

## Evaluation Purpose, Objectives of the evaluation, geographic coverage and scope

The purpose of the endline evaluation was to assess and draw lessons from the 'Space for Kids to be Kids' project in Maharashtra and Rajasthan (2017 – 2020) assessing its relevance, effectiveness, efficiency and sustainability according to OECD/DAC criteria. The evaluation aimed to assess the project in terms of promoting early learning in homes, achievement of the intended objectives, gender and equity perspectives as well as utilization of available resources and timely implementation. The evaluation was conducted in four districts[5] of Maharashtra and two districts[6] of Rajasthan. The evaluation scope was to review existing literature on parenting and ECD, conduct quantitative survey with FLWs (AWWs & ASHAs), conduct Key Informant Interviews (KIIs) & In-Depth Interviews (IDIs) with key stakeholders, FLWs and caregivers, and document key lessons learnt. The evaluation took place from Feb 2020 – March 2021. The primary intended audience include Integrated Child Development Services (ICDS) and UNICEF, and the secondary audience include Ministry of Health and Family Welfare (MoHFW), caregivers (mothers/fathers/ family members), and donor agencies, other UN agencies, CSOs/NGOs.

## Brief Methodology

The endline evaluation employed '*mixed-methods approach*'. Both the 'qualitative' and 'quantitative' methods and tools were applied for data collection. The quantitative line of evidence constituted – FLW survey, and qualitative line of evidence constituted – KIIs with stakeholders, IDIs with FLWs, IDIs with parents/caregivers and case-studies.

Given the nature of the current project, a **pre-post evaluation** design (comparing baseline and endline outcomes) was utilized as there was no possibility of selecting a suitable control group for this evaluation (for a quasi-experimental design). Due to COVID-19 circumstances, the evaluation team collected all the required primary data remotely (via phone survey). The change in strategy to collect the data remotely called for adapting the methodology in terms of – trimming down the FLW quantitative survey, replacing FGDs with IDIs for caregiver interviews, dropping direct observations and including questions/themes in qualitative guides which were dropped from FLW quantitative survey questionnaire. For the quantitative FLW survey, in total 1234 FLWs (AWWs & ASHAs) were interviewed (642 in Maharashtra and 592 in Rajasthan). For the qualitative assessment, 54 Key-Informant Interviews (KIIs) with stakeholders, 58 IDIs with FLWs (34 AWWs and 24 ASHAs), and 42 IDIs with parents (21 mothers and 21 fathers) were conducted. The evaluation was supervised by the Evaluation Reference Group (ERG).

## Key findings

**Relevance:** Discussions revealed that while a majority of the parents are able to fulfil needs related to nutrition, health and hygiene, gaps exist in the knowledge and practices regarding other important aspects of early learning and responsive parenting. To bridge this gap, frontline workers are acting as an important communication channel to disseminate vital information to the communities. Being residents of the same villages enables them to interact freely with families, providing requisite information.

Evaluation findings reveal that regular interactions and discussions between the caregivers and FLWs have contributed to a rise in the caregivers' knowledge about early learning, stimulation, and childcare with a gradual shift towards the adoption of right parenting practices. Findings also reveal increased

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[5] Aurangabad, Yavatmal, Pune and Palghar districts
[6] Udaipur and Dungarpur districts

participation of other caregivers in the household like the grandparents, uncle/ aunts, and elder siblings in the meetings and events organized by frontline functionaries.

The evidence suggests that the training provided to FLWs has contributed in improving their knowledge and practices on responsive parenting and ECD, and counselling skills. Discussions with caregivers and FLWs provide evidence on improvements in FLW-caregiver interactions with a rise in duration and depth of discussions in terms of content and engagement during the meetings and home visits. Increased collaboration between the ASHA and AWW (especially in Maharashtra) further improved the quality of use of the meeting platforms.

The intervention targets regions with high marginalized and/or tribal/rural population, making the gender and equity guidelines developed relevant to these areas. The communication material subtly highlights the gender and equity concerns. Evidence suggests that the trainings have contributed in building the confidence and skills of the frontline workers to interact with the caregivers (both male and female) about the importance of gender equality (rearing girl and boy child and involvement of fathers).

One of the main objectives of the project is to enhance the role of fathers in their child's upbringing. The quantitative findings show an increased percentage (although still low) of FLWs organizing fathers' meetings from baseline to endline in both the intervention states. Even so, frontline workers continue to face challenges while counselling fathers of children and only minimal progress has been made in this regard.

Further, the FLWs made efforts to reach out to all members of the community (paying regular home visits, assisting in implementing the learnings and encouraging to attend meeting at the centre), especially the vulnerable groups and those located in remote areas. In some regions in Rajasthan, FLWs travelled in groups of 2-3 through the mountainous region to reach out to families in remote regions. The use of local materials for play activities taught to caregivers ensured their applicability to families from all backgrounds and economic strata.

The project's relevance is also evident in its alignment and complementarity with other government programmes and schemes in the two states. The early learning activities for children have been drawn from already existing state ECE curriculums (such as AAKAR in Maharashtra). The project's activities complement the efforts of the ICDS programme by bringing in components relating to learning and stimulation even among the 0-3 age group, which had been previously ignored.

**Effectiveness:** In the quantitative survey, more than fourth-fifth of AWWs (83.2%) and more than half of ASHAs (55.3%) in Maharashtra and about half of AWWs (46%) and a quarter of ASHAs (23%) in Rajasthan reported that they received training on positive parenting and ECD.

Qualitative interactions with FLWs revealed their satisfaction with the quality of training on responsive parenting and care covering aspects such as content, structure and medium of delivery. Similarly, in the quantitative survey, FLWs commonly reported liking the provision of new information, information supplementing their job performance and helping in refreshing skills &knowledge on parenting and ECD. The FLWs were able to gauge the needs of the family and deliver context-specific messages; they have built positive relationships with the caregivers and become known figures in their communities. Although there was a slight improvement in the interactions of the FLWs with the fathers, they continued to face challenges in promoting fathers' involvement in childcare and development.

The FLWs mostly attributed the improvements in KAP to the training sessions they attended, the expertise and support of the master trainers/supervisors, and the communication materials provided. They also expressed the desire for more training in new areas such as innovative games and techniques of playing with child to promote cognitive development and health and hygiene.

About three-fourth of AWWs and more than half of ASHAs in Maharashtra, and about half of AWWs and slightly more than a quarter of ASHAs in Rajasthan reported that they received the communication material as well as training to use the material to counsel parents on responsive parenting and ECD. About 50% of ASHA and AWW in Rajasthan and 65-70% of the FLWs in Maharashtra rated the communication material as being 'very useful' in counselling the caregivers on responsive parenting and ECD. The FLWs perceived that the communication material made their job easier acting as a visual aid to explain difficult messages in an easy-to-understand manner to the caregivers. The review of the communication material also found the messages being sensitive towards gender and equity concerns, reflecting its inclusive nature. It was also observed that inclusion of children with disabilities in the communication materials does not come across explicitly, though it has been addressed in trainings.

Both the quantitative and qualitative findings suggest that home visits and parents' meetings were the most effective platforms to reach the caregivers besides palak melawas, vaccination day, nutrition day, Annaprashan divas[7] and Godhbharai[8]. Frontline workers sometimes used panchayats and village school teachers' help to deliver gender-related messages. To encourage fathers' participation and build rapport with them, frontline workers suggested organizing customized meetings and counselling sessions for men. For the more vulnerable sections, frontline workers felt that repeated counselling with patience and kindness yielded positive results. Use of digital platforms such as WhatsApp were also noted as a convenient strategy to remain connected with families located in the more remote regions (although network issues persist).

FLWs also reported some challenges in effectively transferring the learnings to parents/caregivers – orthodox mindsets of the villagers, lower participation in interior areas (especially in Rajasthan), busy schedule and other commitments of the caregivers, lower education levels of the community and long distances for FLWs to travel in hilly/ mountainous areas.

The project also faced some challenges in its implementation including convincing government officials, interruptions in the training sessions due to data request from government officials, training fatigue among FLWs, lack of time for ECD activities during vaccination drives or routine immunization activities and supervisor vacancies in remote regions to name a few. Timely corrective action was taken to overcome these challenges – extra attention was given to FLWs who needed additional support during the training sessions, skipping ECD training in months when other sessions were being conducted to prevent training fatigue, filling the vacancies of supervisors by block coordinators or ASHA facilitators among others.

**Efficiency:** The efficiency of the project is reflected in its sensible use of the existing government systems/platforms to implement the project's activities. In both states, the project leveraged and made use of the ICDS government platforms for both capacity building of the frontline workers and counselling of the caregivers. The Anganwadi centre and the network of AWW and ASHA workers took centre stage in the project's implementation. The sector meetings were used for training the FLWs in Rajasthan and in Maharashtra a separate training day in a month was allotted for the training. Home visits, mothers'/ parents' meetings and community-based events (Annaprashana diwas, Godbharai etc.) were used for counselling the parents. In Rajasthan, the use of sector meeting as a training platform for the frontline functionaries contributed to the operation of the project even under budget constraints. However, utilizing sector meetings for trainings had some constraints – often more time being consumed for administrative tasks during sector meetings with less time remaining for training. The project contributed to expanding the frequency and extent of use of the available platforms in terms of regularity of meetings, participation of caregivers, content of the meeting, practical demonstrations etc. The ICDS supervisor visits also witnessed improvements in the level of engagement of the supervisors with both the FLWs and the

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[7] First food intake besides milk at the start of 7th month of baby
[8] Baby shower

caregivers in terms of supervisor paying regular visits to AWCs, prioritizing the visits during days when community meetings are conducted by AWWs and joining FLWs to home visits to support them during counselling to caregivers at home.

**Sustainability:** There is consensus among the stakeholders regarding the scalability of the project to other districts within the intervention states and other states in the country, with all components of the project (including the incremental learning approach) scaled up together to produce favourable outcomes in childcare and development.

There is a consensus among the UNICEF staff members on prior involvement of the government ministries and bureaucrats from the beginning aiding in effective implementation of the project. The project should be included in the annual work plan of the government and responsive parenting should be a part of the policy agenda so that it becomes mainstream in terms of government initiatives.

The project's sustainability and scalability is reflective in its system-based approach focusing on utilizing the existing government infrastructure and human resource in place. Capacities of the AWWs and ASHAs were built by leveraging the existing frontline human resource of ICDS and health departments. The project's sustainability, however, is dependent on numerous factors namely the government's uptake of/ commitment to the project, continuation of the supportive and appreciative enquiry environment[9] for the FLWs created by UNICEF with the support of CSO partners, and regular refresher training for both the FLWs and parents and the support of the district and block-level government officials.

One of the major challenges was to get the attention of the officials at the administrative levels and the policy levels towards the important role played by ECD in childcare. Some other challenges reported were – variability in the educational qualifications of the frontline workers across districts and states, and ASHA workers not getting compensation for the travel and expenses incurred in the training process.

Finally, it is important to highlight that the intensity of support ( provided by the CSO partners) that is provided to the pilot project such as adept trainers, comprehensive training content, frequent training cycles, mentoring and monitoring support to FLWs will be difficult to replicate if it is scaled up to other districts and states, potentially hampering the outcomes that have been seen in the pilot phase. Thus, there is a need to make the project less resource-intensive either by reducing the number of training cycles or by using digital platforms like videos or by conducting online training sessions. In addition to this, having a block coordinator and a district official to take the project forward will ensure its smooth implementation and scalability.

## Conclusions

The evaluation team has drawn conclusions from the key findings according to the research questions that guided the evaluation.

**Relevance**: The project has demonstrated its relevance in building the capacities of frontline functionaries (AWWs and ASHAs) on responsive parenting to achieve the goals of ECD to ultimately reach the caregivers in the community. The FLWs were equipped with the what, why and how of responsive parenting messaging through regular trainings, continuous monitoring and handholding. The project's relevance further gains strength given that responsive parenting is relatively a new area in the Indian context.

The project addressed the most pressing needs of parents regarding child development and care and enhanced their understanding of different ECD aspects. FLWs were also gender-sensitive in organizing

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[9]During the project, UNICEF via support from CSO partners strived to foster an environment of supportive and appreciative enquiry. FLWs were encouraged to freely express their needs in terms of support for training, handholding support required or any other specific support needed which ultimately contributes to improving their knowledge and counselling skills.

suitably timed meetings specifically for fathers and utilized innovative engagement methods e.g. the blackboard painting task outside their homes for children. Although still on the lower side, the emerging role of father as a parent who interacts, and plays is an encouraging improvement. In fact, some fathers have emerged champions for responsive and pro-active parenting for their children, inspiring others.

**Effectiveness**: The evidence suggests that the project, as a pilot, has been *largely effective* in – a) building the skills and capacities of the FLWs on responsive parenting and care, b) utilizing the available institutional platforms to reach out to caregivers. Evidence suggests that the trainings not only built FLW's communication skills and confidence, but also equipped them with necessary skills for improved information dissemination. However, lower proportion of ASHAs (55.3%) in Maharashtra and AWWs (46%) and ASHAs (23%) in Rajasthan reported to have received the training on positive parenting and ECD, suggesting further efforts.

FLWs were able to use the communication materials/tools in communicating with parents at the various platforms effectively. The FLWs perceived that the communication tools made their jobs easier, acted as effective visual aids to explain difficult messages and eased the language barrier.

Gender and equity-based concepts are integrated in the communication package material with clarity and seamlessness. It breaks the gendered roles and responsibilities, toys, communication and activity engagement uses gender-neutral language (English) e.g. their/them/they/child/children.

At the child level, frontline workers have observed the advent of some positive changes, albeit small, in child health, hygiene, education and discipline due to increased knowledge levels of parents and frontline workers.

However, the intervention was *partly effective* in reaching out to fathers due to reasons such as lack of availability, migrant nature of jobs, orthodox mindsets, lack of awareness, and illiteracy. Findings reveal that majority of men considered childcare and parenting outside their domain and were unaware of their responsibilities as fathers. It is critical to engage fathers as well as other family members in the responsive parenting sessions to ensure a more supportive system for the mother and child at home.

Home visits and parent Anganwadi meetings were found to be the most effective platforms to reach caregivers for counselling. Other platforms such as mother's/father's meetings, palak melawas, school, hospital and temple premises, and community centres were also utilized. The enhanced utilization of existing platforms by frontline workers to orient caregivers are in line with the reconstructed theory of change.

**Efficiency**: The evaluation provides evidence on the efficiency of the parenting project in terms of utilizing the available government resources – human resource, infrastructure and institutional platforms such as mothers'/ parents meeting, home-visits, community-based events.

Although the utilization of sector meetings for trainings in Rajasthan was an efficient way of using available government platform, often the issue of lack of time for training of FLWs cropped up due to administrative duties to be rendered. In Maharashtra, instead of sector meetings, separate training sessions were conducted for master trainers and FLWs, with a minimal cost to the system and was found to be more effective as FLWs were able to concentrate and learn better.

**Sustainability**: There is consensus among stakeholders (district and state government officials , UNICEF staff members, and CSO partners) that the intervention is scalable to other blocks/ districts in the two states given the project's utilization of existing government human resource, infrastructure and platforms, and the positive reception of training by the FLWs. Efforts are being made at the block, district and state levels to integrate ECD into their existing working framework, ensuring its sustainability.

Further, for more sustained results, some potential issues need to be addressed – enhanced coordination between ICDS and health department, more frequent and regular refresher trainings for FLWs, providing travel allowance for ASHAs, and re-adjusting the training schedule to cover the critically required contents within less time. Another potential challenge which was addressed well in Maharashtra and should be used as a case study is the teaming up of Anganwadi worker and ASHA (for trainings and joint visits).

Another critical observation is the lack of continuation of the intensity of support provided to the pilot project in its scale up, that can have consequences on the intended outcomes necessitating making the project less resource-intensive.

In sum, the evaluation findings indicate that the supportive resources and structures need to be adjusted for scale-up and the intervention needs to be further institutionalized in the planning processes. The project efficiently and effectively makes use of the existing government resources and supplements and compliments the government ECD initiatives. The project should be streamlined in both the policy agenda and the annual work plan of the government, ensuring that the project's domain becomes mainstream in government initiatives. Tackling of coordination issues with Ministries and Departments will also support project scale-up.

## Lessons learnt

The evaluation has highlighted several learnings that will inform the scaling up of the model in other blocks/ districts in the two intervention states and designing similar interventions.

a) ***Leveraging of existing resources from government schemes/ programmes/ initiatives and empowering frontline functionaries continues to be the mainstay of the project replicability and scalability:*** Leveraging of existing government human and infrastructure resources effectively and efficiently and through strong project components is already resulting in plans afoot to scale to other districts. There is readiness and need in the system to adopt and adapt the project on a wider scale. The inclusive approach of involving officials from different levels has supported in implementation of the project.

b) ***UNICEF's continued advocacy, availability of technical support and commitment on the part of the Government stakeholders have resulted in increased acceptance of the project by the Government of Maharashtra (GoM) and Government of Rajasthan (GoR) and must continue:*** The project's strong acceptance at the government level is reflective in Maharashtra's decision to expand project activities to other districts in the State as well as Rajasthan's plans for distribution of communication packages across the state in the upcoming year/s. UNICEF has played a critical role in the transition of the parenting project into a state-level policy, engaging regularly with ICDS and health departments for policy advocacy. It has also provided high-level technical assistance to the states in the form of training of master trainers, frontline functionaries, developing communication packages, training content etc. Further, a good learning is that committed government stakeholders will augment the impact further.

c) ***Collaboration between ICDS and Health departments in Maharashtra has amplified the results:*** The collaboration between the government departments (ICDS and health) has improved the synergies and the joint trainings under the project led to an amalgamation of the activities and improved their capacities.

d) ***The FLW's and Supervisors knowledge, attitude and perceptions (KAP) are likely to be sustained if capacity building around responsive parenting and better work conditions are ingrained in the system:*** Some positive results of the intervention such as the positive change in the knowledge, attitude, and perceptions (KAP) of FLWs around childcare and parenting, ability to use the available platforms better or supervisor's capacity built as trainer thereby creating a cadre of skilled human

resource from within the system are sustainable only if the capacity building of the frontline workers is ingrained in the system, and a platform for constant support and engagement is maintained.

However, FLW's are poorly compensated, overworked, not given travel expenses or allowances and are drawn into all ground activities continually hence making their job extremely demanding on skill and will with missing job satisfaction and security. Thus, work conditions need to improve and be systemic if the intervention has to create impact at scale.

e) _**Efforts to engage parents – both mothers and fathers and other caregivers is of utmost importance to create a familial support and ownership for ECD**_: Efforts to educate and improve engagement of fathers and  other caregivers including elders in the family to change social norms around parenting and childcare is a good strategy to build a supportive system for the mother and child at home and for the child to receive continued responsive care.

f) _**Including fathers in the childcare remains a challenge**_: Despite best efforts of the project, involving fathers in childcare remains a challenge, requiring concerned efforts from government, UNICEF and development partners.

## Recommendations

### _Recommendations for UNICEF_

a) _**Continue technical assistance to the Governments on responsive parenting and ECD as they scale up and replicate in other districts [immediate and on-going]**_

UNICEF should continue its engagement with the Government of Maharashtra (GoM) and Government of Rajasthan (GoR), providing technical assistance in the following areas:
- Liaising with the state level officials from ICDS and health departments to support in strengthening monitoring and review systems
- Updating/ re-structuring the training modules on responsive parenting and care
- Training of trainers (master trainers)
- Process documentation
- Preparing policy briefs on importance of parenting and child development
- Any other activity identified in consultation with GoM and GoR

b) _**Sustained efforts to encourage the involvement of fathers and family members beyond the mother in responsive parenting [immediate]**_

Sustained efforts are required at the community level to increase the participation of fathers and families in responsive parenting. Separate sessions for fathers are warranted given the tendency of mothers to speak freely in sessions without male members, and/or the sessions for fathers can be presented as something especially for men, to avoid any perceived stigma of being involved in "female" activities.

Innovative strategies like harnessing digital media, recognising and building father champions/leaders (mother or grandparents as well) who become advocacy champions as well, and gender sensitive programming taking account of challenges of time and space would be helpful.  Continuous support to parent leaders as well as possibility of compensation or recognition of their work will help increase their commitment and sustain efforts.

c) _**Keep the main components of the project model with some adjustments [immediate]**_

For a project that was implemented for a relatively short period of time, the results achieved in the domains of capacity building of frontline workers and caregivers, increased utilization of ECD services and alignment of project activities with existing government infrastructure are promising. The components around training, planning, content, methods need to be retained as they are. Adjustments can be done in another iteration on content for modifications in activities for inclusion and equity, including explicit practice-oriented sessions in training modules, and translations in different local and regional languages.

d) **_Equity and inclusion of children with different needs in communication material needs to be continued but more explicitly [immediate]_**

There needs to be explicit training sessions on equity and inclusion.  Also, one more iteration of the content to move to gender neutral language, adding an explicit session on equity and inclusion, and adding modifications for children with different needs is required.

### *Recommendations for Government*

a) **_Integration of responsive parenting intervention into the annual work plan [immediate]_**

The addition of the project in the annual workplan will help build coordination with various departments and enable streamlining the priorities of the local government bodies. The senior officials will have to act as catalysts to encourage and expand the training conducted by an external partner and to bear the costs of the same.  This will also help support clear resource allocation at the government level for integrated ECD. Utilizing sector meetings as a training venue needs some re-thinking to strategically place the training session during the meeting to ensure sufficient time for the training. Review formats will need to include responsive parenting as well, so it is clearly institutionalized, allowing the Governments to systematically review and address issues.

b) **_AWWs and ASHAs collaboration and working together [immediate]_**

The collaboration between the AWWs and ASHAs needs to be leveraged and become a core component of the project implementation given that ASHA's messaging on health and nutrition benefits tremendously by being empowered with responsive parenting strategies.

c) **_Frontline functionaries (AWWs and ASHAs) education, job description and work status improvement [immediate]_**

*Skill, Will* and *Time Amortization* are three essentials to look at. *Skill* - Capacity building of the frontline workers should be ingrained in the system; *Will* - a platform for constant support and engagement needs to be maintained, clarity in FLW's job description with focus on 0-3 and 3-6 age groups and on services beyond the centres as well as inclusion of data monitoring, parenting services and advocacy components; *Time* - trainings need to follow the successful Incremental Learning Approach.

Greater recognition of FLW's work in cash and/or kind, relooking at the variability in the FLW's educational qualifications across districts and states and provision of additional refresher trainings to FLWs with lower levels of education will be immensely helpful.

d) **_Ongoing trainings for parents [immediate and on-going]_**

New parent trainings as well as refreshers on technical aspects of ECD along with guidance and counseling should be continued, ensuring long term sustainability.

e) *__Convergence with line departments [medium to long-term]__*

To ensure convergence of departments, clear set of institutional conditions for implementation should be in place and a clear distribution of tasks between partner departments/organizations should be laid down. Staff involved from other departments could then clearly understand the roles and responsibilities of planning, monitoring and reporting and where they converge as well. Other necessary conditions include available human and financial resources and skills and capacities (technical and administrative) which could be leveraged.

f) *__Harnessing digital technology for responsive parenting [immediate and on-going]__*

Innovative technology usage can improve service delivery, enhance supervision and monitoring, and leverage the use of data in decision making. The use of activity content in the form of a calendar during the pandemic period worked well and needs to be studied and expanded as an additional support.

g) *__Interweaving with POSHAN Abhiyan completely to bring AWWs and ASHAs working together as a team [immediate]__*

Given the tremendous benefit of responsive parenting in breast feeding and complimentary feeding, and the synergistic work done by the AWWs and ASHAs as a team, it is critical that responsive parenting be an integrated ECD approach bringing in WCD, health and ICDS together and complementing efforts.

# Chapter

# I

# INTRODUCTION - OBJECT OF THE EVALUATION

# 1. INTRODUCTION – OBJECT OF THE EVALUATION

This report is for the '*End-line evaluation of Space for Kids to be Kids Project in Maharashtra and Rajasthan*', hereafter referred to as the 'Project'. The project aimed at building the capacities of the frontline workers primarily the AWWs and the ASHAs to effectively support parents/caregivers in improving care of children at the household level and in providing opportunities to support early learning in homes. UNICEF India country office (ICO) contracted Athena Infonomics in partnership with DCOR Consulting to conduct the end-line evaluation. This report has been divided into six chapters. The contents of each chapter have been outlined below.

- **Chapter 1:** This chapter describes the broader context of the project and offers insight on overview of the project under evaluation i.e., Object of the Evaluation.
- **Chapter 2:** This chapter presents the evaluation's purpose, scope, objectives and its design.
- **Chapter 3:** This chapter explains the evaluation design, methodology employed, the mechanisms for quality assurance, ethical considerations, the implementation approach, evaluation management and an outline of evaluation team.
- **Chapter 4:** This chapter presents key evaluation findings according to OECD-DAC criteria
- **Chapter 5:** This chapter describes evaluation conclusions and lessons learnt
- **Chapter 6:** This chapter outlines the recommendations based on key findings
- **Annexures:** All necessary supporting details including Terms of Reference (ToR), Evaluation Matrix, sampling details, FLW survey graphs and tables have been included as Annexures. These have been placed at the end of the report.

## 1.1. Background and context

### 1.1.1. Global context

Early childhood (till 6 years of age) is a critical period that affects the holistic development of an individual and determines their ability to reach their optimum health, social, and economic potential. This period shapes the adult life as the cognitive and social skills of a child begin to develop and mature during this time period. Comprehensive development and well-being of children, which consists of physical and mental health, cognitive functioning, and social and emotional development, is strongly interconnected with long-term outcomes of completing school education and learning levels, better livelihood opportunities, and mental health.

Evidence from literature suggests that children from low-income families are more likely to exhibit developmental delays, behavioural problems, and other disabilities than children from wealthier families. Children from vulnerable and disadvantages families are most likely to miss the development milestones in their early childhood due to their extreme exposure to cumulative effects of risk factors, including lack of access to basic water and sanitation facilities, quality health services, nutritional inputs and quality day care and preschool programmes. As a result of these risks, these children are less likely to be enrolled in schools at the right age, which further affects their development. This also results in more likelihood of them attaining lower achievement levels for their age and to have poorer cognitive ability[10]. As per recent

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[10] Vegas, E. & Santibáñez, L. 2010. The Promise of Early Childhood Development in Latin America and the Caribbean. World Bank Publications, The World Bank, number 9385.

global estimates[11], 50 million children aged under 5 (about 43%) in low- and middle-income countries are at risk of not reaching their developmental potential, which can have long-term effects on their cognitive development[12]. The IECEI[13] study by CECED, ASER and UNICEF reported low levels of school readiness but estimated significant positive impact of preschool programmes on school readiness level among children.

Research studies showcase that children from lower-income families face several achievement gaps by the time they reach kindergarten stage. About 175 million children (50%) across the world are not enrolled in pre-primary education during the crucial years[14]. The situation is further aggravated in low-income countries, where only one in every five children has access to pre-primary education. This implies that by the time they start the schooling, they can be two to three years of learning behind advantaged peers. In the Indian context too, data highlights major deficiencies in children's school readiness even when they have attended anganwadi centres of the ICDS or private preschools.[15]  This gap persists and most often widens as the schooling years pass. These gaps can have adverse effects on the overall development of the individual affecting their health, educational outcomes, and financial situation in later life.

However, in case effective interventions are taken in the early years, the probability of offsetting the negative trends are enhanced, thereby providing more opportunities to younger children and better outcomes in terms of access to education, quality of learning, physical growth and health, and overall productivity. Given the ripple effects ECD interventions have over the life span of beneficiaries, these are among the most cost-effective investments a country can make in the human development and capital formation of its people[16].

### *Putting ECD at the core of global policy landscape*

The discourse around Early Childhood Development (ECD) was initiated by the United Nations Convention on the Rights of the Child (UNCRC), General Comment 7 [17]. The UNCRC defines ECD as physical, cognitive, linguistic, and socioemotional development of young children until they transition to primary school (typically around age 6). The right to a child's development has been accepted and embraced by the international community, putting early child development as a key focus area in policymaking globally. The different international protocols and conventions adopted by global players in the development space has been outlined in Figure 1.

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[11] Grantham-McGregor, S, Cheung, YB, Cueto, S. (2007).  Developmental potential in the first 5 years for children in developing countries. Lancet. 369(9555):60-70. doi:10.1016/S0140-6736(07)60032-4.

[12] Black MM, Walker SP, Fernald LCH, Andersen CT, DiGirolamo AM, Lu C, McCoy DC, Fink G, Shawar YR, Shiffman J, Devercelli AE, Wodon QT, Vargas-Barón E, Grantham-McGregor S, Lancet Early Childhood Development Series Steering Committee. Lancet. 2017 Jan 7; 389(10064):77-90.

[13] http://img.asercentre.org/docs/Research%20and%20Assessments/Current/Education/Research%20Projects/IECEIStudyReport2017.pdf

[14] United Nations Children's Fund, A World Ready to Learn: Prioritizing quality early childhood education, UNICEF, New York, April 2019.

[15] http://img.asercentre.org/docs/ASER%202019/conceptnote2019aser.pdf

[16] Heckman, J.J. (2000) Policies to Foster Human Capital, Research in Economics, 54, 3-56, Available online at: http://ideallibrary.com (accessed 27/05/2020).

[17] UN Committee on the Rights of the Child (CRC), General comment No. 7 (2005): Implementing Child Rights in Early Childhood, 20 September 2006, CRC/C/GC/7/Rev.1, available at: https://www.refworld.org/docid/460bc5a62.html [accessed 31 May 2020].

| 1989 | Convention on the Rights of the Child (CRC) | This outlines the basic rights that children everywhere should have: the right to survival; to develop to the fullest; protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. |
| 2000 | Millennial Development Goals (MDGs) | Six of the eight MDGs can best be met if the rights of children to health, education, protection and equality are protected. These efforts helped reduce rates of child mortality by more than half between 1990 and 2015. |
| 2010 | Moscow Framework of action | In the first ever World Conference on Early Childhood Care and Education organised by UNESCO, the stakeholders recommended the governments to take innovative measures to overcome all forms of discrimination and make quality ECCD provision available to children from poor and disadvantaged groups, to children with disabilities, and to marginalised populations as well as those in emergency situations affected by conflict and disasters, with specific focus on reducing gender discrimination. |
| 2015 | Sustainable Development Goals (SDGs) | Children are affected by all of the SDGs, whether poverty (Goal 1), hunger (Goal 2), health (Goal 3), education (Goal 4), gender equality (Goal 5), climate change (Goal 13) or violence against children (Goal 16.2). |

*Figure 1: Key global ECD interventions*

### ECD and SDGs

The Sustainable Development Goals (SDGs), which act as a roadmap for creating a better future, present an opportunity to build on the progress achieved in the field of ECD by providing optimum conditions for children to survive and thrive. The SDGs recognize the link between ECD and equity, productivity, wealth creation, sustainable growth and therefore a brighter and successful future for children. Embedded in the SDGs are targets on malnutrition, child mortality, early learning and violence – targets that outline an agenda for ECD.

Provisioning and strengthening of ECD is key to achieving at least seven of the SDGs on poverty, hunger, health (including child mortality), education, gender, water and sanitation, and inequality. Target 4.2 of the SDGs explicitly focuses on ECD, i.e., "by 2030 ensure that all girls and boys have access to quality ECD, care and pre-primary education so that they are ready for primary education".

The Sustainable Development Goals (SDGs) and the Global Strategy for Women's, Children's and Adolescents' Health have embraced young children's development, seeing it as central to the transformation that the world seeks to achieve by 2030.[18] [19]

Further information on importance and rationale of ECD and global approaches and frameworks has been presented in *Annexure 02*.

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[18] Survive, Thrive, Transform – The Global Strategy for Women's, Children's and Adolescents' Health (2016 – 2030). New York: United Nations; 2015.

[19] Transforming our World: The 2030 Agenda for Sustainable Development. New York: United Nations; 2015.

## 1.1.2. Indian context

In India, according to Census 2011 data, there are 164.48 million children in the age group 0-6 years. While significant progress has been made with regard to maternal and child health over the past decade - infant mortality rates (IMR) are down to 33 per 1000 live births in 2017[20]; the under-five mortality rates (U5MR) have decreased to 37 deaths per 1,000 live births in 2019[21]; maternal mortality rates have fallen to 145 per 100,000 live births; child poverty rates stand at 14%,[22] much more remains to be done as the progress is spread unevenly across the country. Both the level and the rate of improvement of child health in India remain widely unequal. Infant mortality rates in Uttar Pradesh and Madhya Pradesh are more than four times than those of Kerala, while the gap between the most and least vaccinated states is more than 40 percentage points.[23] Even within states, some groups are more vulnerable than others; infant mortality rates for rural children are up to 1.5 times higher than their urban counterparts.

According to Comprehensive National Nutrition Survey[24] (CNNS) 2016-18, over half of all children started to breastfeed in the first hour after birth (57%) and almost three-fifths of children in India were exclusively breastfed (58%) in the six months of life. Over half (53%) of the infants aged 6 to 8 months received timely initiation of complementary feeding.

To stand by its commitment towards early childhood care and development, the Government of India (GOI) rolled out the Integrated Child Development Services (ICDS) Scheme in 1975, the world's largest community-based program. The major beneficiaries identified under the scheme are children in the age group of 0-6 years, pregnant women, lactating mothers, and adolescent girls. Besides ICDS, Government of India also focuses on remediating disadvantaged groups and reducing the inequalities of early childhood.

Further strengthening the policy landscape, the Central Government approved the National Early Childhood Care and Education (ECCE) Policy in 2013 along with the National ECCE Curriculum Framework and Quality Standards for ECCE programme. The policy caters to all children under 6 years of age and commits to universal access to quality early childhood education and integrated development experience. It lays down some priority areas which include early stimulation experiences for children below 3 years; developmentally appropriate, play-based preschool education for the age group 3 to 6 years; and a structured school readiness component for 5- to 6-year-olds. The National Curriculum Framework (2013) defined age-specific curricular objectives for each of the subgroups within the under-six age range and laid out the basic principles of providing age-appropriate, play-based, integrated, experiential, contextual and inclusive teaching-learning experiences. The UNICEF project being evaluated (Space for Kids to be Kids) supports the Government's implementation of the National ECCE Policy adopted in 2013; the policy notes the importance of parental involvement in the care and development of children, which the project interventions aim to support.

### 1.1.1.1.  Key schemes contributing to ECD in India

India has developed important schemes, policies and frameworks that respond to the situation of early childhood development in India, for example, the National Early Childhood Care and Education Policy (2013); The National Early Childhood Care and Education Curriculum(2014); the Samagra Shiksha Abhiyan Framework (2018) and POSHAN Abhiyaan which focuses on first 1000 days, which brings pre-primary

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20 Source: Sample Registration Survey Bulletin- 2019, Ministry of Home Affairs

21 Source: Countdown to 2030- Country Profiles on Early Childhood Development (India), UNICEF

22 Source: Countdown to 2030- Country Profiles on Early Childhood Development (India), UNICEF

23 Adhvaryu, A. et al., 2016- Early Childhood Development in India: Assessment and Policy Recommendations

24 https://nhm.gov.in/WriteReadData/l892s/1405796031571201348.pdf

under the same umbrella as other levels of schooling. Most recently, National Education Policy 2020 underlines the importance of early childhood education and provides guidelines for making pre-primary education compulsory for ages 3-6.

Some of the important schemes and their key objectives have been presented below and are mapped further to the nurturing care framework:

*Table 1: ECD important Schemes and Objectives in India*

| Scheme | Scope | Objective |
|---|---|---|
| **Integrated Child Development Services (ICDS)** | National-level Scheme, implemented by the States targeting children in the age group 0-6, pregnant women and lactating mothers. | • Improving the nutritional and health status of children<br>• Laying the foundation for proper psychological, physical and social development of the child<br>• Reducing the incidence of mortality, morbidity, malnutrition and school dropouts<br>• Achieving effective co-ordination of policy and implementation amongst the various departments to promote child development<br>• Enhancing the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education |
| **Facility-Based New-born and Child Care** | National level scheme implemented by the State Governments | Setting up of facilities for the care of new-born and their mothers such as Special New-born Care Units (SNCUs), New-born Stabilization Units (NBSUs) and New-born Baby Corners (NBCCs). |
| **Janani Shishu Suraksha Karyakram (JSSK)** | National level scheme implemented by the State Governments | It has provisions for both pregnant women and sick new-born till 1 year after birth such as free and zero expense treatment, free drugs, and consumables, free diagnostics & diet, free provision of blood, free transport from home to health institutions etc. |
| **Facility Based Integrated Management of Neonatal and Childhood Illness (F-IMNCI)** | National Level Scheme targeting health personnel at the community and facility level | Aims to empower the Health personnel with the skills to manage new-born and childhood illness at the community level as well as at the facility. |
| **Home Based New-born Care (HBNC)** | National level scheme implemented by the State Governments | Incentivize ASHA (Accredited Social Health Activist) to provide Home Based New-born Care. ASHA will make visits to all new-borns according to a specified schedule up to 42 days of life. |
| **Home-Based Care for Young Child (HBYC)** | National level scheme implemented by the State Governments | It is an extension of the HBNC program to promote evidence-based interventions delivered in four key domains namely nutrition, health, childhood development and WASH (Water, Sanitation and Hygiene). Under HBYC, five additional home visits will be carried out by ASHA with support from Anganwadi workers to promote early initiation of breastfeeding, exclusive breastfeeding till 6 months and continued breastfeeding till the second year of life along with adequate complementary feeding, prevention of childhood Pneumonia and Diarrhoea and to ensure age-appropriate immunization and early childhood development |
| **Poshan Abhiyaan** | National level scheme | Flagship program to improve nutritional outcomes for children, pregnant women and lactating mothers was launched in 2018 as part of the National Nutrition Mission (NNM). Also engages |

| | | |
|---|---|---|
| | | in community outreach and awareness building on issues related to ECD. |
| **Rajiv Gandhi National Creche Scheme for the Children of Working Mothers' (RGNCS)** | National level scheme, implemented in both urban and rural areas by the State governments | The scheme aims to provide quality day-care facilities for children between 6 months-6 years of age. The scheme supports working mothers and aims to promote the holistic development of the child, educate parents/caregivers on better childcare practices and improve the health and nutrition status of the children enrolled. |

### 1.1.1.2. ECD interventions aligned to Nurturing Care Framework[25]

Nurturing care refers to conditions created by public policies, programmes, and services. These conditions enable communities and caregivers to ensure children's good health and nutrition and protect them from threats. The Nurturing Care Framework provides a roadmap for action. It builds on state-of-the-art evidence about how early childhood development unfolds and how it can be improved by policies and interventions. The table below summarizes ECD interventions aligned to the Nurturing care framework-

| Good Health | Adequate Nutrition | Responsive Caregiving | Opportunities for Early Learning |
|---|---|---|---|
| • Family planning<br>• Immunization for mothers and children<br>• Prevention and cessation of smoking, alcohol and substance use<br>• Prevention of mother-to-child transmission of HIV<br>• Support for caregivers' mental health<br>• Antenatal and childbirth care<br>• Prevention of preterm births<br>• Essential care for new-born babies, with extra care for small and sick babies<br>• Kangaroo care for low-birthweight babies<br>• Support for timely and appropriate care-seeking for sick children<br>• Integrated management of childhood illness<br>• Early detection of disabling conditions (such as problems with sight and hearing)<br>• Care for children with developmental difficulties and disabilities | • Maternal nutrition<br>• Support for early initiation, exclusive breastfeeding and continued breastfeeding after 6 months<br>• Support for appropriate complementary feeding and for transition to a healthy family diet<br>• Micronutrient supplementation for mother and child, as needed<br>• Fortification of staple foods<br>• Growth monitoring and promotion, including intervention and referral when indicated<br>• Deworming<br>• Support for appropriate child feeding during illness<br>• Management of moderate and severe malnutrition as well as being overweight or obese | • Skin-to-skin contact immediately afterbirth<br>• Kangaroo care for low-birthweight babies<br>• Responsive feeding<br>• Interventions that encourage play and communication activities of caregiver with the child<br>• Interventions to promote caregiver sensitivity and responsiveness to children cues<br>• Support for caregiver's mental health<br>• Involving fathers, extended family and other partners<br>• Social support from families, community groups and faith communities | • Information, support and counselling about opportunities for early learning, including the use of common household objects and home-made toys<br>• Play, reading and story-telling groups for caregivers and children<br>• Using local language in children's daily care |

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[25] Britto PR, Lye SJ, Proulx K, et al. Nurturing care: promoting early childhood development. Lancet. 2017;389(10064):91–102.

Alignment of the key ECD schemes with the Nurturing care framework, can be further understood, at a glance, in the table below.

*Table 2: ECD Schemes and their alignment to Nurturing Care Framework*

| Schemes | Alignment with Nurturing Care Framework | | | |
| --- | --- | --- | --- | --- |
| | Good Health | Adequate Nutrition | Responsive Caregiving | Opportunities for Early Learning |
| Integrated Child Development Services (ICDS) | ✓ | ✓ | ✓ | ✓ |
| Facility-Based New-born and Child Care | ✓ | ✓ | | |
| Janani Shishu Suraksha Karyakram (JSSK) | ✓ | ✓ | | |
| Facility Based Integrated Management of Neonatal and Childhood Illness (F-IMNCI) | ✓ | | | |
| Home Based New-born Care (HBNC) | ✓ | ✓ | ✓ | |
| Home-Based Care for Young Child (HBYC) | ✓ | ✓ | ✓ | ✓ |
| POSHAN Abhiyaan | | ✓ | ✓ | |
| Rajiv Gandhi National Creche Scheme for the Children of Working Mothers' (RGNCS) | ✓ | ✓ | ✓ | |

## 1.2. Introduction of IKEA ECD Project

### 1.2.1. Space for Kids to be Kids Project

The project "Spaces for kids to be kids" is a project supported by IKEA Foundation to improve early development of children in two states of India – Maharashtra and Rajasthan. The project was initiated in August 2017, in a partnership with the Department of Women and Child Development in the states of Maharashtra and Rajasthan. The pilot phase of the project spanned till first quarter of 2020 with plans to scale up in all the blocks in the intervention districts at the time of evaluation. However, the scope of the evaluation is only the pilot phase of the project. Hence, this evaluation serves two purposes as an endline evaluation of the pilot phase and formative evaluation to integrate the learnings into the scale up process for subsequent phase/s. The project in India adopts a 'system-based approach' and utilizes the platforms available within the ICDS system to reach caregivers. System based approach focuses on utilizing existing government structures - for capacity building of frontline workers (AWW and ASHA); as well as the delivery of quality services including counselling of parents through existing platforms of ICDS; leveraging the ongoing government programmes such as Poshan Abhiyaan, Rashtriya Bal Swasthya Karyakram (RBSK), Home Based Young Child Care (HBYC) and strengthening early childhood education under the umbrella of the ICDS programme.

As foregrounded in the nurturing care framework too, early experiences, including responsive and positive interactions with adults, parents and caregivers, are critical for children's development, growth, and health. Parents play a critical role in facilitating early experiences through the provision of nurturing care, defined as care which ensures health, nutrition, responsive caregiving, safety and security, social-emotional well-

being, and early learning. A wide body of research on infant and childhood development shows that nurturing, responsive and stimulating interactions between young children and their parents and caregivers positively and permanently strengthens the ability to learn with the possibility of changing brain function for life.

*In the context of the current project, parenting can be understood as the interactions, behaviours, emotions, knowledge beliefs, attitudes, and practices associated with the provision of nurturing care which is defined as care which ensures health, nutrition, responsive caregiving, safety and security, social emotional well-being and early learning[26]. The term parenting is not limited to biological parents but extends to any guardian or caregiver providing consistent care to the child. Within the larger programme of strengthening the delivery of ECCE programme through the anganwadi centre - one of the key aspects of the project was to strengthen the parental involvement in childcare.*

The project's strategic thrust was on building the capacity of the frontline workers primarily the AWWs and the ASHAs to effectively support parents/caregivers in improving care of children and in providing opportunities to support early learning at household level. The strategic components of the project included development of training materials, communication packages on parental care; building capacity of the frontline functionaries (AWWs and ASHAs), which includes training and on the job support to enhance their knowledge, attitude and perceptions on parenting care; and use of such learning through various platforms for quality counselling and interaction with the parents/caregivers.

The IKEA Foundation funded project aimed that both boy and girl child have equal access to services for early childhood care and education which will contribute towards ensuring all girls and boys survive, thrive and develop to their fullest potential. The project interventions were designed to emphasize that child-care is not only the responsibility of mothers but also needs the involvement of fathers.

**Selection of districts and blocks**: Select districts[27] in each state were identified for implementation of the project activities. Districts were selected targeting marginalized populations of children (children from tribal groups, children living in urban slums, and children living in rural areas. In each of the selected districts, specific blocks were identified for implementation of the project activities. In each state, blocks within the district were selected based on certain parameters. In Maharashtra, districts have been selected targeting marginalized populations of children (children from tribal groups, children living in urban slums, and children living in rural areas. Further, blocks were selected in consultation with government on the basis of the least number of staff vacancies in ICDS. In Rajasthan, the blocks selected were those with ongoing programme on nutrition/education.  It is to be noted that initially the project activities were proposed to only target Anganwadi workers however, with the launch of POSHAN Abhiyaan and HBYC it became important that ASHAs were also included in the project (in the first half of 2018).

**Integrated ECD**: The integrated ECD project was designed based on UNICEF's - pilot to policy to results-at-scale. In the planned training cascade, the project built the capacity of ICDS and health system functionaries, including frontline workers[28] to raise awareness and build the capacity of parents and caregivers in providing nurturing care, positive parenting and early stimulation to enable them in positively influencing the development trajectory of children in their care. It was expected that the AWW's and ASHA's through interaction with parents, caregivers, and communities, using the available platforms,

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[26] Nurturing Care Framework - a framework for helping children survive and thrive to transform health and human potential was created in response to strong evidence and growing recognition that the early years are critical for human development. https://www.who.int/maternal_child_adolescent/documents/nurturing-care-early-childhood-development/en/

[27] Aurangabad, Palghar, Pune and Yavatmal districts in Maharashtra; Dungarpur and Udaipur districts in Rajasthan

28 AWWs and ASHAs

such as home visits, ECCE Days, VHSNDs, Mothers' meeting and Community Group Meetings, promote early stimulation and positive parenting. ICDS system has been at the center of the whole intervention given its key role in promoting child wellbeing in the country on behalf of the government. For the current project, ICDS supported in terms of making the human resources (AWW supervisors, AWWs) available for the capacity building purposes on nurturing care and responsive parenting, providing high-level inputs and guidance.

The project involved working in select districts in the state, partnering with the government to integrate ECD (stimulation and learning) into the existing programme interventions under Nutrition, Education and Health to promote improved coordination and convergence for holistic ECD. The project aimed to improve service provision and utilization and improve the coverage and quality of counselling and communication support to parents/caregivers to provide nurturing care and early learning opportunities to their children This project is an innovation in India since promoting parental involvement for quality ECD, both in terms of improving their awareness with regards to care and development of their children and increasing demand for quality services, had not been implemented in India.

The project built on the ongoing government programmes for maternal health, nutrition and ECE through ICDS and NHM. For sustainability and to ensure scale up, interventions were designed within the overall governments' capacity development strategy linked to ongoing programmes e.g. POSHAN Abhiyaan, Rashtriya Bal Swasthya Karyakram (RBSK), Home Based Young Child Care (HBYC) and strengthening early childhood education under the umbrella of the ICDS programme.

**Utilization of existing government structures**: In both states, the implementation of activities has been through existing government structures: for capacity building of frontline workers (AWW and ASHA); as well as the delivery of quality services including counselling of parents through existing platforms of ICDS. The ongoing capacity building programme for ICDS officials/ functionaries was done through the Incremental Learning Approach (ILA) and especially for FLWs (Anganwadi Workers or AWWs and ASHAs) using pre-existing platforms of monthly meetings with supervisors. In line with national policy objectives under nutrition, education, and health, the program aims to especially focus on promoting responsive parenting to influence long-term development outcomes for children across the country.

For further details on the project and the implementation modality in both the intervention states, please refer to *Annexure 03*.

## Role of UNICEF

UNICEF continues to play a robust role in improving, supporting, and strengthening the quality of services for children, for example, quality of care and education. It provided technical support for the development of the National ECCE Policy, the National Curriculum Framework and Quality Standards on ECCE, and state feasibility studies. Furthermore, it provided support to develop early learning and development standards for children aged 3-6 years. UNICEF also supported a five-year longitudinal study on early childhood education tracking students from preschool to the early primary grades, completed in 2016. Some of the key findings of the ECE longitudinal study have informed the development of the current project and the need to target frontline workers and parents with information and knowledge on ECD.

For the current project, UNICEF India was the lead technical and resource stakeholder with primary role in project design, providing technical and financial support to partners for the implementation of the project in two states of Rajasthan and Maharashtra, largely in rural areas. The role further involved advocacy with state government partners (Maharashtra and Rajasthan) and building the capacity of government officials and frontline workers to raise the awareness of parents on the importance of ECD and their key role in this regard in two states under the Integrated Child Development Services programme.

Specifically, also through promoting parental involvement for quality ECD, both in terms of improving their awareness with regard to care and development of their children and increasing demand for quality services. The relative importance of the current object of evaluation to UNICEF is very high given ECD is still a new and emerging space within Indian context and the learnings from the current evaluation would be of significant importance for UNICEF's ECD initiatives in India.

## Role of CSO

Civil Society Organisations (CSO)[29] partners were selected to provide technical and monitoring support to the project. They contributed towards development of training materials, communication toolkit for parents of children (0-6 years), monitoring tools, training, supervision and mentoring of frontline workers.

## Role of Government

The government was an important stakeholder and played a role right from the start in different phases of the project. Essentially, ICDS as the main government entity responsible for the nutrition and primary education services to the children in the country, supported in terms of making the human resources (AWW supervisors, AWWs) available for the capacity building purposes on nurturing care and responsive parenting, providing high-level inputs and guidance, supporting in the use of available platforms and integrating training cascade in planned meets. MoHFW as the main government entity responsible for delivering health-related services to pregnant women/ mothers/ children in the country, supported in terms of making the human resources (ASHAs) available for the capacity building purposes on nurturing care and responsive parenting, providing high level inputs and guidance. There were also some blocks In Rajasthan particularly, where the project was implemented exclusively with government support since CSO Partner support in implementation was not available in those blocks.

## Policies/schemes that involve FLWs as implementers

ICDS (Integrated Child Development Services) works under the guidelines and directives of the MWCD (Ministry of Women and Child Development) and has the largest outreach in the form of its Anganwadi Centres (AWC's), seen as centres for integrated and holistic development of the child. The key functionary at the centre is the AWW (Anganwadi Worker) and the Anganwadi Helper (AWH) and provide a comprehensive set of services meeting the health, nutrition and early learning and development needs of children. The AWW also provides support to the frontline functionaries of NRHM (National Rural Health Mission), the ASHA (Accredited Social Health Activist) and ANM (Auxiliary Nurse and Midwife), in delivering health and nutrition services at the community level.

AWW is largely responsible for centre based activity and outreach services. She has a packed portfolio and is the key implementor for many schemes at the community level. Her key responsibilities include –

- **Early Childhood Education:** providing play and activity-based learning for 3-6 year old children including school readiness
- **Supplementary Nutrition Programme (SNP):** Overall responsibility for SNP for 3-6 years, THR (Take home ration) for under-threes and Pregnant and lactating mothers (P&L). Supporting **POSHAN Abhiyaan**.
- Growth monitoring and promotion and use of **MCPC** (Mother-Child Protection Card)
- Care of children who are underweight

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[29] Mahatma Gandhi Institute of Medical Sciences Sewagram, Gram Mangal and Save the Children in Maharashtra and Unnati and Prarambh in Rajasthan.

- **Home Visits:** for home-based counseling and guidance especially for under-threes including Infant and young child feeding **(IYCF)**, Early Stimulation and development, Counseling of pregnant and lactating mothers and supporting **HBNC (Home Based New-born Care) and HBYC** (**Home-Based Care for Young Child)**
- Organizing Village Health and Nutrition Day **(VHND)** with the support of ASHA and AWH.
- Organizing **ECCE Day** to monitor developmental milestones of children (0-6 years) using the MCP card and ECCE Card
- Referrals for medical attention in children and P&L women.
- Participation in Village Health Sanitation Committee **(VHSNC)**
- Creating linkages and collaborate with other sectors especially health, panchayat, education, drinking water, sanitation, etc. for improving health and nutrition status of the community.
- Coordination, facilitation, advocacy, community mobilization and record maintenance too.
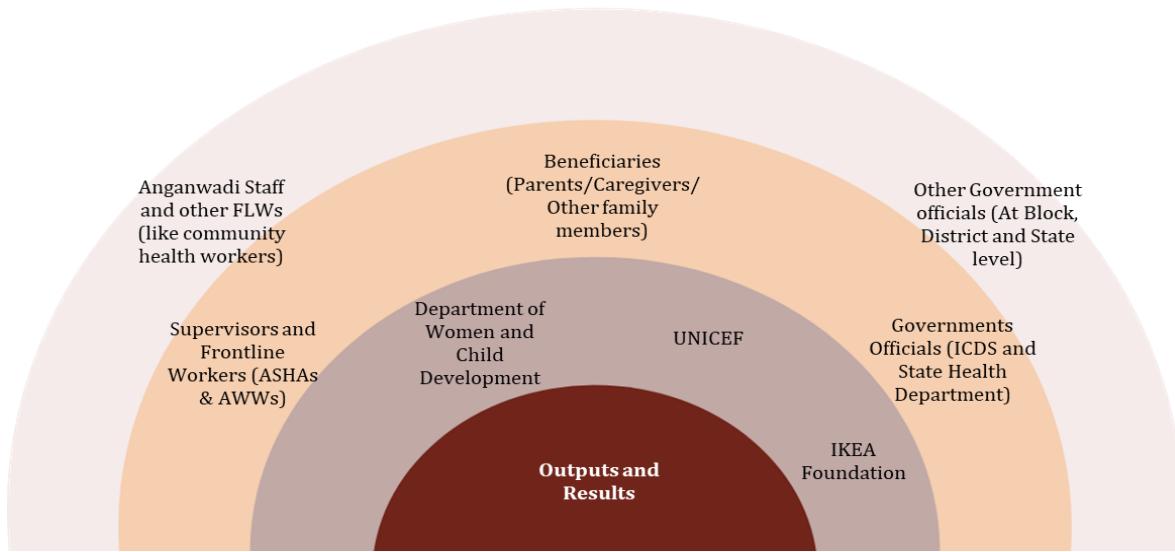
ASHA's as mandated under NHRM, are community level care providers. Their work includes a mix of tasks: facilitating access to health care services, building awareness about health care entitlements especially amongst the poor and marginalized, promoting healthy behaviours and mobilizing for collective action for better health outcomes and meeting curative care needs as appropriate to the organization of service delivery in that area and compatible with her training and skills. They specifically work with pregnant women along with AWW to promote institutional delivery, counsel pregnant women on health, nutrition and schemes like JSY. For newborn, she provides HBNC and HBYC and informs about schemes like Janani Shishu Suraksha Karyakram (JSSK) and ensures they get the benefits and care if the newborn is sick. She also helps families to access Facility Based Integrated Management of Neonatal and Childhood Illness (F-IMNCI) and Facility-Based New-born and Child Care. For children, she arranges VHSND, and plays an important role in management of childhood illnesses and care of undernourished children. Also, anemia control in adolescent girls and convening meetings of VHSNC.

More information related to the project, review of training material/ communication packages and baseline evaluation have been presented in *Annexure 03*, *Annexure 04* and *Annexure 05*.

## 1.2.2. Project beneficiaries, stakeholders and geography

| Space for Kids to be Kids project | |
|---|---|
| **OBJECTIVE** | To build the capacities of the frontline workers primarily AWWs and ASHAs on positive parenting and ECD to effectively support parents/caregivers in improving the care of children at the household level and in providing opportunities to support early learning in homes |
| **STAKEHOLDERS** | UNICEF India, Civil Society Organisations (CSOs)[30], Anganwadi Workers (AWWs), Anganwadi Staff, Accredited Social Health Representatives (ASHAs), other providers (ECD caregivers, community health workers), government officials (district, block, sector), community representatives |
| **TARGET GROUPS (BENEFICIARIES)** | **Primary target group of the project**: FLWs (AWWs/ASHAs)<br>**Ultimate target group**: Caregivers/ parents and children aged 0-6 years |
| **COVERAGE** | *Maharashtra*: Aurangabad, Palghar, Pune and Yavatmal districts<br>*Rajasthan*: Dungarpur and Udaipur |

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30 Mahatma Gandhi Institute of Medical Sciences Sewagram, Gram Mangal and Save the Children in Maharashtra and Unnati and Prarambh in Rajasthan.

Please refer *Annexure 07* for more information on stakeholder mapping.

## 1.3.   Project Theory of Change (ToC)

A generic ToC was available in the ToR. Based on the available ToC and preliminary discussions with UNICEF country and state teams, the Evaluation Team constructed a broad ToC. This retrospectively constructed ToC is very descriptive and thus far from exhaustive programme theory. Pathways were not mapped i.e. from activities to outputs or from outputs to outcomes as it required wider consultations and inputs from programme teams which was out of the scope of the current evaluation. Resultantly, the assumptions associated with the specific pathways are not listed. The Evaluation Team has provided broad assumptions for instance at activity, output, outcome level.

Below we provide the broad ToCs constructed for both the intervention states –

## Maharashtra

| PROBLEM | a) Lack of positive and responsive parenting care (early stimulation; responsive feeding) hinder ECD outcomes; b) Gender discrimination – children are subjected to gendered nurture and care which impact ECD outcomes | |
|---|---|---|
| **Impact** | **All young children survive, thrive and develop to their fullest potential** | **ASSUMPTIONS** |
| **Intermediate Outcomes** | • Improved understanding and practices of parents/caregivers on responsive parenting and early childhood care to create enabling environment for children at home<br>• Improved Early Initiation of Breast Feeding, EBF practices in communities; improved quality and utilization of services<br>• Improved IYCF practices; Improved dietary diversity; Improved nutritional outcomes for children<br>• Improved learning activities at home of children (0-6 years); Improved learning environment for children | • Available tools are used effectively<br>• Parents understand the messages provided by FLWs<br>• Parents are motivated to create a learning environment at home for child<br>• Institutional (govt) support exists |
| **Immediate Outcomes** | • Enhanced utilization of existing resources (Samvedansheel palakatv flip charts, MCP cards, home visit registers, communication tools etc) and platforms by FLWs to orient parents/caregivers on ECD related aspects<br>• Improved quality of counselling and interaction of FLWs with community | |
| **Output** | • Improved capacities of ICDS functionaries and ASHAs; Improved knowledge, skills, practices of FLWs on ECD/responsive parenting<br>• FLWs use tools available/ newly developed (Samvedansheel Palakatv and MCP cards) to orient parents/caregivers in the community (through parents meetings, community based events, Palak Melawa)<br>• FLWs orient the parents/caregivers in the community on positive parenting (early stimulation and responsive feeding) & gender discrimination in ECD context (through messages and demonstrations)<br>• Enhanced confidence of FLWs to interact with community members (particularly fathers)/ demonstrate the messages<br>• Parents/caregivers receive new information on ECD and positive parenting | • Communication tools are available with FLWs<br>• FLWs are motivated to improve their learnings and practices; orient the parents/caregivers in the community<br>• Parents attend the CBE/meetings organized by FLWs<br>• Institutional (govt) support exists |
| **Activities** | • Strengthening of existing platforms (parent's meeting, VHNDs, growth monitoring week, CBE, home visits, family fairs) for delivery of key messages<br>• Trainings in cascading manner (ILA modules)<br>• Supportive supervision for FLWs – providing hands on mentoring support during home visits on pregnancy, child care and early stimulation, HBYC care | • Training materials are developed on time; training schedule is followed as planned<br>• FLWs are available for trainings<br>• Institutional (govt) support exists<br>• AWW supervisors are motivated to provide hand-holding support to FLWs |
| **Inputs/ Resources** | • Training packages for ICDS and health functionaries – IYCF, early stimulation, parental education for early learning and social outcomes<br>• Capacity building support from CSO partners<br>• Existing government resources/ infrastructure (parent's meeting, VHND, growth monitoring week, Community Based Event, home visits, family fairs - *palakmelas*)<br>• *Samvedansheel Palakatv* (responsive parenting) flip charts for communicating messages | • Partnerships with govt/CSO partners are established on time<br>• Needs assessment is completed on time<br>• Institutional (government) support exists |

*Figure 2: Model ToC for intervention in Maharashtra*
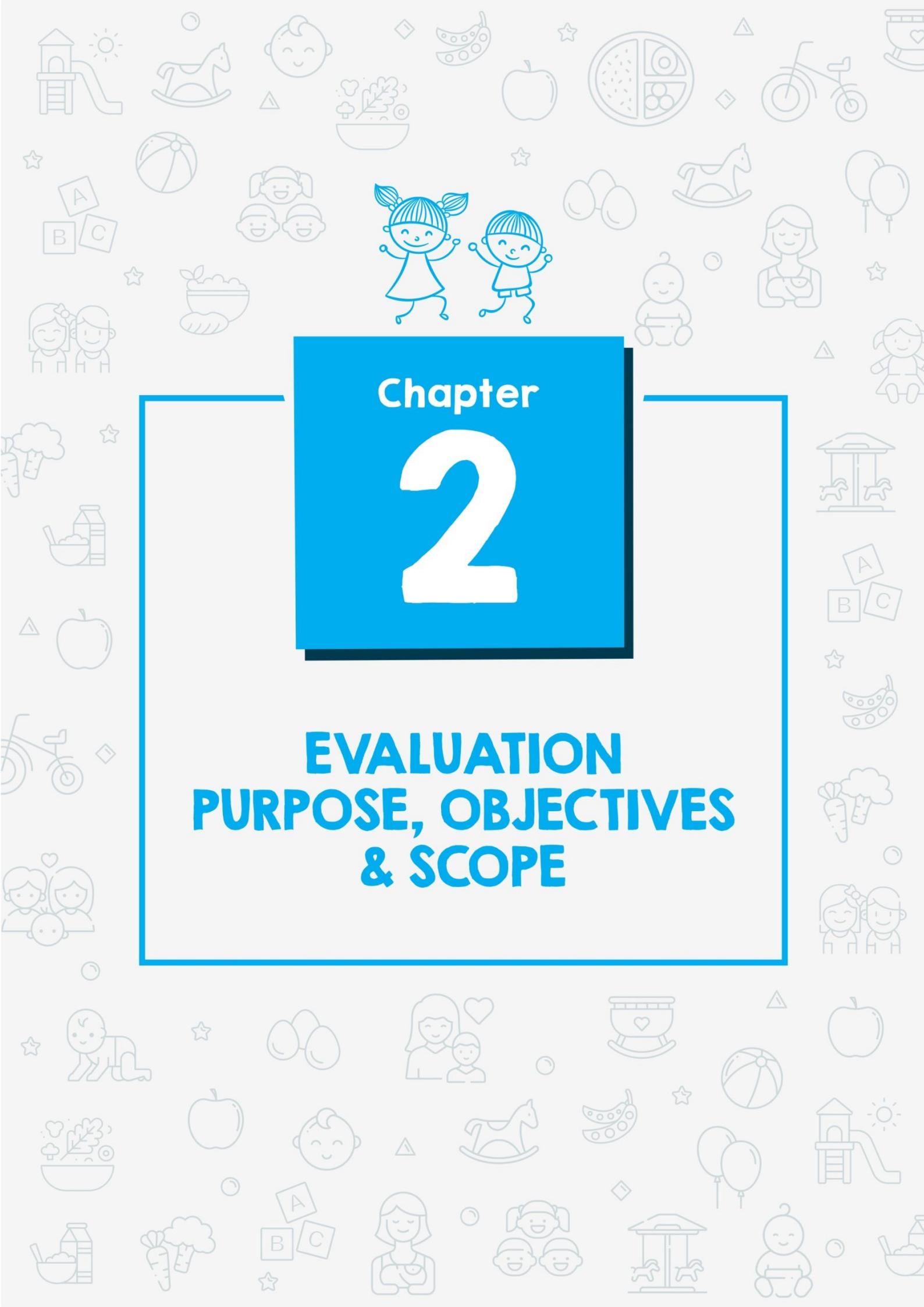
## Rajasthan

| PROBLEM | a) Lack of positive and responsive parenting care (early stimulation; responsive feeding) hinder ECD outcomes; b) Gender discrimination – children are subjected to gendered nurture and care which impact ECD outcomes | |
|---|---|---|
| **Impact** | **All young children survive, thrive and develop to their fullest potential** | **ASSUMPTIONS** |
| **Intermediate Outcomes** | • Improved understanding and practices of parents/caregivers on responsive parenting and early childhood care to create enabling environment for children at home<br>• Improved Early Initiation of Breast Feeding, EBF practices in communities; improved quality and utilization of services<br>• Improved IYCF practices; Improved dietary diversity; Improved nutritional outcomes for children<br>• Improved learning activities at home of children (0-6 years); Improved learning environment for children | • Available tools are used effectively<br>• Parents understand the messages provided by FLWs<br>• Parents are motivated to create a learning environment at home for child<br>• Institutional (govt) support exists |
| **Immediate Outcomes** | • Enhanced utilization of existing resources (Sabrang, MCP cards, home visit registers, communication tools etc) and platforms by FLWs to orient parents/caregivers on ECD related aspects<br>• Improved quality of counselling and interaction of FLWs with community | |
| **Output** | • Improved capacities of ICDS functionaries and ASHAs; Improved knowledge, skills, practices of FLWs on ECD/responsive parenting<br>• FLWs use tools available/ newly developed (Sabrang cards and MCP cards) to orient parents/caregivers in the community (through community meetings, PAM, mother's meeting)<br>• FLWs orient the parents/caregivers in the community on positive parenting (early stimulation and responsive feeding) & gender discrimination in ECD context (through messages and demonstrations)<br>• Enhanced confidence of FLWs to interact with community members (particularly fathers)/ demonstrate the messages<br>• Parents/caregivers receive new information on ECD and positive parenting | • Communication tools are available with FLWs<br>• FLWs are motivated to improve their learnings and practices; orient the parents/caregivers in the community<br>• Parents attend the CBE/meetings organized by FLWs<br>• Institutional (govt) support exists |
| **Activities** | • Capacity building of master trainers (ICDS officials and resource persons from CSOs) on responsive parenting care (early stimulation; responsive feeding)<br>• Training of FLWs (AWWs & ASHAs) on responsive parenting care and safety (monthly sector meetings) by master trainers/CSO Partner<br>• Supportive supervision for FLWs – providing hands on mentoring support during home visits/ CBE on pregnancy, child care and early stimulation | • Training materials are developed on time; training schedule is followed as planned<br>• FLWs are available for trainings<br>• Institutional (govt) support exists<br>• AWW supervisors are motivated to provide hand-holding support to FLWs |
| **Inputs/ Resources** | • Available tools under nutrition programme (MCP cards)<br>• Sabrang cards (tool for engaging parents to create a learning environment at home)<br>• Home visit registers; Manuals for capacity building of FLWs (ILA modules); Model centers at AWCs<br>• Capacity building support from CSO partners<br>• Existing government resources/ infrastructure (FLWs, Lady Supervisor, ASHA, various platforms such as sector meetings, parent anganwadi meetings, home visits, CBE: Annaprashanadivas, Suposhan Diwas, Garbhwastha Paramarsh and mother's meeting) | • Partnerships with govt/CSO partners are established on time<br>• Needs assessment is completed on time<br>• Institutional (government) support exists |

The **outputs, immediate and intermediate outcomes**, and **impact** narratives are similar for both the interventions in Maharashtra and Rajasthan. The program logic slightly differs at the **inputs** and **activities** level in both the states. In Maharashtra, training packages were built on existing ICDS and health functionaries modules such as IYCF, early stimulation, parental education whereas in Rajasthan MCP cards were mostly used. Institutional platforms such as Palakmelawas were used in Maharashtra to reach out to the parents besides other generally used community platforms and in Rajasthan sector meetings were utilized for training of FLWs and community-based events such as Godhbharai and Annaprashan were also used. Samvedansheel palakatv was developed as a communication material in Maharashtra and SabRang cards were developed in Rajasthan.

It is to be noted that the current evaluation stops exploring the results of the project at '*immediate outcome*' level (assessing '*intermediate outcomes*' and '*impact*' are out of the scope of the current evaluation)

Please refer *Annexure 08* for more details on how evaluation team connected some key ToC components to select KEQs/SEQs.

# Chapter

# 2

# EVALUATION PURPOSE, OBJECTIVES & SCOPE

# 2. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

## 2.1. Evaluation Rationale

The evaluation of the 'Space for Kids to be Kids' project was necessary for several reasons. First, it was important to ascertain whether the positive parenting intervention actually worked as intended, and to determine its strengths as well as areas for improvement. Second, there is not much evidence on positive parenting currently available in India, and this evaluation was intended to generate important evidence for early child development in India, where this is still a relatively new area. Third, this evaluation has the opportunity to influence policy decisions, in both Maharashtra and Rajasthan, as well as nationally, using the evaluation findings to support scale-up. Specifically, the findings were intended to generate learnings for the government on the sustainability and scalability of such a systems approach in which interventions for early childhood development were designed within the overall governments' capacity development strategy linked to various ongoing programmes. Aside from the donor requirement, the timing of the evaluation was apt as there is a strong appetite from the concerned state governments to learn from the evaluation findings before strategizing on scaling up in other districts.

## 2.2. Evaluation Objectives

The main objectives of this evaluation are to:

1. Assess the relevance of the project, specifically the role of parental support and involvement to support early childhood development including the support of early learning in the home.
2. Assess the effectiveness of the programme in the select districts in Maharashtra and Rajasthan, specifically in terms of whether it has achieved its intended immediate and intermediate outcomes or not
3. Assess the programme effectiveness from gender and equity perspective; specifically to what extent the programme was able to achieve its gender and equity focus e.g. reach out to vulnerable communities as well as fathers.
4. Assess the efficiency of the programme in terms of utilisation of available resources and timely implementation, and understand where processes can be improved for better programme delivery
5. Capture immediate results of the interventions if any that support pathways to programme impact
6. Determine the readiness for the programme to be scaled up to other districts
7. Assess the sustainability of the programme in terms of ownership of the government
8. Capture good practices and lessons learned

## 2.3. Evaluation Scope - Geographic focus and time period

The evaluation was conducted in four districts[31] of Maharashtra and two districts[32] of Rajasthan, where the 'Space for Kids to be Kids' project has been implemented, between August 2017 - June 2020. In order to assess the changes in knowledge, attitudes and practices (KAP) of FLWs on ECD, those FLWs were chosen for data collection where the parenting intervention has been at least of one-year duration after the training.

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[31] Aurangabad, Yavatmal, Pune and Palghar districts
[32] Udaipur and Dungarpur districts

## 2.4. Evaluation stakeholders, roles, and possible use & users of the evaluation findings
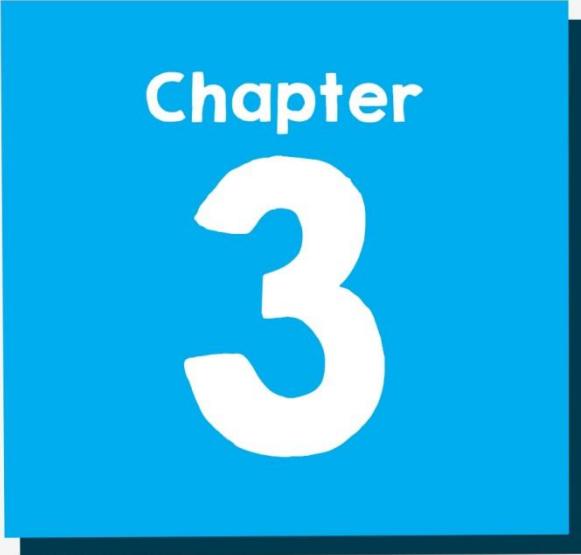
| Stakeholder name | Role | Interest/ Use |
|---|---|---|
| **Evaluation Primary Stakeholders** | | |
| United Nations Children's Fund (UNICEF) India | UNICEF initiated this evaluation and is responsible to steer the overall management (planning, execution, quality assurance in line with UNEG/UNICEF guidelines) of the Evaluation, provide necessary support to the evaluation team in terms of liaising with government stakeholders, CSO partners etc. | To have an objective assessment of *Space for Kids to be Kids project*. This would feed into UNICEF's accountability objectives. Through this formative evaluation, UNICEF wants to learn from the experience to inform future programming.<br><br>From UNICEF programming perspective, the conclusions and recommendations from this evaluation informs UNICEF's support to government, for improving the quality of ECD programmes, with a specific focus on promoting positive parenting for children below the age of 6 years. The dissemination of the findings from the evaluation enables UNICEF to reach out to parents, caregivers, professionals and the larger community and create awareness regarding ECD services with a specific focus on promoting parental involvement in providing nurturing care for their children.<br><br>Further, the evaluation will add to the knowledge base around responsive parenting and ECD at regional and global levels and the learning will help shape future assistance for countries with a similar profile and context. |
| Integrated Child Development Services (ICDS) department (national & state) | To provide access to relevant information of AWWs, documents and data to AWCs; to facilitate evaluators in planning, coordinating and execution of the evaluation. | ICDS department expects that recommendations will provide guidance on improving the parenting practices at home for better ECD outcomes for children.<br><br>The findings from the evaluation will be used to inform the national and state level policy makers and programme planners about improving the quality of ECD services with a specific focus on promoting responsive parenting for children in 0-6-years age-group. |
| **Evaluation Secondary Stakeholders** | | |
| Ministry of Health and Family Welfare (MoHFW) | To facilitate access to the evaluators to relevant data (contacts of ASHAs). | To see how far the cooperation between Health and ICDS systems has worked in joint trainings (in Maharashtra).<br>To highlight approaches and avenues to help improve the engagement of health department in responsive parenting and ECD. |
| Caregivers (mothers/ fathers/ family | Though caregivers were not involved in planning of the evaluation (given its formative nature), however, they hold | To identify the needs of parents and areas where ECD related services could be improved further. |

| members) of children | significance as a key respondent/s for the evaluation | |
|---|---|---|
| Donor agencies, other UN agencies, CSOs/INGOs | Not involved in planning of the evaluation, however, holds significance as a potential partner to further promote and enhance the ECD related initiatives | To understand UNICEF's support to government on responsive parenting for better ECD outcomes for children. The findings, learning and recommendations will guide future funding priorities for the institutional donors interested in ECD.<br><br>The findings from the evaluation contributes to evidence building in India on improving the quality of ECD services with a specific focus on promoting parental involvement. The findings also inform other key stakeholders who are part of the ecosystem, including CSOs, academic institutions who work closely with state governments in improving the quality of ECD services. |

## 2.5. Key deviations from ToR

In view of the COVID-19 pandemic circumstances, there have been some deviations from original ToR. The key deviations from original ToR have been mentioned below:

- As on-field data collection was not possible due to COVID-19 circumstances, evaluation team collected the primary data through remote data collection (via phone surveys)
- Instead of FGDs with the parents/caregivers, IDIs were conducted
- Direct Process Observation was dropped because, due to the COVID-19, observing in-person interactions of FLWs with parents/caregivers was not possible
- Some specific KEQs which were earlier planned to be answered with the help of quantitative FLW survey (as one of the lines of evidence) were answered with the help of IDIs with FLWs (as some questions from FLW survey questionnaire were dropped).
- In order to account for potential non-response rate during remote data collection during FLW quantitative survey, a buffer of 100% was added to original sampled list (Odd and Even sampling strategy)

# Chapter

# 3

# EVALUATION DESIGN, METHODS, QUALITY ASSURANCE, ETHICS, & IMPLEMENTATION

# 3. EVALUATION DESIGN, METHODS, QUALITY ASSURANCE, ETHICS AND IMPLEMENTATION

## 3.1 Evaluation Design

As outlined in the ToR, for this assignment, the evaluation team used *mixed-methods* – quantitative and qualitative approaches. The quantitative line of evidence constituted – FLW survey, and qualitative line of evidence constituted – KIIs with stakeholders, IDIs with FLWs, IDIs with parents/caregivers and case-studies.

Solely depending on the quantitative line of evidence (FLW survey) could not generate a perspective of other key stakeholders (govt officials, project teams, CSO partners, master trainers, parents) as the quantitative study was focused on FLWs. Therefore, to capture the perceptions of the final target beneficiaries (caregivers/parents) a component of IDI was included; KIIs were included to source the insights from key stakeholders; IDIs with FLWs provided qualitative insights and case studies helped in highlighting best practices. Therefore, mixed-method approach was best suited for the current evaluation to assess the contribution of the project better.

The quantitative component (FLW survey) produced evidence on the changes in knowledge, attitudes and practices (KAP) of FLWs regarding ECD and childcare. The qualitative components (KIIs and IDIs) generated valuable information on relevance, appropriateness, acceptability of the interventions, aspects of implementation fidelity and bottlenecks from key stakeholders.

**Evaluation Design**

Given the nature of the current project, a *pre-post evaluation* design was utilized as there was no possibility of selecting a suitable control group for this evaluation (for a quasi-experimental design). The baseline was conducted in last quarter of 2017 and the project started rolling out from early 2018. The current endline evaluation was conducted from Mar/Apr 2020 – Mar 2021 with the data collection spanning from Dec 2020 – Jan 2021. Further, as quantitative component (FLW survey) was limited in establishing contribution (as it was not an RCT/quasi-experimental design), the insights and learnings generated through qualitative lines of evidence (KIIs and IDIs) helped in validating the quantitative findings and supported in establishing preliminary evidence for intervention effectiveness.

## 3.2 Evaluation Methods

The evaluation aimed to understand the following in the context of early childhood development (ECD) in the intervention districts of Rajasthan and Maharashtra with the specific objectives as understood from the Terms of Reference (ToR):

1. *Conduct an extensive review of existing literature* to understand whether the training content developed for FLWs and parents/caregivers on positive parenting was relevant and was of good quality (including gender and equity dimensions); understand linkages between positive parenting and ECD, and to generate good understanding of the role of parenting (especially the best practices) in regions other than intervention states
2. *Conduct quantitative surveys* with FLWs (AWWs & ASHAs) to measure the KAP (Knowledge, Attitudes and Practices) with respect to ECD and positive parenting to understand to what extent the project contributed to improved learnings of FLWs

3.  ***Conduct key informant interviews*** amongst the different stakeholders in the project such as relevant government departments (ICDS, health), members of CSOs, UNICEF staff members, master trainers to understand the implementation of the positive parenting intervention and to assess what has worked and not in terms of achieving intended outputs and immediate outcomes
4.  ***Conduct In-depth interviews*** with – (*a) FLWs (AWWs & ASHAs)* to understand how the training aided in changing their attitudes and beliefs, helped them to address challenges, usefulness of the training provided and to capture suggestions on improvements, and *(b) parents/caregivers* to understand their perceptions regarding the needs being addressed, improvement in the quality of counselling provided by FLWs to them, and key barriers and challenges faced by them to provide care to children.
5.  ***Document key innovations/achievements and challenges*** of the project through specific case studies

## 3.3   Evaluation Criteria and Questions

The evaluation methodology is based on the ***OECD/DAC evaluation criteria[33]*** to answer key evaluation questions. As outlined in the ToR, evaluation team focused on four OECD/DAC evaluation criteria (*relevance, effectiveness, efficiency, sustainability*) except '*impact*' criteria as the impact evaluation is expected to take place at a later stage once the intervention has been running for sufficient time to be able to affect behavior and practices of parents/caregivers regarding positive parenting.

| Criteria and Evaluation Questions |
| --- |
| **RELEVANCE** |
| EQ1: To what extent is the parenting programme delivered by FLWs in the community (hereafter 'the intervention') relevant to the caregivers in selected districts of Maharashtra and Rajasthan? |
| EQ2: To what extent is the training that FLWs receive to deliver the intervention relevant and adequate for the target population (parents/caregivers of child)? |
| EQ3: To what extent is the intervention aligned to the broader objectives of the project |
| EQ4: To what extent is the intervention aligned to the priorities of the government and other partners, specifically the Early Childhood Development strategies and plans? |
| **EFFECTIVENESS** |
| EQ5: To what extent were the inputs or activities of the intervention delivered as planned, specifically: development of communication materials, training materials, training of FLWs? |
| EQ6: What was the quality of the training to FLWs, in terms of content, structure and delivery medium? |
| EQ7: To what extent was the training able to build the skills and capacity of FLWs to counsel and support parents/caregivers on parenting care? |
| EQ8: To what extent did FLWs effectively transfer their learnings to the parents/caregivers on parenting care and creating a learning environment at home? |
| EQ9: To what extent were existing platforms used effectively to reach caregivers for counselling? (e.g. Anganwadi centres and home visits) |
| **EFFICIENCY** |
| EQ10: To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes? |
| EQ11: How the existing government platforms for continuing education and training has been used to bring efficiency? |
| **SUSTAINABILITY** |

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[33] Since during the inception phase, the OECD criteria was just updated, specifically including 'Coherence' criteria was not possible. However, the evaluation questions/ sub-questions with 'Coherence' focus have been highlighted with an asterisk (*).

| EQ12: Is the intervention and implementation modality scalable to other areas of the state? |
| EQ13: Are any of the positive results of the intervention likely to be sustained? |
| EQ14: To what extent there is government ownership to sustain the focus on parenting care for improved ECD services? |

A detailed evaluation matrix has been presented in *Annexure 09*.

## 3.4    Evaluation Methods

### 3.3.1.  Quantitative Research

*Quantitative surveys* were conducted with FLWs (AWWs & ASHAs) to measure the KAP (Knowledge, Attitudes and Practices) with respect to ECD and positive parenting; understand to what extent the project contributed to improved learnings of FLWs and to identify the gaps in the process. The quantitative survey questionnaire was based on the baseline questionnaire to ensure the comparability of results. It is to be noted that due to the COVID-19 pandemic circumstances, all the indicators from baseline FLW survey could not be included due to remote data collection. Evaluation team in consultation with UNICEF program team identified key sections to be included to adapt to remote data collection methodology. The missing indicators were qualitatively assessed with the help of IDIs with the FLWs.

### 3.3.2.  Sampling Plan and sample covered

For purposes of this assessment, a *two-stage cluster random sampling* was used i.e., clustering at district and block level powered to provide state-level estimates. The evaluation team ensured to select FLWs from all the intervention blocks within a district. The team used systematic random sampling to select Anganwadi Centers (AWCs) from a block ensuring the representativeness of geographic typology (rural/urban/tribal). Once the sample of AWCs was arrived, the evaluation team sourced the list of AWWs within those selected AWCs from the UNICEF/ CDPO office. The sample was selected to be reflective of the underlying population of FLWs (proportionate to the FLW population in each intervention district and within each district, proportionate to FLW population in each intervention block). It is to be noted that the endline evaluation did not follow up the same FLWs (cohort) selected during baseline and as such during endline evaluation, the FLW sampling was re-done.

**Eligibility criteria:** FLWs from areas (blocks) where parenting intervention covering children 0-6 years has been implemented for *at least one year*.

A detailed sampling plan for the endline evaluation has been presented in *Annexure 06*.

**Sample Covered**

**Maharashtra**

The number of FLWs interviewed from each intervention district in Maharashtra -

| District | AWW | ASHA |
|---|---|---|
| | **Sample achieved** | |
| Aurangabad | 143 | 68 |
| Yavatmal | 165 | 74 |
| Pune | 131 | - |
| Palghar | 42 | 19 |
| **Total** | **481** | **161** |

**Rajasthan**

The number of FLWs interviewed from each intervention district in Rajasthan for both AWWs and ASHAs has been presented in below:

| District | AWW | ASHA |
|---|---|---|
| | Sample achieved | |
| Udaipur | 251 | 71 |
| Dungarpur | 200 | 70 |
| **Total** | **451** | **141** |

The evaluation team obtained the contact numbers of all the AWCs from the intervention area. Firstly, the AWWs of the selected AWCs were contacted to obtain the appointments. In case AWW from any of the selected primary AWCs was not available, the team replaced the same from secondary/buffer AWCs in each block.

### 3.3.3. Qualitative Research

**Sampling for qualitative assessment**: The evaluation team used purposive sampling for the qualitative data collection to maximize the range of experiences. A detailed process of selection of respondents for qualitative interviews is presented under *Annexure 10*. The Qualitative assessment included two lines of evidences – Key Informant Interviews (KIIs) and In-Depth Interviews (IDIs). Evaluation team included 'case studies' (wherever possible), as this depended on availability of the case study participants due to remote data collection strategy. The details of each qualitative line of evidence is provided in subsequent sections.

The aim of the KIIs and IDIs was to determine the relevance/ appropriateness/ acceptability of the interventions, implementation fidelity and any bottlenecks as perceived by the key stakeholders.

### 3.3.3.1.    Key Informant Interviews

The qualitative assessment focused on the six intervention districts [34]. To gain a comprehensive understanding of the current multi-sectoral approach of the intervention and its immediate outcomes, key informant interviews (KII) were undertaken with relevant government departments (ICDS, health, education), members of CSOs, UNICEF staff members, master trainers.

*Key informant interviews* were held in order to gather insights on the reach and effectiveness of the overall project with a focus on what has worked and not in terms of achieving intended outputs and immediate outcomes. Evaluation team consulted UNICEF State teams (Maharashtra and Rajasthan) and CSO partners to come up with a list of KII participants.

Below table provides a brief snapshot of KIIs participants covered:

| State | Respondent group | No. of KIIs done |
|---|---|---|
| Maharashtra | UNICEF | 2 |
| | Government Officials | 14 |
| | CSO Partner | 3 |
| | Master trainers | 14 |
| Rajasthan | UNICEF | 2 |
| | Government Officials | 2 |

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[34] Aurangabad, Yavatmal, Pune & Palghar in Maharashtra and Udaipur and Dungarpur in Rajasthan

| | | |
|---|---|---|
| | CSO Partner | 1 |
| | Master trainers | 16 |
| | **Total** | **54** |

KII study tool was developed with a focus on answering the key questions mentioned in the Evaluation Matrix.

### 3.3.3.2. In-Depth Interviews (IDIs)

In addition to the KIIs, evaluation team conducted **IDIs** in the six intervention districts with – a) **FLWs (AWWs and ASHAs)** to qualitatively explore utilization of available institutional platforms/ communication tools/ materials, challenges and barriers in reaching out to community, changes in cultural beliefs and attitudes, capacity building needs, and b) **parents/caregivers** of the children to explore their perception regarding the quality of services delivered. It is to be noted that since the project envisaged to engage fathers in parent meetings conducted by FLWs, we conducted about 25% of the IDIs exclusively with fathers of children.

**a. FLWs (AWWs & ASHAs)**

A brief snapshot of the IDIs conducted with FLWs is provided below:

| State | AWWs | ASHAs |
|---|---|---|
| Maharashtra | 16 | 12 |
| Rajasthan | 18 | 12 |
| **Total** | **34** | **24** |

Only those FLWs who reported that they received training during the quantitative survey have been included in the qualitative interviews.

**b. Parents/caregivers**

A brief snapshot of the IDIs conducted with parents/caregivers is provided below:

| State | Mothers (0-3 child) | Fathers (0-3 child) | Mothers (3-6 child) | Fathers (3-6 child) |
|---|---|---|---|---|
| Maharashtra | 4 | 8 | 8 | 4 |
| Rajasthan | 3 | 6 | 6 | 3 |
| **Sub-Total** | **7** | **14** | **14** | **7** |
| **Total** | **42** | | | |

IDI guide was developed with a focus on answering the key questions mentioned in Evaluation Matrix and building on the baseline tool. For further details on the selection process for FLWs and parents, please refer to *Annexure 10*.

### 3.3.4. COVID-19 Implications

Initially, the evaluation team planned to collect all the primary data in person on the field. But, due to unexpected circumstances created by the COVID-19 pandemic, in-person on the field data collection was not possible. Therefore, the evaluation team in consultation with UNICEF Country and State offices decided to collect all the primary data remotely (via phone survey).

Following the decision to collect all the primary data remotely, the evaluation team adapted the study tools and evaluation design (in consultation with UNICEF ICO and state offices) to account for possible risks involved in the remote data collection strategy. The following necessary revisions/ adjustments were made during the inception phase to adapt the evaluation to remote data collection strategy –

- The FLW quantitative tool which was quite lengthier was trimmed down to optimal level with an objective to complete the interview via phone survey within 30-35 minutes

- Additional line of evidence – *IDIs with FLWs* was added to qualitative answer the questions dropped during the FLW quantitative tool trimming process

- Further, the FGDs planned with parents/caregivers (0-3 and 3-6 child) was replaced with IDIs

- The evaluation team in consultation with UNICEF ICO and state offices created a matrix mapping quantitative and qualitative lines of evidence with KEQs/SEQs to strategically spread the information across the respondents which helped in tailoring the study tools to each respondent strategically

For further details on COVID-19 adaptations, pilot testing of tools and lessons learnt, please refer to *Annexure 11*.

## 3.5    Analysis Approaches

**Quantitative data analysis**

All tabulations of the FLW quantitative survey were based on a variety of stratifications, i.e. disaggregation by State, type of respondent (AWW and ASHA), and type of area (rural/urban/tribal) for all key areas of the investigation – Knowledge, Attitudes and Practices of FLWs. Output tables (by sub-groups) were generated for the purpose of reporting findings in the report. Initial analysis will be done in **STATA** to generate proportions, frequency tables and cross-tabulations.

*Contribution analysis*

It is to be noted that the endline evaluation did not follow up the same FLWs (cohort) selected during baseline evaluation and for endline evaluation, sampling was re-done.  Findings from end-line for Maharashtra was comparable with baseline as the geographic scope from baseline and end-line hasn't changed and the sampling strategy used during baseline and endline are similar. Further, as the current evaluation was not an RCT, in addition to the quantitative FLW survey, the evaluation team used qualitative lines of evidence (KIIs and IDIs) to identify contribution in Maharashtra. Further, the demographic characteristics (religion, social category and education) of FLWs across baseline and endline were quite similar in both the states (refer to Figure 25, 26 and 27 in *Annexure 17*).

A pre-post comparison analysis of quantitative data from FLW survey for Rajasthan was challenging because:

- During the baseline only about 200 FLWs (150 AWWs and 50 ASHAs) were interviewed in two intervention districts of Rajasthan
- These 200 respondents were spread across 24 blocks of two intervention districts (14 blocks in Udaipur and 10 blocks in Dungarpur) during baseline
- For the current evaluation, since the evaluation team considered only blocks where the intervention has been at-least for a year, the team was able to select respondents from 8 blocks only from the two intervention districts (5 in Dungarpur and 3 in Udaipur) – therefore, the results of evaluation comparing the two different geographic scopes during baseline and end-line must be interpreted cautiously

We explored the evidence from qualitative lines of evidence as well and tried to assemble, assess and strengthen the contribution narrative. It has to be noted that 'contribution analysis' does not seek to conclusively prove whether, or how far, the intervention has contributed to a change or set of changes. Instead, it seeks to reduce uncertainty. Therefore, the aim was to produce a plausible, evidence-based narrative that a reasonable person would be likely to agree with.

Also please note that the results from the quantitative findings cannot conclude attribution or contribution completely to the project and must be interpreted cautiously

**Qualitative data analysis**

To analyse the qualitative data (KII /IDIs), the evaluation team used a blended approach of thematic and content analysis to identify key themes and trends occurring in the responses. The qualitative data from the KIIs and IDIs was analysed in RQDA software through transcripts developed from the recordings during KII and IDI sessions. Subsequently, data was summarized, coded and categorized into themes (data reduction) to understand points of agreement and contention among different stakeholder groups. Continuous iterative revision of texts was carried out to identify and code the main patterns and categories in the data. Eventually, the data was organized, interpreted and synthesized into conclusions (data display).

A detailed analysis approach to report findings is presented in *Annexure 13*.

## 3.6    Quality Assurance – Field Work and Data Collection Procedures

**Field Protocols**

The list below highlights the key considerations and/ or measures taken to ensure quality of all data collection processes (FLW survey, KIIs, IDIs) and during data consolidation, analysis and reporting phases. A more detailed information on the primary data collection, quality assurance mechanism is presented in *Annexure 10*.

- **Pre-testing of tools**: All tools were pre-tested and modified appropriately, before full-scale application.
- **Extensive training**: All the data collection team members deployed for data collection underwent an extensive training led by the ECD expert and evaluation team members.
- **Deployment**: It was ensured that only those members who received complete training were deployed for primary data collection
- **Audio recordings:** Audio recordings of all the data collection processes (FLW survey, KIIs, IDIs) were secured with prior permission from the respondents/ participants. Later, all the qualitative data (KIIs and IDIs) was transcribed, cleaned, coded, categorized, and processed for analysis purposes.
- **Appointments:** Appointments for interviews were secured from all respondents/ participants in advance
- **Confidentiality and anonymity:** Confidentiality and Anonymity of the data was ensured by – a) respondent's identity was separated from the datasets, b) identifiable information was erased immediately after completion of data cleaning, and c) only designated and authorized team members had access to datasets during data processing and analysis
- **All cultural, social and gender norms** of the areas/ communities interviewed were respected completely.

A detailed note on remote data collection, challenges, mitigation measures and lessons learnt has been provided in *Annexure 11*.

## 3.7    Potential Risks and Mitigation Measures

| Risk type | Risk assessment | Proposed mitigation measures |
|---|---|---|
| Appropriate Methodology | Medium risk | • Maharashtra: Robust sampling ensured the sample of FLW for quantitative interview selected provides state-level estimates<br>• Rajasthan: For Rajasthan, the evaluation relied more heavily on the qualitative lines of evidences (KIIs, IDIs, and case-studies)<br>• Adjusting for non-response rate (by increasing the sample size to account for non-response)<br>• Participants for KIIs, IDIs were selected upon consultations with client, implementation partners, and local level govt officials<br>• Sensitive treatment of refusals or 'don't know'<br>• Using standard and calibrated model question sequence |
| Researchers and translators | Low risk | • Researchers and translators were carefully selected and appropriate to the context, including consideration of any gender or religious sensitivities. The level of researchers selected for the data collection was higher than the standard household surveys<br>• All research staff received rigorous training in interviewing techniques and had appropriate communication skills with respect to vulnerable and at-risk populations |
| Support from government functionaries (Health, ICDS, education) | Medium risk | • Support from state level and district level officials was sought before the initiation of the study<br>• The research objectives were clearly communicated at the start of the primary data collection to alleviate any misinterpretation by the local government officials<br>• Ensured data confidentiality and communicate standard data governance policies |
| Safe and appropriate space for participants | Low/Medium risk | • Participants were made to feel safe and not intimidated by the interviews – through a clear and detailed rapport script. |
| Time and seasonality | Low risk | • Surveys were undertaken considering the sensitivity to timing (time of the interview, duration, school hours, holidays, festivals, months were FLWs are engaged in special programs, etc) as well as the seasonality of work of parents/caregivers (times of harvest, peak manufacturing seasons, etc). |

| Management of data | Low risk | • All data collected were kept in a secure manner and keeping with the requirements for anonymity, delinked from participants of the research.<br>• Particular consideration was given to the risks associated with the digital collection of data, including privacy and security |
|---|---|---|
| Low recall of FLWs | Medium risk | • Locally used terms (as proposed by UNICEF) were used to help FLWs identify/recall the trainings received as a part of the project to minimize the risk of recall<br>• FLWs were probed multiple times and were provided adequate time to recollect the trainings received with the aid of locally used terms<br>• It was ensured that enumerators are well trained |
| Sampling for qualitative interactions (IDIs) of FLWs and parents/caregivers | Medium risk | • In order to minimize the risk of selection bias in selecting FLWs and parents for IDIs, appropriate methodology was deployed to minimize the risk of bias in selection of participants for IDIs and maximize range of experiences.<br><br>Further details on sample selection process of qualitative participants have been presented under **Annexure 10**. |

## 3.8    Ethics and UNEG guidelines

The current evaluation is grounded in the ethical research frameworks on protecting human subjects. The evaluation team adhered to 'UNICEF procedure for ethical standards in research, evaluation, data collection and analysis' on independence, impartiality, credibility, conflicts of interest and accountability.

*Informed Consent*: Informed consent of the participant in the fullest meaning, including genuine choice, and is central to the surveys. The right to say applies to both adults and children, and the interviewers were trained to explain the participants that they are free to refuse to participate or to answer certain questions. During the remote data collection, verbal consent was obtained by the enumerator over the phone for both recording and conduct of interview. In case the participant denied consent for recording but provided consent for the interview, then the team proceeded without recording the interview. In cases where the participant did not consent to participate in the interview, such participants were not included in the evaluation.

*Do No Harm*: The principle of non-maleficence is sacrosanct to avoid harm to the human subjects of the research, both through acts of commission or omission. Extensive training of the field enumerators with clear instructions for engagement and exit strategies in case of even perceived harm during the process of data collection was inbuilt into the methodology. Further, inorder to reduce the time required to complete the administration of study tools within 30 mins, the evaluation team trimmed down some select sections and adapted the study tools to remote data collection strategy. This was done in consultation with the UNICEF team and the revised tools were rigorously pilot-tested twice for flow, clarity and the time taken by the tools to strengthen the flow of the tools and also to ensure that the tools/ guides won't take more than 30 mins.

*Respect and Justice*: The principle of respect implies valuing humans including children and their lived realities. It requires recognition that their decisions exist within broader personal, relational, social, cultural, legal and environmental contexts.

*Privacy and Confidentiality*: Privacy and confidentiality are critical considerations in the ethical collection of data on individuals. Risks associated with privacy and confidentiality was considered throughout the research process. The informed consent process was physically separated from transcriptions and surveys. With regards to the collection, transmission, storage, analysis, and destruction of data, clear and strict security protocols were developed, minimizing those who have access, ensuring physical or electronic safeguards, and encryption keys, methods of destruction of the data, including the security of the cloud storage. All the respondents were clearly informed that the information they provide will only be used for the evaluation purpose and no individual data will be shared externally in any form and is completely confidential. It was stressed that the analysis will be done at an aggregate level only.

All information gained from the interviews was treated in a confidential way. To protect the confidentiality, the records contained no names or personal identifiers. Throughout, care was taken not to raise expectations on the potential benefits that participants would gain from the project.

Further, during the quantitative FLW survey, evaluation team explicitly mentioned that participants will not face any disciplinary consequences as a result of participating in the study. Evaluation team emphasized the formative nature of the exercise and clearly conveyed that the learning will be used to improve the trainings provided to FLWs. The evaluation team undertook an ethics training/course provided by UNICEF course on ethics in evaluations.

On the sensitive topics related to parenting, in order to reduce the risk for discomfort, the evaluation team clearly indicated this for the prospective participants, so that those who may not want to discuss personal matters can choose not to participate. In addition, team emphasized that those who decided to participate can choose to withdraw from the study at any time without any explanation, refrain from answering a specific question, or refrain from engaging in any activity that makes them uncomfortable.

*COVID*: UNICEF has stopped all in-person data collection during COVID-19 and the evaluation team adhered to this by collecting all the primary data remotely (via phone surveys).

### 3.7.1. Evaluation standards

The evaluation design and implementation has compiled to the ethical standards and quality assurance standards and guidelines as per UNICEF[35] and UNEG[36] guidelines.

**Compliance to UNEG/ UNICEF Ethical Norms, and UNEG Guidelines**

The evaluation team ensured strict compliance with 'UNEG Norms and Standards (2017)' during all stages of evaluation (inception, design, tools development and testing, data collection & analysis, and reporting/dissemination).  The key considerations included:

- Independence, impartiality, and credibility of evaluation judgements
- Accountability and utility of evaluation
- Respect and protection of the Human Rights and Gender Quality

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[35] Unicef procedures for ethical standards in research, evaluation, data collection and analysis, 2015 (https://www.unicef.org/media/54796/file)

[36] Norms and standards for evaluation (file:///D:/Athena%20Infonomics%20-%2008012021/MLE%20projects%20-%20Athena/UNICEF%20India%20-%20ECD%20Evaluation/ Endline%20Report%20Writing/UNEG%20and%20UNICEF%20gudielines/UNEG%20Norms%20&%20Standards%20for%20Evaluation _English-2017.pdf)

All evaluation team members undertook the UNICEF course on Ethics – '*Introduction to Ethics in Evidence Generation*'. The evaluators were well acquainted with and applied all reporting standards (content, structure, presentation, completeness, quality of evidence etc.) as prescribed in 2017 UNICEF adapted UNEG Evaluation Reports standards (2015), UNICEF Global Evaluation Report Oversight System (GEROS) Handbook[37].

**Integration of gender and equity in the evaluation**

The evaluation used a gender/equity responsive methodology. For the FLW quantitative survey, since the sampling population was completely female (AWWs and ASHAs), there was no need for any gender related consideration in the methodology. However, on the equity side, evaluation team included FLWs from all the different geographical regions – rural/tribal/urban in the FLW quantitative survey. For the IDIs with parents/caregivers, equal number of fathers and mothers were included in the IDIs to source perspectives of both. Also, care was taken to select respondents for caregiver interviews to be presentative of different social categories and from rural/ tribal/ urban areas.

Also, only female interviews were deployed for the interviews with FLWs and caregivers. During the analysis, disaggregation by rural/ tribal/urban areas has been take care of and for the IDIs with caregivers, qualitative analysis was done separately for both fathers and mothers and the results presented accordingly in the findings section.

Although evaluation did not focus on exploring the children with disability, however, some questions were included in the FLW survey on child disabilities (seeing, hearing).
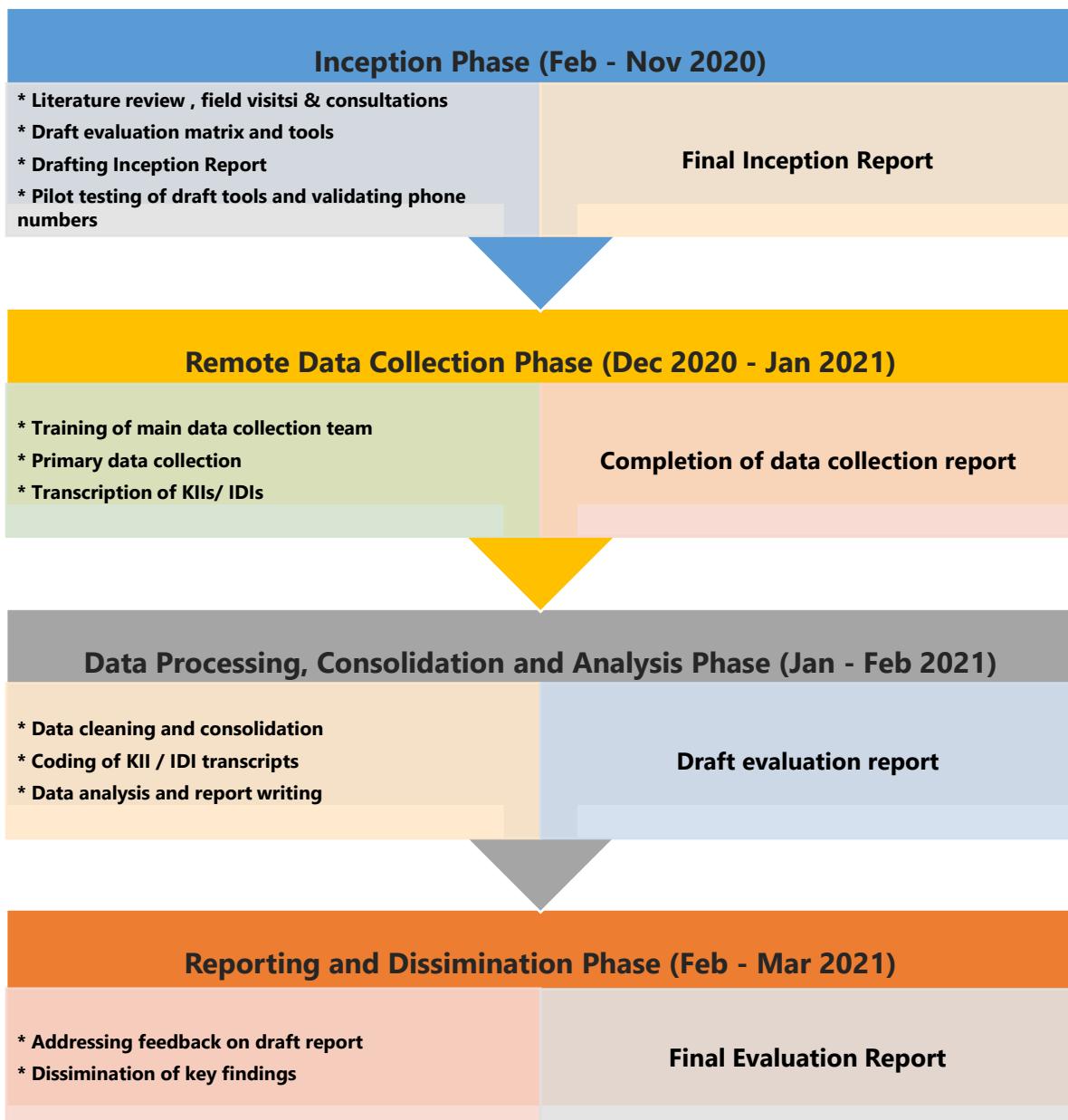
## 3.9   Evaluation Implementation

The 'Participatory' approach remains the hallmark of the evaluation. This implies that all key stakeholders such as implementing partners (CSOs), frontline workers (AWWs and ASHAs), communities and UNICEF country office staff and state office staff (Maharashtra and Rajasthan) were consulted during different phases of the evaluation.

The evaluation followed a linear approach comprising of four phases. Each phase included activities contributing to evaluation deliverables. The visual below shows key phases of the evaluation, timeline and associated deliverables. The evaluation was undertaken from Feb 2020 to Mar 2021.

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[37] https://www.unicef.org/evaluation/media/1381/file/GEROS%20Handbook.pdf

## Inception Phase (Feb - Nov 2020)

* Literature review , field visitsi & consultations
* Draft evaluation matrix and tools
* Drafting Inception Report
* Pilot testing of draft tools and validating phone numbers

**Final Inception Report**

## Remote Data Collection Phase (Dec 2020 - Jan 2021)

* Training of main data collection team
* Primary data collection
* Transcription of KIIs/ IDIs

**Completion of data collection report**

## Data Processing, Consolidation and Analysis Phase (Jan - Feb 2021)

* Data cleaning and consolidation
* Coding of KII / IDI transcripts
* Data analysis and report writing

**Draft evaluation report**

## Reporting and Dissimination Phase (Feb - Mar 2021)

* Addressing feedback on draft report
* Dissimination of key findings

**Final Evaluation Report**

## 3.10   Evaluation Management

The evaluation was steered and supervised by the 'Evaluation Reference Group (ERG)'. From UNICEF India Country Office (ICO), the evaluation was facilitated and managed by the 'Monitoring and Evaluation Specialist' and 'Quality Assurance Manager'. The Nutrition and Education Specialists from ICO provided technical inputs during the evaluation. UNICEF state offices (Maharashtra and Rajasthan) provided supported and facilitated access to stakeholders.
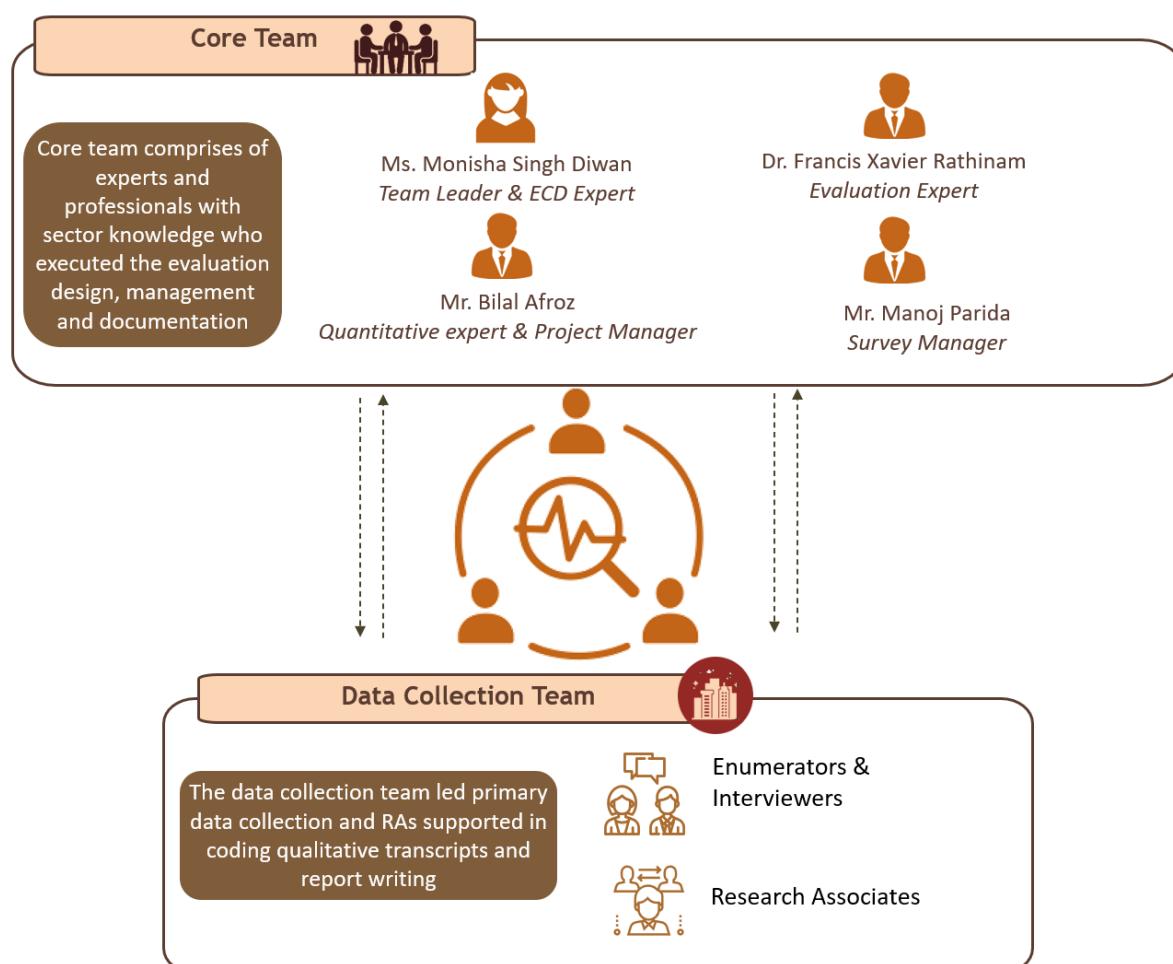
Athena Infonomics India Pvt Ltd was recruited to lead the evaluation as 'Independent Evaluator'. Athena Infonomics as lead contractor planned and implemented the evaluation. For the purpose of this evaluation, Athena onboarded an ECD expert and partnered with DCOR Consulting for primary data collection. DCOR as a partner led the primary data collection by arranging local resources and coordinated the primary data collection. For more details on the core evaluation team members and roles, please refer *Annexure 12*.

## 3.11  Limitations of the evaluation

- Since the current evaluation was based on a before-after study design, results from the quantitative findings cannot conclude attribution or contribution completely to the project and must be interpreted cautiously
- The sampling strategy of selecting about 50% of FLWs who are in the project for around 2 years and selecting about 50% of the FLWs who are in the project at-least for a year was not possible due to programmatic constraints/modalities thereby limiting the scope of reasonably linking (attribution or contribution) of findings to the project
- A pre-post comparison analysis of quantitative data from FLW survey for Rajasthan was challenging because:
    o During the baseline only about 200 FLWs (150 AWWs and 50 ASHAs) have been interviewed in two intervention districts of Rajasthan
    o These 200 respondents were spread across 24 blocks of two intervention districts (14 blocks in Udaipur and 10 blocks in Dungarpur) during baseline
    o For the current evaluation, since the evaluation team considered only blocks where the intervention has been at-least for a year, the team was able to select respondents from 8 blocks from the two intervention districts (5 in Dungarpur and 3 in Udaipur) – therefore, the results of evaluation comparing the two different geographic scope during baseline and end-line must be interpreted cautiously
- Absence of project theory of change (ToC)/logic model or project performance measurement framework before the initiation of project limits assessment of achievement/progress of results concretely. However, the available generic ToC was reconstructed during inception phase in a retrospective manner. Wherever possible, an attempt has been made to align the outputs and immediate outcomes with the KEQs/ SEQs.
- Assessing the sustainability of the intervention from the cost-benefit perspective is out the scope of the current evaluation
- Since due to COVID-19 circumstances, some of the sections from FLW quantitative survey has been dropped, the KEQs related to these dropped sections were answered qualitatively only

# Chapter

# 4

# KEY EVALUATION FINDINGS

# 4. KEY EVALUATION FINDINGS

## 4.1. Relevance
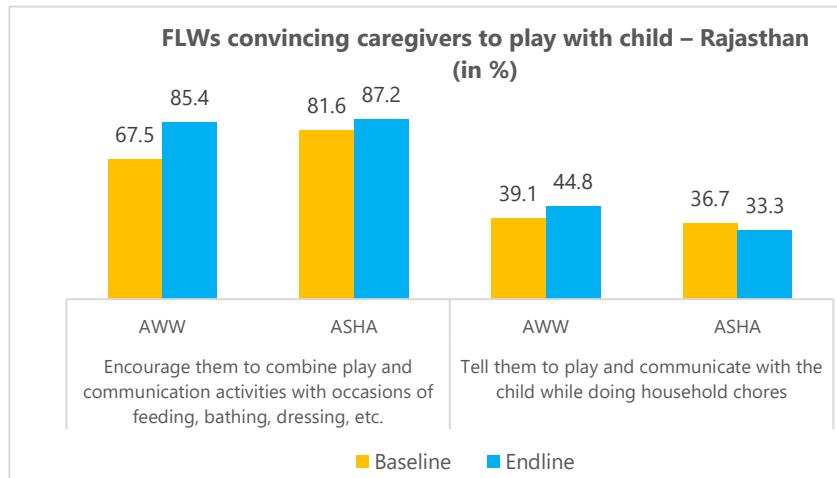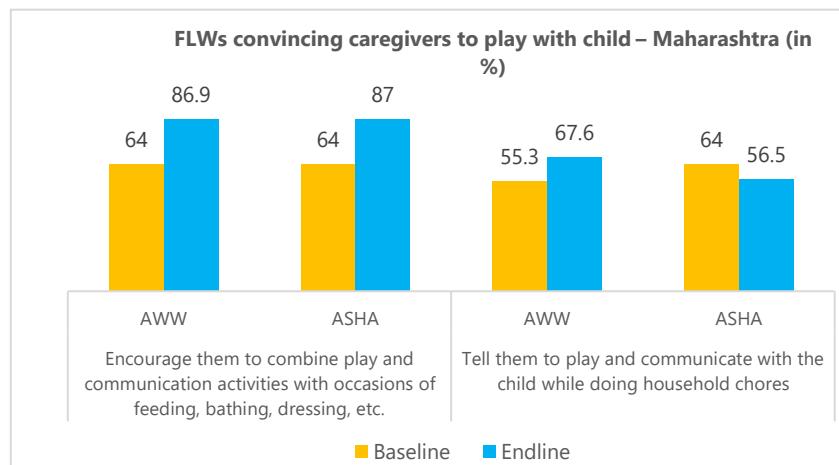
**EQ1: To what extent is the parenting programme delivered by FLWs in the community ('the intervention') relevant to the caregivers in selected districts of Maharashtra and Rajasthan?**

*SEQ 1.1: What needs of parents/caregivers are being addressed and how well?*

The parenting project is addressing the most pressing needs of parents with regard to child development and care. The intervention strives to build the capacity of frontline workers to enable them to deliver quality early childhood development (ECD) services to parents and other caregivers.

Discussions reveal that parental needs regarding the care and development of children center around providing proper nutrition, maintaining health and hygiene, taking care of children and engaging in play activities. While a majority of the parents are able to fulfil needs related to nutrition, health and hygiene, gaps exist in the knowledge and practices regarding other important aspects of early learning and responsive parenting.

To bridge this gap, frontline workers are acting as an important communication channel to disseminate vital information to the communities. Being residents of the same villages enables them to interact freely with families, providing requisite information.



FLWs convincing caregivers to play with child – Maharashtra (in %)



FLWs convincing caregivers to play with child – Rajasthan (in %)

Most of the caregivers (especially mothers) note that meetings with frontline workers have helped increase their understanding regarding different aspects of ECD such as parent-child interaction, play and stimulation, child discipline, immunization, nutrition and feeding practices, health and hygiene, education, and has increased the level of engagement with their children. One of the most important aspects of the intervention has been its focus on the social and emotional needs of the child, and frontline workers have been educating more and more caregivers regarding its importance for holistic development.

As can be observed in the figure above, there have been improvements in terms of FLWs encouraging caregivers to combine play and communication activities with occasion of feeding, bathing, dressing etc. and counselling parents to play and communicate with the child while doing household chores.

During the interviews, many parents (especially mothers) reported being satisfied with the counselling provided by the FLWs and were happy to see the changes in their child's growth and development after adopting ECD practices. However, this was more of a qualitative reflection from the caregivers and could not be substantiated with any other quantitative data as the current evaluation only included qualitative interviews with caregivers.

*Earlier we were not so worried about cleanliness but after knowing its importance we are now more aware. (Father of 0-3 years old, Dungarpur)*

*The counselling (provided by AWW) on childcare and development was quite helpful. We learnt about various needs of the children and the ways to handle their problems and how to better communicate with them. (Mother of 3-6 years old, Pimpri, Pune)*

*I am completely satisfied with them (AWW/ASHA). Because of them I was able to know how we should take care of the child, how to feed them. They told us what we should feed our child so that they would grow and when we feed that to our child, we see the result. (Mother of 0-3 years old, Girwa, Udaipur)*

*I received counselling regarding taking care of children, to give emphasis on their games and sports, to take care about their food, to give them vaccines on time, like for polio, to play with them, to take care of them, not to leave them alone and to feed them with our hand. (Mother of 0-3 years old, Girwa, Udaipur)*

*Children are emotionally attached with their parents. Mother is the first teacher of a child. She can teach those things which a teacher cannot teach. Family is the first school of a child. A child enters the school at the age of 5 but a mother can teach a child from a very early age. (District government official, Aurangabad)*

*For a long time, we have been providing messages to the parents, and creating awareness, but we weren't getting the exact output in a way we wanted. Because the parents were not aware about how to apply their knowledge in practice for their kids, and that is exactly what we are doing in ECD. (District government official, Aurangabad)*

### SEQ 1.2: Are other relevant caregivers in the household also being addressed?

The responsibility for the care and development of children does not lie solely with the parents. Other members of the family such as the grandparents, in-laws, and elder siblings, even neighbors, are involved in the upbringing of children. Given their active engagement, it becomes vital to educate and counsel these caregivers about the importance of ECD practices since their opinions on parenting practices influence the childcare methods adopted in the family.

The intervention provided numerous platforms and opportunities for engagement with and participation of other caregivers; with an increase in the interactions between the FLWs and other caregivers, during home-visits and other meetings. The two major platforms utilized for the same are home visits and anganwadi meetings. A majority of the parents note that frontline workers interact with all members of the family during their visits and share information regarding various aspects of child development and care. Caregivers, other than parents, are also invited to the meetings and events organized at the Anganwadi. They are often invited to the Anganwadi and are taught proper childcare practices to enhance the wellbeing of the child.

The qualitative interviews reveal that many caregivers, besides parents, started attending meetings and events organized by FLWs. For example, in urban areas, grandparents attend meetings on behalf of the parents who have gone out for work. Since the content for the training and counselling sessions are made for the family in general, it is easy to engage all kinds of caregivers in order to change social norms around parenting and childcare. The frontline workers are trained to identify the needs of the family members and provide appropriate counselling support. For example, the 'Palak Melawa', a community-based event in Maharashtra, is being utilized to spread awareness regarding ECD among the community members.

> *We also invite the grandparents to the anganwadi. If it's not possible for both to come, either the grandfather or the grandmother comes. Along with them, the aunties of the children also visit the Anganwadis. Therefore, whenever they come, we explain these things again and again. (Lady Supervisor, Udaipur)*

### SEQ1.3: To what extent does the intervention factor in gender aspects?

The intervention strives to factor in different gender aspects such as bias against the girl child, son preference, unequal care, and even the division of responsibilities of childcare between the mother and the father.

The communication materials[38] distributed as part of the intervention have subtle messages highlighting the importance of gender equality and the frontline workers are trained to disseminate those messages to sensitise the communities. For example, while developing the training content, the illustrations in the parenting guides and activity banks were kept gender-neutral, with no specific activities assigned to boys or girls.

In the baseline study, it was found that fathers did not play a major role in the lives of the children. They did not take an active interest in their lives and only interacted with the children occasionally. It was also revealed that childcare activities were considered to be outside the father's domain. To address this, messages were included in the communication material to educate fathers regarding their parenting responsibilities. Frontline workers are provided with training in order to build their capacities to interact with fathers and provide appropriate counselling support.

Moreover, frontline workers have organized meetings and events, especially for fathers (baba palak sabha[39], father's meeting etc.), in order to encourage participation and increase their engagement in childcare. For example, to encourage the participation of fathers, a blackboard was created for the child in the house. Frontline workers called all the fathers and distributed blackboard paint, explaining its uses. This was a great platform that highlighted the role of the fathers.

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[38] '*Samvedansheel Palakatv*' in Maharashtra and '*Sab Rang*' cards in Rajasthan
[39] In Pune and Palghar

*Initially, one of the parents in Aurangabad block whom I would like to quote, one of the fathers shared with us that, when he used to enter his house his kids used to only look at him and rather hide from him. Because when he came from outside, he used to shout at them, or he told them not to talk or play. But after (programme), he said he is now spending 30-45 minutes daily with his kids to play after he freshens up in the evenings. This example has encouraged other parents as well. (District government official, Aurangabad)*

*Earlier they (parents) wouldn't immunize the girl child. But if there is a boy child, they would take care of him nicely and would take him to the hospital. But now it's not like that. They take their girl child for immunization. If the girl child catches fever, then also they take her to the hospital. Earlier if the girl would catch fever, they would keep her at home and treat her at home. And they wouldn't take her to hospital. But it's not like that now. (ASHA Supervisor, Yavatmal)*

*No, nowadays it is (difference in care provided to girl and boy child) not that much, previously there used to be, now whether a girl studies or boy studies it is equal in both cases. Nowadays whatever children we have, one or two, all are generally educated and developed. (Lady Supervisor, Dungarpur)*

### SEQ 1.4: Are the gender aspects responsive to the context and UNICEF's gender programming ambitions?

The intervention follows UNICEF's gender programming ambitions. As per UNICEF staff members, the gender guidelines are ingrained in all projects undertaken by UNICEF. These standards are adhered to from the beginning, when partnerships are established and plans are made to address gender in the project and through the partnerships. The UNICEF implementation team does not approve a project unless it adheres to the gender aspects.

For the parenting project, the project team made a conscious effort to engage all family members such as the fathers and the grandparents, to create channels for open communication and participation. Gender aspects are inculcated in the training and communication materials developed as part of the intervention. Moreover, the content developed has gone through a purposive screening to check if any form of gender bias is present in the material.

The areas where the intervention is being implemented experience high incidence of gender discrimination, making the gender guidelines extremely relevant for these regions. For example, women in Rajasthan do not even count the girl child when asked how many children they have. Thus, it is imperative to keep these biases in mind on the field, while interacting with mothers from these areas.

Similarly, discussions have been conducted with the frontline workers to understand issues or preconceived biases they might have, while on the field. For example, when conducting home visits with both parents present in the room, it was revealed that the frontline workers would maintain eye contact with the mother and mostly ignore the father. To address such concerns, training has been provided to frontline workers so that they are able to interact more effectively with fathers and other members of the family. Improvement on this front are evident in the quantitative data which shows an increase in the confidence level of FLWs when interacting with male caregivers about various aspects of childcare and development in comparison to the baseline.

Although it is easy to control for biases in the written material and content, it is difficult to adhere to these standards while taking training or delivering it to the frontline workers. The UNICEF team strives to script these aspects to the extent possible into the training material, but the implementation and use of the material by the supervisors is out of the purview of the team.

### SEQ 1.5: To what extent does the intervention factor in equity aspects?

The intervention is being implemented in some of the most backward areas of the districts and tribal blocks where the majority of the families are illiterate and below the poverty line (BPL). For example, for

equal representation, both the urban and tribal populations in Maharashtra have been considered, since the challenges in the two communities are different.

Although no special module has been designed, equity aspects are subtly ingrained into project activities. For example, frontline workers are encouraged to engage with the socially and economically disadvantaged sections, harder to reach populations, and children with special needs. Many frontline workers reveal that they are utilizing home visits to increase their interactions with families from vulnerable sections to encourage them to avail services from the Anganwadi. In addition, most of the frontline workers reveal that they are now able to provide support to parents of children with special needs.

To ensure access for even the most vulnerable families, FLWs are encouraged to interact in the local language and use the communication materials to aid understanding during training sessions. Frontline workers also teach parents to use locally available materials to make toys and play material for the children, making this accessible for even the poorest families. The activities for the children included in the communication material were also easily modifiable as per the space available in the house without any assumptions on set space availability.

During the pandemic, in the state of Maharashtra, communication shifted to digital platforms such as WhatsApp and Facebook. However, families who did not have access to mobile phones were visited by frontline workers who shared messages around ECD using pictures and communication materials. The training sessions have empowered the frontline workers to independently take steps to focus more on the underprivileged families in their communities.

### SEQ 1.6: Are the equity aspects responsive to the context and UNICEF's equity programming ambitions?

The intervention is responsive to UNICEF's equity programming ambitions and strives to factor in differences, not only at the regional level, but also at the household level. For example, the intervention has developed activities taking into account different household characteristics such as the kind of material easily available in the house, space constraints, etc.

The project focused on children (girl and boy below 6 years) in general and did not have a specific focus on children with special needs. But, the training sessions with supervisors usually included conversations around these children and how different activities can be modified in order to increase their access to ECD services. While not exclusively included in the training material, the intervention tries to influence the thinking of the supervisors and frontline workers to focus on inclusivity and pay special attention to vulnerable groups.

Interviews with UNICEF staff members from Maharashtra reveal that training regarding children with disabilities are technical and full of terminologies and concepts that are difficult to grasp. To overcome this, the intervention follows a different approach designed to make the frontline workers think and understand activities from the child's point of view. For example, if a FLW observes that a child with a disability is unable to hold a small thing, he/she can replace it with something big, that is easy to hold. The idea is to improve the access of ECD activities for these children, even if FLWs are unable to identify the disability that the child is suffering from.

## EQ2: To what extent is the training that FLWs receive to deliver the intervention relevant and adequate for the target population (parents/caregivers of child)?

### SEQ 2.1: Did the training address ways to change cultural beliefs and attitudes around parenting?

The interviews with frontline workers reveal common cultural beliefs and attitudes regarding parenting and early childhood development prevailing in their respective villages. Many frontline workers agree that blind beliefs and practices without proper counselling can, in fact, be detrimental to child's wellbeing.

Common practices such as not feeding breastmilk to newborn babies, bathing sick babies, not immunizing young children, and reliance on traditional remedies, are still prevalent (mostly in Rajasthan) despite their negative impact on child health and development.

During qualitative interviews, frontline workers in general reported how training and repeated counselling sessions on responsive parenting and care have helped them make progress within their communities and shift towards modern, scientific practices. In their meetings, frontline workers counsel parents and other caregivers about old traditions and superstitions that might have a negative impact on child development and health. For example, frontline workers encourage mothers to breastfeed babies for the first six months, citing numerous benefits for child health and development. Earlier, many families would deliver babies at home, without proper medical attention at hand. However, many frontline workers report a change in such behaviours with more and more parents opting to go to hospitals for institutional deliveries. They also report a gradual positive change, although a long way to go still (especially in Rajasthan), in mindsets and attitudes of parents and other caregivers devoting more time towards children and their development. This corroborates with the evidence from research in 11 low and middle-income countries which shows that encouraging caregivers to play and interact with their children 0-3 years can increase the time and resources parents invest in their children's development[40].

These findings are corroborated by parents who acknowledge the usefulness of the counselling provided to them, sharing various positive experiences on following the advice given by the frontline workers on child development and care. For example, many parents have noted the health benefits of providing proper nutrition to their children. Anganwadi enrolment rates have also increased as parents realise the importance of early childhood education in the lives of their children[41]. The review of the communication material evidenced that Information elicited in the communication packages focused on changing cultural beliefs and attitudes towards parenting with a key focus on what, why and how of responsive parenting. Parents also reveal that interactions with frontline workers are useful in busting old myths and cultural beliefs prevailing in their villages related to child development and care and help them to change their mindsets.

*Earlier, when children came in between the works of mothers, they scolded at first but now they engage their children in their work so that they can learn. Now beating and scolding has been very less. So, this attitude is changing gradually. (Lady Supervisor, Aurangabad)*

*Old age people say that if you will not let a child drink water then the child would suffer from a disease called ("Sukhkal"). The old aged people gave 'ajwain' and 'gudpani' to the child who has just taken birth because they don't want the baby to get ill. In this generation people don't do this but if the old age people in the home say to do it, then they definitely do it. This is not good, there is still this method and tradition present in society. (AWW, Udaipur)*

*We face a lot of problems; Suppose the child is suffering from jaundice or measles, if I suggest they (caregivers) take the child to hospital they will tell "No, it is the incarnation/blessings of God". (AWW, Udaipur)*

*Beliefs like not giving the mother's milk for the first three days are not good for the child. Baby needs mother's milk. We all know that we cannot give a baby anything to eat for 6 months (besides breast milk). The old generation people say to give the baby biscuit & milk, we try to say that it's wrong, we shouldn't give them anything to eat for 6 months but they don't listen. (AWW, Udaipur)*

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[40] https://www.povertyactionlab.org/policy-insight/encouraging-early-childhood-stimulation-parents-and-caregivers-improve-child
[41] As substantiated in ASER 2019: aserreport2019earlyyearsfinal.pdf

*Yes, they (old beliefs) are harmful for children. We are talking with community people in the meetings and pay home visits to make them aware, educate and sensitize them on child development, immunization, malnourishment, growth of the child, education etc. They are listening to our advice and a positive change in attitude is slowly being seen. (ASHA, Dungarpur)*

*Yes, there were some old beliefs but not now. Previously, when a baby was born then people gave them honey, but now parents give them mother's milk. These things didn't happen before but are happening now. I can say it is a progress. They also used eyeliner for the baby but now most of them are not using it. Most blind faiths are not followed now. (AWW, Aurangabad)*

*Earlier when people followed their grandparents, they didn't breastfeed the child for 2 -3 days but now only after 30 minutes of delivery breastfeeding is done.*
*The parents who followed the age-old traditions, for them it's a serious damage to their baby. Also, people didn't give the doses on time but now people are more serious about the doses (immunization). (AWW, Aurangabad)*

*Some people have traditional views and treat their children traditionally. But nowadays, it doesn't happen. Now, mothers give treatment to their child according to the doctor's advice if he/she is sick. In the past, children were treated according to cultural beliefs, like some cultural thread is tied to their arm. But now, if anyone gets sick, like stomach pain, dysentery then we give ORS packet first. And if it is not cured, then the mother takes the child to the doctor. (ASHA, Palghar)*

*In the past, people cut the umbilical cord of the baby at home by hand and now it is being done in the hospital. We also tell them to keep the tiles clean of their house and at least use a sterilized blade for cutting the umbilical cord if some are doing it at home even after repeated counseling.  But mostly, the delivery process is happening at the hospital.  (AWW, Aurangabad)*

*Earlier when Anganwadi teachers used to go to their (caregivers') houses they didn't pay respect but now they say please come and sit. If they advise anything they listen and agree to implement that or to do that for the kids. (ASHA/Anganwadi Supervisor, Palgarh)*

*Earlier, people didn't talk with us and didn't want to listen to us, but nowadays they welcome the caregivers and offer them seats and greet them in a very respectful way. People did not bother to listen to us as they thought that it was our job to convince them, but now things have changed, and they appreciate our work. (Lady Supervisor, Udaipur)*

### SEQ 2.2: Did the training address the gender and equity-based challenges the frontline worker experience?

Interviews with frontline workers reveal that progress has been made on the gender front. Reiterating this, many government officials highlight a positive change in mindsets of FLWs in their respective areas and speak about numerous government schemes, such as the 'Majhi Kanya Bhagyashree' and 'Bhagyashree Yojana' launched in Maharashtra, that help to educate parents and spread awareness regarding gender equality

However, challenges do exist in many parts where children continue to face discrimination such as parents being biased in favour of the male child (son preference), neglecting the girl child's care and diet, neglecting the girl child's education, and even aborting the girl child in some cases. Another form of gender discrimination that has been widely reported is the low involvement of the fathers in parenting (especially in Rajasthan), with childcare duties being essentially seen as the mother's responsibility.

While challenges exist, many frontline workers report that the training sessions on responsive parenting and care have equipped them with the required confidence and skills to counsel parents and other caregivers about the importance of gender equality and helped them make progress towards achieving a more gender neutral mindset in their communities. Supervisors also note instances of fathers taking a more active role in their children's lives - playing with them, bringing them to the Anganwadi and, sometimes, even attending the meetings and events organized by the frontline workers, although still low.

On the equity front, the two most commonly reported challenges are the inability of caregivers to provide minimum care to children from socially and economically disadvantaged backgrounds and the stigma surrounding children with disabilities. Frontline workers reveal facing several difficulties in counselling parents from weaker sections since a majority do not have the means, or even the will, to provide optimal care for the development of their children. Moreover, such families are largely uneducated, making it difficult to achieve significant progress even after repeated counselling and home visits.

Faced with these challenges, frontline workers highlight how the training received helps them manage difficult situations and persevere. Some common solutions discussed are - collaborating with other workers for problem solving, discussions with higher level officials like supervisors, repeated counselling, and home visits. The FLWs take active steps to ensure that the ECD services are provided to every household in their community including the families located in remote locations. In Udaipur, for example, the FLWs travel in groups of 2-3 through the mountainous region to reach out to families located in remote communities.

*Even today there are prejudices regarding a girl child. Every time we pay a visit to their (caregivers') home we have complaints of taunting the mother for the birth of a girl child. We have to make the family understand the importance of a girl child and it is not in the hands of mother or anyone if she is giving birth to a male or a female child. Also, we make them understand that a girl is a gift of god to the family and the society too. (ASHA, Palgarh)*

*I have come across many situations where mothers are mostly held responsible for childcare while there is low involvement of fathers in childcare. For instance, if the mother goes to work somewhere, she has to return home early to look after their children whereas it is not the case with the father. (AWW, Pune)*

*There are few such things which are still happening. If someone has 3 daughters, then they continue giving birth until they have a son. So, we tell these people that it is not in our hands, both a girl and a boy are equal. Our training has taught us a lot on how to convey such sensitive messages to people. (ASHA, Palgarh)*

*We counsel them (caregivers) about the importance of equality. Now they don't discriminate against boys and girls. They treat girls as much as they treat boys. Now they pamper girls more than boys and love them more. (AWW, Yavatmal)*

*We have one disabled baby girl in our village. Her parents never pay attention to her. When we counselled them about the treatment and its importance, only then they got treatment for her at the hospital. But after 2-3 months, she is still ill. Her parents still ignore her and don't care. (ASHA, Yavatmal)*

*We have to tell those (economically/socially weak) parents again and again. They are unable to understand it easily...and they all remain busy in their work, in farming, so we go to visit their homes*

*and there we tell them about Aanganwadi services, vaccination program, about their children's education and care. (AWW, Aurangabad)*

*Yes, change is occurring. Before, they didn't treat them equally, but now we explain to them that both boys and girls are equal. Both boys and girls are equally qualified to do everything. Whatever boys can do, the girls could also do the same.*
*In their (caregivers') old days, both will be there to help. I explain to them that there is nothing like a boy or girl, both are the same. I even give examples from our own village that there are such families where instead of boys, the girls are taking care of their parents in their old days. After that I have observed a change in them. Now most of them don't have any kind of partiality between boy and girl child. (AWW, Udaipur)*

*Children who are from the economically & socially weaker sections are usually physically weak and need extra care and they need to be fed several types of protein rich foods. Their parents are not able to provide good healthcare and education to their children. In the training it was specifically told to try to reach the vulnerable groups, so we do it as much as possible.  (ASHA, Udaipur)*

*We provide information to all the families whether they are poor or rich and I personally inform them (AWWs) not to leave a single family while counselling in the meetings. (Lady Supervisor, Dungarpur)*

*Yes, we face some challenges. The parents from weaker sections are both working, and they don't give much time to their children or attend meetings. So, when I meet them, I try to convince them to give some time to their children and think about their development. (ASHA, Dungarpur)*

## Inspiring scores of workers – A Lady Supervisor

*Some events have the power to bring about great change in the lives of many. For Ms. Vandana Nanote of Yavatmal district, Maharashtra the Early Childhood Development (ECD) intervention was such an event. She has been working as a lady supervisor since 1993 and managing 32 Anganwadi Centers under her. Especially, she is grateful to the intervention for giving her the opportunity to significantly upgrade her basket of knowledge about the issues of mothers and children.*

*Through the intervention, the lady supervisor learnt more about child development, practices to be adopted by pregnant mothers, health, and nutrition and others, which gave her the self-confidence to counsel mothers and caregivers. With her new-found knowledge, she came to understand the benefits of physical and mental stimulation for holistic development of children; and the ills of harsh punishment such as scolding and beating young children.*

*The knowledge and confidence gained by the lady supervisor was gradually passed down to the frontline workers (FLWs). Vandana trained, encouraged, and motivated the frontline workers on early childhood development and care. She tried to remove their fear of talking to people and built their confidence to provide counselling to both mothers and fathers in the community. The FLWs weren't scolded when they made mistakes, instead, they were encouraged, appreciated, and shown how to do things in a better manner. With time, the FLWs enhanced their knowledge and skill set, which attracted a greater number of parents to listen to the FLWs at Anganwadi centers and during home visits and created demand for new knowledge among them.*

*Through meetings and home visits, parents and other caregivers were taught about nutrition, practices to take care of the breastfeeding mothers and pregnant women, playing with babies, responsive parenting and care. Earlier, toys were bought without any thought, but now parents were taught games that would positively impact child development. They were taught how to use everyday household objects and activities like cooking and washing to play with kids and teach them new things. Posters and charts were used to help parents understand these concepts, which made counselling easy and effective.*

*The ECD intervention's activities led to an increase in people's interest in learning more about child development, and important ECD practices. Earlier, only mothers attended meetings related to childcare, however, the intervention made fathers realize their parenting duties and many of them started to attend parent's meetings and home visits. In addition, separate meetings were arranged for parents based on the age brackets of their children. Because of this, parents experienced significant improvements in their knowledge base regarding early childhood development and incorporated this in guiding their children towards better physical, cognitive, social and emotional development.*

*Vandana experienced the positive impact of the ECD intervention on two fronts. One as a woman, for the development of the children in her area. The second as a lady supervisor, for improving the knowledge and skills of the frontline workers. She is confident that both fronts would help in the betterment of the children and positively impact the growth story of the communities.*

## EQ3: To what extent is the intervention aligned to the broader objectives of the project?

*SEQ 3.1: How relevant is the strategy (promoting parental involvement) for ensuring quality early childhood development?*

The project is designed to build the capacities of frontline workers to enable them to improve quality and coverage of services. The first six years of a child's life are crucial in determining the future quality of life; hence, it becomes imperative to train and educate parents regarding proper ECD practices.

To achieve this, in Maharashtra the cascade training model has been adopted to train frontline workers, who ultimately disseminate the requisite counselling on parenting and ECD to the target beneficiaries. In the model, the project staff train the supervisors (master trainers), who in turn train the frontline workers, who finally train parents and other caregivers in the community. The project has undergone a continuous cycle of iterations since its implementation, with many additions and deletions after collecting experiences from the field.

In Rajasthan, the project was aligned with the ongoing government programs and cascading model was not adopted as in Maharashtra. The project grew organically in Rajasthan building in from the experiences in the field. It started from small rounds of pilot to gradual roll-out of nutrition and education interventions across the blocks in the two intervention districts. For more details on project implementation, please refer to *Annexure 03*.

To improve the counselling support provided to the parents, both the communication style of the frontline workers and the material itself required changes. For example, in districts of Udaipur and Dungarpur, particular dialects are used by the parents. In order to ensure effective communication, it was decided that frontline workers would make use of local words and terms while interacting with parents.

The emphasis of the project was on building the skills of those who immediately engage with the children through home visits and on initiating dialogue on child care among mothers and other caregivers (tried to influence the social norms) by conducting parents' meetings and community-based events. Review of the communication material also revealed that the project focuses on an intergenerational approach wherein mothers and children attend sessions together and perform activities together, which is known to lead to greater impact.

In Maharashtra, another major achievement is the successful alignment of the project with the state AAKAR curriculum. The intervention keeps the curriculum as a reference point and engages with the children in front of the parents to ensure they understand the essence of the project activities. The intervention is using existing resources to make changes on ground, indicating the cost effectiveness and scalability of the project, and its ability to reach all the caregivers using minimal resources (efficiency).

Given the context, the strategy of the intervention to promote parental involvement for ensuring quality early childhood development is highly relevant and valid.

> *When we talk of Poshan Abhiyan, when we talk of nutrition or women and child in our country, we basically focus on all very urgent kind of issues. But we should understand that to make these urgent kinds of issues less urgent in the future, we need to start working on ECD. (State government official, Maharashtra)*

> *In our area, playing with children, bringing toys for the children are treated as waste of time. But we have seen the change in this type of thinking. The way the parents talk to their children has changed. They have started doing many activities with the children in between their work too. The bond is being formed very nicely and the parents have started understanding their children. (State Government Official, Maharashtra)*

## SEQ 3.2: How do the envisaged activities and outputs improve quality of counselling and communication support to parents/caregivers?

In the interviews, frontline workers discuss how training and capacity building on responsive parenting and care have improved their counselling skills, increased their confidence and aided in providing effective counselling support to parents and other caregivers. The training sessions provide frontline workers with new information and techniques that lead to better communication of key messages with their communities. FLWs are encouraged to communicate in the local language/ dialect and are provided with communication materials to aid easy understanding.

Stakeholders observed that after the advent of the project, meetings have become more interactive and are able to engage caregivers better. A government official from Maharashtra explained how the duration of the home visits increased from around 5-10 minutes to about 30 minutes since the advent of the ECD project. In addition to this, the ASHA and Anganwadi workers now conduct home visits and parents' meetings together, which has further led to an improvement in the quality of these platforms.

In Maharashtra, the improvement is evident in the change in the manner in which mothers' meetings are conducted. Earlier, the meetings consisted of the ASHA workers delivering information in the form of a lecture to a group of mothers. Nowadays, however, both the ASHA and the Anganwadi worker (sometimes accompanied by the supervisor) conduct the meetings, which have now become more interactive in nature. Such synergies between AWW and ASHA were not widely reported by stakeholders in Rajasthan.

Use of locally found materials to make play materials, dancing, singing and other activities make the sessions more enjoyable for the participants and improve communication between the caregivers and frontline workers. Frontline workers used an evidence-based communication strategy by demonstrating the activities with the children in front of the caregivers. This ensured that the caregivers understood the 'why' behind the activity and could adopt it easily in their daily routines.

> *As an Anganwadi worker, when I visit someone's home, I feel more confident after the training! In the training we were taught to speak in the language which is comfortable to the community members, so I now explain things to them in Babri. Now I am more aware of the things and can explain better to the community members than before. (AWW, Dungarpur)*

> *The way they (ASHA/AWW) interacted has quite changed and the way they provided counselling has also improved. (Mother of 0-3 years old, Pune)*

> *After ECD (project) and making quality home visits, ASHAs have now become a prominent personality of their village. Now every child, adolescent, women of every household could recognise ASHA and she is involved in major activities of the village. (Government official, Yavatmal)*

> *Initially some of the mothers came and sat only for 15 minutes and some of them never came but now they are coming with interest because they are getting to learn new things and stay the entire duration of the meeting. The quality of home visits and mothers meetings have improved a lot. (Government official, Yavatmal)*

> *The training was helpful. Due to the training they (FLWs) are able to counsel caregivers on various aspects of child development which they themselves didn't know before the training. (Lady Supervisor, Palgarh)*

## At the Forefront – An Anganwadi Worker

*For many years, Veena, an Anganwadi worker from Palghar district of Maharahstra, has been at the forefront of providing important government services to mothers and children in her community. From visiting pregnant women and asking them to register their names at Anganwadi, giving them MCP cards, to providing essential services to pregnant women, lactating mothers, and children; Veena has done it all. Earlier, people in her community would give birth at home and give honey and water to newborns. However, Veena has been successful in making them understand the benefits of institutional delivery and importance of mother's milk for the child and the harm of giving anything other than that.*

*Through the parenting and Early Childhood Development (ECD) intervention, Veena got training on methods of talking to children and counseling parents on the innovative methods designed for the physical, cognitive, emotional, and social development of children. For example, she would teach caregivers the importance of treating children with love and care, and counsel them against beating and other harsh forms of punishment. She would also teach pregnant women the importance of the first 1000 days - things to do during pregnancy and lactation, and educate mothers on child health and nutrition using pictures and flipchart which were easy to understand and remember.*



*During home visits and parent's meetings, Veena would teach parents and grandparents effective ways of looking after children, and would also demonstrate different ways to stimulate the child. For example, she would show parents how to use vegetables available at home to teach kids about colors, shapes, and counting. She would encourage parents to engage their children in innovative activities such as drawing and colouring. Parents would learn whatever was taught during meetings and home visits and try to repeat these activities at home, with their children.*

*Veena revealed that whatsapp numbers of parents were taken and categorized into different groups according to the age bracket (0-3 years or 3-6 years old) of their children and whether they were pregnant or lactating. Using this, Veena would disseminate messages related to ECD and share relevant audio/video content with parents over whatsapp. For parents who did not own smartphones, Veena would show them the videos on her own phone when she would visit them during home visits.*

*According to Veena, she faced some challenges in her community. For example, initially, the attendance of parents at Anganwadi meetings was low. Also, since many parents did not own smartphones, it was difficult for her to share all the messages with them. Veena also reported that people of the older generation, such as the grandparents, resisted the new methods being taught on childcare and development and she found it difficult to convince them. She would also face challenges when both parents were working, as it became difficult to attend the meetings and they were seldom available for home visits.*

*However, with time and perseverance, Veena has been able to convince parents and other caregivers regarding the importance of ECD for the development of children. As people realized the benefits of the positive parenting and ECD, they became more receptive and attendance improved. Fathers also started engaging with their children, whenever they got time after work in the evenings.*

*Veena has found huge potential in the parenting intervention and observed its positive impact on herself, caregivers and larger community. She is proud of her role as the beneficiary-facing functionary and believes that if her whole community accepts the parenting and early childhood intervention wholeheartedly, it would be awarded with enhanced well-being of its children, which would boost the welfare of the community as well.*

## EQ4: To what extent is the intervention aligned to the priorities of the government and other partners, specifically the Early Childhood Development strategies and plans?

*SEQ 4.1: To what extent the intervention is aligned to the state ECE curriculum?*

The intervention and the state ECE curriculum are similarly aligned in their goals and objectives in both the states (Maharashtra and Rajasthan). However, in terms of scope and implementation, the intervention is different when compared to other programmes around preschool education. While early childhood development focuses on children from conception upto the age of six, the focus of preschool education is on the age group 3-6 years. Moreover, earlier programmes have focused more on preschool education and nutrition while neglecting other aspects of development. Thus, the present intervention is supplementing the efforts of earlier programmes such as the Integrated Child Development Services (ICDS) scheme by bringing in aspects related to responsive parenting and cognitive development.

The intervention strives to prepare young children to attend formal schooling by exposing them to play and stimulation to enable early learning and development. For children who have already been exposed to such activities at home, the preschool education that is part of the Anganwadi centres becomes even more beneficial. While the ECE curriculum tries to enhance the level of activities that are provided to children in the 3-6 years age group in the Anganwadi centres, the goal of the intervention is to enhance the capacities of the parents and increase the level of engagement with their children. To do so, it is important to align the activities being conducted at home with those that are being organized at the Anganwadi centres and encourage complementarities between the two.

Interviews with UNICEF staff from Rajasthan reveal that the competency that was available in the curriculum has been used as the base for developing the ECD messages. The creative skills for the age group 3-5 years present in the curriculum and the UNICEF early learning development scale have been used to develop the messages and the training manual. This is further corroborated by the analysis of the communication material which showed that the material for caregivers focusing on the 3-6 age group is aligned to the state ECE curriculum. Many activities have been picked from the curriculum and redesigned so they are suitable for learning at home, making use of the same principles and the same language. The alignment between the two is also evident in project objectives since they strive for the smooth transition of children from the 0-3 to the 3-6 years age group.

In Maharashtra, while there are many similarities between the AAKAR curriculum and the intervention, the scope of AAKAR is limited to brief conferences, corner meetings and information related to motherhood. However, the present intervention is helping parents apply the learnings disseminated by frontline workers in their daily activities. AAKAR is the state government's curriculum for ECE in Maharashtra, while the parent meetings, as part of the intervention, involve all aspects of physical, social and emotional, motor, language and literacy development. While AAKAR has an objective of making the Anganwadi children school ready, the parent meetings explain what being school ready actually entails. During the pandemic period, the AAKAR curriculum has been used to convert 80 activity suggestions into video and audio formats, which were then made available to the Anganwadis for parents to make children learn at home.

> *It (ECD project) is aligned (with state ECE curriculum). Because the activities which we conduct during the pre-school education, that comes under early stimulation. If early stimulation is being given by the activities, then the child comes with preparation. I said that previously there was insecurity. But now children come to the Anganwadi with a sense of security which is helpful for them to establish a good rapport with the AWW and to get used to the environment. It has become very easy for them because of that early stimulation. It is also becoming easier for the Anganwadi workers for taking pre-school education in Anganwadi because the environment which they need for their development,*

*they are getting that from their home. Now the development is happening as per their age, which should happen. (State govt official, Maharashtra)*

*SEQ 4.2: What are the existing activities that are being planned or carried out by the government and other partners under ECD in the two States?*

There are a number of existing ECD activities being carried out by the government and other partners in the two states. For example, in Maharashtra the AAKAR curriculum is being implemented under which the monthly syllabus for children in the age group 3-6 years is designed to be used in the teachings provided in the Anganwadis.

The ICDS scheme is similarly aligned with a focus on health, nutrition, preschool education and hygiene. In collaboration with UNICEF, the scheme developed a yearlong calendar composed of messages to be shared with parents in Rajasthan. In addition, the ICDS is planning to provide workbooks containing activities for children in the age group 3-5 years. For the Parent Anganwadi Meeting (PAM), orientation of the Anganwadi workers is being organized as part of their annual work plan.

Delivery of education services to the children through the use of social media and internet are other schemes that are being carried out by the government in Maharashtra. The Computer-Aided System has also been implemented by the government where the development indicators of children are regularly updated into an online database. This is helpful for monitoring the work being done on ground.

In 2018, the Home-Based Care for Young Child (HBYC) Programme was rolled out in Maharashtra and is in the implementation stage in Rajasthan. The programme aims to improve the nutrition status, growth and early childhood development of young children (3 months - 2 years), through additional home visits by the frontline workers. It has also been reported that the government is focusing on expanding the MCP card statewide in Maharashtra.

A number of community-based events are being conducted under the 'Poshan Abhiyan', which was restarted in 2018. The Village Health Sanitation and Nutrition Day (VHNSD), a platform to provide preventive and development services to the community, is organized monthly in the villages. The 'Surakhsit Matritva Abhiyan', a scheme to provide quality antenatal care universally to all pregnant women free of cost every month is also being implemented in Maharashtra.

Another project in Maharashtra is the 'Tarang Suposhit', which is being introduced by the ICDS department, Rajmata Foundation and UNICEF. This is a digital platform that can be used to reach parents and other caregivers. It has been developed due to the difficulties the frontline workers have faced in reaching parents during the pandemic period. UNICEF supported the development of the messages related to stimulation and development for this platform.

*SEQ 4.3: How is the intervention aligned with these activities? What are aspects of similarity/overlap? What are aspects of difference/divergence?*

There are various aspects of similarities and differences between the current intervention and ongoing government programmes. For example, the intervention is well aligned with the objectives of the government's ICDS programme. While ICDS focuses on physical and mental development of children, the responsive parenting and care intervention brings in aspects of language, cognitive and skill development, thus complementing the efforts of the ICDS programme. In an interview, a CSO partner highlighted the need for the current project, stating that the state and district authorities have focused more on the age group 3-6 years, largely neglecting children in the age group 0-3 years. While ICDS has supported the nutrition and health aspects of this age group, the development and stimulation side has been ignored before this intervention. For example, while the MCP card did contain information regarding development, frontline workers were not using this because they were not aware of its importance earlier.

A UNICEF staff member discussed how the intervention takes a different approach to programme activities already existing under ICDS. Instead of mechanically performing certain tasks such as weighing the child, tracking nutrition status, and home visits; the intervention encourages open engagement and focuses on increasing parental involvement in childcare and development. For example, while weighing the child, frontline workers now discuss any issues regarding malnutrition and explain what can be done to improve the nutritional status of the child. The intervention is also heavily influenced by the AAKAR curriculum in Maharashtra and is trying to move the activities under the curriculum from the centres to the homes. Many of the government activities mentioned earlier have similar goals as the intervention's, and work for the better development of the children in these communities.

The intervention is trying to use existing platforms more efficiently. For example, monthly mothers' meetings were conducted even before the advent of the intervention where messages for all the age groups were shared together. However, after the intervention, meetings are being organized separately for mothers with children from different age groups making the content more relevant and leading to a spike in the level of interest of the mothers in the community.

In Maharashtra, for the digital media platform, the messages regarding early stimulation and development were developed by the UNICEF and CSO partner team who provided inputs for nutrition and responsive feeding. Similarly, while the aim of the HBYC programme aligns well with that of the UNICEF intervention, the intensity of application of the intervention is greater and has a wider scope with a focus on children from conception upto six years. Moreover, the training provided to the workers under the UNICEF intervention has been more intense.

A UNICEF staff member from Maharashtra compares the HYBC programme and the Rashtriya Bal Swasthya Karyakram being implemented by the government to the present intervention, discussing the differences in project focus. The two government programmes do not focus on the softer side of ECD such as the interactions between the parents and the children, instead focusing on more clinical aspects such as the early identification of defects, development delays, deficiencies and diseases.

*SEQ 4.4: Any collaborative efforts and coordination with other partners for convergence?*

At the state level, various departments like the Rural Development Department and the Rationing Department have been involved since the rollout of the project. In Maharashtra, the AAKAR curriculum, which has heavily influenced the present intervention, has been developed by the ICDS in partnership with UNICEF and MSCERT (Maharashtra State Council for Education and Research Training). It has been utilized for the capacity building of the supervisors and the frontline workers.

Interviews with UNICEF staff from Rajasthan reveal that partnerships have been established with various organizations namely - Vedanta, IPE Global, Pratham, Lupin, Tata Trust and Seva Mandir; for the promotion of ECD in the state. On the other hand, while Maharashtra does not have organisations working at the state level, several implementing partners are working at the district levels. For example, in Palghar, at least 5 NGOs are working in the ECD domain. These organisations are not working in silos but are operating in a collaborative manner with assistance from ICDS. They are building on AAKAR which is acting as a bedrock for the design of an intervention and for the assessment of a program. In Maharashtra, most agencies have been working for ECE, and very few operate in the ECD domain. The government is open to collaboration as long as a parallel system is not created and they are able to see changes on the ground.

Another initiative reported by UNICEF staff from Maharashtra is the ECE quality tool, which is a step to create a common platform so that the efforts of all organizations go hand-in-hand and there is scope to learn from each other.

## 4.2. Effectiveness

### EQ5: To what extent were the inputs or activities of the intervention delivered as planned, specifically: development of communication materials, training materials, training of FLWs?

*SEQ 5.1: Were the tools and standards developed to gauge project quality and child development and learning useful?*

In Maharashtra, to gauge the quality of parent's meetings, the first observation form was developed with a focus on the behaviour of the frontline workers. This was developed by experts and was aligned to other ECD tools to collect feedback from the Anganwadis. The tool was added to the ECE quality tool which had been developed earlier in the state of Maharashtra. The development of the tool was a collaborative effort involving all relevant stakeholders such as the academic panel with ECD and parenting experts, representatives of supervisors from Pune and Palgarh, and the block coordinators. Checklists were widely utilized to monitor home visits, parent's meetings, and palak melawas, among others. They were also used for field training, where block coordinators would observe the training sessions and use the checklist to enter information into a google form in order to discuss loopholes with the supervisors and come up with effective solutions for the same. In addition, a concurrent monitoring form was used to track the number of home visits, mothers' meetings, and any other programme conducted.

In Rajasthan, observation sheets were utilized to measure development changes, if any, in the FLWs and parents during the course of the project. These observation sheets were filled for both the baseline and endline periods, to generate reports for the benefit of the team. Interviews with UNICEF staff members from Rajasthan revealed that tools used for reporting the status of the ECD project to the district and the state governments were also utilized as monitoring tools by UNICEF. The ECD project made use of the existing materials and tools that were developed for the government ECD programs like the 1000 days programme. This meant that no new tools had to be fed into the system, ensuring its sustainability in the long term.

*SEQ 5.2: What were the bottlenecks in terms of implementation, and why?*

The intervention faced a number of challenges during implementation. First and foremost, interviews with UNICEF staff from Rajasthan revealed that UNICEF staff faced some difficulty in convincing state and district level officials to become a part of the intervention since they were of the view that parents from socially and economically weaker sections could not play a role in their child's development – health, nutrition, childcare and education.

Initially in Rajasthan as reported by a UNICEF staff, training for frontline workers was conducted in the Anganwadi centres but when centres were closed in the middle of implementation, training had to be shifted to the sector meetings. Here too, UNICEF faced challenges. Since the sector meetings were being utilized for administrative purposes before the advent of the intervention, UNICEF had to push hard to ensure time for training as part of the meeting agenda. Several other training related challenges were also discussed. AWW Supervisors from Rajasthan reported that allocating time for the training during the sector meetings was a challenge as most of the time goes into administrative activities.

In Maharashtra, it was reported that sudden data requests from government officials often interrupted training sessions for the frontline workers. FLWs also experienced training fatigue due to a number of different trainings, such as the ECD training, CAS training and AAKAR training, being organized in a single month. Another challenge highlighted by a CSO partner from Maharashtra with implementation was associated with parent's meetings and palak sabhas. In Pune and Palghar, in the beginning, 4 meetings a month were planned, however, both the frontline workers and the parents were not comfortable with this

arrangement. While frontline workers felt overworked, parents found it difficult to take out time for all the different activities planned.

It was also noticed that the frontline workers were unable to focus on core activities of the intervention such as home visits, and mother's meetings when different vaccination campaigns were ongoing, particularly in Maharashtra. Thus, there was a need to better utilize these campaigns for carrying out ECD activities. In addition, interview with CSO partner from Maharashtra revealed that vacancies for supervisors was a challenge, especially in the remote and tribal areas. This was a major challenge as the supervisors were responsible for training the frontline workers in the cascading model adopted in Maharashtra. Because of a shortage of supervisors, some had 70-80 FLWs under them against the norm of 20-30 FLWs, negatively impacting the quality of supervision as the supervisors found it challenging to conduct the training sessions.

> *Most of the time they (FLWs) think that the entire responsibility is being shouldered upon them. They feel that they are doing all the tasks of the department together. They have to organize everything including the meetings, co-ordinate the tasks and that makes them think that the government has imposed a lot of load on them. They feel that they aren't paid enough or respected enough for their work. (Lady Supervisor, Udaipur)*

*SEQ 5.3: Was timely corrective action taken, when issues emerged?*

As mentioned earlier, initially, government officials at state were not supportive of the intervention. To convince them, UNICEF staff in Rajasthan highlighted examples from states like Kerala and even countries abroad and took officials for field visits in order to showcase the interactions between the Anganwadi workers and the parents. Once officials understood the potential value for child development, sentiments turned more positive.

Although several training related challenges emerged, efforts were made to resolve these quickly for the smooth implementation of the intervention. For example, a supervisor from Dungarpur noted that some frontline workers were not attentive during training sessions; in such cases, supervisors shifted these frontline workers to the front rows to be able to pay more attention to them. There were also instances of the less educated frontline workers not being able to grasp what was being taught. To overcome this, supervisors in Udaipur gave repeated training and asked them to regularly revise whatever was being taught. They even demonstrated concepts using role-play to aid understanding.

Supervisors also faced resource constraints, although a majority of the time they managed to arrange the required supplies from nearby places as reported by supervisors from Rajasthan. However, this was heavily dependent on budgets, which were also constrained at most places.

In Maharashtra, training fatigue presented a major issue when the ECD, ILA and AAKAR training were combined to establish coordination in the training curriculums. To overcome this, the ECD training sessions in Maharashtra were skipped in the months when the CAS training was undertaken. Further, the AAKAR curriculum for the age group 0-3 years, was inculcated in the form of home-based activities. During the pandemic, when all forms of physical interaction like meetings came to a halt for a long period of time, the planned activities were implemented using digital platforms. These platforms also helped people stay connected with the frontline workers and the supervisors.

In Maharashtra, the number of palak sabhas was reduced to 2 meetings a month since frontline workers and parents were not comfortable with the initially planned 4 meetings. Eventually, palak sabhas became a part of community-based events, which were already present in the ICDS calendars. Thus, the intervention became aligned to these events and frontline workers were trained to achieve several objectives in the same event.

Similarly, in Maharashtra supervisor vacancies, especially in the remote and tribal areas, were filled by block coordinators, ASHA facilitators or the project staff themselves, who spent extra time during the sector meetings on the training of the frontline workers.

*SEQ 5.4: To what extent were the FLWs able to use the communication materials/tools in communicating with parents at the various platforms?*

As part of the project, frontline workers were equipped with communication materials in the form of flipcharts/cards ('*SabRang*' cards in Rajasthan and '*Samvendasheel palakatv*' in Maharashtra) and posters to counsel parents. These materials contained information on nutrition, play and engagement, messages for pregnant women and other ECD related information. The materials not only acted as a guide for the frontline workers but also contained graphics to make the sessions more interactive.

| Inputs/ Activities | | Outputs | | Outcomes |
|---|---|---|---|---|
| • Samvedansheel Palakatv (responsive parenting) flipcharts and MCP cards<br>• Capacity building of FLWs | ⇨ | • FLWs use tools available /newly developed to orient parents/caregivers in the community | ⇨ | • Enhanced utilization of existing resources (flipcharts, MCP cards, communication tools etc.) and platforms by FLWs to orient parents/caregivers on ECD related aspects |

*Figure 4: Reconstructed Theory of Change*

It is to be noted that the distribution of communication material is still ongoing and all the FLWs have not received the communication material still. In Rajasthan, government has taken up the printing and distribution of communication material (SabRang) cards and is in progress. About three-fourth of AWWs and more than half of ASHAs in Maharashtra, and about half of AWWs and slightly more than a quarter of ASHAs in Rajasthan reported that they received the communication material to counsel the parents on responsive parenting and ECD.

**% of FLWs who reported that they received communication material/tool to counsel parents**

| | Maharashtra | | Rajasthan | |
|---|---|---|---|---|
| | AWW | ASHA | AWW | ASHA |
| % | 68 | 57 | 50 | 29 |

Frontline workers who received communication material reported that they were trained to use it in order to convey their learnings more effectively to their communities - a positive output that was in line with the reconstructed theory of change. These findings were also corroborated by quantitative data which showed that more than 50% of ASHA and Anganwadi workers in Rajasthan reported the communication package as 'very useful', while approximately 65% to 70% of the frontline workers in Maharashtra gave a similar rating.

**FLWs reporting usefulness of communication material/tool in counselling parents on positive parenting and ECD**



*Figure 5: FLWs reporting usefulness of communication material/tool in counselling parents on positive parenting and ECD*

During the qualitative interactions, frontline workers reported that they felt that the communication tools made their jobs easier, acted as effective visual aids to explain even the most difficult messages and eased the language barrier. Moreover, it was reported that the tools helped in establishing trust in the minds of the community members and strengthened their belief in the messages conveyed by the frontline workers.

Discussions also revealed that frontline workers found the messages in the communication materials useful to counsel parents and other caregivers. In particular, messages related to cleanliness, health, cognitive development of children and the parent-child bond, were found to be most useful. Additionally, frontline workers suggested adding more messages related to toys and creative ways for brain stimulation. They also suggested adding more pictures, since it was observed that both parents and children were more attracted to pictorial representations.

Further, quantitative findings signify that FLWs mostly utilized home visits and mothers meeting in Maharashtra, and parent anganwadi meetings (PAM) and home visits in Rajasthan to use the communication material to provide messages to the community.

On the beneficiary front, parents presented a mixed view of the frontline workers' ability to use the communication materials provided to them. While some parents reported that frontline workers did not use any materials while counseling them, many others appreciated the information provided in these materials and observed it aided their understanding around various aspects of early childhood development. Supervisors and other government officials also received positive feedback from parents when they went on the field to understand how well the communication materials were being utilized. Due to the availability of age-appropriate communication material for children, the quality of the training for the parents had improved. To further elaborate, information shared was aligned to the age of the children being cared for, be it newborn, infant, toddler, or preschooler. Because it was relevant in its immediacy and need, parental engagement was more.

> *Communication material were provided to us and we also took them with us while visiting the homes in the village. We got training too so we took the cards with us wherever we went and showed it to the parents. A lot of information was there on those cards related to child development and care. The good thing was that everybody believed and listened to us after seeing those cards. (AWW, Aurangabad)*

*Parents were quite enthusiastic after we showed them the materials such as flipcharts, pictorial materials for counselling them on the childcare and development in a better and in a more practical way. (AWW, Pune)*

*Messages like parents should give time to their children, they should look after their studies at home are most useful. The messages related to the cognitive development of the children which were there in the book are also good. Also, children can make various craft items with paper which would help them improve their creativity. Something of this kind or ways to improve a child's creativity can be added in the communication material. (AWW, Dungarpur)*

*Messages related to washing hands were good, keeping home clean, brain development, parent-child bonding, using locally available material to make play things, and good behaviour all were good messages. These were good things which I found. (ASHA, Aurangabad)*

*Many times when the Anganwadi workers are stuck up with some issues like how certain things can be implemented, the pictorial charts help them a lot to tackle the issue and explain it to the parents. Many frontline workers used these ECD play cards, even small colourful leaflets to tell the parents. (District govt official, Aurangabad)*

*If we make them (parents) do activities from the pages of the book, the father, and the mother both become happy and satisfied that their child has learnt something. And in that process the frontline workers also participate with them, playing and entertaining them and they too feel content and satisfied. (Lady Supervisor, Dungarpur)*

## An Opportunity for Collective Empowerment – A Lady Supervisor

*As a lady supervisor, if Sunita Pardeshi (Aurangabad, Maharashtra) could think of one programme holding great promise for the betterment of the children, parents and frontline workers (FLWs) alike, it would be the responsive parenting and Early Childhood Development (ECD) intervention.*

*As part of the intervention, she learnt about brain cells, the different stages of physical and mental development in a child's life, the connection between play and brain development, methods to engage young children and babies using visual material and sounds, and other important ECD practices integral for the holistic development of children. Having been trained on ECD herself, she trained the FLWs under her on the same to increase their capacity and skills on the field.*

*Before the intervention, the FLWs lacked the confidence to address large gatherings. However, the training as part of the ECD intervention, equipped them with the necessary knowledge, skills, and confidence to counsel parents and other caregivers on early childhood development using platforms such as parent's meetings and home visits. The one-of-a-kind activity-based training involved role-play of actual scenarios with roles being enacted by FLWs themselves to increase their confidence through rigorous practice.*

*Before the advent of the intervention, FLWs would only instruct the parents on particular tasks, however, the ECD training taught them the proper methods to conduct parent's meetings and home visits. FLWs were taught techniques to counsel the caregivers, greet them, listen to them, praise them, encourage them, and gain their trust and confidence, which made the parent's meetings and home visits quite successful. They were taught to counsel, not only the parents, but also the other caregivers who were directly or indirectly involved in the nurturing and care of the child. Sunita, in her capacity as a lady supervisor, makes all attempt to rectify any shortcomings she observed while supervising the FLWs on home visits and parent's meetings.*

*According to Sunita, the ECD intervention employed innovative approaches like the Palak Melas which involved the set up of different stalls and demonstration of activities that parents could use with their children for stimulation and development. Demonstrations were also conducted on the use of everyday items like utensils, vegetables and grains in play activities with the children. As an example, flour could be used to teach writing and drawing in a fun way.*

*Further, Sunita shares that the intervention had considerable positive impacts on the parents, children and the FLWs. It facilitated collaboration between ASHAs and Anganwadi Workers, who shared work responsibility during the period of the intervention. Parents and other family members got involved in early childhood development activities for their children. Even though the fathers' attendance at parent's meetings was low, many of them participated in the discussions during the home visits. The parents implemented their learnings on the proper methods for feeding, bathing, clothing, and mentally stimulating the child using everyday objects to enable the learning of shapes, sizes, and colors etc.*

*As an example, Sunita shared the story of a mother with two malnourished children who gained right knowledge and awareness after participating in the intervention. Not only did the mother learn many new activities, she also applied these in her life and gradually her children's health improved.*

*Earlier, parents and other caregivers did not appreciate the importance of ECD and considered it an extra burden. However, because of the continuous counselling support provided to them by FLWs, parents and other caregivers came to understand the value of positive parenting and care in the development of their children. They even realized that the ECD activities made childcare easier and was complementing their daily activities. Scheduling home visits as per the availability of the parents and adopting an appreciative communication style while interacting with the caregivers, motivated them to participate in the meetings and home visits.*

*Being closely involved with the intervention, Sunita has a few suggestions. She proposed to increase the involvement of the village youth in the ECD intervention which could be achieved by setting up play gardens in every gram panchayat where the youth could devote some time for the development of the young children in the communities. Sunita strongly believes in the potential of the ECD intervention to bring significant improvements in the physical, cognitive, social and emotional abilities of the children and recommends its continuation for a longer time.*

## EQ6: What was the quality of the training to FLWs, in terms of content, structure and delivery medium?

*SEQ 6.1: What did FLWs like about the training (all training programmes), what did they find useful?*

*SEQ 6.2: What did FLWs dislike about the training, what did they not find so useful and why?*

*SEQ 6.3: What suggestions do FLWs have for improvements?*

In the quantitative survey, more than fourth-fifth of AWWs (83.2%) and more than half of ASHAs (55.3%) in Maharashtra and about half of AWWs (46%) and a quarter of ASHAs (23%) in Rajasthan reported that they received training on positive parenting and ECD. There may be various possible reasons for low reporting of receipt of training by FLWs. One of the reasons could be FLW recall issue due to considerable gap between the time FLWs were last trained and the timing of main data collection. The project activities mostly concluded by first quarter of 2020 and the some of the FLWs were trained in the last quarter of 2019. The data collection spanned from Dec 2020 – Jan 2021. The other reason could be that FLWs generally receive other trainings throughout the year as a part of their job and in some cases, it might be difficult for FLWs to clearly distinguish which training they received. Further, COVID might have had an impact on the recall ability of the FLWs due to the increased work pressure during pandemic. Also, as can be seen in the results, the recall in Maharashtra is higher when compared to Rajasthan. This could possibly be because in Maharashtra, once the master trainers were trained, they organized the trainings for FLWs on a separate day in a month and hence the FLWs had better chances of recalling the trainings received in Maharashtra since the trainings happened on a separate day in a month. In Rajasthan, since the training was conducted during sector meetings itself, FLWs might in some cases not recall that the trainings received during these meetings. Finally, it might indeed be the case that the FLWs may not have received any training on positive parenting and ECD.
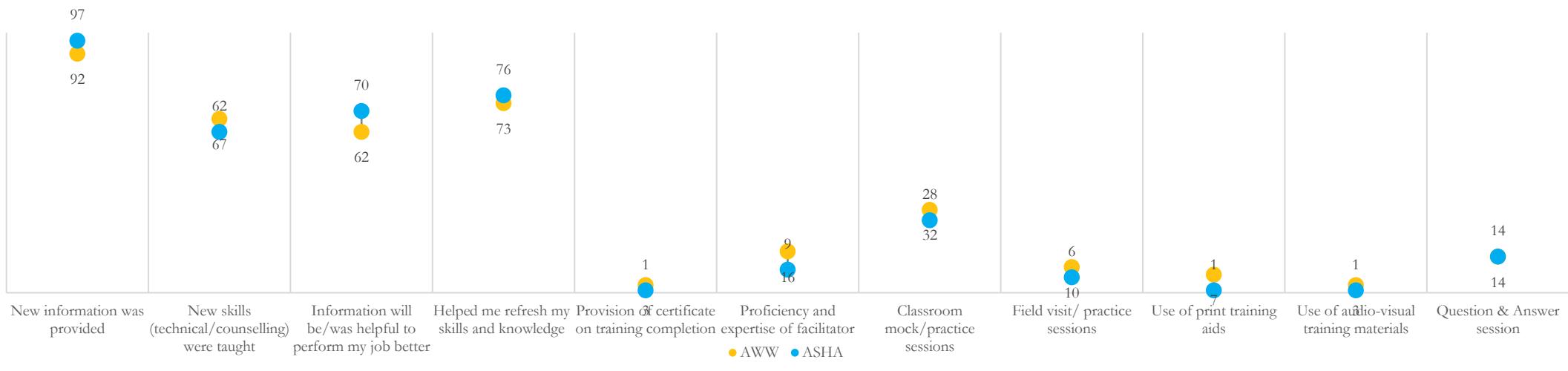
To mitigate the risk of recall issue and distinguish the training, the evaluation team has rigorously tested the study tools twice and included verbal clues, simplified local language during pilot testing phase and during main data collection phase, enumerators probed multiple times and provided sufficient time for FLWs to recall the training in case they received one. In spite of our best efforts, there is always a possibility that a few FLWs might not clearly recall the trainings they received.

Interviews with frontline workers provided in-depth insights into the quality of training covering aspects such as content, structure and medium of delivery. Overall, during the in-depth interviews, frontline workers expressed their satisfaction with the training received on responsive parenting and care. They were happy with the new information and skills provided in the sessions as it improved their knowledge base on parenting and care. Similarly, in the quantitative survey, when asked about what they liked about the parenting and ECD training[42] FLWs commonly reported that they liked the new information being provided, information will help to perform their job better and help in refreshing their skills and knowledge on parenting and ECD. Many frontline workers also felt that the sessions built their confidence and ultimately increased their efficiency on the field while counselling parents and other caregivers. Further, it could be observed that FLWs in Maharashtra are more satisfied with the trainings when compared to Rajasthan.

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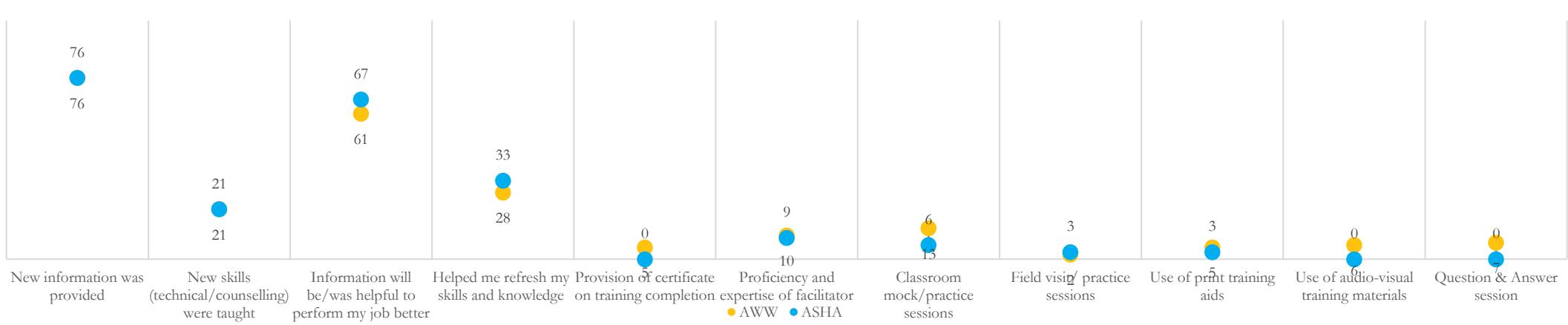
[42] The team did not read out the options to the FLWs. The responses from the FLWs were self-reported.

**FLWs reporting what they liked about the trainings they received on positive parenting and ECD – Maharashtra (in %)**



| Category | AWW | ASHA |
|---|---|---|
| New information was provided | 92 | 97 |
| New skills (technical/counselling) were taught | 62 | 67 |
| Information will be/was helpful to perform my job better | 62 | 70 |
| Helped me refresh my skills and knowledge | 73 | 76 |
| Provision of certificate on training completion | 1 | |
| Proficiency and expertise of facilitator | 9 | 16 |
| Classroom mock/practice sessions | 28 | 32 |
| Field visit/ practice sessions | 6 | 10 |
| Use of print training aids | 1 | 7 |
| Use of audio-visual training materials | 1 | |
| Question & Answer session | 14 | 14 |

**FLWs reporting what they liked about the trainings they received on positive parenting and ECD – Rajasthan (in %)**



| Category | AWW | ASHA |
|---|---|---|
| New information was provided | 76 | 76 |
| New skills (technical/counselling) were taught | 21 | 21 |
| Information will be/was helpful to perform my job better | 61 | 67 |
| Helped me refresh my skills and knowledge | 28 | 33 |
| Provision of certificate on training completion | 0 | |
| Proficiency and expertise of facilitator | 9 | 10 |
| Classroom mock/practice sessions | 6 | 13 |
| Field visit/ practice sessions | 3 | |
| Use of print training aids | 3 | 5 |
| Use of audio-visual training materials | 0 | |
| Question & Answer session | 0 | 7 |

They also appreciated the practical techniques taught in the sessions and the wide range of topics covered. While the overwhelming response was positive, a few frontline workers felt the training sessions were time-consuming and did not provide enough new information, everytime.

Many frontline workers requested regular training sessions on new and existing topics in order to improve their performance. They expressed their enthusiasm toward expanding their knowledge and capacity regarding different aspects of child development and parenting. This was in line with quantitative findings, which showed that a substantial percentage of the frontline workers expressed the need for training in new areas (80% (AWW) & 45% (ASHA) in Maharashtra; and 58% (AWW) & 23% (ASHA) in Rajasthan).
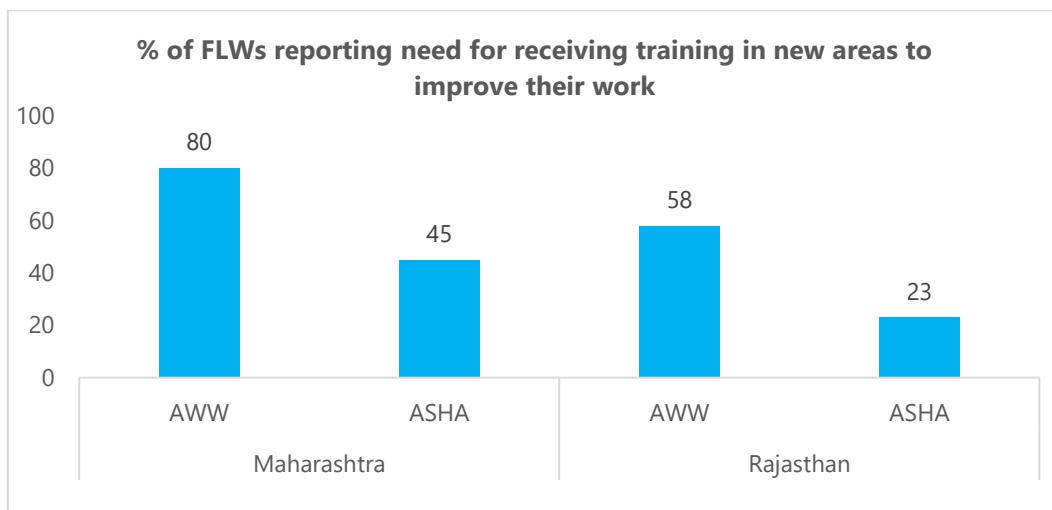


*Figure 6: Percentage of FLWs reporting need for receiving training in new areas to improve their work*

*We have been taught in a very simple and effective way about what and how parents should say and treat their children with the help of clips, charts, pictures, etc. I have gained a lot from the training. (AWW, Pune)*

*The training has helped us a lot, there were enough practice sessions and they helped build our skills. Without the training a lot of things would have been difficult to understand related to positive parenting and ECD. (AWW, Palgarh)*

*Sometimes there is nothing new to teach in the extra time of training. The training place could be made more comfortable. (AWW, Yavatmal)*

### SEQ 6.4: Whether messaging in the communication package customized to gender and vulnerable groups?

The communication package material and messaging is equitable to different groups and gender. Gender and equity-based concepts are integrated with clarity. Take for example, responsive parenting being the responsibility of both parents and other family members - this is clearly depicted and integrated through the content. There is an active representation of mothers, fathers and other family members such as grandmother, grandfather and siblings engaging in touch, talk and play with both the girl child as well as the boy child; the prevalent household roles are challenged through depictions like fathers shelling peas or mothers playing ball;  fathers are depicted playing active games with their daughters or reading out stories to their sons; boys are seen engaging in quieter activities like rangoli making as well and helping their parents in household chores; the pictorial representation also comprises different geographical realities such as urban/rural and different cultural contexts and brings in the elders in the family consistently as contributors in child-rearing. The material also creates a supportive environment for the

mother by enabling the families' active and able support in child-rearing. The visual-laden material addresses the needs of parents who are lower-educated or illiterate as well. Context-specific examples also make the learning more relevant.

The material breaks the gendered role of toys, communication and activity engagement - by whom and for whom and where being a focus. It actively engages fathers and grandparents in providing positive parenting to children at home and explicitly addresses father's role in caregiving and breaking stereotypes regarding roles and responsibilities. The activities suggested use materials that are easily accessible at home and environs so that there isn't any need to purchase anything and the poorest of the house will have it.

The material has gone through purposive screening to address implicit biases in messaging and materials were developed through a participatory process. Most of the messaging uses gender-neutral language (English) e.g. their/them/they/child/children. Some of the messaging uses he/she and some of the messaging omits gender inclusive language and uses he, his and him instead of she/he, his/her's or him/her. It was also observed that inclusion of children with different needs does not come across explicitly and as shared by a UNICEF staff, has been addressed in trainings suggesting modifications in response to individual and family needs and contexts.

During the discussions, some frontline workers were able to identify messages related to gender and vulnerable groups as part of the communication package received. Gender-related messages were focused on promoting equality between the girl child and the boy child; improving health, education and related outcomes for the girl child; educating communities about harmful practices such as female foeticide or infanticide and counselling fathers and other members of the family regarding parental roles and responsibilities.

For vulnerable groups, communication materials contained information to encourage frontline workers to focus more on helping children from socially and economically disadvantaged backgrounds.

> *Both the parents are equally responsible for taking care of their child. It's not written anywhere that it is the father who has to earn money and it is the mother who has to look after her child. (AWW, Udaipur)*
>
> *We were told that people who were financially weak or the family was hard to reach, we should sit together and communicate together. Through this we can give them more information at one place and also clear their doubts about child development. (AWW, Dungarpur)*
>
> *We have to concentrate on the poor child more. We concentrate on them more and give the services of anganwadi like give them food and take care of them. (ASHA, Udaipur )*

## A Vehicle of Transformation – ASHA worker

*Living in a small family with her husband, and her 17-year-old son, Laxmi has been an ASHA worker since 2010 in the Girwa block of Udaipur district in Rajasthan. Being a health worker, she has been actively involved in being the first responder for the health issues of the villagers, especially for women and children in the region. As an ASHA worker, she has been responsible for various activities such as registering pregnant women, taking them for institutional deliveries, visiting new mothers after the third, seventh, fourteenth and twenty first days, checking on the health of newborns, educating young mothers on keeping their babies healthy, giving information on nutrition and hygiene, and others.*

*Laxmi has always put a lot of emphasis on nutrition and has tried to keep malnourishment at bay in her community in collaboration with the Anganwadi worker. She has made it a point to regularly check the weight of the children under her care, and if any child is found to be malnourished, she takes immediate steps to remedy the situation or avoid it in the future altogether. However, Laxmi shares that she felt inadequate while providing these services as she is the only ASHA worker responsible for a population of 2300 people, instead of being responsible for the needs of a population of 1000.*

*Although Laxmi already possessed some knowledge regarding early childhood development (ECD), she mentions that the training as part of the parenting and ECD intervention by UNICEF expanded her knowledge base significantly. She learnt methods and activities pertaining to different aspects of early childhood development, and techniques to counsel parents and other caregivers in the community. Laxmi recalled that families in her community were unaware of the importance of early childhood development and the intervention played a huge role in introducing them to the concepts necessary for building a base for the physical, cognitive, emotional, and social development of their children.*

*Utilizing parent's meetings and home visits, Laxmi teaches the parents different methods of engaging with their children via play and other activities used for stimulating cognitive and physical development. Parents are counselled on how to utilize their immediate surroundings and locally available material while interacting with their children. She provides an example - parents could teach children about colors and shapes by showing children different vegetables, or parents could mimic different sounds and characters while teaching children stories or poems. Parents could assess their children's abilities and their progress while doing these activities. In case a child is unable to do an activity, Laxmi advises the parents to provide them more practice and not shout at them.*

*Being at the forefront of this life-changing intervention, Laxmi truly believes in the value of early childhood development in bringing long lasting mental and physical transformation for the children in her community. She is proud to be a part of the intervention that is shaping the future generation of the community and the community itself.*

## EQ7: To what extent was the training able to build the skills and capacity of FLWs to counsel and support parents/caregivers on parenting care?

*SEQ 7.1: To what extent there was change in knowledge, attitude and perceptions of FLWs on the role of parenting in ECD?*

| Inputs/ Activities | | Outputs | | Outcomes |
|---|---|---|---|---|
| • Training packages for ICDS and health functionaries<br>• Training of FLWs by master trainers<br>• Supportive supervision for FLWs | ⇨ | • Improved capacities of FLWs; improved knowledge, skills and practices on ECD/responsive parenting<br>• Enhanced confidence of FLWs to interact with community members | ⇨ | • Improved quality of counselling and interaction of FLWs with community |

*Figure 7: Reconstructed Theory of Change*
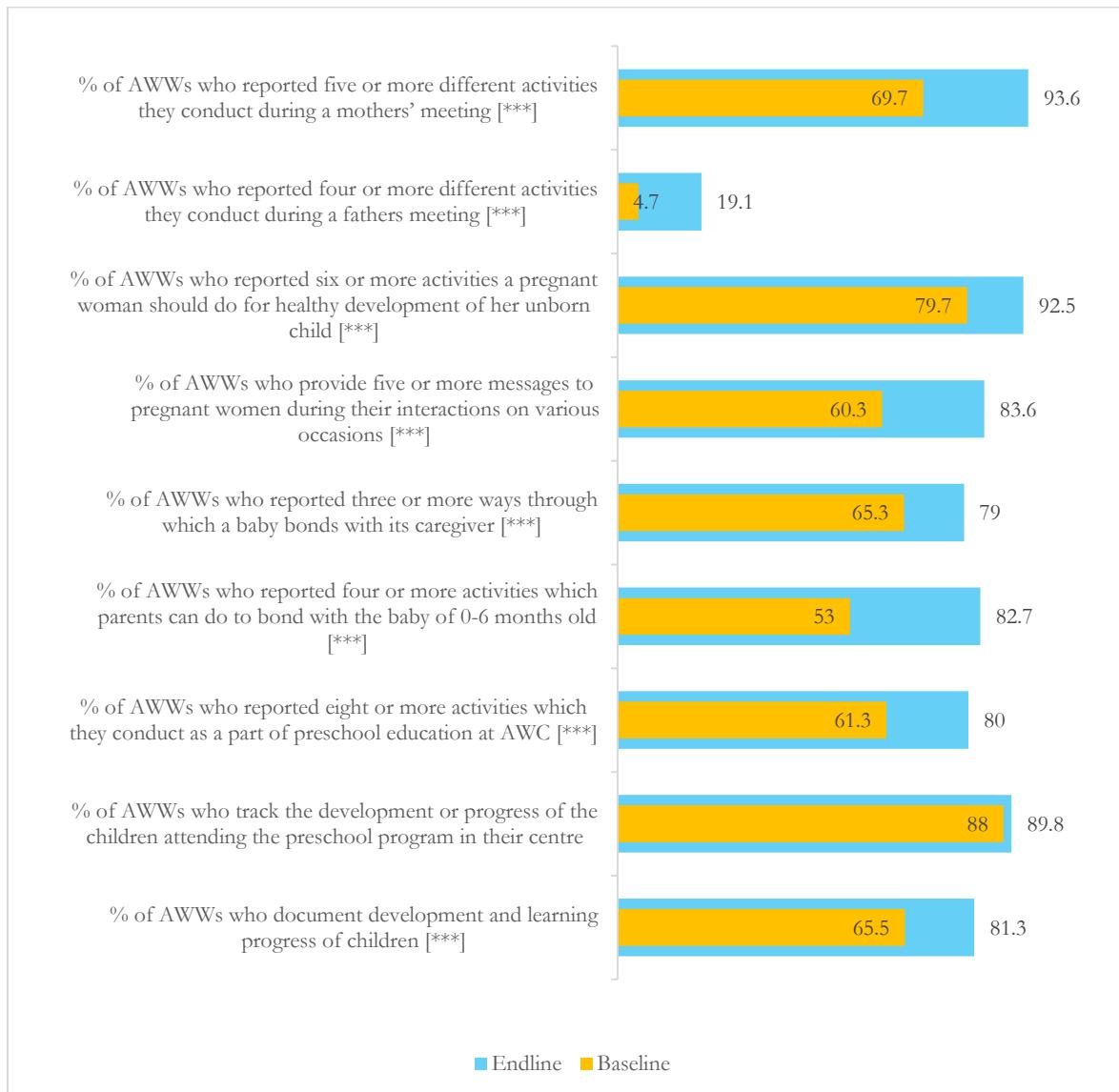
The quantitative survey results signify a positive change in the knowledge, attitude, and perceptions of FLWs in both Maharashtra and Rajasthan with the gains being higher in Maharashtra compared to Rajasthan. The detailed analysis of FLW quantitative survey has been presented in *Annexure 17*.

> **Note:** *Throughout the summary report, the significant differences across sites have been highlighted with start mark (\*) in the figures. Below is the notation for each significance level –*
>
> *\*   significant at 10% significance level*
> *\*\* significant at 5% significance level*
> *\*\*\*significant at 1% significance level*
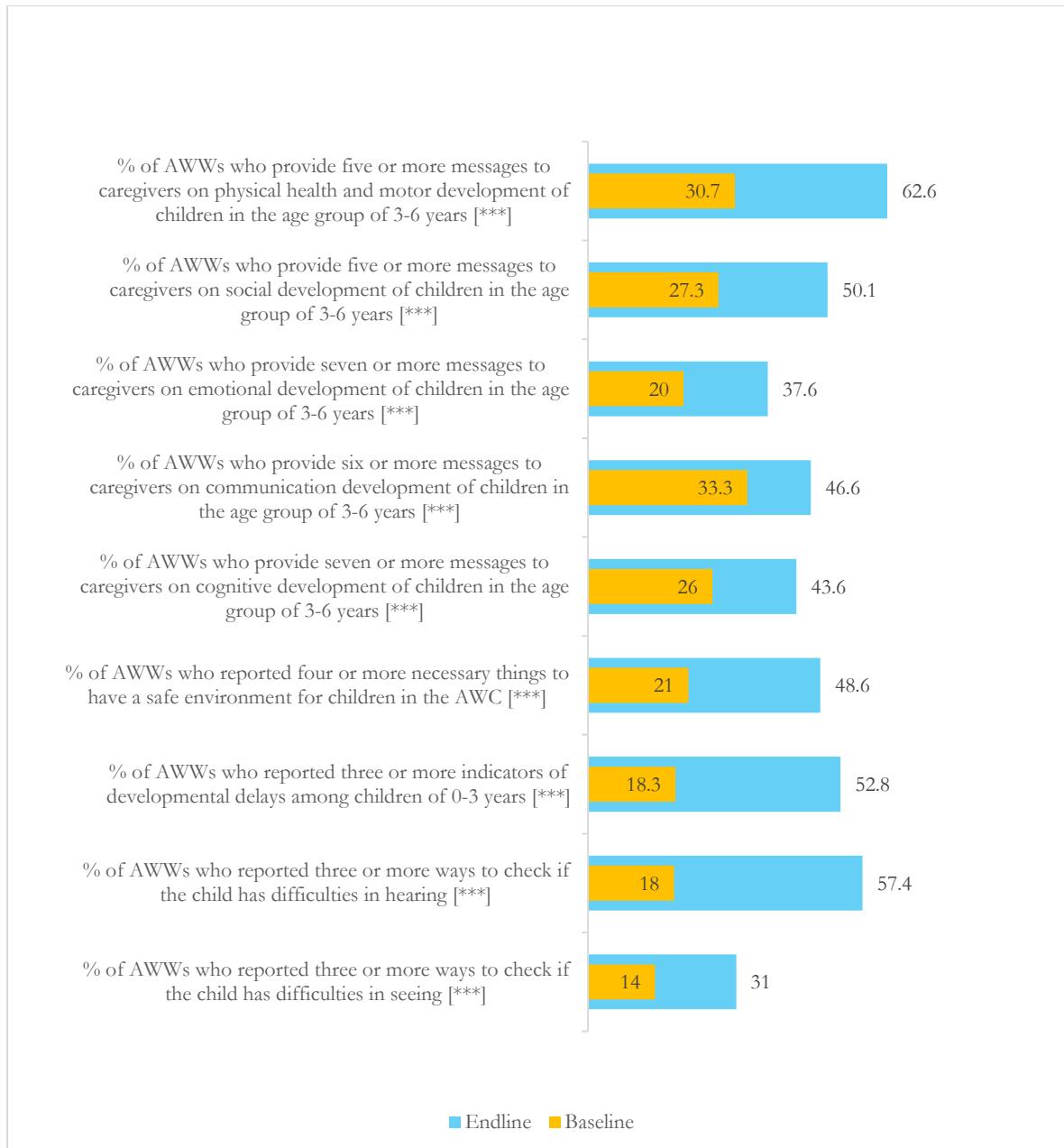
**Maharashtra**

**AWW**



Please refer figures 29, 33, 39, 43, 49, 51, 75 for more detailed information on the above indicators

| Indicator | Baseline | Endline |
|---|---|---|
| % of AWWs who provide five or more messages to caregivers on physical health and motor development of children in the age group of 3-6 years [***] | 30.7 | 62.6 |
| % of AWWs who provide five or more messages to caregivers on social development of children in the age group of 3-6 years [***] | 27.3 | 50.1 |
| % of AWWs who provide seven or more messages to caregivers on emotional development of children in the age group of 3-6 years [***] | 20 | 37.6 |
| % of AWWs who provide six or more messages to caregivers on communication development of children in the age group of 3-6 years [***] | 33.3 | 46.6 |
| % of AWWs who provide seven or more messages to caregivers on cognitive development of children in the age group of 3-6 years [***] | 26 | 43.6 |
| % of AWWs who reported four or more necessary things to have a safe environment for children in the AWC [***] | 21 | 48.6 |
| % of AWWs who reported three or more indicators of developmental delays among children of 0-3 years [***] | 18.3 | 52.8 |
| % of AWWs who reported three or more ways to check if the child has difficulties in hearing [***] | 18 | 57.4 |
| % of AWWs who reported three or more ways to check if the child has difficulties in seeing [***] | 14 | 31 |

■ Endline    ■ Baseline

Please refer figures 57, 61, 63, 65, 67, 71, 79, 81, 83 for more detailed information on the above indicators

## ASHA



% of ASHAs who reported five or more different activities they conduct during a mothers' meeting [***] — Baseline 70, Endline 92

% of ASHAs who reported four or more different activities they conduct during a fathers meeting [***] — Baseline 3, Endline 16.2

% of ASHAs who reported six or more activities a pregnant woman should do for healthy development of her unborn child — Baseline 83, Endline 81.4

% of ASHAs who provide five or more messages to pregnant women during their interactions on various occasions [***] — Baseline 58, Endline 87

% of ASHAs who reported three or more ways through which a baby bonds with its caregiver [***] — Baseline 56, Endline 81.4

% of ASHAs who reported four or more activities which parents can do to bond with the baby of 0-6 months old [***] — Baseline 60, Endline 88.2

■ Endline  ■ Baseline

ASHA

**Rajasthan**

**AWW**



Please refer figures 30, 34, 40, 44, 50, 52, 76 for more detailed information on the above indicators

% of AWWs who provide five or more messages to caregivers on physical health and motor development of children in the age group of 3-6 years — Baseline 25.2, Endline 29.3

% of AWWs who provide five or more messages to caregivers on social development of children in the age group of 3-6 years [**] — Baseline 25.1, Endline 35.5

% of AWWs who provide seven or more messages to caregivers on emotional development of children in the age group of 3-6 years [**] — Baseline 21.2, Endline 30.6

% of AWWs who provide six or more messages to caregivers on communication development of children in the age group of 3-6 years [**] — Baseline 24.5, Endline 35

% of AWWs who provide seven or more messages to caregivers on cognitive development of children in the age group of 3-6 years — Baseline 24.5, Endline 28.4

% of AWWs who reported four or more necessary things to have a safe environment for children in the AWC [***] — Baseline 17.2, Endline 33.3

% of AWWs who reported three or more indicators of developmental delays among children of 0-3 years [***] — Baseline 15.9, Endline 27

% of AWWs who reported three or more ways to check if the child has difficulties in hearing [***] — Baseline 10.6, Endline 20.6

% of AWWs who reported three or more ways to check if the child has difficulties in seeing — Baseline 8.6, Endline 11.8

■ Endline  ■ Baseline

Please refer figures 58, 62, 64, 66, 68, 72, 80, 82, 84 for more detailed information on the above indicators

**ASHA**



The improvement in the capacities of the frontline workers, according to the reconstructed theory of change, was corroborated by the information gathered during the discussions with various stakeholders. It was revealed that a significant improvement had occurred in the knowledge, attitude and perceptions of frontline workers on the role of parenting in early childhood development. Supervisors were happy to note this positive change, post training (especially in Maharashtra). According to them, training sessions helped to build the confidence of the frontline workers and left them better equipped to counsel parents and other caregivers. Due to the improvement in their knowledge base, frontline workers became more aware of different aspects of responsive parenting and ECD. For example, frontline workers were able to counsel parents on the importance of parent-child interactions. As a result, communication between parents and children increased, and parents started devoting more time to their children.

Not only this, the trainings have also led to an improvement in the attitude of the frontline workers towards children during the meetings, as reported by a CSO partner in an interview. The FLWs now understand that children required guidance and support, and not domination and hence should be treated with respect. Frontline workers counselled parents on the importance of play for children - not only for physical and cognitive development, but also to keep children proactive, happy and engaged with their surroundings. Caregivers were encouraged to combine play and communication activities with occasions such as feeding, dressing, and bathing if they were short of time. As per quantitative findings, the percentage of frontline workers convincing caregivers to play with their children went up from 64% to 86.9% (AWW) and 64% to 87% (ASHA) in Maharashtra; and from 67.5% to 85.4% (AWW) and 81.6% to 87.2% (ASHA) in Rajasthan.

*Figure 8: FLWs convincing caregivers to play with child – Maharashtra (in %)*



*Figure 9: FLWs convincing caregivers to play with child – Rajasthan (in %)*

Frontline workers were also able to discuss the importance of the parent-child bond and age-appropriate discipline. FLWs encouraged parents to establish a friendly, open and loving relationship with their children and avoid quarreling or bad behaviour with them. This is evident in the quantitative data which shows a rise in the percentage of frontline workers counselling about the importance of parent-child bonding in mothers meetings from 36.5% to 52.1% (AWW) and 36.8% and 41.5% (ASHA) in Maharashtra; and from 35.3% to 40.4% (AWW) and 32.7% to 38% (ASHA) in Rajasthan.

Highlighting the importance of discipline in daily life, frontline workers counselled parents against beating as a punishment, instead emphasizing the need for calm and friendly discussions to help children realise their mistakes. There is a considerable rise in the percentage of frontline workers who reported conversing about discipline and punishment methods in mothers meetings from baseline to endline in both the states; from 38.8% to 47.3% (AWW) and 27.4% to 36.5% (ASHA) in Maharashtra; and from 18.7% to 24.7% (AWW) and 18.4% to 29.2% (ASHA) in Rajasthan.

*There is a need for communication between children and parents. Children understand this early on and it becomes very important in their development and it also makes their relationship better and stronger. (AWW, Pune)*

*Even if parents are busy with their work, we tell them to spend some time with their children in the evening as children are happy to play or spend some time with their parents. (AWW, Pune)*

*Through playing games children develop physical strength, increasing their internal strength, increase sharpness, and develop physically stronger. (AWW, Palgarh)*

*Every child loves to play. If parents play with their child, it will relax the child very much and he/ she will grow in a friendly atmosphere. It is very important for parents to play with their child. (ASHA, Dungarpur)*

*Bonding means if we behave freely with the children, if we mix with them, the bond between the parents and children will be good. Be friendly and loving. The bonding will be strong through positive parenting, which contributes to development of children. In addition to that, if they communicate more with children, then their relationship would become good and the bonding between them would be much stronger. We give counselling to them regarding this. (AWW, Aurangabad)*

*We advise the parents to never shout at them (children) or get angry at them. There are some children who get very frightened when they see their parents in such a state. So, what the parents should do is to give their children time apart from work and try to build a friendly relationship with them. We tell the parents, not to punish the children. We tell the parents that if they do anything in front of kids they will always copy. So, they should never behave in front of them in a wrong manner at home, so that they will not be affected negatively by it and they will have a good life. The children will copy their behaviour of shouting or violence, so it is always better to treat them with love. (AWW, Palgarh)*

*I would say it (ECD training) helped in a major way in changing the beliefs of supervisors and frontline workers. If you talk to them, the frontline workers and supervisors, so many of them would narrate to you stories of how this whole concept has benefitted them, or some of those who had completed their families, would come to us and say if the project had come earlier, it would have benefited our families, our children, it would have benefitted us. (CSO Partner, Maharashtra)*

*In Palghar one of the ICDS supervisors spoke during the training and she gave an example that she has a grandchild and she was of the view that the daughter-in-law should give more attention to the grandson. And after coming to this training, she started insisting to her own son, that he should also participate equally, not only her daughter-in-law. There when she confessed this, many people started talking about this. (CSO Partner)*

### SEQ 7.2: What factors influenced in building the skills and capacities of FLWs?

A majority of the frontline workers attributed the improvement in their skills and capacities to three factors, namely, the training sessions, the expertise of master trainers/supervisors, and the communication materials provided as part of the project. In Maharashtra, frontline workers also reported being satisfied with the training conducted and were highly appreciative of the support network provided by the senior officials and project staff. In Rajasthan, however, there was a mixed sentiment among FLWs, with some FLWs reporting that they were satisfied with the trainings and some noting that concentrating on the training after the administrative tasks during sector meeting was a challenge and very few opportunities for refresher trainings.

A CSO partner from Maharashtra noted that the appreciative communication method used in the training session by the supervisors played an important role in enhancing the FLWs' interest in the sessions. In the beginning, the supervisors were continuously handholding the frontline workers and providing active support on ground. The training sessions were experiential in nature with demonstrations of all the activities that the FLWs had to on the field, which has been highly appreciated.

During the discussions, supervisors revealed that the training sessions were an important factor in building the skills and capacities of the FLWs as they were very detailed and explored relevant concepts in depth. In Maharashtra, AWW Supervisors and ASHA facilitators specifically highlight that the strategy to have a separate training day during a month (apart from sector meeting) was very helpful in completely focusing on the training without worrying about the administrative tasks and lack of time. A supervisor from Pune reported that the training helped built the confidence levels of the frontline workers. The structure of continuous and refresher training proposed under project was useful in improving the knowledge level of the frontline workers. Not only that, the training focused on building the practical skills of frontline workers which helped them on the field.

A supervisor from Udaipur noted the clarity and simplicity in understanding of the ECD material provided to them, leading to an improvement in the quality of the counselling sessions with the parents.

> *Before training I didn't have proper skills and the ability to talk with parents but because of the training, we were taught how to explain things to the parents in a simple way. (ASHA, Aurangabad)*

*SEQ 7.3: Did the training lead to intended changes in communication style and behaviour of FLWs when engaging with parents/caregivers?*



| Inputs/ Activities | Outputs | Outcomes |
|---|---|---|
| • Training packages for ICDS and health functionaries <br> • Training of FLWs by master trainers <br> • Supportive supervision for FLWs | • Improved capacities of FLWs; improved knowledge, skills and practices on ECD/responsive parenting <br> • Enhanced confidence of FLWs to interact with community members | • Improved quality of counselling and interaction of FLWs with community |

*Figure 10: Reconstructed Theory of Change*

In line with the expected immediate outcome of the reconstructed theory of change, frontline workers and supervisors largely agreed that the training improved the communication style and behaviour of the frontline workers when interacting with parents and other caregivers. The training not only built their communication skills and confidence, it also equipped them with the necessary skills that would result in better information dissemination. FLWs noted that it was easier to connect with caregivers and build rapport post training, leading to more number of people being counselled effectively. The training although did not have specific dedicated session on building these skills, it however was ingrained within the ECD training sessions and during mock sessions. Aspects such as how to communicate with caregivers, how to ask them questions, how to encourage them to ask questions, how to connect with them were discussed. Due to the trainings, the FLWs were able to develop the skillset that enabled them to gauge and understand the needs of the caregivers, and then deliver context specific messages.

They also noticed some positive changes in the communities. While earlier frontline workers were mostly ignored, now families had started to greet them, show them respect and invite them into their homes. Many FLWs also reported an increase in parental enthusiasm and engagement, with more and more families voluntarily approaching them with questions regarding parenting and care. This was also

corroborated by parents who reported an increase in the engagement between the frontline workers and the caregivers.

FLWs attributed these changes to the better counselling support parents received, as well as the communication materials and flip charts provided, which lent authenticity to their messages.

In their interviews, parents (mostly mothers) spoke positively about the FLWs behaviour and conduct while conducting meetings and delivering ECD messages. They highlighted a few key changes observed in the services provided by the frontline workers including, better message delivery using simple vocabulary in the local language; improvement in behaviour and conduct while interacting with parents; increase in the number of visits; and practical demonstrations of messages. Parents also revealed that the addition of play and activities made meetings with frontline workers more enjoyable and increased their enthusiasm. However, these positive aspects were less commonly reported by fathers (especially in Rajasthan) as most of them mention that they do not regularly meet their FLWs. Interestingly, fathers from Pune and Palghar reported that they to a large extent, regularly participated in meetings organized by FLWs (baba palak sabha) and noted improvements in the interactions between them and FLWs.

*We have been trying to counsel caregivers from the beginning but through training we have been taught the proper way of interacting with the parents. After receiving the training on ECD and communication material, we could make people understand better and connect with them. Our morale increased. (AWW, Dungarpur)*

*In the training provided, we were told how to communicate with parents, how to ask them questions, and how to answer their questions. When done with the training it has been very useful for us to tackle such challenges. (ASHA, Aurangabad)*

*Earlier, when we used to explain, people didn't pay much attention. But, after receiving the training on parenting and ECD, when we went to explain to them, we have undertaken a new way of explaining things with the help of charts and pictures. Due to this, people used to pay much more attention. Now it is easy for us to understand their views and thoughts due to which it was easy on our part to give proper answers to their questions and make them understand various developmental aspects. (AWW, Udaipur)*

*Earlier it was like 10-15 mothers sitting with one ASHA alone and receiving lectures. This was the earlier way of mothers meeting. This is my own experience while I visited the ASHA on a monitoring visit. This was the earlier picture. Now when I visit 6 blocks where the piloting has been done, there I see ASHA, Anganwadi worker, supervisor or the block facilitator all are sitting together with the mother and equally involving mothers in the discussions and activities. So, there has been a good quality change in mother's activity. (District govt official, Yavatmal)*

*In the beginning, ASHA and Anganwadi workers worked independently. But now we are together. So, there is an impact on people that we work together and go together. (ASHA/Anganwadi Supervisor, Aurangabad)*

*Another important thing that I would like to mention that with lots of efforts, we have been able to create an environment to a large extent I would say, not fully, but to a large extent an environment of appreciative enquiry, an environment of support or build a supportive structure around these FLWs, and it is very important that this continues. (CSO Partner, Maharashtra)*

*SEQ 7.4: Did the training build the skills of FLWs to counsel the fathers of children?*

Quantitative findings show an increase (although still low) in the percentage of FLWs organizing fathers meeting from baseline to endline in both Maharashtra and Rajasthan. This was corroborated by the qualitative interviews which revealed that frontline workers continued to face challenges while counselling fathers of the children, and only a minimal progress has been made in this regard.
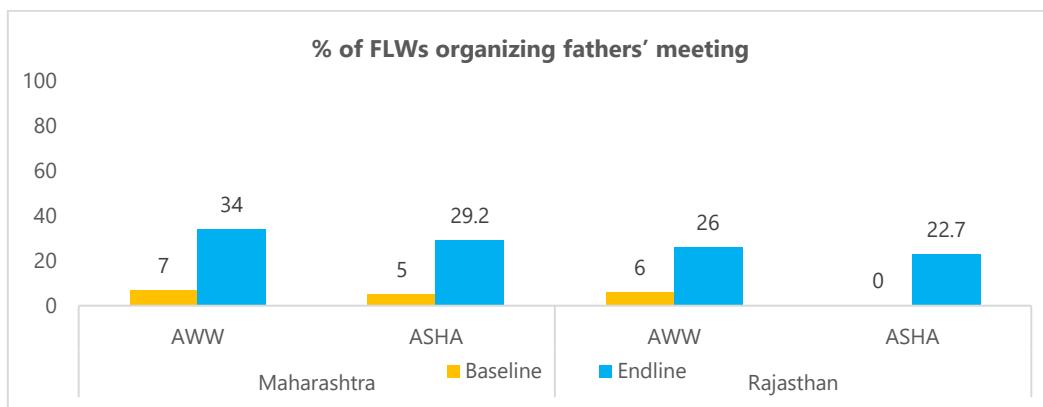


*Figure 11: Percentage of FLWs organizing fathers' meeting*

Some of the major challenges outlined were lack of availability of fathers due to their occupations, migrant nature of jobs, orthodox mindsets, lack of awareness, illiteracy, and alcohol addiction. Frontline workers reported (especially in Rajasthan) that a majority of the men considered childcare and parenting outside their domain and were unaware of their responsibilities as fathers.

Despite this, many FLWs reported an improvement in their counselling skills, especially with respect to fathers, post training. The new information and techniques learnt during training built their confidence while interacting with fathers and other family members. This was also corroborated by parents who shared that many frontline workers were communicating with fathers on home visits. This was further supported by quantitative findings which showed a jump in the confidence levels of both ASHA and Anganwadi workers when interacting with male caregivers regarding various aspects of child development.
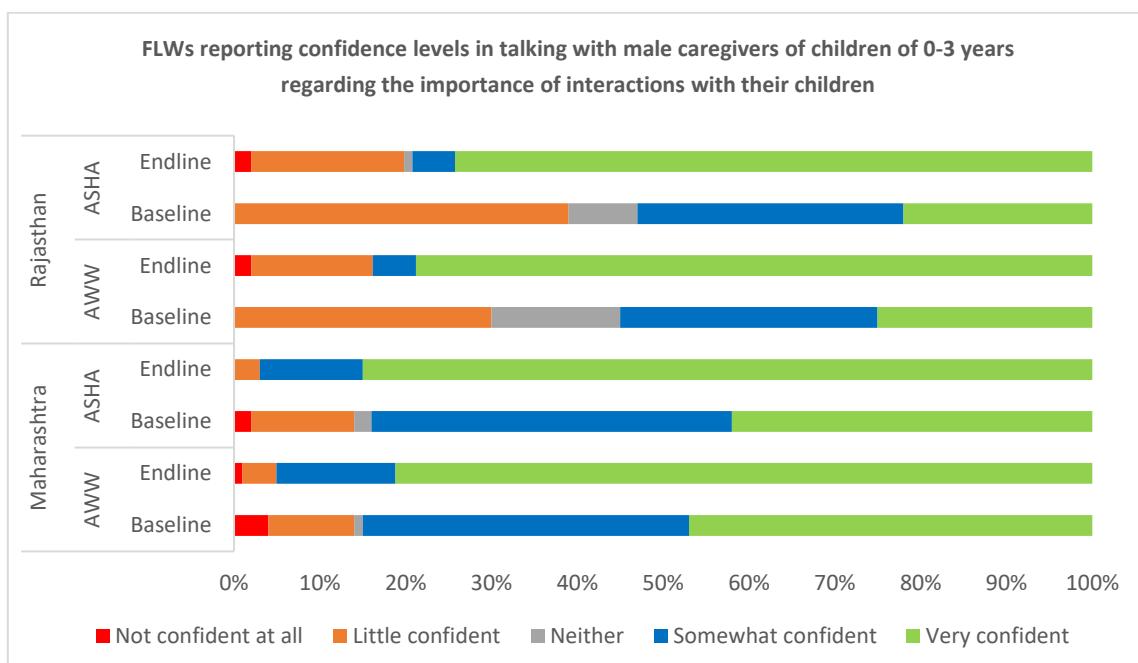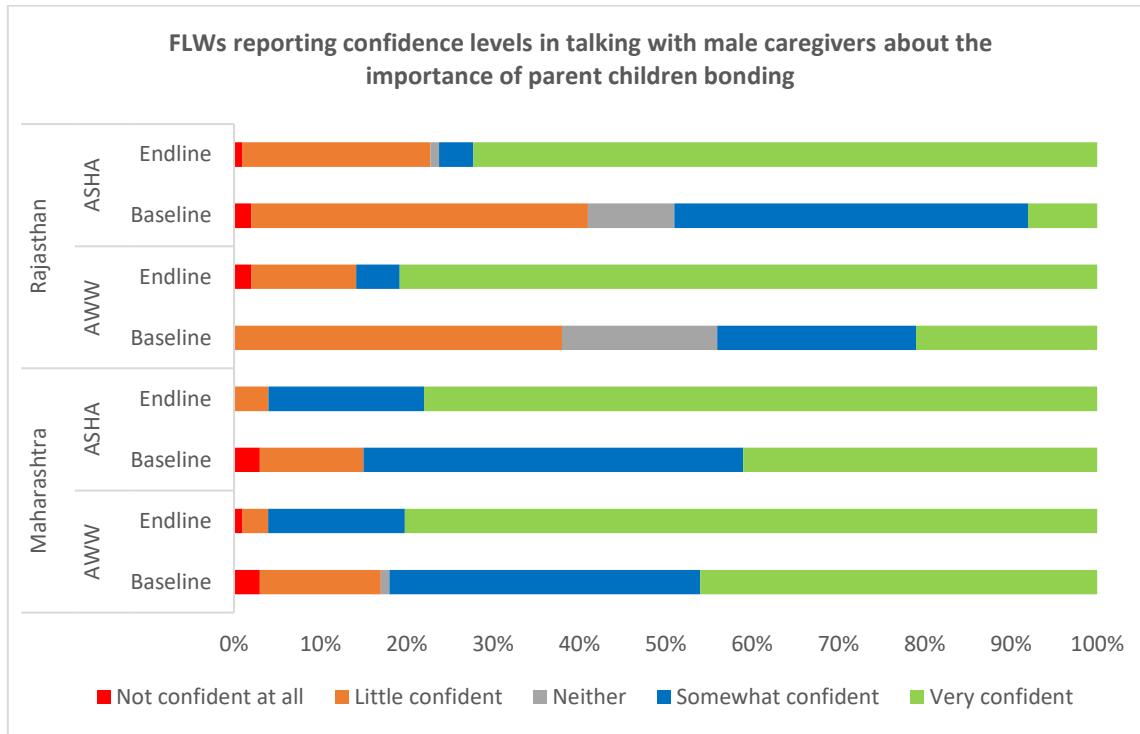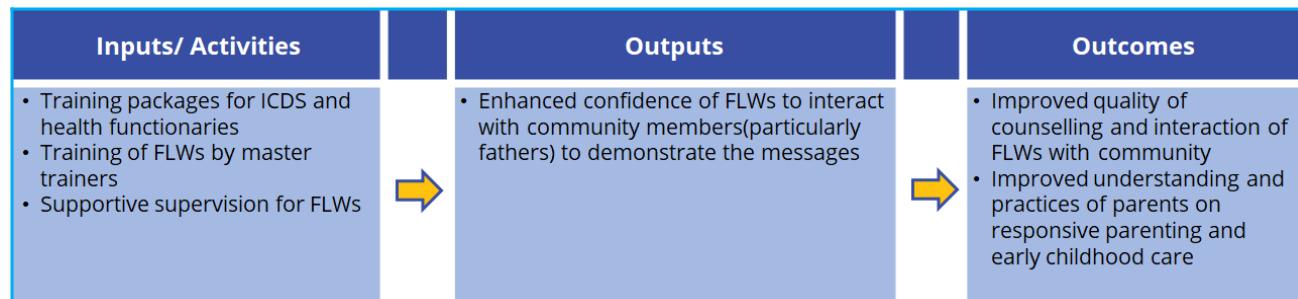


*Figure 12: FLWs reporting confidence levels in talking with male caregivers of children of 0-3 years regarding the importance of interactions with their children*

*Figure 13: FLWs reporting confidence levels in talking with male caregivers about the importance of parent children bonding*

In the interviews, it was observed that some of the fathers had gained knowledge regarding positive parenting and were beginning to participate in meetings, even though a majority still did not interact with the frontline workers nor did they attend meetings conducted in their communities. Thus, an improvement in the abilities and confidence of the FLWs to interact with fathers, albeit small, was in line with the expected output of the reconstructed theory of change.



*Figure 14: Reconstructed Theory of Change*

To encourage fathers' participation, supervisors suggested putting up posters on relevant issues in communal spaces in the village and delivering messages during the Gram Sabhas which witnessed large participation from gents. It was also suggested that frontline workers could take help from persons of influence in the community such as the sarpanch and the priest to convince fathers to participate more in early childhood development meetings and activities.

*I remember earlier the fathers were unaware of many things but now after counseling they are more aware of their child wellbeing. We told them their importance in parenting so they are now more aware. (ASHA, Aurangabad)*

*Earlier, child care was a work for only women. But, after much counseling, men are also participating in parenting, although still low. This can be considered as a vital change. They are now themselves coming and asking various aspects of childcare. (AWW, Yavatmal)*

*Actually, children's mothers are coming to us. Fathers are out for work. So, we are counseling the mothers. But when we go for home visit we meet the father then we make them aware about taking proper care of the child and mother etc. We ask the father to give some time to the mother to rest. Enroll the child in Anganwadi center or school, if the child is above 6 years. (ASHA, Dungarpur)*

*On parent's meeting day or immunization day the parents bring the kids and most of the times the fathers bring the kids so we talk to them then. They bring the kids in their scooter or motorcycle themselves for vaccination, so they must stay for 10 minutes and we talk to them during that time. But this happens rarely. (Lady Supervisor, Pune)*

*Due to the training the frontline workers are now confident in motivating the fathers in childcare which was earlier difficult. (Lady Supervisor, Udaipur)*

*We are now able to give advice to fathers. Generally, we say not to discriminate between a boy and girl andwe tell the father to treat both of them equally. Childcare is their (fathers' and mothers') collective responsibility. If a mother is engaged in work, then they should engage children with them by singing songs, telling some lessons, etc. In case of sickness, the child's father should take care of it. (ASHA, Palgarh)*

*The frontline workers believe in themselves. They believe I have the essential knowledge. I can communicate with the fathers with confidence. So, earlier when the fathers were coming to mothers' meetings, the FLWs were a little bit hesitant, like how I can initiate dialogue with them, but now over the practice of so many months they are more confident. (CSO Partner)*

## A Good Samaritan – A Father

*For Nilesh Dastridath from Pune, Maharashtra his two daughters are the apples of his eyes. Like any good parent, he is concerned about their wellbeing and holistic development. Apart from food, clothing, and hygiene, he is aware of the importance of education in shaping his daughters' future. This has led him to admit both his daughters into the nearby school for formal education. The girls are learning a lot of things and their father remains excited to learn from them. To the extent possible, he also tries to teach them alphabets and numbers by himself at home. Despite being a doting father, Nilesh remains busy with work, and is able to engage with his daughters only during early mornings or late evenings. The girls stay in the care of their mother and grandparents for the better part of their days.*

*The lockdown, during the pandemic period, resulted in a temporary shutdown of the girls' school as physical classes were suspended. Like most educational institutions, the school had to shift their classes online. The school made a WhatsApp group for parents where it conducted meetings, uploaded materials as pictures and videos, and conducted virtual classes. Nilesh advised his daughters to take classes and study online and guided them whenever he found time.*

*The Early Childhood Development (ECD) intervention introduced by UNICEF presented an exciting opportunity for Nilesh and educated him regarding the importance of ECD in the physical, cognitive, emotional and social development of children. He makes all attempt to attend the meetings and/ or home visits conducted by frontline functionaries. While work keeps him busy and sometimes does not let him attend the parent's meetings or home visits by the frontline workers, he makes sure his wife attends the meetings and took active part in the home visits, so that he could learn about the ECD intervention through her.*

*Through the meetings and home visits as part of the intervention, Nilesh was able to learn new and innovative methods to engage his daughters while teaching them the alphabets and numbers and identifying objects. With the help of innovative storytelling methods, charts, pictures, and games, he continues to stimulate his daughters, both, physically and mentally. The grandparents also received counselling on proper parenting and ECD practices, since the girls spent a significant amount of time with them.*

*Being a good Samaritan, Nilesh was not only concerned about the development of his own daughters but was also concerned about the development of the neighborhood children. When schools were shut, he would visit his neighbors on Sundays to show them how to use the internet for accessing online study materials and taking classes online. After experiencing the benefits of the ECD intervention, Nilesh began to motivate and counsel other parents to adopt this new philosophy and method of parenting children in their early childhood. He found that other parents were equally interested in adopting the innovative methods for the better physical, cognitive, emotional, and social development of their children.*

## EQ8: To what extent did FLWs effectively transfer their learnings to the parents/caregivers on parenting care and creating a learning environment at home?

*SEQ 8.1: Were specific strategies adopted to reach out to parents/caregivers across gender and various vulnerable groups?*

To increase the involvement of fathers and other family members like grandparents, aunts and uncles, frontline workers utilized home visits to counsel family members together and explain their responsibilities. Home visits were also preferred when parents and other caregivers could not attend anganwadi meetings due to busy schedules and other reasons. Many frontline workers felt that it was easier to give sensitive information to people inside the comfort of their homes, and it also gave frontline workers the opportunity to interact with all family members.

While delivering gender related messages, frontline workers sometimes took the help of panchayats and teachers in the village schools to counsel parents. Such messages were not only delivered to girls or parents who have a girl child but to all sets of families during sensitization.

To encourage fathers' participation and build rapport with them, frontline workers suggested organizing customized meetings and counselling sessions for men, regular home visits in the evenings (or whenever fathers might be available) and constant communication via telephones, WhatsApp etc. if fathers were unavailable to meet in person.

Frontline workers also reported that it was easier to reach special groups on cultural events when the whole village gathered together for celebrations. Such events presented convenient opportunities to meet all the families, including the hardest to reach populations, and counsel them on child care and parenting.

For the more vulnerable sections, frontline workers felt that repeated counselling with patience and kindness yielded positive results. Many frontline workers reported visiting such households at least once a week to spend an hour or two providing family members with counselling support and advice. On these visits, frontline workers provided the households with information regarding government schemes and Anganwadi facilities, in order to encourage families to avail these benefits. Frontline workers also delivered context-specific messages to the families in the tribal community to make them more relatable and understandable.

Use of digital platforms such as WhatsApp were also noted as a convenient strategy to remain connected with families located in the more remote regions (although network issues persist). Lady supervisors and frontline workers explained that audio messages were often recorded and shared with the parents over a WhatsApp group. These recordings contained messages related to early childhood development, health or activities that parents could carry out with their children. This method was especially useful during the pandemic and was used with all members of the community and not only with those located far away.

*I liked the way we tried to make the fathers participate in the parenting of the children. In the beginning, we had called mothers and grandmothers, but for fathers, we slowly informed them and they increased their participation in this. So, it feels good. Now we can see more participation of fathers in childcare in the society because of that. Otherwise this generally does not happen in villages. (AWW, Aurangabad)*

*We have a case study which was documented in videos where one of the fathers confessed to us that he was getting very restless as to why my wife is very eager and doesn't want to miss even a minute of this parent meeting. So, I followed her even when I was not invited and he said that it was really great for him to come and sit down and understand why his wife is taking interest in the child's*

*development and he was missing it. So, he said he will come again to all the Palak Sabhas.. (CSO Partner, Maharashtra)*

*For such households (vulnerable sections) we make them understand again and again. We go to their home regularly and make them understand. We go to their homes to provide counselling and if in that week there are any games or toys in the Anganwadi, we invite their child and make him/her play games and we give them nutritious food. We tell them that all these are available so you come and take it, we make them understand like this. (AWW, Dungarpur)*

### SEQ 8.2: What were the barriers and challenges faced by FLWs in the effective transfer of knowledge to parents/caregivers?

One of the major barriers faced by frontline workers was the *orthodox mindset* prevailing in their respective villages, an aspect which is more prevalent in Rajasthan. As revealed by a supervisor from Dungarpur, some of the parents in the community did not even let the FLWs weigh the child due to their beliefs. Moreover, a large portion of the population in the interiors of Rajasthan are *uneducated* making it difficult for them to understand the advice being given by the frontline workers.

Since many families did not understand the importance of early childhood development and positive parenting, they did not attend meetings and hence, many frontline workers complained of *lower participation* in these interior areas. FLWs also reported that parents and caregivers often did not participate because of busy schedules and other commitments. A supervisor from Dungarpur noted the absence of fathers in the parents meetings in the Angawandi centres, even after having been invited for the same.
A government official from Pune reported that parents often leave their children in the care of the elder siblings or the grandparents. The FLWs have to thus target these groups for disseminating the ECD messages. The challenge here is that the grandparents are not that responsive to the counselling surrounding child development and care, citing their own children's upbringing.

Lady supervisors from Pune and Udaipur also revealed that the FLWs' preoccupation in other activities like conducting surveys for government departments, pension work, ration and Aadhar card related work takes time away from conducting the ECD activities. In some areas, tiny communities with a different language exists. The FLWs in this case face issues in getting the ECD message across to the target groups due to language barriers. The FLWs normally make use of the pictorial representation in the communication material to explain the messages to the caregivers from such tiny communities.

Another major barrier noted by a CSO partner from Maharashtra is the long distances that the FLWs have to travel. The frontline workers do not have access to vehicles and in many cases have to walk for 3-4 Kms to conduct home visits.

A lady supervisor from Udaipur has reported the frontline workers' complaints about the high workload and low pay. There is need to make the pay commensurate with the private employment alternatives that are available to the frontline workers.

In their interviews, some parents highlighted similar challenges, citing lack of time and difficulty in understanding the counselling of the FLWs as major constraints for effective knowledge transfer. Supervisors also noted that it would take frontline workers some time to strengthen their skills, given that responsive parenting is a relatively new concept. Challenges related to the communication materials developed were also discussed in the interviews. It was mentioned that some frontline workers were overwhelmed by the amount of information and were unable to present it effectively. FLWs also revealed they faced difficulties in holding the posters, while simultaneously explaining the information to parents

due to the posters' large size. A lady supervisor from Dungarpur noted the need for the FLWs to have more booklets to be used on the field. Such challenges also hindered their ability to effectively communicate with the caregivers.

> *Many times when we go to invite people to our events/programs, some people are there who always say that they won't be able to attend due to the lack of time. They ignore us. The problem is that not every parent comes to the meetings. No matter the number of times we visit their home, only about 30% parents attend the meetings. (AWW, Pune)*

> *There are parents who did not understand whatever we told them and some are there who even after understanding the things didn't want to accept it. They argue with us. It is all about poor mindset. It is a challenge here since many are illiterate. (ASHA, Palgarh)*

> *Some people are conservative, some are not. We usually go to villages and keep telling people that you should do these things, only then they understand that it is a good thing.*
> *And there are some people who are busy with their work, they tell us, they have no time for children. Children will grow even without such effort. In addition to that we have to explain them. (AWW, Udaipur)*

## Agent of Change – An Anganwadi Worker

*In the hilly areas of Shishod village in Dungarpur district of Rajasthan, 30-year-old Mahinda Katara has spent 8 years as an Anganwadi worker. She has been actively involved in providing different services in the areas of health, hygiene and nutrition, to the mothers and children of the village. For example, she has been providing information regarding the importance of mother's milk for babies and has also been teaching and playing with the children at the Anganwadi.*

*As part of the parenting and Early Childhood Development (ECD) intervention, Mahinda has been trained on various aspects of parenting and care. She mentions that she has gained new knowledge regarding ECD and has learnt techniques to counsel parents on the same. The training has built her skills and given her the confidence to interact with parents and other caregivers.*

*Utilizing meetings and home visits, she has been teaching parents and grandparents different methods to effectively engage with children while doing household chores such as teaching children the colours, sizes, and shapes of vegetables while cooking. Being a strong believer in positive parenting, she has constantly emphasized that appreciation - talking gently and lovingly with children, is the key to their development and acts as a way of positive reinforcement.*

*Mahinda says she has observed changes among the parents' behavior after the advent of the ECD intervention. Parents have been able to follow the messages being delivered using flip charts and pictures and demonstrate the lessons learnt as part of the intervention, such as asking children to bring the cups after counting them, or identify groceries, during home visits from the Anganwadi workers. Mahinda has noted that many children were easily able to carry out such exercises and enjoyed doing them.*

*Mahinda shares that being a part of the intervention provided her a sense of achievement as she has been an agent of change and has been helping the physical, cognitive, emotional and social development of the children in her community. She feels proud to have been able to contribute to bringing light to the future of the children, and in turn, to the community.*

## EQ9: To what extent were existing platforms used effectively to reach caregivers for counselling? (e.g. Anganwadi centres and home visits)

*SEQ 9.1: To what extent FLWs optimally utilized the contact points (Mothers meeting, PAM, community meetings, home visits) that they have with parents/caregivers for delivering quality ECD services?*

In line with quantitative findings, the majority of frontline workers agreed that home visits and parent anganwadi meetings were the most effective platforms to reach caregivers for counselling. This sentiment was also shared by the other stakeholders namely government officials, supervisors, CSO partners and the UNICEF staff members. These two platforms were preferred due to convenience and easy availability of facilities. The home visits also enabled the dissemination of ECD messages to those caregivers who were unable to attend the meetings and events organized in the Anganwadi centres due to lack of time or distance. The mothers' meetings are also excellent platforms for the delivery of information to a large group with a common objective.
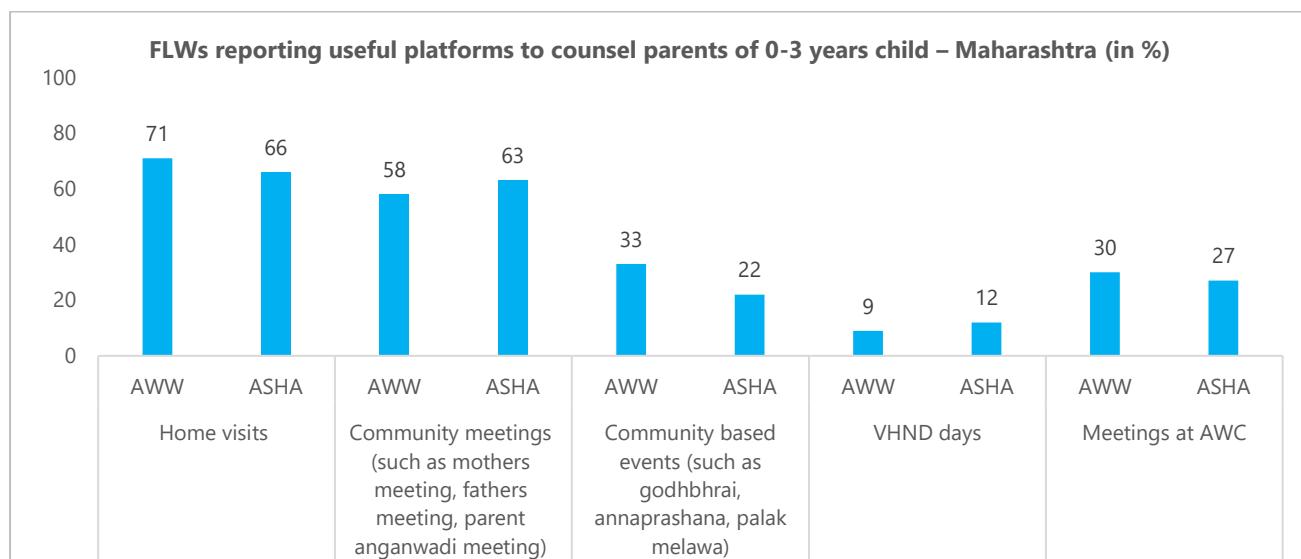


Figure 15: FLWs reporting useful platforms to counsel parents of 0-3 years child – Maharashtra (in %)
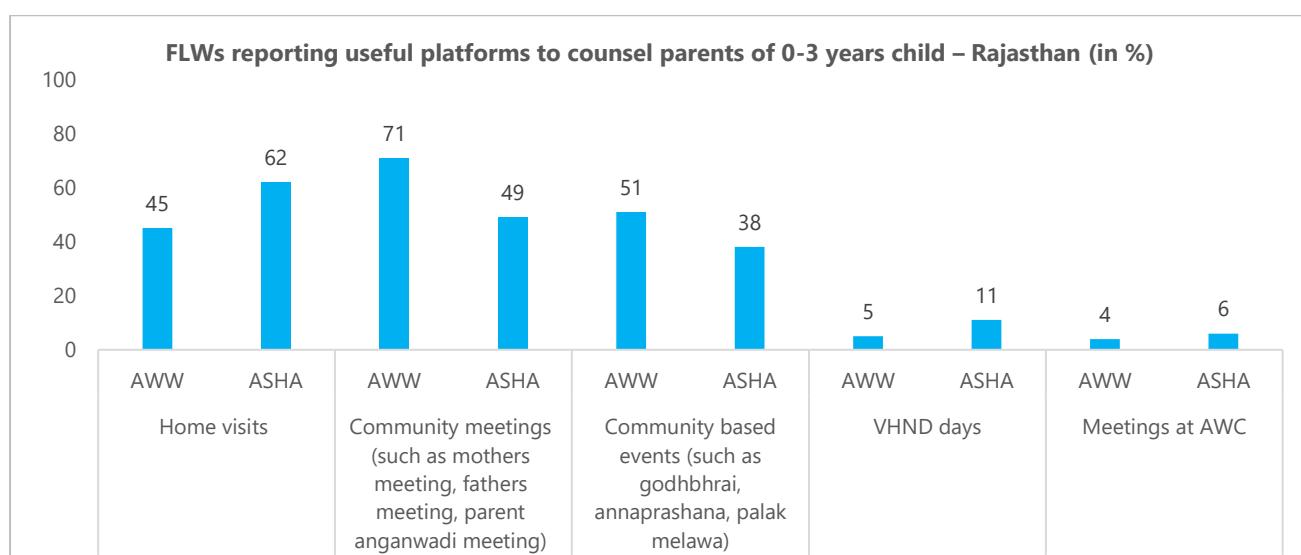


Figure 16: FLWs reporting useful platforms to counsel parents of 0-3 years child – Rajasthan (in %)

**FLWs reporting useful platforms to counsel parents of 3-6 years child – Maharashtra (in %)**

| | AWW | ASHA | AWW | ASHA | AWW | ASHA | AWW | ASHA | AWW | ASHA |
|---|---|---|---|---|---|---|---|---|---|---|
| | 62 | 61 | 58 | 60 | 32 | 27 | 9 | 12 | 34 | 28 |
| | Home visits | | Community meetings (such as mothers meeting, fathers meeting, parent anganwadi meeting) | | Community based events (such as godhbhrai, annaprashana, palak melawa) | | VHND days | | Meetings at AWC | |
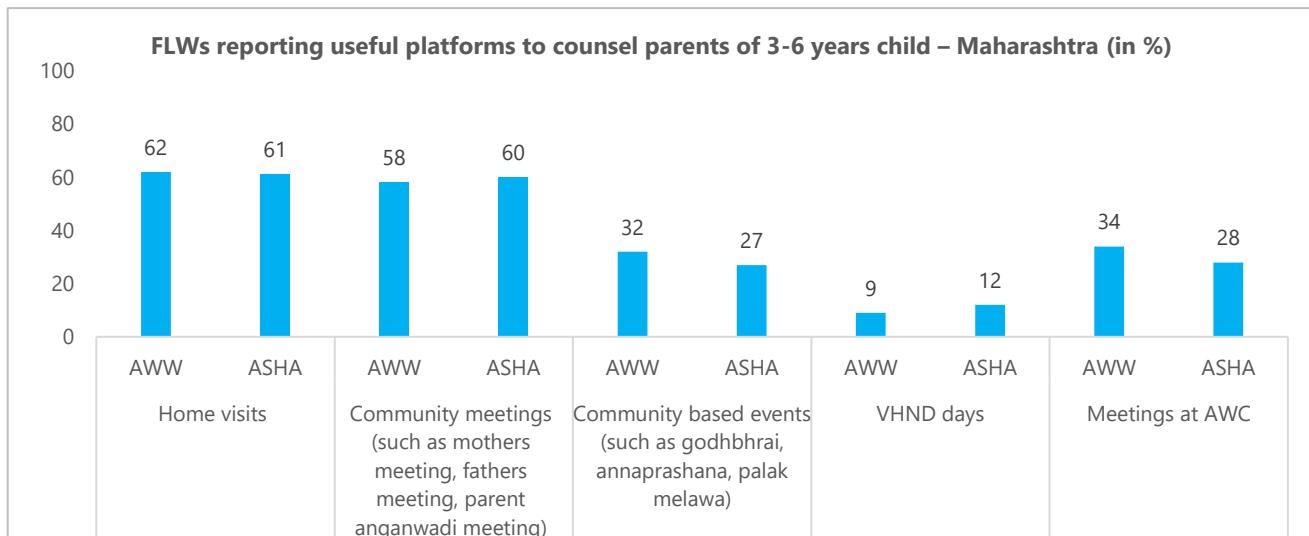
*Figure 17: FLWs reporting useful platforms to counsel parents of 3-6 years child – Maharashtra (in %)*

Other platforms such as mother's/father's meetings, palak melawas, school, hospital and temple premises, and community centres were also utilized. Many frontline workers reported that events such as Vaccination Day, Nutrition Day and cultural festivals such as Father's Day, Mother's Day, Teacher's Day etc., were important contact points for meeting a large number of people and interacting with them. These findings suggest an enhanced utilization of existing platforms by frontline workers to orient caregivers on the importance of early childhood development and are in line with the reconstructed theory of change.

| Inputs/ Activities | Outputs | Outcomes |
|---|---|---|
| • Samvedansheel Palakatv (responsive parenting) flipcharts and MCP cards<br>• Capacity building of FLWs | • FLWs use tools available /newly developed to orient parents/caregivers in the community | • Enhanced utilization of existing resources (flipcharts, MCP cards, communication tools etc.) and platforms by FLWs to orient parents/caregivers on ECD related aspects |
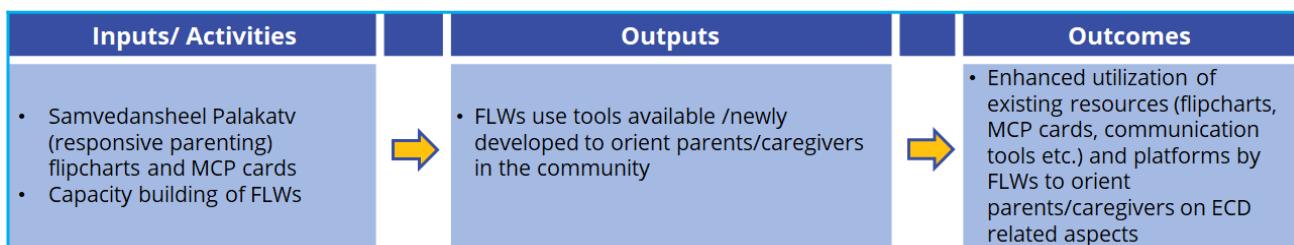
*Figure 19: Reconstructed Theory of Change*

**FLWs reporting useful platforms to counsel parents of 3-6 years child – Rajasthan (in %)**

| | AWW | ASHA | AWW | ASHA | AWW | ASHA | AWW | ASHA | AWW | ASHA |
|---|---|---|---|---|---|---|---|---|---|---|
| | 39 | 59 | 82 | 60 | 37 | 20 | 3 | 5 | 4 | 6 |
| | Home visits | | Community meetings (such as mothers meeting, fathers meeting, parent meeting) | | Community based events (such as godhbhrai, annaprashana, palak | | VHND days | | Meetings at AWC | |
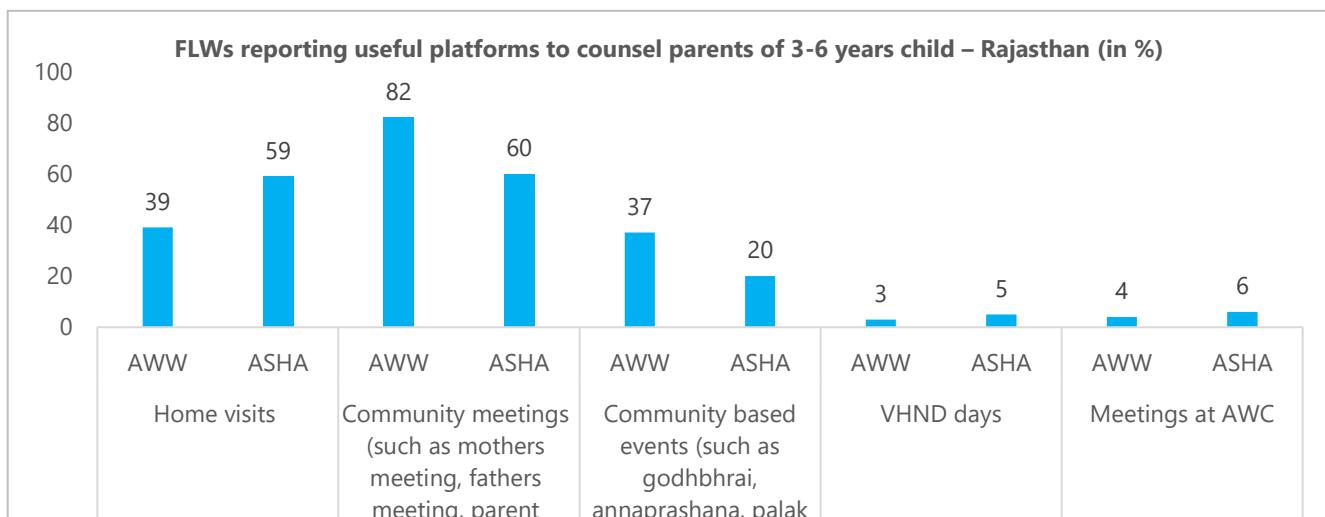
*Figure 18: FLWs reporting useful platforms to counsel parents of 3-6 years child – Rajasthan (in %)*

Mothers shared that frontline workers also made an effort to interact with the community members during community based events such as Annaprashan divas and Godhbharai. They reported that there was regular and continuous engagement between parents and the FLWs via different events, and they usually met both the Anganwadi and the ASHA workers two to three times a month.

A lady supervisor from Udaipur noted that the FLWs conducted meetings for the fathers on new moon day. There is a belief in the community that on new moon day every month, the farmers and agricultural workers do not touch their farming equipment. The FLWs make use of this opportunity to conduct meetings for the fathers who are otherwise unavailable due to their work commitments.

A CSO partner from Maharashtra has noted the innovative methods that have been used by the FLWs to reach out to members in the community. An example shared was the use of morning walks through the communities wherein the Anganwadi workers sing songs with ECD messages locally known as Prabhat Feri.

As mentioned earlier, during the pandemic, digital platforms gained popularity with WhatsApp groups being used by the frontline workers to impart important information to the parents in their communities.

> *We like using anganwadi centre because here all tools and material are available to give information properly to parents and caregivers. (AWW, Dungarpur)*

> *The project made the best possible use of the available institutional platforms and demonstrated that nothing can be better than these platforms. All we need to do is energize and use these platforms so you can really transform the families and the caregivers and make them understand the importance of nourishing and nurturing. (UNICEF Staff, Maharashtra)*

*SEQ 9.2: What problems and challenges hindered FLWs for not utilizing the contact points effectively?*

As mentioned in the section above, home visits and Anganwadi meetings were utilized most effectively by the frontline workers. However, there were some challenges involved. FLWs pointed out that sometimes family members were preoccupied with household work during home visits, and thus, did not pay attention to what was being discussed. Long distances, lack of transportation and remote locations were other common challenges faced by frontline workers while utilizing home visits.

For Anganwadi meetings, low participation and parents walking in late were major challenges. The lack of adherence to the meeting timings by the parents' also leads to lack of time to explain all the topics in the meeting agenda. In some areas where Anganwadi centres were used for multiple social purposes, Anganwadi workers found it difficult to conduct meetings due to space constraints.

A CSO partner from Maharashtra noted that the Palak melawas and the community-based events (CBEs) were not conducted as regularly as planned. There is a need to expand the usage and purview of the CBEs to make them more innovative and empowering for the parents. The FLWs also, in turn, found it difficult to manage the organization of the community-based events.

> *Many times, it happens that parents are unable to come during Anganwadi timings, so we must organize it according to their convenience. Like if they come at 1 o'clock we keep the schedule at 1, if they come at 8, we schedule it to 8. We must do this because most of the people in the village go for agriculture work in the early morning so when they come home before lunch for some time, we call them at that time. (Lady Supervisor, Palgarh)*

## The Ultimate Guide – A Mother

*Being a mother is difficult - and caring for four children at a young age just adds to the difficulty. Twenty-five-year-old Parvati Henab of Bijuda village from Bicchiwara district of Rajasthan has been juggling farming responsibilities and childcare duties for quite a few years now. Like any other mother, she has been bathing, clothing, and feeding her children, every single day. Having completed her schooling till 10th standard, the knowledge acquired by Parvati has come in handy while teaching her children alphabets and basic numeracy skills. As a mother, she has remained by the side of her children for a majority of the time, however, her husband has only been able to engage with the children for about an hour a day. The grandparents have also been involved in the childcare activities.*

*The advent of the parenting and Early Childhood Development (ECD) saw active participation from Parvati's side. She regularly attended the mother's meetings, and other platforms earmarked for disseminating messages related to early childhood development. Parvati and her whole family were engaged via regular home visits by the frontline workers who counselled the family members on the importance of early childhood development for the physical, cognitive, social and emotional development of the children. The frontline workers organized different activities, such as, showing pictures in books, informing parents about the right kind of clothes for children, playing games with the kids, teaching caregivers how to control anger, teaching children counting in a fun and practical way etc.; all of which were highly appreciated by Parvati.*

*Incorporating the knowledge and activities related to childcare into their daily lives, Parvati and her children started enjoying themselves while learning new things. Recognizing fruits and vegetables while holding them and counting rotis (flatbread) while cooking became a favorite pass time in the household.*

*Parvati was quick to realize the importance of early childhood development in creating the solid base for the physical, cognitive, social, and emotional wellbeing of her children. She found the hands on and practical activities, efficient, as well as enjoyable and noticed an increase in engagement with her children.*

## 4.3.    Efficiency

### EQ10: To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes?

*SEQ 10.1: To what extent effective coordination and collaboration with existing govt. programmes and interventions were made during the implementation?*

In both the states, the implementation of activities has been through existing government platforms: for capacity building of frontline workers (AWWs and ASHAs); as well as the delivery of quality services including counselling of parents through existing platforms of ICDS.

The intervention used existing government resources (human resource + infrastructure) for its implementation. For example, the intervention was implemented in collaboration with the health departments and the ICDS using the network of the ASHA and Anganwadi workers. The Anganwadis have taken centre stage in the implementation of the parenting project.

One of the main government platforms the intervention utilized is the ICDS system. The network of the ICDS goes to the village level through the government machinery i.e. through the zila parishad, the principal council and urban area corporations.

In Rajasthan, existing institutional platforms, like sector meetings, were used as training platforms by the supervisors and block coordinators to train the frontline workers. Not only that, platforms such as home visits and mother's meetings were in use even prior to the advent of the intervention, but the intervention expanded the frequency of use of these platforms and the scope of activities on the meeting agenda. As reported by a UNICEF staff from Rajasthan, the use of the existing government platforms enabled the project to operate even under budget constraints. However, utilizing sector meetings for trainings had some constraints - often more time being consumed for administrative tasks during sector meetings with less time remaining for training of FLWs. Further, the project leveraged the existing community platforms such as Parent Anganwadi Meeting (PAM), home visits, community-based events such as Annaprashana diwas and Godhbharai to reach out to caregivers in Rajasthan.

In Maharashtra, instead of sector meetings, separate training sessions were conducted for master trainers and FLWs. The training on responsive parenting was rolled out in five cycles of five days each for master trainers (constituting AWW supervisors and ASHA facilitators). The trained master trainers further rolled-out the training to the FLWs. Each master trainer after the conclusion of each cycle of training (provided by CSO) rolled out the contents of that particular cycle of training to FLWs in three days within a period of three months (one day per month).

As conveyed by a CSO partner in Maharashtra, the reason for organizing separate training sessions apart from sector meetings was that the administrative tasks were very time-consuming and left little time for conducting the training sessions. Hence, UNICEF and CSO partners convinced the government officials to allocate a separate day in a month (apart from sector meeting) to organize the training for FLWs. This aided FLWs to focus completely on the training module without worrying about the time and other regular administrative activities. Further, in Maharashtra, the existing community platforms such as mothers meeting, home visits, palak melawas and community-based events such as Annaprashana diwas and Godhbharai have been used to reach out to caregivers.

The project also made use of the platforms developed under other government schemes in order to increase efficiency and cost-effectiveness of the project. As an example, under the Poshan Abhiyan in Maharashtra, all the Anganwadi workers were provided with android mobiles to carry out their daily

reporting. This digitization led to a rise in the communication intensity and reporting and was beneficial in monitoring the ECD project. These digital platforms were also beneficial in the continuation of ECD activities after the advent of the pandemic. On similar lines, the use of various platforms like audio-visual, television and radio channels like Aakashvani was made to convey ECD messages to the people during the pandemic period.

## EQ11: How the existing government platforms for continuing education and training has been used to bring efficiency?

*SEQ 11.1: To what extent the sector meeting and ICDS supervisor visits has been leveraged for project efficiency?*

In Rajasthan, the sector meetings were initially used for administrative work like collation of data. The ECD intervention added trainings of the frontline workers to the agenda of the sector meetings. The sector meeting was the only existing platform that could be used as a training avenue for the frontline workers since this was the only time ASHA and Anganwadi workers came together.  Besides conducting training, the on-ground challenges being faced by frontline workers in their respective areas were discussed in order to reach solutions. The sector meetings witnessed participation from block coordinators, representatives from ICDS and health department, and UNICEF staff members.

In Maharashtra, where the administrative work was very time consuming and left little time for conducting the training sessions, a separate day was allocated for training at the discretion of the supervisors and the frontline workers. As reported by a CSO partner from Maharashtra, minimal expenses had to be incurred by the system for the separate training session as it was easily incorporated into the existing system. This was not the case in Rajasthan, where the sector meetings was the only training platform for the frontline workers.

Interviews with the UNICEF staff from Maharashtra revealed that conducting the training sessions as part of the sector meetings was not the ideal scenario given the workload of the supervisors but was the most efficient way given the current infrastructure. This was a platform which was readily available and where the health and ICDS departments came together.

The ICDS supervisor visits also witnessed drastic changes after the advent of the project. Earlier, the supervisors checked the facilities in the anganwadis including the quality of the food and non-formal education. However, the level of engagement of the supervisors increased after the intervention was implemented. During their visits, they not only interacted with the frontline workers, but also with the parents. The supervisors normally scheduled their visits on days when either parent's meetings or other community-based events were taking place in the anganwadis. They observed and provided feedback on how the frontline workers were interacting with the parents. In some instances, the supervisors also accompanied the FLWs on home visits and demonstrated methods that could be used to interact with the parents.

There was an improvement in the scope of engagement of the supervisors during the anganwadi visits after the ECD project was implemented. In an interview, a supervisor from Udaipur reported that wherever she visited the Anganwadi centres, she enquired about the children who were not attending the AWC or about the parents who did not actively participate in the activities conducted in the centres; she tried to understand the reasoning behind the absence and provide solutions for improvement. On similar lines, another supervisor from Yavatmal reported checking on children who appeared malnourished or weak and meeting their families to discuss about feeding practices on their visits to the Anganwadi centres.

> *In the visit of ours every Thursday, we let them (FLWs) explain those things (ECD counselling) to us. We check the quality of what has been conveyed by the frontline workers. (Lady Supervisor, Pune)*

> *Whenever we make visits to the Anganwadi centers we inform them earlier to tell all the parents to come that day. We then address the parents and give them information regarding positive and responsive parenting. We see which ones need more help and then we give them information and look out for them accordingly. (Lady Supervisor, Pune)*

## 4.4. Sustainability

### EQ12: Is the intervention and implementation modality scalable to other areas of the state?

*SEQ 12.1: To what extent the models for promoting parental involvement (communication package, training modules, capacity building and monitoring) adopted in the project, scalable to other districts?*

All the stakeholders such as the government officials at state, district, UNICEF staff members, and CSO partners are of the view that the project should be scaled up to other districts in the two intervention states (Maharashtra and Rajasthan). The scalability of the present model is apparent in the fact that it makes use of the existing government human resource and infrastructure like the ICDS and health workers (AWWs, ASHAs, AWW supervisors and ASHA facilitators),, sector meetings, and community platforms such as parents meeting, home visits, palak melawas, and community-based events such as Annaprashana and Godhbharai. The government officials have found this project to be influential in nature with the caregivers in the areas where it has been implemented.

All the components of the project are essential for the development of children and should be implemented as a whole package. The incremental learning approach used in the FLWs' training is especially important since it provides critical information about the child's growth. The other components of the project that show potential for scaling to other districts and states include the ECD messages, parent's and mother's meetings, community-based events, planned activities on a daily and monthly basis, and the workshops on nutrition.

An interview with a UNICEF staff from Maharashtra reveals that the decision to expand the program in the remaining blocks in Yavatmal and Aurangabad districts and in Gadchiroli district has already been made and plans are underway for its implementation. The scalability of the project is also apparent in the positive reception of the training by the frontline workers, as reported by a district government official from Aurangabad.

UNICEF staff members have also commonly mentioned that when scaling up the project, there is a need to have intensive engagement with the government departments.

Digital media should be used while scaling up the project since it is a resource-saving method. Digital media like videos can be used to provide teachings to the parents in the community. Catchy slogans or captions can be used while spreading messages using posters or WhatsApp to attract the attention of the parents. The successful use of these techniques in Maharashtra has been witnessed during the pandemic where digital platforms were used to share messages on ECD with parents who were not necessarily part of the project before.

> *I realized after seeing this (project) that if they would have given this type of training to FLWs earlier, then it would have been very beneficial because they could have reached every parent and thereby explain the importance of child development to everyone. They could have explained to them that for their children's brain development they don't need expensive toys to play with their children. Any household item can be used to play with the child. (District government official, Yavatmal)*

*The district administration has decided to scale up this (ECD) project from a few blocks to all the blocks in the district. And we are scaling up all the modules because we have seen the differences in the community. (District Government Official, Aurangabad)*

*When we initially tried to scale up, the frontline workers thought of the program as an addition of one more problem (task). Whenever we launch any new program, this is the first issue that we have to face every time. But when we started training them (FLWs), they enjoyed it and realised that it wasn't only for the community, but they also missed many things when they were parenting their own children. (District Government Official, Aurangabad)*

*SEQ 12.2: What are the issues and challenges in design or implementation if any, that need to be addressed before scaling up the interventions?*

Even though the project relied on existing government platforms, it faced some challenges in its implementation. One of the major challenges was to get the attention of the officials at the administrative levels and the policy levels towards the important role played by ECD in childcare. There is a consensus among the UNICEF staff members about prior involvement of the government ministries from the beginning of the implementation of the project. There is a need to convince the bureaucrats and make sure that the project is present in the annual work plan of the government. The issue that the project targets should be a part of the policy agenda of the government, so that it becomes mainstream in terms of the government initiatives. Coordination issues should also be tackled before the scaling up the project.

In Maharashtra, another bottleneck was that initially the ASHA and the Anganwadi workers used to work separately. ASHA worked for the health department and the Anganwadis worked for the ICDS, with different responsibilities granted to both. A related challenge was the lack of availability of the data, given that the FLWs did not share information amongst them. The joint trainings provided under the project led to an amalgamation of the activities of these two groups and improved their relationships. The FLWs started conducting joint meetings, which led to a rise in the quality of home visits and also led to the active sharing of data and information.

There are some challenges in the implementation of the training to the FLWs that needs to be tackled before scaling up. The first challenge is the variability in the educational qualifications of the frontline workers across districts and states. The FLWs with lower levels of education require more refresher trainings in comparison to FLWs with higher educational levels.

The second challenge that was faced while training was that ASHA workers were not getting compensation for the travel and expenses incurred for taking the training once in a month from the health department. The ICDS department is proactive in reimbursing the anganwadi workers for their training expenses and that encourages the frontline workers to attend the meetings. The lack thereof for the ASHA workers affected their attendance in the training.

Another crucial recommendation is to capture in a video format palak sabhas that don't work well instead of just scripting them. This will ensure that the supervisors know what design of the palak sabha is missing and act as a support system for them and the frontline workers.

It is important to highlight that the intensity of support that is provided to the pilot project will be difficult to replicate if it is scaled up to other districts and states. The level of the monitoring and the coordination will not be the same and can hamper the outcomes that have been seen in the pilot phase. Thus, there is a need to make the project less resources intensive either by reducing the number of training cycles or by using digital platforms like videos or by conducting online training sessions. In addition to this, having a block coordinator and a district official to take the project forward will ensure its smooth implementation

and scalability. Further, in Rajasthan, utilizing sector meetings as a training venue needs some re-thinking to strategically place the training session during the course of the meeting to ensure sufficient time.

> *Most of the time they (FLWs) think that the entire responsibility is being shouldered upon them. They feel that they are doing all the tasks of the department together. They think that they're being paid less and also have to organize everything including the meetings, co-ordinate the tasks and that makes them say that the government has imposed a lot of load on them and they feel that they aren't paid enough or respected enough for their work. (Lady Supervisor, Udaipur)*

## EQ13: Are any of the positive results of the intervention likely to be sustained?

*SEQ 13.1: What are the positive results and which of these results are likely to be sustained? Why?*

One of the most commonly discussed results by almost all the stakeholders is the positive change in the knowledge, attitude and perceptions (KAP) of FLWs around childcare and parenting. This was corroborated with the quantitative findings which show improvements in the KAP of FLWs in both the states (*Annexure 17*). Moreover, frontline workers have themselves experienced the benefits of the training provided and note a positive change in their skills and capacities. They have become more confident and have noted improvement in their communication and counselling skills. The FLWs see value in the messages that they share, and also have developed the ability to tailor the messages as per the needs of the caregivers. These results are sustainable if the capacity building of the frontline workers is ingrained in the system, and a platform for constant support and engagement is maintained.

FLWs also report an increase in the parent response rate and an improvement in meeting attendance, indicating a change in the community perspective. The supervisors and the parents have noted an improvement in the quality of home visits and mothers' meetings, partly attributable to the joint participation of the anganwadi workers and the ASHAs. At the child level, frontline workers have observed advent of some positive changes, albeit small, in child health, hygiene, education and discipline. This is due to the increased knowledge levels of both the frontline workers and the parents, and the positive relationships that they have built with each other.

The improvements in the functioning of the anganwadis is another positive development of the project which is likely to be sustained. As reported by a government official from Yavatmal, the project led to an increase in the involvement of the ASHA facilitators, block community mobilizers and the lady supervisors. The ASHA's role and responsibility has been enhanced with the inclusion of Palak melawas and mothers' meetings to their work agendas. There is also an improvement in the communication gaps between the supervisors and the FLWs, leading to a reduction in the supervisory gap that had existed before.

Another positive result which was discussed but still at a preliminary stage is the knowledge and attitudes of caregivers around childcare and parenting. Stakeholders including frontline workers, UNICEF staff members and CSO partners report that parents are better informed and more interested in their children's development as a result of the intervention. Some of the parents are now spending more time with their children. These results are likely to be sustained as once parents realize the benefits of these activities on the children's welfare and development, they will continue that engagement for a long time.

> *Now people are giving importance to education of children, sending them to Aanganwadi centres regularly. Keeping them clean and tidy and also giving them good food. (ASHA, Udaipur)*

> *It (ECD project) has yielded some great results and impacts and it can be observed in our district. As I said now, the National Family Health Survey has helped us to understand the indices that indicate malnutrition among children in our district. Our district has performed quite well. So, the results*

*which are visible are seemingly good and the impact of the project is note-worthy as well. (District govt. official, Yavatmal)*

*I think the whole approach of the capacity development (of the FLWs) was not that, you know, I teach and you learn, it was mutual teaching and mutual learning and I think that is really translated into very clear sense of empowerment and also adequate skills which have helped them to really know the job that they are doing more comprehensively and with better results. (UNICEF Staff, Maharashtra)*

*There was one common feedback that we are getting from Anganwadi workers saying that "we knew that we had to do something about early child education. We have heard that is important. We really understand the project and we feel confident talking about it and taking it to homes because we have a lot of materials to engage with parents." (UNICEF Staff)*

*ECD made them (FLWs) very innovative and today, they come out with such innovative videos and all, you will be amazed! So, innovations are coming from them. (UNICEF Staff)*

*The attention to parenting has been one of the positive results of this. Parenting for health and nutrition was always there. But parenting for learning, the attention to that is a good thing and is one of the positive results. So much that the education department jumped at it and they were absolutely going to do it for their anganwadi centres. (UNICEF Staff)*

### SEQ 13.2: Are any areas of the intervention clearly unsustainable? What lessons can be learned from such areas?

Despite the success that the project has achieved, there are certain components of the project that might be difficult to sustain in the future. For example, parents require renewed and continuous training on the technical aspects of the project since it is difficult for them to retain information on technical terms such as cognitive development, responsive parenting and so on. A mechanism to refresh their knowledge on such relevant topics can lead to sustainability in the long term.

As per a government official from Yavatmal, Palak melawas might be difficult to sustain in the long term. Even though these melawas are successfully conducted by the FLWs and the parents have built an interest in such events, they require continuous support, a budget and planning for their implementation. If this support is not continued, it will be difficult to sustain them in the future.

The feedback mechanism developed between the ICDS supervisor and the Anganwadi worker might be difficult to sustain in the long term since the block coordinator took on many of the responsibilities of the supervisors as per a CSO partner from Maharashtra.

Another important aspect shared by a UNICEF staff from Rajasthan is that the direct support that was granted to frontline workers under the pilot project is not scalable to other areas. This was only part of the learning project and is not something that can be replicated in other districts, given its resource intensity. In addition to this, the support provided by the CSO partners is an area that is difficult to replicate and sustain in the long term without an injection of funding support.

*There have been communities where the attendance to the Palak Sabhas was restricted, or the Anganwadi worker wasn't influential mostly because of the relationship of the supervisor and another work which was given priority to. So, the struggles will continue. Sustaining this and doing this again and again is going to be a real bottleneck because once reinforcement from partners like us stops, and they take over their own role, I think, they will face more challenges. (CSO Partner)*

### SEQ 13.3: What are the major factors that influenced the achievement or nonachievement of sustainability of the intervention?

As per a CSO partner and UNICEF staff member from Maharashtra, one of the main factors that will contribute to the sustainability of the project is the continuation of monthly training sessions for the frontline workers or at least refresher training sessions from time to time. Without this continuous supportive and appreciative system for the frontline workers, it will be difficult to sustain the positive results

The core approaches adopted by the project such as home visits already existed in the Health and ICDS infrastructure. These are mandated by the government and will continue to function in the future as well. The fact that the project is built within the government schemes and within the scope of the government funding can ensure its sustainability as per a CSO partner and UNICEF staff member. The regular monthly meetings with CDPOs and monitoring with supervisors has to be integrated holistically into the project. There is a need to provide the frontline workers with constant support and to have active communication with them.

The shift in the priority of the local government bodies is one area that hampers the sustainability of the project. The changing of department heads is also of concern since it takes time to convince the new official of the importance of ECD and the importance of the project.

Another factor that will determine the sustainability of the project is the catalyst for supervisor training in Maharashtra. The training for the frontline workers is performed within the system, however, the training of the supervisor is done by an external partner. So, the senior officials will have to act as catalysts to encourage and spread the training to the supervisors, as well as bear the related costs of the same.

> *A simple thing that I believe in and we all talk about is believing in the intent and capacity of each one of us. And we believed in the intent and the capacity of the supervisors and frontline workers, and that paved the way, because that helped us build an excellent relationship with supervisors and FLWs. Everyone felt part of the project, everyone owned the project. And that was the major reason due to which the kind of response we have got in this project, that was possible. And while we used an appreciative approach while we were dealing with supervisors and FLWs, we also had liaison with higher authorities. So, they knew that this is what the system also wants and that was very helpful. (CSO Partner)*

> *I think the frontline workers led a huge part because as they are the members of the community, the community has more acceptance for their words rather than the someone external to their community and telling something. (CSO Partner)*

> *The best thing about ECD training was the participatory role of each person. They (FLWs) really enjoyed it. That really makes a huge difference. They (FLWs) agreed and felt that the project was for them, and they could stay in the program and make some change. (District Government Official, Aurangabad)*

> *Without constant support and constant communication with the field functionaries, it is not possible to keep it (project activities) sustainable. (UNICEF Staff, Rajasthan)*

## A Caring Guardian – An Uncle

*Twenty-three-year-old Rajesh, of Amarpura village in Udaipur district of Rajasthan, has been an uncle for quite a few years. Though unmarried, he has in-depth knowledge regarding the issues of women and children in his community and has observed many changes related to the same in his village. Earlier, children started school at the age of 6 years, however, nowadays toddlers were getting pre-schooled at the age of 3 in the Anganwadi centers, before joining formal schools. He has also observed a decline in the fertility rate in his community with families preferring 1-2 children, as compared to 4-5 children in the past.*

*Parents in the community had always wanted their children to develop but lacked awareness on the proper methods for bringing about that change. Rajesh found the parenting and Early Childhood Development (ECD) intervention a welcome change in the lives of the parents and children of the community. Through regular parent's meetings and home visits, parents were counseled on ways to educate their children effectively on different aspects of early childhood development. While a majority of the men remained busy with work, mothers made it a point to attend the meetings and discussions organized by the frontline workers. Rajesh, his niece's mother, and grandmother - all attended these meetings.*

*The parent anganwadi meetings and home visits were organized to train and educate parents and other caregivers regarding early childhood development and care. They were taught effective learning techniques to engage young children at home such as teaching children about shapes, sizes and colors by showing them vegetables in the kitchen, holding children's hands and teaching them how to write, teaching young children proper hygiene practices via demonstrations, using play to stimulate physical and cognitive development. Parents were repeatedly counselled not to beat or shout at children citing development concerns; instead they were taught to handle their children with love and care.*

*Being actively involved in the intervention, Rajesh took it upon himself to increase his engagement with his niece to foster her care and development. He would conduct surprise tests such as asking his niece to recite poems she had learnt, stories she had heard, the names of birds and trees, colors of the things present in their surroundings etc. Observing gradual changes in her responses, Rajesh realized the true importance of early childhood development in creating a strong base for the physical and mental development of his niece, and bringing a bright future for her, her parents, and the society at large.*

# EQ14: To what extent there is government ownership to sustain the focus on parenting care for improved ECD services?

*SEQ 14.1: What are the specific components in which the state government would continue the focus on parenting care for improved ECD services?*

The government is likely to continue its focus on preschool education and the AAKAR curriculum as noted by a government official from Aurangabad. The ECD modules which have been introduced as part of the intervention are informative and easy to understand and are likely to supplement the government's efforts around preschool education. Being a part of the ICDS scheme, the focus on the 1000 days programme is likely to be sustained for a long time. Given that refresher training is organized by the government, they can ensure that ECD is a part of the refresher training given to the frontline workers.

In Maharashtra, the government will continue to support the implementation of the parent's meeting platform. This is because the activity suggestions for the meeting are derived from the government's AAKAR curriculum. In addition to this, the ECD tool and the Palak Sabha tool have been prepared and fitted into the functioning of the meetings.

The Home Based Young Child Care programme is a flagship government scheme being implemented in Maharashtra in the ECD domain, which can incorporate and sustain aspects of responsive parenting and stimulation from the UNICEF project. In the nutrition domain, focus will continue on responsive feeding and complementary foods, and on parenting and stimulation for early learning.

In Rajasthan, as reported by an official from Dungarpur the government's focus on certain schemes such as the Pradhan Mantri Surakshit Matritva Abhiyan and Indira Gandhi Priyadarshini Yojana for child health will be retained for a long time. The areas of child health and nutrition will continue to garner the attention of the government officials. A UNICEF staff from Rajasthan has also noted that the government will continue to focus on parent anganwadi meetings and home visits, given that they are already a part of the government infrastructure.

In addition to this, focus on budgeting for the schemes being implemented by the government will be enhanced. Given that the training delivered to the frontline workers have budgetary constraints, the expansion of these services warrants an expansion of the budget allocation towards these programs.

The expansion of non-formal education for children under the new education policy in the country will also renew focus on the needs and requirements of children under the age of six.

*SEQ 14.2: To what extent the sub-district, district and state-level officials of ICDS and Health have been involved in the project intervention?*
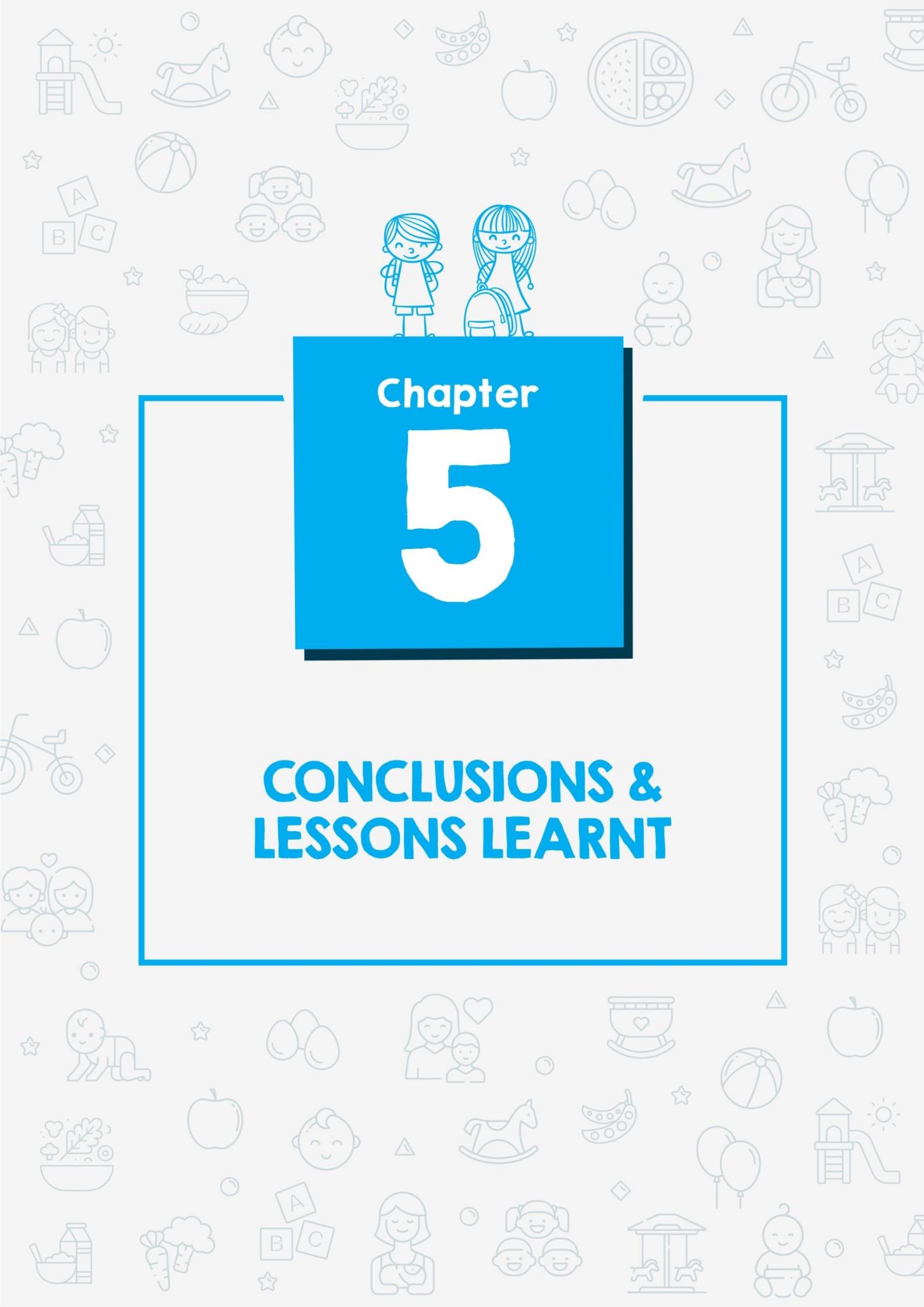
Various levels of officials from ICDS and Health were involved during the planning of field training, supporting supervisors in their training to the frontline workers and providing administrative support for the training. One of the CSO partners noted that they received more support from the ICDS department in comparison to the health department. They were present for the training and reviewed the progress on the project actively. They were informed from the very beginning about the project activities.

Officials at four levels, the Secretary, Director, Deputy Director, and CDPOs were well informed which ensured their continued support. They were advocates of the project and pushed it forward. The project team took these officials for home visits, to mothers' meetings and palak melawa. Seeing the components of the program live in action and based on their own experience in these field visits, they appreciated the additions that were being made for the project.

One of the CSO partners from Maharashtra noted that their team did not expect staff from the health department to have proactive engagement with the project since the health department's priority is on diseases and other treatment-related activities. However, they were surprised to see the participation from the department's employees on a large scale, although their participation ebbed in the COVID period.

*The district level and block level staff were so moved and so excited with this intervention that they said, this intervention can't go forward till we join the training. So, we must join the training. (CSO partner)*

*So, definitely state ICDS, they were on board. From day one they were part of all the discussion. Lady supervisors, anganwadi workers, they were part of developing those materials, those packages which we used for this parenting program. Later, the principal secretary and minister were very happy to see that package. They wanted to scale it up in all the anganwadi centres with the proper training mechanism. (UNICEF Staff)*

# Chapter

# 5

# CONCLUSIONS & LESSONS LEARNT

# 5. CONCLUSIONS AND LESSONS LEARNT

## 5.1. Conclusions

The evaluation team has drawn conclusions from the key findings according to the research questions that guided the evaluation. It has been structured along the evaluation criteria, summarizing the key findings and analysis for each of the evaluation criteria.

**Relevance**: The project has demonstrated its relevance in building the capacities of frontline functionaries (AWWs and ASHAs) on responsive parenting to achieve the goals of ECD to ultimately reach the caregivers in the community. The FLWs were equipped with the what, why and how of responsive parenting messaging through regular trainings, continuous monitoring and handholding. The project's relevance further gains strength given that responsive parenting is relatively a new area in the Indian context.

The project addressed the most pressing needs of parents regarding child development and care and enhanced their understanding of different ECD aspects. FLWs were also gender-sensitive in organizing suitably timed meetings specifically for fathers and utilized innovative engagement methods e.g. the blackboard painting task outside their homes for children. Although still on the lower side, the emerging role of father as a parent who interacts, and plays is an encouraging improvement from a role where they were feared or not involved. In fact, as some of the case studies illustrate, some fathers have emerged champions for responsive and pro-active parenting for their children, inspiring others.

**Effectiveness**: The evidence suggests that the project, as a pilot, has been *largely effective* in – a) building the skills and capacities of the FLWs (AWWs and ASHAs) on responsive parenting and care, b) utilizing the available institutional platforms to reach out to caregivers. Evidence suggests that the trainings not only built FLW's communication skills and confidence, but also equipped them with necessary skills for improved information dissemination. However, lower proportion of ASHAs (55.3%) in Maharashtra and AWWs (46%) and ASHAs (23%) in Rajasthan reported to have received the training on positive parenting and ECD. This suggests further efforts required to include all the FLWs in these training sessions.

FLWs were able to use the communication materials/tools in communicating with parents at the various platforms effectively. The communication materials in the form of flipcharts/cards and posters to counsel parents contained information on nutrition, play and engagement, messages for pregnant women and other ECD related information. The FLWs perceived that the communication tools made their jobs easier, acted as effective visual aids to explain difficult messages and eased the language barrier.

Gender and equity-based concepts are integrated in the communication package material with clarity and seamlessness. It breaks the gendered roles and responsibilities, toys, communication and activity engagement. Most of the messaging uses gender-neutral language (English) e.g. their/them/they/child/children.

At the child level, frontline workers have observed the advent of some positive changes, albeit small, in child health, hygiene, education and discipline. This is due to the increased knowledge levels of both the frontline workers and the parents, and the positive relationships developed with each other.

However, the intervention was *partly effective* in reaching out to fathers due to reasons such as lack of availability of fathers due to work, migrant nature of jobs, orthodox mindsets, lack of awareness, and illiteracy. Findings reveal that majority of men considered childcare and parenting outside their domain and were unaware of their responsibilities as fathers. It is critical to engage fathers as well as other family members in the responsive parenting sessions to ensure a more supportive system for the mother and child at home.

Home visits and parent Anganwadi meetings were found to be the most effective platforms to reach caregivers for counselling. Other platforms such as mother's/father's meetings, palak melawas, school, hospital and temple premises, and community centres were also utilized. Findings suggest an enhanced utilization of existing platforms by frontline workers to orient caregivers on the importance of early childhood development and are in line with the reconstructed theory of change.

**Efficiency**: The evaluation provides evidence on the efficiency of the parenting project in terms of utilizing the available government resources – human resource, infrastructure and institutional platforms such as mothers'/ parents meeting, home-visits, community-based events.

Although the utilization of sector meetings for trainings in Rajasthan was an efficient way of using available government platform, often the issue of lack of time for training of FLWs cropped up due to administrative duties to be rendered. In Maharashtra, instead of sector meetings, separate training sessions were conducted for master trainers and FLWs, with a minimal cost to the system. Although there was a slightly greater time requirement from master trainers and FLWs. Having a separate day in a month for FLW's ECD training was more effective as FLWs were able to concentrate and learn better.

**Sustainability**: There is consensus among stakeholders (government officials at state and district, levels, UNICEF staff members, and CSO partners) that the intervention is scalable to other blocks/ districts in the two intervention states. The scalability of the present model is apparent in the fact that the project utilizes existing government human resource, infrastructure and platforms, and the positive reception of training by the FLWs. Efforts are being made at the block, district and state levels to integrate ECD into their existing working framework, which ensures its sustainability.

Further, for more sustained results, some potential issues need to be addressed – enhanced coordination between ICDS and health department, more frequent and regular refresher trainings for FLWs, providing travel allowance for ASHAs, and re-adjusting the training schedule to cover the critically required contents within less time. Another potential challenge which was addressed well in Maharashtra and should be used as a case study is the teaming up of Anganwadi worker and ASHA (for trainings and joint visits).

Another critical observation is the lack of continuation of the intensity of support provided to the pilot project in its scale up, that can have consequences on the intended outcomes from the intervention. Thus, the project should be made less resource-intensive either by reducing the number of training cycles or by using digital platforms like videos or by conducting online training sessions.

In sum, the evaluation findings indicate that the supportive resources and structures need to be adjusted for scale-up and the intervention needs to be further institutionalized in the planning processes. The project efficiently and effectively makes use of the existing government resource and infrastructure and supplements and compliments the government ECD initiatives. The project should be streamlined in both the policy agenda and the annual work plan of the government, ensuring that the project's domain becomes mainstream in government initiatives. Tackling of coordination issues with Ministries and Departments will also support project scale-up.

## 5.2. Lessons learnt

The evaluation has highlighted several learnings that will inform the scaling up of the model in other blocks/ districts in the two intervention states and designing similar interventions.

a) *Leveraging of existing resources from government schemes/ programmes/ initiatives and empowering frontline functionaries continues to be the mainstay of the project replicability and scalability:* The scalability of the present model is apparent in the fact that it makes use of the existing government human resource and infrastructure like the ICDS and Healthcare workers, sector meetings, community platforms and community-based events; as well as aligns communication material content to the existing preschool curricula and uses tools already existing in the system like the MCP card. This leveraging of existing resources effectively and efficiently and through strong project components, is already resulting in plans afoot to scale to other districts. There is readiness and need in the system to adopt and adapt the project on a wider scale. The inclusive approach of involving officials from different levels has supported in implementation of the project. The advocacy efforts from UNICEF and CSO partners have been critical in sustaining the project and supporting scalability.

b) *UNICEF's continued advocacy, availability of technical support and commitment on the part of the Government stakeholders have resulted in increased acceptance of the project by the Government of Maharashtra (GoM) and Government of Rajasthan (GoR) and must continue:* The project has seen strong acceptance from both the Government of Maharashtra (GoM) and Government of Rajasthan (GoR). This is reflective in Maharashtra's decision to expand project activities to other districts in the State as well as Rajasthan's plans for distribution of communication packages across the state in the upcoming year/s. UNICEF has played a critical role in the transition of the parenting project into a state-level policy, engaging regularly with ICDS and health departments for policy advocacy. It has also provided high-level technical assistance to the states in the form of training of master trainers, frontline functionaries, developing communication packages, training content etc. Further, a good learning is that committed government stakeholders will augment the impact further.

c) *Collaboration between ICDS and Health departments in Maharashtra has amplified the results:* The collaboration between the government departments (ICDS and health) has improved the synergies and the joint trainings under the project led to an amalgamation of the activities and improved their capacities. Further, FLWs have started conducted joint meetings which led to a rise in the quality of home visits and community meetings.

d) *The FLW's and Supervisors knowledge, attitude and perceptions (KAP) are likely to be sustained if capacity building around responsive parenting and better work conditions are ingrained in the system:* As the most important part of the project and those who connect with families and communities to work on behaviour change, frontline functionaries (AWWs and ASHAs) act as the nucleus of the intervention. There are positive results of the intervention which are likely to be sustained such as the positive change in the knowledge, attitude, and perceptions (KAP) of FLWs around childcare and parenting, ability to use the available platforms better or supervisor's capacity built as trainer thereby creating a cadre of skilled human resource from within the system.
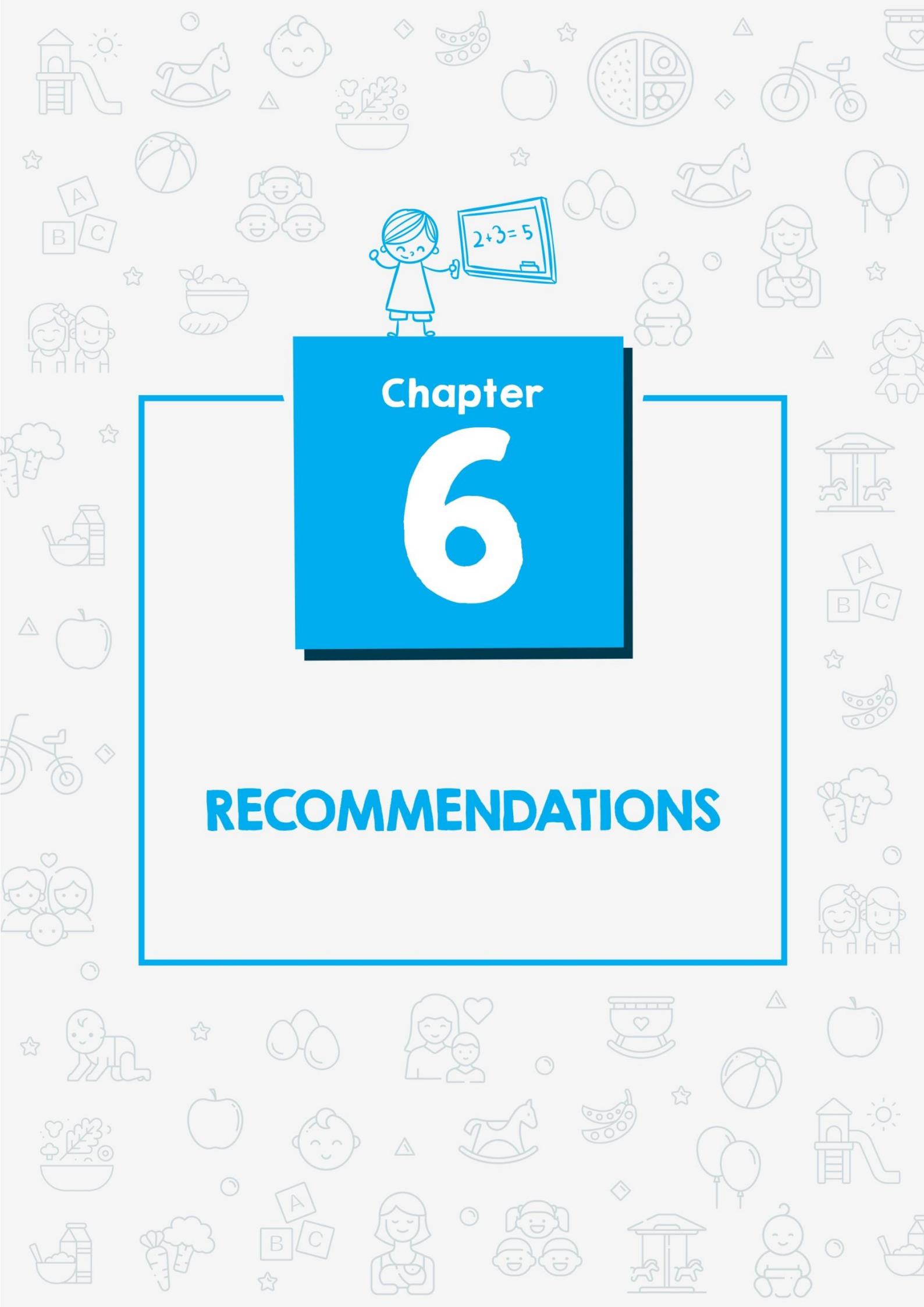
These results are sustainable if the capacity building of the frontline workers is ingrained in the system, and a platform for constant support and engagement is maintained. Positive changes have been noted at all levels – increased parent response rate and improved meeting attendance indicate a changing community perspective; improvement in the quality of interactions between FLWs and caregivers partly attributable to the joint functioning of the ASHAs and AWWs; and small improvements in child health, hygiene and discipline due to increased knowledge of FLWs and caregivers.

However, FLW's are poorly compensated, overworked, not given travel expenses or allowances and are drawn into all ground activities continually hence making their job extremely demanding on skill and will but the needed job satisfaction and security are missing in the form of compensation. Thus, work conditions need to improve and be systemic if the intervention has to create impact at scale.

e) ***Efforts to engage parents – both mothers and fathers and other caregivers is of utmost importance to create a familial support and ownership for ECD:*** The results show that it is very important to engage fathers as well as other family members in responsive parenting sessions. Efforts to educate and improve engagement of fathers and other caregivers including elders in the family to change social norms around parenting and childcare is a good strategy to build a supportive system for the mother and child at home and for the child to receive continued responsive care.

Parents however would require renewed and continuous training on the technical aspects to retain information. A mechanism to refresh their knowledge can lead to sustainability in the long term. Other mediums like video and audio messaging could be harnessed as well.

f) ***Including fathers in the childcare remains a challenge:*** Despite best efforts of the project, involving fathers in childcare remains a challenge due to lack of availability of fathers, migrant nature of jobs, orthodox mindsets, lack of awareness, and illiteracy. This merit concerned efforts from government, UNICEF and development partners to encourage the involvement of fathers in the childcare and development for the well-being of the children.

# Chapter

# 6

# RECOMMENDATIONS

# 6. RECOMMENDATIONS

## 6.1. Recommendations based on key findings

The following recommendations were formulated based on (i) discussions with various stakeholders, involved in design and implementation of the parenting project, such as frontline functionaries (AWWs and ASHAs), master trainers (lady supervisors and ASHA facilitators), government officials at different levels, CSO partners and UNICEF; (ii) analysing the perceptions of ultimate beneficiaries of the project – caregivers of children 0-6 years; (iii) FLW survey findings and, (iv) review of relevant project documents. The recommendations have incorporated views and perceptions of these stakeholders to provide practical suggestions, which support and improve future programming and implementation.

*Recommendations for UNICEF*

a) ***Continue technical assistance to the Governments on responsive parenting and ECD as they scale up and replicate in other districts [immediate and on-going]***

UNICEF should continue its engagement with the Government of Maharashtra (GoM) and Government of Rajasthan (GoR), providing technical assistance in the following areas:
- Liaising with the state level officials from ICDS and health departments to support in strengthening monitoring and review systems
- Updating/ re-structuring the training modules on responsive parenting and care
- Training of trainers (master trainers)
- Process documentation
- Preparing policy briefs on importance of parenting and child development
- Any other activity identified in consultation with GoM and GoR

b) ***Sustained efforts to encourage the involvement of fathers and family members beyond the mother in responsive parenting [immediate]***

Sustained efforts are required at the community level to increase the participation of fathers and families in responsive parenting. Separate sessions for fathers are warranted given the tendency of mothers to speak freely in sessions without male members, and/or the sessions for fathers can be presented as something especially for men, to avoid any perceived stigma of being involved in "female" activities. Keeping in mind the challenges posed by the existing socio- cultural norms which often act as inhibitors, for all future programmes, greater efforts are needed for including fathers and families (especially grandparents) in ECD responsive parenting initiatives.

Discussions on household roles and responsibilities and decision-making processes around childcare can be incorporated in sessions to facilitate behaviour change. Innovative strategies like harnessing digital media, recognising and building father champions/leaders (mother or grandparents as well) who become advocacy champions as well, and gender sensitive programming taking account of challenges of time and space would be helpful. It is important to provide continuous support to parent leaders to help them implement behaviour change exercises around existing parenting practices. Lastly, parental leaders could also be compensated or recognised for their work to increase their level of commitment with the project.

c) ***Keep the main components of the project model with some adjustments [immediate]***

For a project that was implemented for a relatively short period of time, the results achieved in the domains of capacity building of frontline workers, increased knowledge base of parents and caregivers,

increased utilization of ECD services as well as alignment of project activities within the realm of the existing government infrastructure are promising. The overall logic of the project and the way it is implemented do not need to be substantively modified. The components around training, planning, content, methods need to be retained as they are. Adjustments that need to be made can be done in another iteration on content for modifications in activities for inclusion and equity, including explicit practice-oriented sessions in training modules, and translations in different languages.

d) **_Equity and inclusion of children with different needs in communication material needs to be continued but more explicitly [immediate]_**

There needs to be explicit training sessions on equity and inclusion.  Also, one more iteration of the content to move to gender neutral language, adding an explicit session on equity and inclusion, and adding modifications for children with different needs is required especially in the context of care of children from socially and economically disadvantaged sections as well as children with disabilities. In addition, translation of the communication material content to local and regional languages will make the intervention more implementable.

### Recommendations for Government

h) **_Integration of responsive parenting intervention into the annual work plan [immediate]_**

The addition of the project in the annual workplan will help build coordination with various departments right from the start and enable streamlining the priorities of the local government bodies. The senior officials will have to act as catalysts to encourage and expand the training conducted by an external partner and to bear the costs of the same.  This will also help support clear resource allocation at the government level for integrated ECD. Utilizing sector meetings as a training venue needs some re-thinking to strategically place the training session during the meeting to ensure sufficient time for the training. Review formats will need to include responsive parenting as well, so it is clearly institutionalized, allowing the Governments to systematically review and address issues.

i) **_AWWs and ASHAs collaboration and working together [immediate]_**

The collaboration between the AWWs and ASHAs needs to be leveraged and become a core component of the project implementation given that ASHA's messaging on health and nutrition benefits tremendously by being empowered with responsive parenting strategies.

j) **_Frontline functionaries (AWWs and ASHAs) education, job description and work status improvement [immediate]_**

_Skill, Will_ and _Time Amortization_ are three essentials to look at. _Skill_ - Capacity building of the frontline workers should be ingrained in the system; _Will_ - a platform for constant support and engagement needs to be maintained, clarity in FLW's job description with focus on 0-3 and 3-6 age groups and on services beyond the centres as well as inclusion of data monitoring, parenting services and advocacy components;  _Time_ - trainings need to follow the successful Incremental Learning Approach.

There needs to be greater recognition of their work in cash and/or kind, further enhancing participation in FLW services. The variability in the educational qualifications of the frontline workers across districts and states needs to be relooked. In addition, FLWs with lower levels of education should receive more refresher trainings in comparison to FLWs with higher educational levels.

k) **_Ongoing trainings for parents [immediate and on-going]_**

Parents require renewed and continuous training on the technical aspects of ECD. New parent trainings as well as refreshers along with guidance and counseling as in the project should be continued, ensuring long term sustainability.

l) *Convergence with line departments [medium to long-term]*
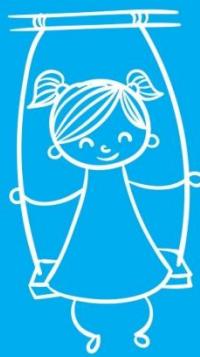
To ensure convergence of departments, clear set of institutional conditions for implementation should be in place and a clear distribution of tasks between partner departments/organizations should be laid down. Staff involved from other departments could then clearly understand the roles and responsibilities of planning, monitoring and reporting and where they converge as well. Other necessary conditions include available human and financial resources and skills and capacities (technical and administrative) which could be leveraged.

m) *Harnessing digital technology for responsive parenting [immediate and on-going]*

Innovative technology usage can improve service delivery, enhance supervision and monitoring, and leverage the use of data in decision making. The use of activity content in the form of a calendar during the pandemic period worked well and needs to be studied and expanded as an additional support. Use of digital platforms and telephonic networks (such as Whatsapp or an SMS group) should be considered, especially for the beneficiaries located in remote and far-flung regions.

n) *Interweaving with POSHAN Abhiyan completely to bring AWWs and ASHAs working together as a team [immediate]*

Given the tremendous benefit of responsive parenting in breast feeding and complimentary feeding, and the synergistic work done by the AWWs and ASHAs as a team, it is critical that responsive parenting be an integrated ECD approach bringing in WCD, health and ICDS together and complementing efforts. Joint meetings to detail the implantation plan for the project in their respective regions will not only improve planning and resource allocation but will also remove duplication of efforts across departments.

# ANNEXES

# ANNEXURES

## Annexure  1: Terms of Reference for the evaluation

TERMS OF REFERENCE

**Evaluation of the project "Space for Kids to be Kids" in Maharashtra and Rajasthan**

## 1.  Background

The first six years of a child's life, a period of rapid brain development and learning, are particularly critical. Early childhood research and programmes have consistently demonstrated that provision of services to support early childhood survival, growth and development along with parenting care and safety are pre-requisites for early childhood development. Young children's healthy development depends on nurturing care—defined as care which ensures health, nutrition, responsive caregiving, safety and security, and early learning.

Positive parenting is essential for building a secure relationship for healthy development of the child, both boys and girls. It builds resilience, promotes brain development and is essential for the child to function well as an adult. Caregiving that is responsive, gender neutral and disciplinary practices influence behaviours in early childhood and are also a predictor of adult behaviour. Furthermore, parental support and involvement is important once children go to preschool as well, as children who have learning support at home have better school readiness and learning outcomes in the early primary grades.

In keeping with the spirit of the Convention on the Rights of the Child, family and parenting support is increasingly recognized as an important part of national social policies and social investment packages aimed at reducing poverty, decreasing inequality and promoting positive parental and child well-being.

**Focus on the young child in India**
The Integrated Child Development Services Programme of Ministry of Women and Child Development is a multi-sectoral endeavour which aims at integrated delivery of a package of services for children of 0–6 years of age, pregnant and lactating mothers and adolescent girls from disadvantaged sections belonging to poorest of the poor families. Anganwadi centres, established under the Integrated Child Development Services (ICDS) programme for the delivery of early child development services, have service provisions which includes nutrition, health, play-based pre-school education. A fixed day approach namely the Village Health Sanitation and Nutrition Day (VHSND) organized at the anganwadi centre is a key platform to deliver the integrated package of services for health and nutrition. The fixed monthly Early Childhood Care and Education (ECCE) Day is a platform for interface between the Anganwadi worker (AWW) and the parents/community on care and education with a specific focus on children in the pre-school programme. The VHSND and the ECCE day are complemented with other activities such as mothers' meeting and preschool

activities organized at the anganwadi centres and home visits undertaken by the AWW and the Accredited Social Health Activist (ASHA), who is a community health worker instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural Health Mission (NRHM).

**Early Childhood Development and Gender**
Gender inequality in India often manifests itself early, children are subjected to gendered nurture and care. Data indicates that median duration of exclusive breastfeeding and any breastfeeding is longer for boys as compared to girls (NFHS-4). In India under-five mortality rate is higher among girls as compared to boys. Gender discrimination together with son preference results in young girls receiving less nutrition, health-care, opportunities to play and access early learning. Also, it is during the early years that girls and boys learn gendered attitudes and expectations - from parents, caregivers, other family members and teachers. Right from the earliest age boys are prepared for their future role as provider and protector, and girls as mothers and caregivers. Learning these rules and expectations can be limiting for all children –particularly limiting for girls. Programming that supports young girls and boys to develop to their fullest potential while also working to transform unequal gendered power relations, and challenge "traditional" gender socialisation processes offers a key opportunity to break the inter-generational cycle of gender discrimination, and to advance rights of girl children.

**IKEA Project**
The current intervention "Spaces for kids to be kids" is a multi-country IKEA Foundation (Stitching IKEA Foundation) supported project to improve early development.  The intervention in India adopts a system-based approach and utilizes the platforms available within the Anganwadi services to reach caregivers.  Strategic thrust is on building the capacity of the frontline workers primarily the AWW and the ASHAs to effectively support parents/caregivers in improving care of children at household level and in providing opportunities to support early learning in homes. The strategic components of the intervention include development of training materials, communication packages on parental care; building capacity of the frontline functionaries (AWWs and ASHAs), which includes training and on the job support to enhance their knowledge, attitude and perceptions on parenting care; and use of such learning through various platforms for quality counselling and interaction with the parents/caregivers.

The IKEA funded project with its gender dimension aims that both male and female children have equal access to services for early childhood care and education which will contribute towards ensuring all girls and boys survive, thrive and develop to their fullest potential. The project interventions are designed to emphasise that child care is not only the responsibility of mothers but also needs the involvement of fathers. The capacity building of frontline functionaries included how to use communication materials/tools in communicating with fathers as well.

In the context of the present intervention, parenting can be understood as the interactions, behaviours, emotions, knowledge beliefs, attitudes, and practices associated with the provision of nurturing care which is defined as care which ensures health, nutrition, responsive caregiving,

safety and security, social emotional well-being and early learning[43]. The term parenting is not limited to biological parents but extends to any guardian or caregiver providing consistent care to the child.

To know more about current practices around parenting for early childhood development please refer to Annex 1.

**Project implementation**

The intervention has been designed based on UNICEF's approach to ensuring sustainable development adopting pilot to policy to results-at-scale. The project in India aimed to improve service provision and utilization and improve the coverage and quality of counselling and communication support to parents/caregivers to provide nurturing care and early learning opportunities to their children. The intervention covers select districts in the states of Maharashtra and Rajasthan. This project is an innovation in India since promoting parental involvement for quality early childhood development (ECD), both in terms of improving their awareness with regards to care and development of their children and increasing demand for quality services, had not been implemented in India.

For sustainability and to ensure scale up, interventions were designed within the overall governments' capacity development strategy linked to ongoing programmes e.g. Poshan Abhiyaan, Rashtriya Bal Swasthya Karyakram (RBSK), Home Based Young Child Care (HBYC) and strengthening early childhood education under the umbrella of the ICDS programme. In both states, the implementation of activities has been through existing government structures: for capacity building of frontline workers (AWW and ASHA); as well as the delivery of quality services including counselling of parents through existing platforms of ICDS.

The project was initiated in August 2017, in a partnership with the Department of Women and Child Development in the states of Maharashtra and Rajasthan. Select districts[44] in each state were identified for implementation of the project activities. In each of the selected districts, specific blocks were identified for implementation of the project activities. Districts have been selected targeting marginalized populations of children (children from tribal groups, children living in urban slums, and children living in rural areas.  In each state, blocks within the district were selected based on certain parameters. In Maharashtra, blocks were selected in consultation with government on the basis of the least number of staff vacancies in ICDS. In Rajasthan, the blocks selected were those with ongoing programme on nutrition/education.  UNICEF was responsible for developing the project design and providing technical support to partners for the implementation of the project. Civil Society Organisations (CSO)[45] partners were selected to provide technical and monitoring support to the project and were responsible for developing the

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[43] Nurturing Care Framework - a framework for helping children survive and thrive to transform health and human potential was created in response to strong evidence and growing recognition that the early years are critical for human development. https://www.who.int/maternal_child_adolescent/documents/nurturing-care-early-childhood-development/en/

[44] Aurangabad, Palghar, Pune and Yavatmal districts in Maharashtra; Dungarpur and Udaipur districts in Rajasthan

[45] Mahatma Gandhi Institute of Medical Sciences Sewagram, Gram Mangal and Save the Children in Maharashtra and Unnati and Prarambh in Rajasthan.

training material and communication toolkit for parents of children (0-6 years) and imparting training to front line workers (FLW). The target for each state was to build the capacity of 2,500 frontline workers across the selected geographies.

Each state has adopted a capacity building strategy to suit the programming context as well as the platforms available for communicating with parents e.g. in Maharashtra an Incremental Learning Approach (ILA) was adopted for training. ILA builds learning incrementally to enable the frontline workers to internalize the learning, develop skills and take necessary actions. Training used games, activities and demonstrations on how to conduct a mothers' meetings and home visits. In Rajasthan, the capacity building of frontline workers was implemented during the monthly sector meetings organised by the field supervisors. A team of field supervisors was trained to equip them with skills and knowledge on training AWW on positive parenting with special reference to responsive parenting including early stimulation and creating a learning environment at home. The implementation approach in each state was different. The brief notes on the implementation strategy adopted by each state is attached in Annex 6.

Training of FLWs followed a cascade training model. The training programme content covered various aspects of early childhood development as outlined in the nurturing care framework along with an understanding of early childhood education (ECE) focussing on all domains of development and linked to the ECE curriculum. The training programmes also focussed on building skills on effectively communicating key messages using the communication tools, for counselling parents during, meetings and home visits. CSO partners in each state imparted training to the master trainers including ICDS field supervisors and ASHA facilitators and also provided oversight to trainings for quality assurance. In case of Rajasthan a mix of ICDS officials and resource persons from CSOs were part of the master trainers' group. The master trainers in turn imparted training to the FLWs on responsive parenting, and on creation of a learning environment at home for child development etc.

In Rajasthan, the trained FLWs reached out to parents/caregivers through the existing platform of mothers' meeting, community meetings, Parent Anganwadi Meeting (PAM) [46] with parents/caregivers, home visits and community-based events, maternal and child health and nutrition sessions. The intervention prioritized the effective use of communication tools (MAA tool kit for promoting infant and young child feeding, POSHAN Abhiyaan key takeaways, Mother Child Protection card and communication cards (*Sabrang*) developed focussing on promoting learning at home for children age 3-6-years-old) and improving the coverage and quality of these events. Parenting communication toolkit Sab Rang in Rajasthan focused on key messages for counselling parents to promote learning at home for children 3-6-year-old. These messages were aligned to the developmental milestones laid down in the Early Learning Development Standards (ELDS) developed and standardized for children in India.

In Maharashtra, parents' meetings, VHND, growth monitoring week, community-based events, home visits and family fairs (*palakmelas*), were strengthened for the delivery of parenting messages. The focus of messages for children in the 0-3 age group was on exclusive breastfeeding,

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[46] In Rajasthan the monthly ECCE day is referred to as Parent Anganwadi Meeting (PAM)

complimentary feeding, responsive feeding, feeding during illness, care of a new-born baby, growth monitoring and promotion, and play and communication.

The *Samvedansheel Palakatv* (Responsive Parenting) flip-charts were developed for communicating messages for responsive parenting focussing on children in the 3-6 age group. The key messages have been aligned to the state ECE curriculum *Aakar*. Learning was further reinforced through supportive supervision by Field Supervisors and ASHA (Accredited Social Health Activist) mentors or the CSO partners.

The project envisaged a number of immediate outcome and two intermediate outcomes from the intervention. The immediate outcome of the project intervention is increase in knowledge, attitude and practices of FLWS, who received the training from Master trainers. The two intermediate outcomes are: change perceived by parents/caregivers on improved services in terms of improvement in the quality of counselling and interaction with the community; and new information on parenting received by parents/caregivers. Hence, the evaluation will not only assess all the project activities including capacity building of frontline workers to communicate parenting messages but also to what extent the FLWs transferred these learnings to the parents/caregivers through various platforms such as Mothers meeting, Parent Anganwadi Meeting (PAM)/Monthly ECCE day, home visits and community meetings.

A baseline study[47] was commissioned and the study covered the six intervention districts and assessed the knowledge, attitude and practices of the frontline workers (both AWW and ASHA workers). The baseline was done as part of a formative study on parenting that examined how raising children (both girls and boys) is understood among different stakeholders and what sources of parenting support exist for parents and caregivers. The study used mixed method approach with quantitative survey and Dyads (anganwadi worker and ASHA interviewed together) with the frontline workers. Computer assisted individual interviews were conducted with 600 AWWs and; 14 dyads were also conducted to explore their current level of involvement, expertise and training on ECD.

## 2. Rationale & Objectives

### Rationale

The evaluation of the 'Space for Kids to be Kids' project is necessary at this stage for several reasons. First, it is important to ascertain whether the positive parenting intervention actually worked as intended, and to determine its strengths as well as areas for improvement (and this is also why an evaluation is required by the donor). Second, there is not much evidence on positive parenting currently available in India, and this evaluation will generate important evidence for early child development in India, where this is still a relatively new area. Third, this evaluation has the opportunity to influence policy decisions, in both Maharashtra and Rajasthan, as well as nationally, using the evaluation findings to support scale-up. Specifically, the findings will generate learnings for the government on the sustainability and scalability of such a systems approach in which interventions for early childhood development were designed within the overall governments' capacity development strategy linked to various ongoing programmes. Aside from the donor requirement, due in early 2020, the timing of the evaluation is apt as there is strong

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[47] Formative Study on Parenting, UNICEF 2017

appetite from the concerned state governments to learn from the evaluation findings before strategizing on scaling up in other districts.

**Objectives:**

The **main objectives** of this evaluation are to:

9.  Assess the relevance of the project, specifically the role of parental support and involvement to support early childhood development including the support of early learning in the home.
10. Assess the effectiveness of the programme in the select districts in Maharashtra and Rajasthan, specifically in terms of whether it has achieved its intended immediate and intermediate outcomes or not
11. Assess the programme effectiveness from gender and equity perspective; specifically to what extent the programme was able to achieve its gender and equity focus e.g. reach out to vulnerable communities as well as fathers.
12. Assess the efficiency of the programme in terms of utilisation of available resources and timely implementation, and understand where processes can be improved for better programme delivery
13. Capture immediate results of the interventions if any that support pathways to programme impact
14. Determine the readiness for the programme to be scaled up to other districts
15. Assess the sustainability of the programme in terms of ownership of the government
16. Capture good practices and lessons learned

## 3. Use of Findings

As described, the findings from the evaluation will be used to inform the national and state level policy makers and programme planners about improving the quality of ECD services with a specific focus on promoting responsive parenting for children in 0-6-years age-group. For the states of Maharashtra and Rajasthan, the findings will be of great importance as the intervention has been implemented in selected districts through the existing structures and platform of ICDS. As the two state governments are planning for scaling up of this intervention across all anganwadi centres, the learnings and recommendations of this evaluation will be of great value.

From UNICEF programming perspective, the conclusions and recommendations from this evaluation will inform UNICEFs support to government, for improving the quality of ECD programmes, with a specific focus on promoting positive parenting for children below the age of 6 years. The dissemination of the findings from the evaluation will enable UNICEF to reach out to parents, caregivers, professionals and the larger community and create awareness regarding ECD services with a specific focus on promoting parental involvement in providing nurturing care for their children.

The findings from the evaluation will contribute to evidence building in India on improving the quality of ECD services with a specific focus on promoting parental involvement. The findings will also inform other key stakeholders who are part of the ecosystem, including CSOs, academic institutions who work closely with state governments in improving the quality of ECD services.

## 4. Publication Plan

The findings will be made publicly available, as per UNICEF's Evaluation Policy, and published on UNICEF's website. At this stage there is no intention to publish the results academically since the results are meant primarily for programmatic purposes. However, a final decision around this will be taken during the Inception phase of the evaluation. The findings will be disseminated internally by UNICEF through various programme network meetings. The findings of the study will also be disseminated at the national and state level, to the officials of the relevant ministries and their departments in the implementing states to inform scale-up of the programme.

Any publication will follow UNICEF's guidelines. For academic publishing, UNICEF's Guidance on External Publishing should be followed.

## 5. Scope of the Evaluation

**Evaluation criteria and questions**

The evaluation will cover the OECD/DAC evaluation criteria of relevance, efficiency, effectiveness and sustainability. The evaluation of impact is beyond the scope of this TOR, and is anticipated to take place at a later stage, once the intervention has been running for sufficient time to be able to affect behaviour and practices of parents/caregivers regarding positive parenting.

The evaluation should focus on two broad aspects of the cascade training method: (i) the training causal chain, such as quality of the training of the master trainers, supervision of the trainers, testing of FLWs, replacement of trainers, training of new FLWs as old ones leave, etc); (ii) the organizational causal chain, specifically UNICEF working with CSOs to train government workers at level middle to train front line workers at level bottom.

The draft evaluation framework matrix including the evaluation questions is given in Annex 2. The matrix will be revised by the evaluation team, in consultation with UNICEF, during the inception phase. Based on their understanding, bidders are encouraged to add additional gender and equity specific questions and sub-questions in each evaluation criteria.

**Geographic focus and scope**

The evaluation will be conducted in four districts of Maharashtra and two districts of Rajasthan, where the 'Space for Kids to be Kids' project has been implemented, between August 2017- till the date of commencement of the study. It is pertinent to mention here that State-specific training packages and communication tools, including parenting communication toolkit, were developed to suit the programme context in both the states. Hence, the evaluation design and approach should factor in the state level specificities.

**Time Period**

The evaluation will cover activities implemented between August 2017 till the commencement of the study. In order to assess the extent to which the FLWs used their learnings to communicate with parents/caregivers, through various platforms, those FLWs will be chosen for data collection where the parenting intervention should be at least of one-year duration after the training.

## 6. Methodology

In order to meet the objectives, it is expected that this formative evaluation will use a cross-sectional mixed-methods design, involving both quantitative and qualitative data collection and analysis of both primary and secondary data sources. A quantitative survey will predominantly be used to assess to see changes in knowledge, attitude and practices of frontline functionaries regarding ECD, while qualitative methods such as key informant interviews, focus groups and case studies will be used to determine some of the more descriptive results. It is further suggested that observation is used, especially to measure the actual behaviour and practices of FLWs when they are interacting with parents/caregivers. The quantitative survey will need to adopt a similar methodology as the baseline study, to allow for a pre- post- comparison on the knowledge and attitudes of front line workers.

In addition to interacting with FLWs, the evaluation will need to capture the views and opinions of various stakeholders involved in the project implementation including government functionaries from the relevant departments at state and district levels, CSO partners, Master trainers and the UNICEF staff. Furthermore, it is expected that there will be data collection with parents/primary caregivers, to understand the change perceived by parents/caregivers on improved services in terms of improvement in the quality of counselling and interaction with the community, and to assess whether parents/caregivers received new information on parenting.

The proposed methodology, as set out in more detail below, is based on experience of designing similar evaluations but should be enhanced based on the bidders' understanding of the project, and objectives and scope of the evaluation. Therefore, the agency could either utilise a similar methodological approach to what is being proposed below or further suggest improvements/modifications to the proposed methodology in their technical proposals. The design, analytical methods and tools will be agreed between the selected agency and UNICEF during the inception phase.

Importantly, bidders need to outline in sufficient detail in their proposals how they will be able to conclude attribution and contribution of outputs and outcomes to the programme. Given the way in which the project was implemented, it is not feasible to identify a control area to conclude. In an intervention district, certain blocks were selected for the project intervention and currently the process of scaling up is going on in other blocks of the district. Hence, it is difficult to select a control block for comparison.

In order to help the bidder to develop a robust evaluation design and to understand the pathways of change, a broad Theory of Change (ToC) of ECD is given in Annex 5. The bidder will develop a ToC of the project intervention reconstructively based on their understanding of the broad ToC and review of other project documents. The draft ToC will be shared during the inception report stage and this ToC will be finalized in consultation with UNICEF programme team.

### a) Desk review of documents

This will entail review of all key documents of the 'Space for Kids to be Kids' project, including training modules, communication packages developed with key messages for different age groups of children focusing on health, responsive care, nutrition, safety and protection and early learning along with training materials developed for capacity building of FLWs. The review will aim to assess whether the content was relevant for FLWs and parents/caregivers and whether they

were of good quality, as well as evaluate gender and equity issues: e.g. whether messaging in the communication package is gender neutral; whether messaging is customized to vulnerable groups etc. In addition, the existing programme documents, baseline report and partner reports will be reviewed. These will be useful in developing the study tools, and especially the baseline report will be an important source to help design the quantitative survey, as mentioned above.

The desk review will also entail reading of important guidelines and policy papers such as

- National Early Childhood Care and Education Policy (https://wcd.nic.in/sites/default/files/ecce_gazatte_notification_policy_comp.pdf)
- India Early Childhood Education Impact Study and Policy brief (http://img.asercentre.org/docs/Research%20and%20Assessments/Current/Education/Research%20Projects/IECEIStudyReport2017.pdf),
- National Guidelines for ECCE day (https://wcd.nic.in/sites/default/files/eccedaydtd05082013.pdf),
- Home Based Young Child Care Guidelines (http://nhsrcindia.org/sites/default/files/Handbook%20for%20ASHA%20on%20Home%20Based%20Care%20for%20Young%20Child-English.pdf) etc.

Apart from these guidelines and policy papers, important reports and studies on other parenting programme will be reviewed. This will generate good understanding of the role of parenting especially the best practices in other regions.

**b) Primary data collection**

It is anticipated that primary data collection will be conducted through field visits at state, district, and AWC-level, involving four key components: (i) quantitative survey with sampled frontline workers; (ii) qualitative key informant interviews and FGDs with representatives from relevant government departments at state and district level, representatives of CSO implementing partners, UNICEF staff members at state level, master trainers and parents/caregivers; (iii) observation of FLWs when interacting with parents through various platforms on parenting; and (iv) qualitative interviews for in-depth case studies to provide additional insights into strategies/innovations adopted, key challenges, best practices and lessons learned. All primary data collection should include gender/equity dimensions throughout to the extent possible.

*Quantitative survey*

The quantitative survey will aim to measure the knowledge, attitude and practices of frontline functionaries with respect to early childhood development and positive parenting, as should be based on the methods and tools used in the Baseline study. The Final report of the Baseline study can be accessed at https://unicef-my.sharepoint.com/:b:/g/personal/sahuja_unicef_org/EauJOuMMdgFAor7Za5qOvcQBdoysA-ye-uHWGqttA-Zg9Q?e=VDdUOy. It is pertinent to mention here that the baseline study covered selected indicators. Apart from these indicators, the quantitative survey under this evaluation will capture data and information on additional indicators. Some of the additional areas of inquiry include: quality of training received by FLWs; utilization of existing contact points (no. of meetings organized, participation in meetings etc); ability of the FLWs to use the communication tools to communicate with family; confidence of FLWs to interact with fathers etc. The bidders in their proposal should include other indicators/areas of inquiry to be covered in the survey. The survey

should be administered through CAPI (Computer Assisted Personal Interview), which improves the efficiency and quality of the data collection.

Selection of frontline workers – The sample will be selected from the intervention centres based on a stratified random sampling technique. The stratification will reflect the geographic typology (rural/urban/tribal), duration of the intervention period and the intensity of the intervention (this being especially applicable for Rajasthan)

The project was implemented in selected blocks of four districts of Maharashtra and two districts of Rajasthan. The total number of sample frontline workers in a state will be proportionally divided among the intervention districts. Selection of a frontline worker will be done randomly from the list of AWWs of the select blocks. However, the selection should be done in such a way that the sample will cover all the blocks of an intervention district. As mentioned in the scope of Evaluation section, FLWs will be chosen from areas where the parenting intervention covering children 0-6 years has been implemented for at least one year.

*Sample size calculations* - The sampling universe for each state is 2500 frontline workers across the selected districts. The estimation of a representative sample size at state level will provide a robust sample for undertaking the analysis on variables of interest. A two-stage cluster sampling is adopted to estimate the sample size at state level, i.e. clustering at district level and block level. The sample size estimation is based on a 95% confidence level and a confidence interval (margin of error) of 5%. The estimated sample size is 384. Applying a non-response rate of 5%, the required sample size is estimated to be 400. To adjust the sampling error due to Cluster level sampling a design effect[48] will be considered for providing the required power to the sample size. Taking into account a design effect of 1.5, the total sample for each state will be 600 (400*1.5). Thus, for two states the total sample size will be 1200. The sample of 600 will have proportional representation of AWWs and ASHA.

The agency is encouraged to provide any other sample design with a strong justification behind the same and this will be scored accordingly in the technical evaluation.

### *Key Informant Interviews and Focus Group Discussions*

Qualitative information from stakeholders will be obtained through KIIs and FGDs. Key informant interviews will be conducted with representatives from relevant government departments at state and district level, members of CSO implementing partners, UNICEF staff members at district and state level, and master trainers. The purpose of the KIIs is to understand the implementation of the positive parenting intervention, as well as assess what has worked and not in terms of achieving intended outputs and outcomes. The KIIs will also be able to generate evidence in terms of efficiency of the programme and what bottlenecks were encountered. Focus group discussion will be held with the parents/caregivers to understand the change they have noted in the quality of services delivered with respect to counselling parents, whether the messages are relevant for them, whether this has influenced their parenting practices, whether the FLWs contact has increased with the families, etc. It should be noted that the project envisaged to engage fathers in

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[48] Design Effect- "The *design effect*, often called just *deff*, quantifies the extent to which the expected sampling error in a survey departs from the sampling error that can be expected under simple random sampling." https://docs.displayr.com/wiki/Design_Effects_and_Effective_Sample_Size

the Parent meetings conducted by FLW. Hence, some of the FGDs should be conducted among fathers to bring insights into positive parenting issue.

A suggested number of KIIs and FGDs to be conducted against each respondent group at various levels has been given in the below matrix. The selected agency is encouraged to review and validate this indicative number, and suggest any other participatory tools of qualitative data collection to meet the objectives of the evaluation.

| Respondent group | No. at dist level | No. for 2 states (6 districts) | Total |
|---|---|---|---|
| KIIs with officials of government department (ICDS, Health) | 2 | 2*6 =12 | 12 |
| KIIs with Members of CSO implementing partners | | 4 | 4 |
| KIIs with UNICEF staff members | 1 | 1*6 =6 | 6 |
| KIIs with UNICEF staff members at state | | 2 | 2 |
| KIIs with Master trainers | 4 | 4*6=24 | 24 |
| FGDs with Parents/caregivers | 2 | 2*6=12 | 12 |

*Observation*

Instances of interaction of FLWs with parents/caregivers should be observed in order to ascertain whether FLWs are implementing what they were taught, and specifically how they are interacting with parents/caregivers. It is suggested that in each intervention district three observations will be conducted. A total of 18 observations will be held in 6 districts across the two states. Of the three observations in each district, one will be on AWC based parenting session focussing on children under 3; one will be on AWC based parenting session focussing on children 3-6-year old, and one is on home visit by ASHA for counselling parents. The bidder in the proposal should clearly identify the risks associated with observer bias in such a methodology and will identify risk mitigation strategies.

*Case Studies*

Eight case studies should be developed, four each in Rajasthan and Maharashtra, focusing specifically on key innovations/achievements and challenges of the project. It is expected that the identification of potential cases will be done during the KIIs and FGDs. For each state, the specific areas suggested for the case study include: the achievement of a FLW (ASHA/AWW) from the project; a supervisor highlighting her role in building capacity of frontline worker (Field Supervisor/ASHA mentor); feedback of a family/parents; and engagement of men especially fathers. Any other ideas from the bidder on the topics of case study is welcome in the proposal. A case study template will need to be submitted as part of the inception report.

**c) Quality Assurance**

The evaluation agency should ensure that data collected is of the highest possible quality, including operational checks in the data collection process, as well as dealing appropriately with possible biases. For primary data collection, this entails sufficient oversight and management of the quantitative survey, KIIs and FGDs. Bidders are required to outline in their proposals what quality assurance mechanisms they will put in place. At a minimum however, the expectation is that surveyors and interviewers will be sufficiently trained, that tools and protocols and piloted, and that a management structure exists where field managers will conduct spot checks and data

checks. Furthermore, it is expected that where possible, data from different sources will be used to triangulate the findings. Any potential bias either in the design or implementation of this evaluation should be appropriately mitigated, and agencies are requested to outline in their proposals what risks and risk mitigation strategies they will employ to ensure quality of the evaluation.

**d) Data Analysis**

Standard analytical software needs to be used for both the quantitative and qualitative analysis to allow for comparison of results with the baseline. The quantitative analysis may be done using SPSS, STATA, or another standard package. For the qualitative analysis, analytical software such as NVivo is recommended. Agencies are asked to specify which software they plan to use and their level of experience with using it.

Bidders are expected to propose an appropriate analysis framework and analysis plan to undertake comparison with the baseline on selected variables while undertaking analysis of additional variables in this evaluation. In addition, given that the programme that was implemented in Maharashtra and Rajasthan are slightly different, it is expected that a comparative analysis will be conducted between the two States, as well as a unified analysis for the programme as a whole. The analysis framework and analysis plan will be further refined and validated during the inception phase, and agreed upon by UNICEF. Data emerging from the evaluation will need to be disaggregated by sex, age, social group, etc, to the extent possible.

## 7. Ethical Considerations

The evaluation agency is expected to follow the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and the UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis. In addition, the UNEG norms and standards will be observed. Data collectors must undertake appropriate ethics training as per the UNICEF Procedure. Any primary data collection conducted with stakeholders must only be carried out with informed consent. Data collectors will emphasise the voluntary nature of participation in the evaluation activities. In addition, participants who wish to withdraw from the study after providing consent will be free to do so. All results will be reported at aggregate level and no **identifying information will be disclosed.** The agency bidding for the study should detail their ethical protocols in their proposal, along with their data protection and data storing protocols.

The evaluation agency is strongly encouraged to seek IRB approval for this evaluation; while this evaluation does not involve interacting with children, when speaking to FLWs and parents there could be sensitive issues around parenting that may come up, such as examples of corporal punishment or violence.  Bidders should clearly identify any potential ethical issues and approaches, as well as the processes for ethical review and oversight of the evaluation process in their proposal.

## 8. Risks and Limitations

There are a number of anticipated risks and limitations of this evaluation. Bidders are required to outline risks and appropriate mitigation strategies in their proposals, for the approach and methodology they have chosen.

- Key respondents for KIIs may not be available, especially given the short-time frame available for primary data collection
- There are multiple risks involved while collecting qualitative data. Some of these include, social desirability bias, interviewer or experimenter effect, issues of recall, etc.
- While collecting data from 'implementers', i.e. the key informants, there is a risk of confirmation bias. The agency is encouraged to 1. triangulate findings and 2. Come up with a strategy of identifying what is 'true' if two stakeholders have conflicting statements
- Data loss due to poor handling of data. Leakage of information is a possibility as data is entered at multiple levels, travels from field to the evaluation team and changes various formats. It is required of the agency to put in place transparency measures, such as the Progress Reporting Template with live activity logs to ensure all details are logged and reported in real time.
- Data manipulation- UNICEF teams will conduct on-field audits to ensure all practices stated by the agency in the study design and work plans are followed. In addition, the agency must ensure that the data is collected in the local language/dialect and must minimise information loss during translations.
- Weather and climatic conditions (such as a heatwave, monsoon or natural disasters) may disrupt the evaluation and/or cause delays, and inhibit movement of data collectors, key informants, and the community at large.
- This evaluation does not seek to evaluate the impact of the 'Space for Kids to be Kids' project, only the inputs and outputs, and immediate outcomes. Therefore, cannot conclude whether the scheme had an impact. In addition, it is anticipated that concluding true contribution in terms of immediate outcomes might not be possible, and this should be addressed appropriately in the findings.

9. **Schedule of Tasks & Timeline**

Below is the expected schedule of tasks and timeline:

1. **Kick-off** -Kick-off meeting with UNICEF Social Policy team and Research & Evaluation Specialist -**1 day**
2. **Desk Review and draft inception report** -Reviewing of project documents, baseline report & partner reports; Review of training modules, communication and training materials; Developing Evaluation framework, study design, sampling design and selection, data analysis framework, and work plan; Developing draft data collection tools; Drafting inception report - **3 weeks**
3. **Report review -** Review of draft inception report by UNICEF, external agency and ERG members – **2 weeks**
4. **Finalization of inception report** - Incorporating feedback and finalization of inception report - **1 week**
5. **Finalization of data collection tools** - Piloting and finalizing data collection tools; Translation of tools in local language; Developing data collection implementation plan - **1 week**
6. **Data Collection -** Training of data collection team; Primary data collection in sampled districts in two states – **8 weeks**

7. **Data Analysis -** Entry and cleaning of data; Analysis of qualitative data; Analysis of quantitative data; *(note: it is expected some entry of data will occur concurrent to data collection)* - **2 weeks**

8. **Report writing** - Drafting final report *(note: it is expected some drafting will occur concurrent to data entry & analysis)* - **2 weeks**

9. **Draft Final Report review**- Review of draft report by UNICEF, external agency and ERG members - **2 weeks**

10. **Finalization of Final Report** - Finalizing report and submitting to UNICEF - **2 weeks**

10. **Estimated duration of contract**

Total Number of Months: 6 (January 2020 – June 2020)

**11. Deliverables**

The evaluation will include the following key deliverables. The length, structure and content of the final report will be as per [UNICEF Evaluation Report Standards (GEROS)](). This will be finalized in consultation with UNICEF.

1. Inception report with evaluation design, detailed methodology and analysis plan, ToC of project intervention, data collection tools (30 pages including executive summary, excluding annexes, *see Annex 3 for structure of the inception report*) – Within 6 weeks after the signing the contract

2. Report of the completion of field work – End of week 15

3. Draft final report and power point presentation – End of week 19

4. Accepted final report and final power point presentation (60 pages including executive summary, excluding annexes- *see Annex 4 for structure of the report*)- End of week 23

12. **Qualifications & Experience required**

For this evaluation, we are seeking a qualified evaluation agency or research organisation (minimum 5 years' experience) which is able to leverage the necessary expertise in ECD, covering all domains of nurturing care framework and early childhood education. The organisation should have performed evaluations of similar scale and scope, have a track record of producing reliable data, and evaluation reports. The organisation should be able to have or organise field presence in the two intervention states. The data collection/field team should have knowledge of the local language (Hindi and Marathi). The composition of the evaluation team should ensure gender balance.

The bidding agency should identify an evaluation team leader who should be available to work on the evaluation throughout the evaluation process. Change of the evaluation leader or senior team members will not be accepted without prior approval of UNICEF.

It is for the bidding agency to pre-empt and explicitly mention any possible or potential conflicts of interest while submitting their proposal. This may include details on their involvement with the government and UNICEF, past or ongoing work, individual team member involvement etc.

The evaluation team leader should have the following:

- A post-graduate degree in social sciences, health, child development or a related field; a PhD is preferred
- At least 10 to 15 years of extensive experience in designing, planning, organising, and conducting mixed method evaluations. Experience in the two states being evaluated would be advantageous.
- Proven experience of leading a team of evaluators for an evaluation in the last three years.
- Demonstrated ability to produce high quality evaluation reports; a solid publication record in peer-reviewed journals is strongly preferred
- Experience in ECD is preferred.

The teams must show the mix of skills adequate to meet the requirements set out below. The number of team members should be decided by the bidding organisation taking into account the volume of work, scope of evaluation and time duration to complete the evaluation.

While individual members of the team may possess several of the required competencies, the team as a whole must possess the following:

- Expertise in ECD, healthcare, gender and child rights programming and assessment of training programmes.
- Expertise in programme evaluation, research, sampling, data collection, instrument development, and data analysis.
- Expertise with both qualitative and quantitative research tools will be required, especially with collection, management and analysis of qualitative data.
- Proficiency in English-language writing and presentation.
- Ability to collect data on field (directly, or by sub-contracting).
- Professional level skill in the working languages of the two intervention states (should be able to read documents in Marathi and Hindi, all field level interviews in Maharashtra will have to be in Marathi).

In particular, there should be 2 senior team members who possess the required experience and expertise in ECD, including early childhood education for children 3-6 years of age. These senior experts should have:
- A post-graduate degree in social sciences, education, health or a related field
- At least 8-10 years' experience working in ECD - one member should have expertise related to programmes for children below age 3-years and one member should have expertise in early childhood education  for children 3-6 years
- Experience with ECD in India is strongly preferred
- Experience conducting research and evaluations is preferred
- Proficiency in English-language writing and presentation

Note: If required, two or more agencies may join to make a consortium bid. However, the consortium will need to nominate one agency and individual as the clear point of contact with UNICEF.

## 13. Duty Station

Data collectors from the evaluating agency (or from a partner/sub-contracted agency) will need to be able to coordinate presence in the two states (Rajasthan, Maharashtra), where the evaluation

is to be conducted and should understand the local context and speak and understand the language used in these states.

## 14. Management and Supervision

Evaluation Management: Research & Evaluation Specialist, SPME (UNICEF)

Technical Support: Education Specialist (ECE), and Child Development Specialist, UNICEF.

**UNICEF Responsibility:** UNICEF India's Child Development section and Education section will be responsible for providing the evaluation team with the necessary background information to carry out the evaluation as well as technical inputs throughout. UNICEF India will also keep the evaluation team updated on any changes or development that may affect the evaluation.

For local logistics, the UNICEF State offices will provide necessary support to the evaluation team, such as making introductions to key informants and stakeholders. However, the agency will ensure 'independent selection' of respondents in order to ensure that the responses received are not biased toward or against UNICEF.

The Supply and Procurement Section will remain the focal point for all administrative, financial, and commercial queries and correspondence, including contract amendment.

**Evaluation Reference Group**: An **Evaluation Reference Group** will be formed to oversee the evaluation process and ensure compliance to United Nations Evaluation Group (UNEG) Norms and Standards. It is an independent group of UNICEF and non-UNICEF experts (consisting of technical experts, government representatives) constituted for a specific evaluation by UNICEF India. From the government, UNICEF envisions the empanelment of various officials. In addition, state Child Development Specialists from relevant states will be a part of the Evaluation Reference Group. This group will serve as an advisory body which will support the evaluation by 1. providing strategic direction and technical inputs, 2. monitoring progress and quality, and 3. bringing critical issues to the notice of the Monitoring and Evaluation Specialist.

**Responsibility of the Evaluating Agency:** The evaluation agency will be required to satisfactorily complete all the tasks mentioned in section 13 and all deliverables mentioned in section 15. The "satisfactory completion" of each of these tasks, is subject to review by Evaluation Reference Group and UNICEF internal and external review.

## 15. Official travel involved

The evaluation team will be required to travel to the states of Maharashtra and Rajasthan for data collection and interactions with all stakeholders. These visits will be to the districts of Aurangabad, Palghar, Pune and Yavatmal in Maharashtra and Dungarpur and Udaipur district in Rajasthan.

In addition, core team members from the selected agency will need to travel to UNICEF ICO for a kick-off meeting during the inception phase.

It is assumed that, if the need be, on-field data collectors will be locally recruited by the agency (or a partner/sub-contracted agency). Therefore, their training will be conducted by the agency, individually in each state. It must be clarified that travel cost shall be calculated based on economy class travel, regardless of the length of travel.

# Annexure 2: Importance and Rationale of ECD and global approaches and frameworks

## 2a. Importance and rationale of ECD

Evidence from literature suggests that interventions in the early years of a child's life is more effective than remediation in later stages of life of an individual[49]. Therefore, it becomes essential that governments, in collaboration with development agencies and private sector, invest adequately in ECD programmatic interventions[50]. Such an investment will optimise a government's spending, offsetting higher costs that governments would otherwise face if having to adopt measures later on to ensure all children have equal access to primary school and achieve the desired health and nutritional outcomes. Evidence from economics, behavioural and neurosciences studies, which show that investment in early childhood can potentially yield long-lasting benefits for children, families, communities and nations alike[51].

An extensive analysis of existing ECD programme evaluations[52] found positive trend of outcomes that emulate those found in intervention programmes implemented in developed countries. The study concluded that the potential long-term economic effects of increasing preschool enrolment to 25% or 50% in every low-income and middle-income country has a potential benefit-to-cost ratio ranging from 6.4 to 17.6[53]. In the US studies have shown that the return for every dollar invested in preschool is much greater (8:1) for the individual and society than an investment in school-based programs (3:1)[54]. This corroborates the analysis that ECD is a cost-effective intervention and help in accelerating the economic growth of a nation[55]. As per Lancet series[56], there are a number of interventions and policies which contribute towards holistic development of children, such as family support and strengthening package; caring for the caregiver package; and early learning and protection package. These details have been summarised in the Figure below.

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[49] Doyle, O., Harmon, C. P., Heckman, J. J., & Tremblay, R. E. (2009). Investing in early human development: timing and economic efficiency. Economics and human biology, 7(1), 1–6. https://doi.org/10.1016/j.ehb.2009.01.002

[50] Lynch, R. and Vaghul, K. (December 2015). The benefits and costs of investing in early childhood education, Washington Center for Equitable Growth, Available at equitablegrowth.org.

[51] Supra Note 6.

[52] Supra Note 6.

[53] Supra Note 6.

[54] Heckman, J. J. (2000) Policies to Foster Human Capital, Joint Center for Poverty Research Working Papers 154, Chicago: Northwestern University/University of Chicago.

[55] Hoddinott, J., John A Maluccio, J.A., Jere R Behrman, J.R., Rafael Flores, R., Reynaldo Martorell , R. (2008) Effect of a nutrition intervention during early childhood on economic productivity in Guatemalan adults, The Lancet, Volume 371, Issue 9610, P ages 411 – 416

[56] Lancet. (2016). Advancing Early Childhood Development: from Science to Scale: An Executive Summary for The Lancet's Series, The Lancet, Available online at https://marlin-prod.literatumonline.com/pb-assets/Lancet/stories/series/ecd/Lancet_ECD_Executive_Summary.pdf.
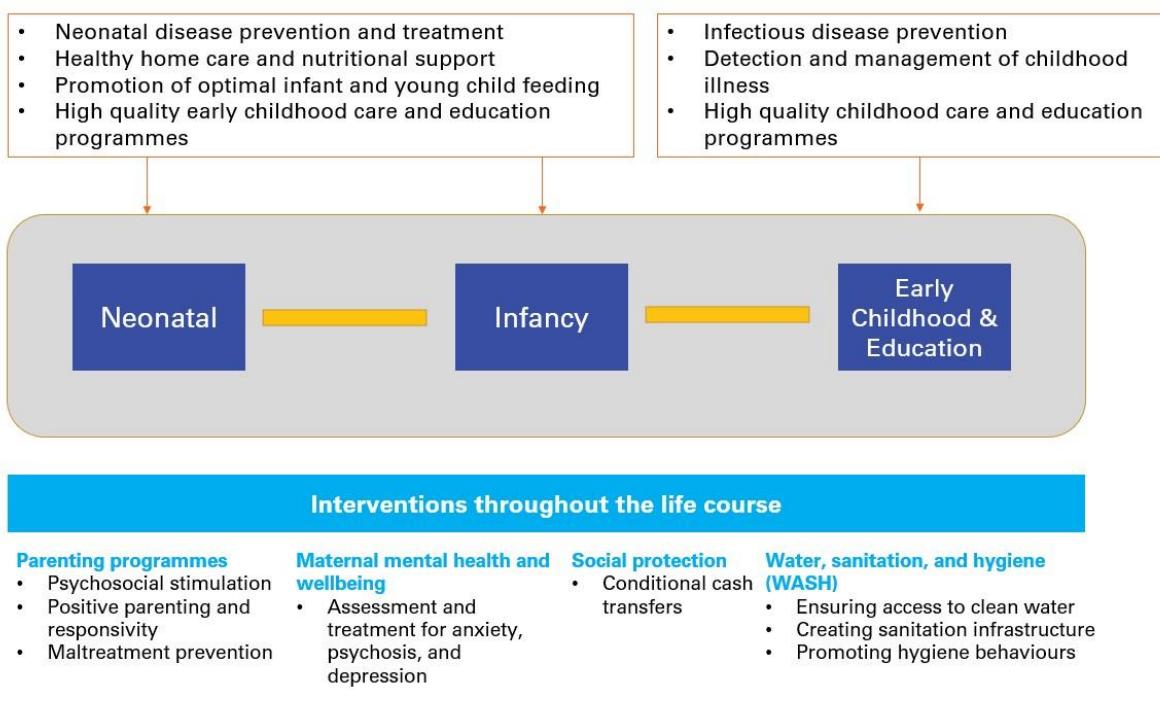
*Figure 20: Interventions for ECD*

Research shows that the early years of a child's life are crucial for optimal development, thus ECD interventions are widely recognized to have high social rates of return, especially in developing countries. ECD is considered as one of the best interventions to prevent inequality caused by poverty, due to its direct impact on child wellbeing (on nutrition, health, cognitive skills, self-help skills and socialisation), on siblings (able to attend school), and on parents (parental employment). Furthermore, ECD, as a package is considerably less costly than any other welfare and custodial service and therefore contributes to greater productivity. For example, in a study conducted in Brazil, it was estimated that the cost of a child in ECD is $100, on the street $200 and in prison $1000[57].

Literature also identifies important factors that promote optimal child development, which includes a mix of quality child-care, caregiver-interaction, maternal education, social support, and breastfeeding[58]. Comprehensive approaches to ECD programmes are designed to improve the cognitive and social-emotional functioning of children, which directly impacts their readiness to learn and grow in a community setting[59]. Beyond this, ECD gives children developmental

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[57] Van der Gaag, J. (2002) From Child development to Human Development in M. E. Young (Ed.) From Early Child Development to Human development: Investing in our Children's Future, Washington DC: The International Bank for Reconstruction and Development/ the World Bank, available at:
http://books.google.co.uk/books?hl=en&lr=&id=peZSOkMjrMwC&oi=fnd&pg=PR3&dq=from+early+child+development+to+human+development&ots=Xk-_NZapeQ&sig=sWCS0tu-q2MavP5VVBz5Vc_mjAs#v=onepage&q=from%20early%20child%20development%20to%20human%20development&f=false .

[58] Kramer MS, Aboud F, Mironova E, et al. (2008). Breastfeeding and child cognitive development: new evidence from a large randomized trial. Arch Gen Psychiatry. 65(5):578-584. doi:10.1001/archpsyc.65.5.578.

[59] Anderson, LM, Shinn, C, Fullilove, MT, et al. (2003). The effectiveness of early childhood development programs. A systematic review. Am J Prev Med. 24(3 Suppl):32-46. doi:10.1016/s0749-3797(02)00655-4.

stimulation, improving their academic and ultimately professional prospects. By combining different aspects of early years support and development, ECD provides a comprehensive and inclusive care package for the backbone of a country- their children. In the short term, it supports the community by enabling parents and families to concentrate on their income and livelihood needs whilst the younger generation is safe and well-cared for at ECD centres. In the long term, it contributes to better standards of living and sustainable opportunities for those who attended ECD programs[60].

There are diverse factors which impact development of children in low- and middle-income countries, and thereby can perpetuate inter-generational disadvantage [61]. These include undernutrition and malnutrition (including iodine and iron-deficiency, child and maternal anaemia[62], minerals and micronutrients deficiency), infectious and other diseases (e.g. malaria, HIV/AIDS, diarrhoea), and adverse psycho-social stimulation (e.g. children's exposure to violence, chronic anxiety and stress, maternal depression).

One of the key factors that affects the early development of child is maternal and child undernutrition. Evidence suggests that maternal and child undernutrition are directly associated with human development and therefore a nation's human capital. Maternal undernutrition during pregnancy contributes to low birth weight babies who, as a result, are vulnerable to infections and other illnesses, leading to infant and child mortality. On the other hand, child undernutrition contributes to stunting, wasting and underweight children. ECD programmes which targeted nutrition and related health practices reduced:

i.      stunting by 36 percent at 36 months,
ii.     mortality between birth and 36 months by 25 percent,
iii.    disability associated with stunting and severe wasting by approximately 25 percent[63].

The period from conception to 24 months of age is a crucial window of opportunity for reducing undernutrition and its adverse effects[64].

Additionally, children's exposure to adverse psycho-social environments (e.g. maltreatment, exposure to violence and situations creating long-term anxiety and fear, inadequate stimulation, maternal stress during pregnancy, and maternal depression) are risk factors which disrupt the neural functioning of the brain and undermine a child's cognitive functioning with lifelong

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[60] Save the Children, Laying the Foundations – Early Childhood Care and Development (2012).

[61] Walker,s. P., Wachs, T.D., Grantham-McGregor, S., Black,M.M., Nelson, C.A., Huffman,S.L., Baker-Henningham, H., Chang, S.M., Hamadani, J.D., Lozoff, B., Meeks Gardner, J.M., Powell, C.A., Rahman, A., Richter, L. (2011a) Inequality in early childhood: risk and protective factors forearly child development, Lancet, 378: 1325–38.

[62] Balarajan, Y., Ramakrishnan, U., Ozaltin, E., Shankar, A., H. and Subramanian, SV (2011) Anaemia in low-income and middle-income countries, The Lancet, Volume 378, Issue 9809, Pages 2123 – 2135.

[63] Bhutta , Z.A., Ahmed, T, Black, R.E., Cousens, S., Dewey, K. Giugliani, E., Haider, B.A., Kirkwood , B., Morris , S.S., Sachdev, H.P.S., Shekar, M., for the Maternal and Child Undernutrition Study Group (2008) What works? Interventions for maternal and child undernutrition and survival, The Lancet, Volume 371, Issue 9610, Pages 417 – 440

[64] Bryce, J., Coitinho, D., Darnton-Hill, I. Pellerier, D., Pinstru—Andersen, P for the Maternal and Child Undernutrition Study Group (2008) Maternal and child undernutrition: effective action at national level, The Lancet, Volume 371, Issue 9611, Pages 510 – 526.

consequences[65]. Parental distress and family conflict also diminish the capacity to offer children adequate care and protection[66]. Similarly, parents' capacity for childcare is reduced, when families live in disaster zones or countries in conflict zones, where there is a breakdown of services and networks of support. The complexity, and immediate and long-term accumulative influences of undernutrition, illness and adverse psycho-social stimulation, and its impact on ECD and life-long opportunities are shown in Figure 3.
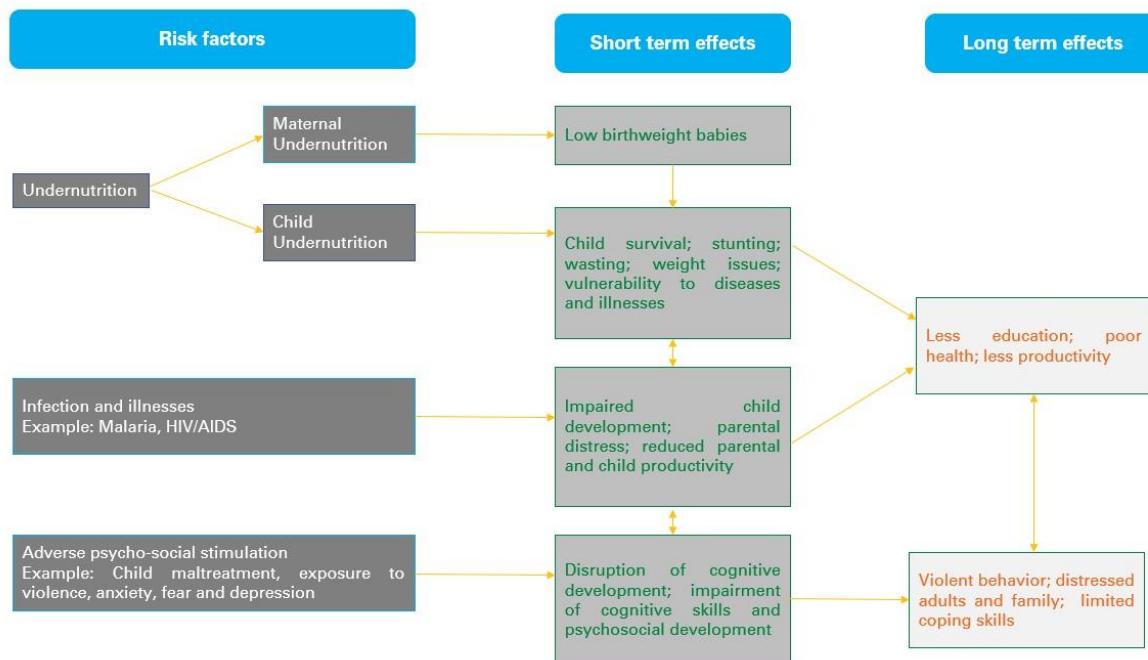


*Figure 21: Effects of risk factors associated with child development*

## 2b. Global approaches and frameworks

*Approach to multi-sectoral ECD*

In order to design effective ECD programmes, it is critical to understand the hidden and complex interlinkages between maternal and child undernutrition and other illnesses. Undernutrition greatly undermines children's survival and detrimentally affects their growth, development, and education. The compound and accumulative effect of these factors perpetuates inter-generational poverty. The social and economic costs of such cases is immeasurable and hence their prevention becomes an imperative priority for any nation.

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[65] Fox , N.A and Shionkoff, J.P. (2011) Violence and development. How persistent fear and anxiety can affect young children's learning and behaviour and health, in Bernard van Leer Foundation (ed.) Hidden Violence: Protecting Young Children at Home, Early Childhood Matters, 116.

[66] Sim, A., Costigan, J. Boone, L., Armstrong, M. (2011) Evidence based and evidence generating. Family-strengthening interventions in humanitarian contexts, in Bernard van Leer Foundation (ed.) Hidden Violence: Protecting Young Children at Home, Early Childhood Matters, 116.

Provision of quality ECD services, that integrate health, nutrition and pyscho-social skills and education, provides a unique opportunity to address developmental needs of young children, over a long duration, in a focused, child-friendly approach. Such approaches contribute to lifelong educational and employment outcomes for children who attend ECD, with wider impact on a society's social capital and wealth.

### *Putting integrated ECD at the core of programmatic interventions*

> "... to be most effective, interventions must be intersectoral, going beyond education to encompass health, nutrition, and protection. The healthy development of a child's brain depends on multiple positive experiences. Nutrition feeds the brain; stimulation sparks the mind; love and protection buffer the negative impact of stress and adversity. And distinct interventions are mutually supportive, achieving the strongest results when delivered together."
> **-- The Lancet, 20 Sept 2014**

While children living in extreme poverty and those in conditions of conflict, disaster or displacement are at greatest risk, children all over the world may be exposed to adversities that impair their optimal development. In response to this urgent need, the World Health Organization, UNICEF and the World Bank, in collaboration with the Partnership for Maternal, Newborn & Child Health, the Early Childhood Development Action Network (ECDAN) and many other partners, have developed the Nurturing Care Framework, which was launched during the Seventy-first World Health Assembly in May 2018.  The Framework provides an evidence-based road map for action and outlines how policies and services can support parents, families, other caregivers and communities in providing nurturing care for young children. It calls for attention to be paid to communities where children are most at risk of being left behind. The Framework depends on a whole-of-society approach, mobilized through a coalition of parents and caregivers, national and local governments, civil society groups, academics, the United Nations, development partners, the private sector, educational institutions and service providers, to ensure that every child gets the best possible start in life.[67]

To reach their full potential, children need the five inter-related and indivisible components of nurturing care: good health, adequate nutrition, safety and security, responsive caregiving and opportunities for learning. In the first years of life, *parents, intimate family members and caregivers* are the closest to the young child and thus the best providers of Nurturing Care. This is why secure family environments are important for young children. In order to provide caregivers
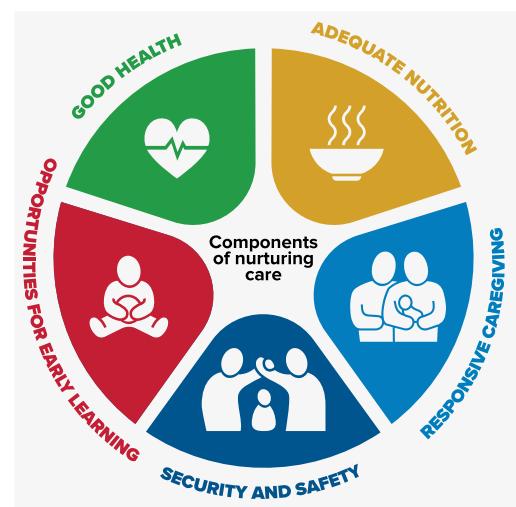


*Figure 22: Components of Nurturing Care*

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[67] Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

with time and resources to provide nurturing care, policies, services and community supports need to be in place.[68]

As discussed in previous sections, including the Nurturing Care Framework, early childhood is seen as the foundation for holistic human development. For a comprehensive understanding, as also guided by the evidence-based framework, it is pertinent to look beyond a single sector approach and focus on a joint approach that tackles the multiple impacts on children's needs. This demands a concerted effort to bring together sectors, which may not be traditionally integrated, under the ambit of ECD programmes like education, health, nutrition and protection.

There are many effective nutritional interventions, but the interventions are not wholesome, and provision tends to be fragmented[69], which results in its inability to reach the poorest and most disadvantaged sections of a population, especially those living in rural and inaccessible parts of the world. Interventions which integrate the various components and dimensions discussed in the sections above have been found to prevent the loss of developmental potential and sustain children's cognitive and educational benefits and psychological functioning[70].

Another advantage of operationalising integrated ECD programmes is its capacity to tackle multiple risk factors in low- and middle-income countries[71]. Integrated ECD programmes which balance nutrition, health services and structured parenting programmes are found to have substantial positive effects on the overall development and productivity of children compared to stand alone programmes[72].

However, in devising an ECD programme, it is imperative to understand the mechanism of its delivery and provisioning. The reason being extent of ECD benefits is conditional on the quality of its provision. There cannot be a 'one-size-fits-all' framework for understanding the ECD programmes but there are certain parameters that determine the quality standards of independently of the country in which it is provided.

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[68] https://nurturing-care.org/about/components/
[69] Morris, S.S. Cogill, B., Uauv, R., for the Maternal and child Undernutrition Study Group (2008) Effective international action against undernutrition: why has it proven so difficult and what can be done to accelerate progress? The Lancet, Volume 371, Issue 9612, Pages 608 – 621.
[70] S. Walker, T. Wachs, S. Grantham_McGregor, M. Black, C. Nelson, S. Huffman, H. Baker_Henningham, S. Chang, J. Hamadani, B. Lozoff, J. Meeks Gardner, C. Powell, A. Rahman and L. Richter (2011) 'Inequality in Early Childhood: Risk and Protective Factors for Early Child Development', The Lancet 378: 1325_1338
[71] Engle, P. L., Black, M.M., Behrman, J.R., Cabral de Mello, M., Gertler, P.J., Kapiriri, L., Martorell, R., Yong, M. E., (2007) Strategies to avoid the loss of developmental potential in more than 200 million children in the developing world, The Lancet, Volume 369, Issue 9557, Pages 229 – 242.
[72] Supra Note 6.

# Annexure 3: Additional information related to the project

## 3a. Key statistics related to project states

The table below provides snapshot of some key indicators from National Family Health Survey (NFHS – 4) for Aurangabad, Yavatmal and Pune districts in Maharashtra. As can be observed, Aurangabad and Yavatmal districts fall behind on indicators related to maternity care (consumption of iron folic acid, antenatal care), child feeding practices and nutritional status of children when compared to overall state average.

*Table 3: Key statistics related to project states - Maharashtra*

| NFHS – 4 (2015 -16): Maharashtra | |
|---|---|
| **Indicator** | **Measure** |
| Under-five mortality rate (U5MR, per 1000 live births) | 29 |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 40.6 |
| Mothers who had full antenatal care[73] (%) | 32.4 |
| Children under age 3 years breastfed within one hour of birth (%) | 57.5 |
| Children under age 6 months exclusively breastfed[74] (%) | 56.6 |
| Total children age 6-23 months receiving an adequate diet[75] (%) | 6.5 |
| Children under 5 years who are stunted (height-for-age)[76] (%) | 34.4 |
| % of children under 6 years receiving supplementary food from anganwadi centre | 48% |
| % of children under 6 years receiving growth monitoring service from anganwadi centre | 46% |
| % of children 3-6 years receiving early childhood care or preschool education from anganwadi centre | 46% |
| % of children under 6 years receiving health check-up services from anganwadi centre | 44% |
| **NFHS – 4 (2015 -16): Aurangabad** | |
| **Indicator** | **Measure** |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 19.8 |
| Mothers who had full antenatal care (%) | 16.4 |
| Children under age 6 months exclusively breastfed (%) | 60.9 |
| Total children age 6-23 months receiving an adequate diet (%) | NA |
| Children under 5 years who are stunted (height-for-age) (%) | 38.6 |
| **NFHS – 4 (2015 -16): Yavatmal** | |
| **Indicator** | **Measure** |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 34.8 |
| Mothers who had full antenatal care (%) | 26.6 |
| Children under age 6 months exclusively breastfed (%) | NA |
| Total children age 6-23 months receiving an adequate diet (%) | 9.8 |

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[73] Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for 100 or more days

[74] Based on the youngest child living with the mother.

[75] Breastfed children receiving 4 or more food groups and a minimum meal frequency, non-breastfed children fed with a minimum of 3 Infant and Young Child Feeding Practices (fed with other milk or milk products at least twice a day, a minimum meal frequency that is receiving solid or semi-solid food at least twice a day for breastfed infants 6-8 months and at least three times a day for breastfed children 9-23 months, and solid or semi-solid foods from at least four food groups not including the milk or milk products food group).

[76] Below -2 standard deviations, based on the WHO standard

| Children under 5 years who are stunted (height-for-age) (%) | 47.4 |
| --- | --- |
| **NFHS – 4 (2015 -16): Pune** | |
| **Indicator** | **Measure** |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 55.9 |
| Mothers who had full antenatal care (%) | 49.9 |
| Children under age 6 months exclusively breastfed (%) | NA |
| Total children age 6-23 months receiving an adequate diet (%) | 8.2 |
| Children under 5 years who are stunted (height-for-age) (%) | 22.4 |

**Note**: *NFHS – 4 district level data for Palghar is not available as the Palghar district was formed in 2014*

The table below provides snapshot of some key indicators from National Family Health Survey (NFHS – 4) for Dungarpur and Udaipur districts in Rajasthan. As can be observed, Dungarpur district falls behind on indicators related to maternity care (consumption of iron folic acid, antenatal care), child feeding practices when compared to overall state average and Udaipur lags behind on indicators related to child feeding practices (EBF) and nutritional status of children (stunting) when compared to overall state average.

*Table 4: Key statistics related to project states - Rajasthan*

| **NFHS – 4 (2015 -16): Rajasthan overall** | |
| --- | --- |
| **Indicator** | **Measure** |
| Under-five mortality rate (U5MR, per 1000 live births) | 51 |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 17.3 |
| Mothers who had full antenatal care[77] (%) | 9.7 |
| Children under age 3 years breastfed within one hour of birth (%) | 28.4 |
| Children under age 6 months exclusively breastfed[78] (%) | 58.2 |
| Total children age 6-23 months receiving an adequate diet[79] (%) | 3.4 |
| Children under 5 years who are stunted (height-for-age)[80] (%) | 39.1 |
| % of children under 6 years receiving supplementary food from anganwadi centre | 32% |
| % of children under 6 years receiving growth monitoring service from anganwadi centre | 28% |
| % of children 3-6 years receiving early childhood care or preschool education from anganwadi centre | 20% |
| % of children under 6 years receiving health check-up services from anganwadi centre | 26% |
| **NFHS – 4 (2015 -16): Dungarpur district** | |
| **Indicator** | **Measure** |

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77. Full antenatal care is at least four antenatal visits, at least one tetanus toxoid (TT) injection and iron folic acid tablets or syrup taken for  100 or more days
78. Based on the youngest child living with the mother.
79. Breastfed children receiving 4 or more food groups and a minimum meal frequency, non-breastfed children fed with a minimum of 3 Infant and Young Child Feeding Practices (fed with other milk or milk products at least twice a day, a minimum meal frequency that is receiving solid or semi-solid food at least twice a day for breastfed infants 6-8 months and at least three times a day for breastfed children 9-23 months, and solid or semi-solid foods from at least four food groups not including the milk or milk products food group).
80. Below -2 standard deviations, based on the WHO standard

| | |
|---|---|
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 8.9 |
| Mothers who had full antenatal care (%) | 5.8 |
| Children under age 6 months exclusively breastfed (%) | 44.4 |
| Total children age 6-23 months receiving an adequate diet (%) | NA |
| Children under 5 years who are stunted (height-for-age) (%) | 46.8 |
| **NFHS – 4 (2015 -16): Udaipur district** | |
| **Indicator** | **Measure** |
| Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%) | 19.5 |
| Mothers who had full antenatal care (%) | 10.9 |
| Children under age 6 months exclusively breastfed (%) | 48 |
| Total children age 6-23 months receiving an adequate diet (%) | 3.5 |
| Children under 5 years who are stunted (height-for-age) (%) | 47.5 |

As informed by the National report on the Rapid Survey of Children (RSOC) 2013-14[81], some pop-up statistics are good to be cognizant of for the project states. Children accessing and attending PSE were low in Rajasthan and more than the National average in Maharashtra.

- The state wise percentage of children 36 to 71 months who attended PSE for 16 or more days was as low as 17% in Rajasthan and 58% in Maharashtra as compared to the National average of 39% annually.
- Children from rural areas tend to attend ICDS run pre-school whereas those from urban areas tend to attend privately run pre-schools more. In Maharashtra, 51.4% (23.2%-Urban and 74.3%-Rural) were attending ICDS Pre-school education and in Rajasthan, 15.5% (11.2%-Urban and 16.9% -Rural) were attending ICDS Pre-school education.
- The incidence of low birth-weight babies in Rajasthan was fairly high at 23 percent.

ASER Survey reports of the last two years place Rajasthan among the bottom five states in learning outcomes linked to reading, writing and arithmetic in the academic year 2018-19. ASER Report 2019[82] states that % of children age 3 and 4 who are not enrolled anywhere is much higher in few states including Rajasthan.

## 3b. Project Implementation

Each state has adopted a capacity building strategy to suit the programming context as well as the platforms available for communicating with parents. Detailed description is provided below:

### 3.6.1.1.   Maharashtra
### *Geography*

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[81] https://wcd.nic.in/sites/default/files/RSOC%20National%20Report%202013-14%20Final.pdf

[82] http://img.asercentre.org/docs/ASER%202019/conceptnote2019aser.pdf

In Maharashtra, the project was rolled out in four districts – Aurangabad, Yavatmal, Pune and Palghar. The details of the number of blocks targeted within each district is provided below:

| State | District | Block | Type |
|---|---|---|---|
| Maharashtra | Aurangabad | Aurangabad 1 | Rural |
| Maharashtra | Aurangabad | Kannad | Rural |
| Maharashtra | Aurangabad | Khultabad | Rural |
| Maharashtra | Aurangabad | Paithan | Rural |
| Maharashtra | Yavatmal | Babulgaon | Rural |
| Maharashtra | Yavatmal | Digras | Rural |
| Maharashtra | Yavatmal | Zari | Rural |
| Maharashtra | Yavatmal | Ghatanji | Tribal |
| Maharashtra | Yavatmal | Pandharkawada | Tribal |
| Maharashtra | Yavatmal | Ralegaon | Tribal |
| Maharashtra | Pune | Pimpri 2 | Rural/Urban |
| Maharashtra | Pune | Hadapsar | Rural/Urban |
| Maharashtra | Pune | Kothrud | Urban |
| Maharashtra | Pune | Pimpri Chinchwad | Urban |
| Maharashtra | Pune | Pune Central | Urban |
| Maharashtra | Pune | Shivaji Nagar | Urban |
| Maharashtra | Palghar | Manor | Tribal |

## *CSO partners*

In Maharashtra, Mahatma Gandhi Institute of Medical Sciences (MGIMS) was responsible for designing of the counselling material for parents related to children in the 0-3 age group and implemented the project in Aurangabad & Yavatmal districts. In Pune & Palghar districts, during the initial stages of the project, Save the Children (STC) supported in design of the counselling material for parents related to children in the 3-6 years age group. But, later, Gram Mangal took up the project implementation in Pune and Palghar districts as the partnership of UNICEF with STC ended.

It is to be noted that the 0-3 year material developed by MGIMS and 3-6 years material developed by STC was used across the four intervention districts for trainings. Only difference was in implementation of the project as mentioned above.

## *Development of training packages & communication materials*

UNICEF Maharashtra along with the CSO partners developed a training package for ICDS and health functionaries on infant and young child feeding inclusive of early stimulation and parental education for early learning and stimulation (covering children 0-6 years). As part of the package a number of training materials were created for master trainers, supervisors, AWWs/ ASHAs, and parents. For more details, please refer to *Annexure 06*.

## *Focus areas*

The following focus areas were defined for 0-3 and 3-6 age groups:

- **0-3 age group**

  This component looks at empowering parents of children in the age group 0-3 years to support their child's development at home. The messages related to 0-3 years child were delivered at the centre through AWWs and through home visits by ASHAs. The key messages are drawn from the following areas:
    - Exclusive breastfeeding
    - Complimentary feeding
    - Responsive parenting
    - Feeding during illness
    - Care of a newborn baby
    - Growth monitoring and promotion
    - Play and communication

  For the parent counselling related to children in 0-3 years age group, MGIMS (Mahatma Gandhi Institute for Medical Sciences) has played a key role in developing content and creating training materials. The implementation has been done by the same partner in Aurangabad and Yavatmal. Save the Children supported in designing the parent counselling material for 3-6 years child age group and Gram Mangal implemented the project in Pune and Palghar. The platforms used to reach caregivers/parents of the children below the age of 3 years were – monthy meetings at the anganwadi centres, community outreach events of POSHAN Abhiyan, Palak Melavas and home visits.

- **3-6 age group**

  The parent counselling material related to children in the 3-6 age group mainly focuses on helping parents understand how to support their child's learning at home. Globally, school readiness is gaining currency (as emphasized in SDG target 4.2[83])  as a viable strategy to close the learning gap and improve equity in achieving lifelong learning and full developmental potential among young children. School readiness has been linked with positive social and behavioural competencies in adulthood as well as improved academic outcomes in primary and secondary school, both in terms of equity and performance. In addition, school readiness has been garnering attention as a strategy for economic development. Approaches to economic growth and development consider human capital as a key conduit for sustained and viable development, the inception of which begins in the early years[84].  The project aims to familiarize parents with ways of how they can help children get school ready by engaging with children through play. The content is designed to be delivered in sessions. The activities suggested in these sessions cover all domains of development, namely, physical development, sensory, perceptual and cognitive development, language, literacy and communication, personal, social and emotional

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[83] SDG Target 4.2: By 2030, ensure that all girls and boys have access to quality early childhood development care and pre-primary education so that they are ready for primary education
[84] School readiness: a conceptual framework, UNICEF, 2012

development and creativity. The sessions provide opportunities to parents to experience the activities on their own and then practice them with their parents. The platforms used to reach caregivers/parents of the children 3-6 years age group were mainly – monthly meetings at the anganwadi centres, growth monitoring sessions, and home visits.

The Samvedansheel Palakatv (Responsive Parenting) flipcharts were developed for communicating messages for responsive parenting focusing on children in the 3-6 age group. The key messages have been aligned to the state ECE curriculum Aakar. Learning was further reinforced through supportive supervision by Field Supervisors and ASHA (Accredited Social Health Activist) mentors or the CSO partners. Please refer to *Annexure 02* for roles and responsibilities of stakeholders in Maharashtra.
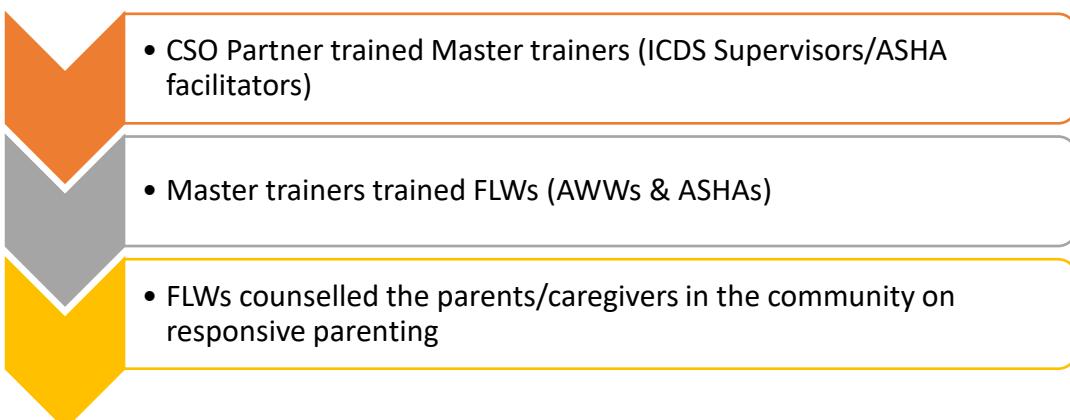
## *Platforms*

The following institutional platforms were strengthened and utilized for the delivery of key messages to 0-6 age child parents/caregivers:

- o Parents' meetings
- o VHND
- o Growth Monitoring week
- o Community Based Events (Godhbhrai; Annaprashan diwas)
- o Home visits
- o Family fairs (palak melas)

## *Training of master trainers*

- An Incremental Learning Approach (ILA) was adopted for training. ILA builds learning incrementally to enable the frontline workers to internalize the learning, develop skills and take necessary actions. Training used games, activities and demonstrations on how to conduct a mothers' meetings and home visits

- The trainings have been delivered in a cascade manner, where the CSO partners trained the ICDS supervisors/ASHA facilitators (master trainers), who in turn trained the AWWs/ASHAs, who ultimately conducted parents' sessions on ground.
- Cascading method of training was adopted in Maharashtra as shown below

- CSO Partner trained Master trainers (ICDS Supervisors/ASHA facilitators)

- Master trainers trained FLWs (AWWs & ASHAs)

- FLWs counselled the parents/caregivers in the community on responsive parenting

- The training on responsive parenting (for 0-6 continuum) was rolled out in five cycles of five days each for master trainers (constituting AWW supervisors and ASHA facilitators). Therefore, each master trainer went through one cycle of 5 days each and there were 5 such cycles (5*5 = 25 days in total).
- The trained master trainers further rolled out the training to the FLWs. Each master trainer after the conclusion of each cycle of training (provided by CSO) rolled out the contents of that particular cycle of training to FLWs in three days within a period three months (one day per month).

**Note**: *In Pune, since this district is primarily an urban area, no ASHA facilitators were available to be included in master trainer's training by CSO partner. Therefore, only AWW supervisors were part of the master training in Pune.*

### _Roll out_

### CSO Partner → Master Trainers

A snapshot on rollout of training from CSO partner to master trainers is provided below:

### Training roll–out: Aurangabad and Yavatmal[85]

*Table 5: Training rollout in Aurangabad and Yavatmal*

| Training Cycle | Topic/s | Duration | | No. of AWW supervisors | | No. of ASHA facilitators | | Remarks |
|---|---|---|---|---|---|---|---|---|
| | | *Planned* | *Actual* | *Planned to attend* | *Actual attended* | *Planned to attend* | *Actual attended* | |
| Cycle 1 | **Health & Nutrition (0–3 years)**: <br> • Growth and development, ECD and its importance <br> • Play and communication <br> • Safe environment <br> • Complementary and responsive feeding <br> • Health and hygiene <br> • Core approaches, Home visits and Mothers' meetings <br> • Facilitation skill, supportive supervision | Aug/Sept 2018 | Aug/Sept 2018 | 50 | 45 | 74 | 67 | |

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[85] Source: CSO partner Aurangabad & Yavatmal – MGIMS

| Cycle | Topic | | | | | | | Remarks |
|---|---|---|---|---|---|---|---|---|
| Cycle 2 | **Health & Nutrition (0–3 years)**: Appreciative inquiry<br><br>**Early Childhood Education (3–6 years)**:<br>• How children learn and role of parents in helping children Learn<br>• Developmental Milestones<br>• ECE (Storytelling, print, shapes and colours, learning by doing, phonemic awareness, involvement of older siblings, sorting and classification, concept of weight, positive disciplining<br>• School Readiness and Aakar | Dec 2018 | Dec 2018 | 61 | 51 | NA | NA | Cycle 2 was not planned for ASHA facilitators |
| Cycle 3 | **Health & Nutrition (0–3 years)**: GMP and resource mapping<br><br>**Early Childhood Education (3–6 years)**: ECE (Importance of age appropriate activities, imagination, not giving readymade answers, pretend play, joyful learning, counting and measurements) | Apr 2019 | Apr 2019 | 45 | 34 | 81 | 73 | |
| Cycle 4 | **Health & Nutrition (0–3 years)**: Anadachi Jatra, data sharing and children with special needs<br><br>**Early Childhood Education (3–6 years)**: Role of | July 2019 | July 2019 | 45 | 43 | 81 | 75 | |

| Cycle 5 | **Health & Nutrition (0–3 years)**: Identifying the weak links in implementation at all levels (family, FLW) and action plan and sustainability plan | Nov 2019 | Nov 2019 | 45 | 29 | 81 | 72 | |
| | adults in child's learning and attachment | | | | | | | |
| | **Early Childhood Education (3–6 years)**: ECE (Pattern, how to avoid screen and senses) | | | | | | | |

## Training roll–out: Pune and Palghar[86]

*Table 6: Training rollout in Pune and Palghar*

| Training Cycle | Topic/s | Duration | | No. of AWW supervisors | | No. of ASHA facilitators | | Remarks |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | *Planned* | *Actual* | *Planned to attend* | *Actual attended* | *Planned to attend* | *Actual attended* | |
| Cycle 1 | **Health & Nutrition (0–3 years)**: Growth and Development, Play and Stimulation, Food and Nutrition, Growth Chart, Stunting and Malnutrition | Oct/Nov 2018 | Jan 2019 | 34 | 34 | 24 | 22 | ASHA facilitators attended Health and Nutrition topics |
| Cycle 2 | **Early Childhood Education (3–6 years)**: *Flipchart 1* – <br>• Topic 1: Role of parents in helping children learn <br>• Topic 2: Use of language to express thoughts | Jan 2019 | Jan 2019 | 34 | 34 | NA | NA | Combined Cycles 1 & 2 for Supervisors training. |

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[86] Source CSO partner in Pune & Palghar – Gram Mangal

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | • Topic 3: Involvement of older sibling<br>• Topic 4: Learning by doing<br>• Topic 5: Positive disciplining<br>• Topic 6: Difference between experiential and rote learning | | | | | | |
| Cycle 3 | **Health & Nutrition (0–3 years)**: Hospital Delivery, Breastfeeding (0-6 months), New-born Infants - Dangerous Symptoms and Referral, Wholesome Food (6 months to 3 years), Sensory and Tactile Stimulation (6 months to 3 years), Pregnancy - Dangerous Symptoms | Mar/Apr 2019 | Apr/May 2019 | 35 | 32 | 24 | 24 | ASHA facilitators attended Health and Nutrition topics |
| | **Early Childhood Education (3–6 years)**: *Flipchart 2* –<br>• Topic 1: Problem solving<br>• Topic 2: Imaginary play, board painting<br>• Topic 3: Counting – numeracy<br>• Topic 4: Measurement<br>• Topic 5: Roads and tunnels<br>• Topic 6: Doodling and scribbling | Mar/Apr 2019 | Apr/May 2019 | 35 | 32 | NA | NA | |
| Cycle 4 | **Health & Nutrition (0–3 years)**: Auditory | July 2019 | Oct 2019 | 28 | 26 | 24 | 22 | ASHA facilitators attended |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | and Visual Impairment, Linguistic Impairment, Mental Disability, Physical Disability, Inclusivity | | | | | | | Health and Nutrition topics |
| | **Early Childhood Education (3–6 years)**: School Readiness, Attachment and Bonding, Role of Elders in Children's Learning, Safe Environment | July 2019 | Oct 2019 | 28 | 26 | NA | NA | |
| Cycle 5 | **Early Childhood Education (3–6 years)**: *Flipchart 3* – Topic 1: Making Designs and Patterns Using Materials from Surroundings Topic 2: Mobile, T.V. and Children Topic 3: Learning Through the Five Senses Topic 4: How Children Learn Topic 5: Protecting the Child's Self-image Topic 6: Palak Melava | Oct 2019 | Oct 2019 | 28 | 26 | NA | NA | Combined Cycles 4 & 5 for Supervisors training |

### No. of AWCs covered

The total number of AWCs covered in each intervention district in Maharashtra is provided below:

| State | District | Block | Type | Total no. of AWCs covered |
|---|---|---|---|---|
| Maharashtra | Aurangabad | Aurangabad 1 | Rural | 234 |
| Maharashtra | Aurangabad | Kannad | Rural | 231 |
| Maharashtra | Aurangabad | Khultabad | Rural | 153 |
| Maharashtra | Aurangabad | Paithan | Rural | 227 |
| Maharashtra | Yavatmal | Babulgaon | Rural | 115 |
| Maharashtra | Yavatmal | Digras | Rural | 113 |
| Maharashtra | Yavatmal | Zari | Rural | 138 |
| Maharashtra | Yavatmal | Ghatanji | Tribal | 176 |

| | | | | |
|---|---|---|---|---|
| Maharashtra | Yavatmal | Pandharkawada | Tribal | 219 |
| Maharashtra | Yavatmal | Ralegaon | Tribal | 184 |
| Maharashtra | Pune | Pimpari 2 | Urban | 34 |
| Maharashtra | Pune | Pimpari 2 | Rural | 83 |
| Maharashtra | Pune | Hadapsar | Urban | 38 |
| Maharashtra | Pune | Hadapsar | Rural | 65 |
| Maharashtra | Pune | Kothrud | Urban | 136 |
| Maharashtra | Pune | Pimpari chinchwad | Urban | 182 |
| Maharashtra | Pune | Pune Central | Urban | 130 |
| Maharashtra | Pune | Shivaji Nagar | Urban | 114 |
| Maharashtra | Palghar | Manor | Tribal | 242 |

**Supportive supervision**

Supportive supervision support was provided by the master trainers (AWW supervisor and ASHA facilitator) to the FLWs during the home visits, at the AWC, parents meeting, community-based events.

## 3.6.1.2. Rajasthan

In Rajasthan, the project was initiated with an assessment of the practices and beliefs of the parents on ECE and their role in bringing up their children. Series of workshops and discussions were held with community, Anganwadi workers to understand the best way to reach out to the parents and other care givers as well as the platforms through which these parents could be reached. The results from the study helped in designing a strategy for creating a learning environment at home. The 'Sabrang' cards were developed after a range of interactions with community. These cards primarily have messages and activities that promote development of children in different domains – physical, motor, social-emotional, language and literacy for the age group 3-6 years.

**Geography**

In Rajasthan, the project was rolled out in two districts – Udaipur and Dungarpur. The details of the number of blocks targeted within each district is provided below:
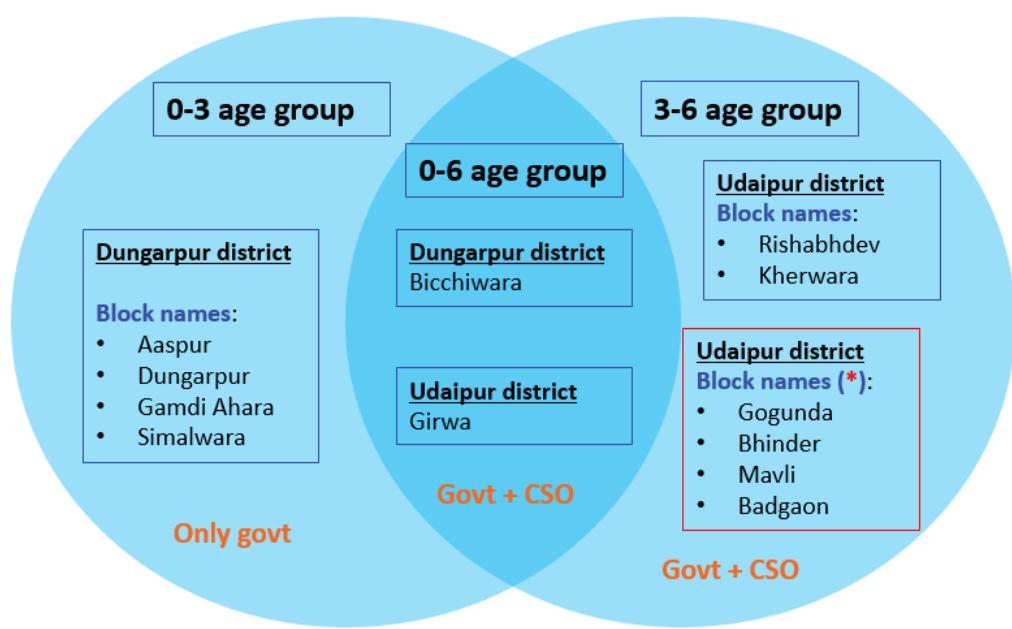
| State | District | Block | Type |
|---|---|---|---|
| Rajasthan | Udaipur | Badgaon* | Rural |
| Rajasthan | Udaipur | Bhinder* | Rural |
| Rajasthan | Udaipur | Girwa | Tribal |
| Rajasthan | Udaipur | Gogunda* | Rural |
| Rajasthan | Udaipur | Kherwara | Tribal |
| Rajasthan | Udaipur | Mavli* | Tribal |
| Rajasthan | Udaipur | Rishabhdev | Tribal |
| Rajasthan | Dungarpur | Aaspur | Tribal |
| Rajasthan | Dungarpur | Bicchiwara | Tribal |

| Rajasthan | Dungarpur | Dungarpur | Tribal |
|-----------|-----------|-----------|--------|
| Rajasthan | Dungarpur | Gamri Ahada | Tribal |
| Rajasthan | Dungarpur | Simalwara | Tribal |

**Note**: * *It is to be noted that since, for the endline, the evaluation team had considered only those blocks for sample selection where the project has been rolled out at least for a year, four blocks from Udaipur (Gogunda, Bhinder, Mavli, Badgaon) were not included in the study as the project was rolled out in second half of 2019 (less than one year of implementation) in these specific blocks.*

## Project specific nuances (for blocks with at least one year of intervention only)

In Rajasthan, the project was implemented in three blocks[87] of Udaipur district and five blocks[88] of Dungarpur district. Among these blocks, the CSO Partner (Unnati Sanshtan) supported the implementation in three blocks (Girwa, Rishabhdev, Kherwara) of Udaipur district and one block (Bichhiwara) in Dungarpur district. In the other four blocks (Aaspur, Dungarpur, Gmadi Ahara, Simalwara) of Dungarpur district UNICEF supported government in building the capacities of AWWs on MYCN  (CSO Partner did not support in implementation in these four blocks in Dungarpur district).   The below graphic helps us visualize the implementation nuances in Rajasthan better:



*Note*: *Please note that in four blocks (Gogunda, Bhinder, Mavli, Badgaon) of Udaipur (outlined with RED color in figure above), the project was rolled out in second half of year 2019 (less than one year of implementation). Since evaluation team considered only those blocks for sample selection where the project has been rolled out at least for a year, these four blocks from Udaipur were not included in the study.*

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[87] Girwa, Rishabhdev, Kherwara blocks in Udaipur
[88] Bicchiwara, Dungarpur, Aaspur, Gmadi Ahara, Simalwara blocks in Dungarpur

## Project Implementation (for blocks with at least one year of intervention only)

### a) CSO supported implementation

The capacity building of frontline workers was implemented during the monthly sector meetings organised by the field supervisors. A team of field supervisors was trained to equip them with skills and knowledge on training AWW on positive parenting with special reference to responsive parenting including early stimulation and creating a learning environment at home.

The trained FLWs reached out to parents/caregivers through the existing platforms – mothers' meeting, community meetings, Parent Anganwadi Meeting (PAM)[89] with parents/caregivers, home visits and community-based events, maternal and child health and nutrition sessions. The project prioritized the effective use of communication tools (MAA tool kit for promoting infant and young child feeding, POSHAN Abhiyaan key takeaways, Mother Child Protection card and communication cards - 'Sabrang' developed focusing on promoting learning at home for children age 3-6-years-old) and improving the coverage and quality of these events. Parenting communication toolkit Sab Rang in Rajasthan focused on key messages for counselling parents to promote learning at home for children 3-6-year-old. These messages were aligned to the developmental milestones laid down in the Early Learning Development Standards (ELDS) developed and standardized for children in India. Institutional platforms [90] were used by the FLWs to reach out to the parents/caregivers. Please refer to *Annexure 02* for roles and responsibilities of stakeholders in Rajasthan.

The number of AWCs supported by the CSO partner in Rajasthan is presented below:

| State | District | Block | Type | Total no. of AWCs |
|-------|----------|-------|------|-------------------|
| Rajasthan | Udaipur | Girwa | Rural | 270 |
| Rajasthan | Udaipur | Kherwara | Tribal | 293 |
| Rajasthan | Udaipur | Rishabhdev | Tribal | 172 |
| Rajasthan | Dungarpur | Bicchiwara | Tribal | 288 |

Among the blocks mentioned above, 87 AWCs from two blocks (61 from Girwa and 26 from Bicchiwara) were developed as model AWCs (in 2018). Among these 87 AWCs CSO partner provided intensive support. Subsequently, in 2019, the project was scaled up to rest of the AWCs in Girwa and Bicchiwara blocks along with AWCs in additional blocks Rishabhdev and Kherwara. During the scale up phase in 2019, CSO partner reached the AWCs in the above-mentioned blocks during sector meetings organized as a part of ICDS programme and also simultaneously continued to provide intensive support in the 87 AWCs from Girwa and Bicchiwara blocks.

| Project focus | Activities over the years | | |
|---------------|------|------|------|
|  | 2017 | 2018 | 2019 |

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[89] In Rajasthan the monthly ECCE day is referred to as Parent Anganwadi Meeting (PAM)
[90] Institutional platforms include – Grabhavastha Paramarsh, Annaprashan Diwas, MCHV (VHND) days, Parent Anganwadi Meeting (PAM) and Home Visits

| | | | |
|---|---|---|---|
| 0-3 age group intervention (Nutrition focus) | Nutrition intervention was not started in 2017<br><br>• (please note that project started from August 2017) | • The Nutrition intervention focused exclusively on first 1000 days messages (MCP cards)<br>• The project was initiated in Girwa and Bicchiwara blocks<br>• CSO Partner provided handholding support to the FLWs<br>• Target groups were – Pregnant women, mothers of 0-6 months and 6-24 months child<br>• Two community events (provisioned under POSHAN Abhiyaan every month) were utilized to reach out to the parents – Godhbhrai, Annaprashan Diwas<br>• Other platforms used were – MCHN days (VHND), Suposhan diwas<br>• In addition, CSO partner also supported the FLWs during home visits, at AWCs, in using home visit register in some select sites | • In four blocks (Aaspur, Gamdi Ahara, Dungarpur, Simalwara) of Dungarpur district the Nutrition intervention was rolled out wherein UNICEF supported government in building capacities of AWWs on MYCN (CSO partner was not involved in rolling out the intervention in these blocks)<br>• In Girwa block and Bichhiwara, in addition to the messages in MCP cards, messages related to early stimulation and responsive feeding were added<br>• Counselling for pregnant women focused on – consumption of tiranga bhojan, resting for two hours, gaining weight, ANC checkups, calcium supplementation, institutional delivery, early initiation of BF,<br>• The counselling also focused on 180 days after delivery – EBF, timely initiation of BF, age appropriate feeding, demonstrations of home made nutritious food in CBE platforms (Godhbharai, Annaprashan) |
| 3-6 age group intervention (Education focus) | • Assessment of the practices and beliefs of the parents on ECE and their role in bringing up their children<br>• Workshops and discussions were held with community, AWWs<br>• Identifying platforms through which parents can be reached<br>• Survey report (existing childcare practices in the community; social contexts) | • Initiated the development of the communication tool (SabRang[91] cards) based on ELDS standard in selected AWCs of two blocks – Girwa and Bicchiwara<br>• Piloted the draft tools in the community and recursively updated the tools based on feedback<br>• Held meetings with CDPO to source insights<br>• Sector meetings were used by the CSO partner to build the capacities of | • SabRang cards were printed and distributed to FLWs<br>• The project was scaled up to all the AWCs in four blocks – Girwa, Kherwara, Rishabhdev in Udaipur district; Bichhiwara block in Dungarpur district<br>• Sector meetings were utilized to build the capacities of LS and FLWs on five domains of development - messages on parenting with the aim of creating a learning environment for children |

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[91] SabRang cards is a communication tool which had messages related to five domains of development for 3-6 age group children. In Rajasthan, FLWs understand Hindi and are well versed with local language – Wadgi. FLWs translated the messages in SanRang cards into the local language in the community.

| | | | |
|---|---|---|---|
| | | • the LS and FLWs (AWWs and ASHAs)<br>• In addition, CSO partner also supported the FLWs during home visits, at AWCs, Parent Anganwadi Meetings (PAM) in some select sites<br>• Finalized the SabRang cards by end of 2018 | • In addition, CSO partner also supported the FLWs during home visits, at AWCs, Parent Anganwadi Meetings (PAM) in some select sites |

### b) Implementation without CSO support

The number of AWCs supported in the government only blocks during the project duration is provided below:

| State | District | Block | Type | Total no. of AWCs |
|---|---|---|---|---|
| Rajasthan | Dungarpur | Aaspur | Tribal | 245 |
| Rajasthan | Dungarpur | Dungarpur | Tribal | 149 |
| Rajasthan | Dungarpur | Gamri Ahada | Tribal | 302 |
| Rajasthan | Dungarpur | Simalwara | Tribal | 295 |

As already mentioned in the 'Project specific nuances' section above, in four blocks (Aaspur, Dungarpur, Gamdi Ahara, Simalwara) of Dungarpur district UNICEF supported government on building capacities of AWWs on MYCN. In these blocks of Dungarpur district, the ECD interventions were integrated into the maternal infant and young child nutrition (MIYCN) programme. All participants were provided training for 3 days based on the MAA (Mothers' Absolute Affection – a programme of MoHFW to accelerate improvements in IYCF with a focus on breastfeeding) with addition of maternal component and missing ECD components like importance of food and feeding in brain development and early stimulation. During the training, discussions were on ANC, maternal diet, maternal weight gain, updated MCP card, IFA and CA supplementation.

For the infants and young children thrust was on – early initiation of breastfeeding, exclusive breastfeeding, timely initiation on CF and age appropriate CF with continued breastfeeding. The early stimulation component included – how to engage with the child.

The MIYCN and ECD components were reinforced through all platforms like Sector meetings by Lady Supervisor under ICDS (LS), ILA sessions by LS and by AWWs during community - based events like Annaprasana (event to mark introduction of CF at 6 months) and Godbharai (baby shower) and through home visits.

### 3c. Concurrent monitoring

### Maharashtra

#### i. Aurangabad and Yavatmal districts

*Tracking trainings provided to Master trainers*

Regarding the trainings provided to master trainers (supervisor and ASHA facilitators) in Aurangabad and Yavatmal, the CSO partner - MGIMS tracked and documented the planned vs actual timelines and the attendance of the participants from ICDS and health departments for each of the five training cycles. The same has been provided in *Table 05* in project description section above.

*Tracking core project activities*

To concurrently monitor three core project activities – (i) mothers meeting, (ii) home visits and (iii) Palak Melawa, check lists were developed for each activity and the same were shared with the supervisors and front line workers. During the first cycle of training, all supervisors have been trained on using the checklists during home visits and mothers' meetings and how to give feedback to the frontline workers.

The below table provides the indicator tracked for each core activity

| Core activity | Indicator/s tracked | Remarks |
|---|---|---|
| Home Visit | Percentage of total pregnant mothers and children 0-6 reached through home visits | Information available only in percentage and not in actual numbers. Further, this indicator has been tracked for the months – March to September 2019. |
| Mothers meeting | a) Percentage mothers' meetings reported of expected mothers' meetings<br>b) Percentage of total pregnant mothers and children 0-6 reached through mothers' meetings | Information available only in percentage and not in actual numbers. Further, this indicator has been tracked for the months – March to September 2019. |
| Palak Melawa | a) Blockwise Palak Melawas conducted<br>b) Number of participants attending Palak Melawas | Analysis of the 'number of palak melawas conducted' and 'number of participants' documented blockwise at the overall project level. No disaggregation by Month/quarter is available. |

*Tracking progress of training at field level*

Further, in order to track the progress of trainings conducted at field level and for internal monitoring and evaluation purposes, an online google form was designed by the CSO. This form was filled by project block coordinators of Aurangabad and Yavatmal districts for the trainings conducted at Sector level. The form also acted as a checklist to understand and evaluate the quality of each training. However, this form was designed to be used only by project staff during project cycle. Therefore, no document of this data is available.

**ii.    Pune and Palghar districts**

*__Tracking trainings provided to Master trainers__*

Regarding the trainings provided to master trainers (supervisor and ASHA facilitators) in Pune and Palghar, the planned vs actual timelines and the attendance of the participants from ICDS and health departments for each of the five training cycles have been tracked and documented. The same has been provided in *Table 07* in project description section above.

*__Tracking core project activities__*

Concurrent monitoring data has been collected and analysed for two core activities – (i) trainings conducted by supervisors for FLWs during the sector meetings and (ii) Palak Sabhas for the period Jan – Dec 2019. The other indicator tracked was related to supervisors mentoring visits during Palak Sabhas. The indicators are provided below:

| Core activity | Indicator/s tracked | Remarks |
|---|---|---|
| Sector trainings | Number of trainings conducted by supervisors during sector meetings | Information available for the period Jan – Dec 2019 and at block level for each month. However, information on how many FLWs attended those sector trainings is not available. |
| Palak Sabhas | Number of Palak Sabhas conducted by AWWs | Information available for the period Jan – Dec 2019 and at block level for each month. However, information on number of participants who attended those Palak Sabhas is available only for the period June – Dec 2019. |
| Supervisors mentoring visits | Average monthly supervisor visits to Palak Sabhas | Information on overall average for the period June – Dec 2019 is available |

## Rajasthan
## Unnati supported blocks

The staff was required to daily fill the ODK forms to capture the data from field which helped in monitoring progress of the project. Staff shared pictures daily and small videos of the work in Unnati's WhatsApp group which was being monitored and reviewed by program coordinator. Sector meetings and trainings were monitored by maintaining attendance sheets and live pictures shared from the meeting. While conducting one to one visits and attending sector meetings, staff used to share the learning and challenges in the staff meeting.

In the AWCs where Unnati provided direct support, pre-post tests were conducted to assess the understanding and learning from the training of the participants on the essential topics. Apart from daily visits at the AWCs by the field staff, field monitoring visits were also conducted by management team on monthly basis to track the activities in the field.

Although data were collected using ODK forms and during pre-post tests during the trainings, the same has **not** been analysed and documented at any level such as sector/ block/ district/ project levels.

# Annexure 4: Review of training material/ communication packages

## Communication Packages

Development is the result of the interaction between the environment and the child. The key aspect of this environment is 'nurturing care', which consists of a core set of interrelated components, including behaviours, attitudes, and knowledge about caregiving (e.g., health, hygiene care and feeding); stimulation (e.g., talking, singing and playing); responsiveness (e.g., early bonding, secure attachment, trust and sensitive communication); and safety (e.g., routines, protection from violence, abuse, neglect, harm and environmental pollution). [92] Parents play a critical role in providing these critical early experiences through the provision of this nurturing care, which ensures health, nutrition, responsive caregiving, safety and security, social- emotional well-being, and early learning.[93] Also, girls and boys see gender inequality in their homes and communities every day and Gender inequalities can start in utero and increase as children age. Gender roles are learned through interactions between a child and his/her immediate environment. Throughout their life cycle, children become aware of their gender, and play styles and behaviours begin to crystallize around that core identity of girl or boy. Adults impose their own gender beliefs and practices through their interactions with young boys and girls. Early childhood is a critical time for the development of boys' and girls' sense of themselves and their place in the world.

While designing the project intervention, parents/caregivers and ICDS functionaries were consulted and engaged as part of the context analyses that were carried out in both states for a better understanding of needs and expectations in relation to ECD services and parenting as well as to under gender and other inequities. This informed the design – both in terms of positive indigenous beliefs and practices that can be built upon, as well as strategies for behaviour change - including the orientation of ICDS functionaries of the states on the importance of promoting positive parenting and improved service delivery. This information has been gathered through in-depth interviews and focus group discussions with supervisors, AWWs, parents and other caregivers.

For developing the communication package, the existing national and global packages/guidelines/training modules related to parenting /care for development were mapped, reviewed and contextualized for the intervention.  Aligned to need for nurturing care, "the intervention" is essentially an integrated ECD package focusing on nourishment and nurturance with a concerted focus on positive parenting including responsive feeding, psychosocial stimulation and learning activities to stimulate optimal  brain development, improved feeding for infants and young children and school readiness. This also addresses parental involvement in the care and development of children as focused on by India's National ECCE Policy ratified in 2013, global guidance by core ECD agencies as well as Early childhood development as a key aspect of UNICEF ICO's new country programme (2018-2022). The intervention has been planned holistically with TLM's, environment, sensitization and training of different levels of functionaries, monitoring and participation of community. An intergenerational approach, where mothers and children attend sessions together or are met with together through home visits etc.  has been planned which is known to lead to greater impact. During the group as well as individual sessions, AWW's and ASHA's model how to play with children, demonstrate feeding and care techniques, demonstrate techniques of problem solving during challenging behaviour situations, and provide other hands-on experiences in real-life situations. Also, the intervention focuses on increasing knowledge among the general community through

92 Pia R. Britto, et al., 'Nurturing Care: Promoting Early Childhood Development', The Lancet, vol. 389, no. 10064, January 2017, pp. 91–102.

http://www.sciencedirect.com/science/article/pii/S0140673616313903.

93 Building Better Brains, 2014; Lancet ECD Series, 2016

platforms such as Palak Melawa on the importance of the earliest years of life for healthy brain development and overall growth and development so that there is more support towards the intervention by the ecosystem.

The communication material is inclusive and has a considerable equity focus, ensuring that the process and the product are driven by the needs of the most vulnerable population. E.g., it ensures active representation of mothers, fathers, and other family members such grandmother, grandfather and siblings; pictures demonstrate different geographical realties such as rural/urban and different cultural contexts and brings in the elders in the family as supportive and active in good practices in child rearing.

Gender focus is overarching e.g, play and early learning is depicted and discussed to learn to interact, play and communicate with those from the other gender. Key messages on ECD are targeting both mothers and fathers and other significant caregivers, emphasizing the importance of their involvement in the care and development of the children – as well as in decision making. Gender socialization seems to begin early with value education, gendered toys for boys and girl. This is also addressed in the pictures depicted in the material. The material also aims to create a supportive environment for the mother by the families active and able support in child rearing.

**Communication Package- Summary**

| State | Communication material List | Main content | Main User | Audience of the material |
|---|---|---|---|---|
| **Maharashtra** | • Parenting guide for caregiver - birth to 6 years | Parenting guide 0-6 includes children's developmental needs and skills, role of parents/ family, prevention of illnesses and safe environment and from where to seek guidance. | Parents and family (primary and secondary caregivers) | Parents and family (grandparents, siblings) |
| | • Job aid for frontline workers- birth to 3 years | Guidance for FLW's to conduct home visits, mothers' meetings, Palak Melawa and do growth monitoring and promotion more effectively. | AWW's and ASHA's | Parents, Family and Community |
| | • English Activity Bank for Frontline workers - birth to 3 years (Manual for Play & Communication) | Play and Communication activities for 0-3 years useful during Home Visits and Mothers' Meetings | AWW's and ASHA's | Parents, Family and Community |
| | • ECE materials ICDS UNICEF- 3 to 6 (Responsive Caregiving | Responsive Caregiving Content for ages 3-6 years for the whole year spread across 3 parts with 6 sessions each and to be used during the parent meets every | AWW's | Parents and Families |

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| | Programme-Part 1, 2, 3) | fortnight. Linked to the ECE State Curriculum Aakar used in AWC's. | | |
| | • MCP Card | It is a tool developed and adopted by Ministry of Health and WCD for informing and educating the mother and family on different aspects of maternal and child care and is a maternal and child care entitlement card, a counselling and family empowerment tool which would ensure tracking of mother and child cohort for health, nutrition and development purposes. As the first contact point between a pregnant woman and the health system, the MCP card creates awareness, facilitates community dialogue and generates demand for uptake of vital services being provided. The MCP Card requires direct action by parents and family members on marking the card when their child achieves age appropriate milestones and marking the Iron Folic Acid (IFA) compliance table after their child receives the appropriate dose of IFA syrup. The milestones and parenting tips provided form a dependable guidance for parents. The purpose of involving families in such a way is to encourage them to take ownership of their child's well-being. ANMs, ASHAs and AWWs help families by demonstrating how to fill the card and ask more aware community members to support those parents. It links maternal and childcare into a continuum of care through the Integrated Child Development Services (ICDS) scheme of Ministry of Women and Child Development and the National Rural Health Mission (NRHM) of the Ministry of Health & Family Welfare (MoHFW). This is complemented with communication cards to counsel parents for creating a positive learning environment at home for children age 3-6 years. | Pregnant women and Families with children under 3 years of age<br><br>Also used by ANM / AWW, Village Groups/ Women (Mahila Mandal) groups, Health and ICDS Supervisors | Pregnant women and families with children under 3 years of age |

| Rajasthan | • Sabrang Positive Parenting Kit Cards (for 3-6 year olds) | Responsive parenting guidance through developmentally appropriate activities across language, cognitive, creative, physical and social domains. Also, guidance on keeping children safe, clean and nourished and nurtured. | AWW's | Parents and families |
|---|---|---|---|---|
| | • Parent Activity Meet Capsules- April -Nov-2018 (for 3-6 olds) | Capsules for establishing flow and organized content for parent meets across 8 months. | AWW's | Parents and families |
| | • First 1000 day guidance and material | Posters focusing on danger signs for pregnant women, key tests for pregnant women, food diversity, hunger cues, weaning and quantity of food, IFA deficiency.<br><br>Key message posters for special days First trimester, annaprasan diwas, swasthya diwas, suposhan diwas etc. | AWW's and ASHA's | Pregnant women, spouses and families |

## Training Materials - Summary

| State | Communication material List | Main content | Main User | Audience of the material |
|---|---|---|---|---|
| Maharashtra | • Training manuals for Facilitators - Cycle 1-5 | **Cycle 1**: Session content focused on growth and development, ECD, domains of development, importance of first 6 years and developmental milestones, brain wiring and firing, positive disciplining, role of parents in child's learning, health and hygiene, planning for home visits and mother's meetings, and planning for field trainings.<br><br>**Cycle 2**: Session content focused on Nutrition, Responsive Feeding , Developmental Milestones, Palak Melawa, Facilitation Skills, Planning and data sharing and a session on Aakar (State ECE Curriculum).<br><br>**Cycle 3**: Session content focused on identifying weak links, action | Anganwadi Supervisors and ASHA Facilitators | FLW's |

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| | | planning, growth monitoring and promotion and detailed planning of field trainings.  **Cycle 4**: Session content focused on children with special needs, risk factors that cause delays, developmental delays, inclusion, role of FLW's, community action plan and innovative play and communication activities | | |
| **Rajasthan** | • Positive Parenting Module (AWW's Effective communication with caregivers) | Content focuses on good child rearing practices, developmentally appropriate activities across different domains of development, health, nutrition safety, effective communication with parents and caregivers and effective meetings. | Anganwadi Supervisors and ASHA Facilitators | FLW's |
| | • AWW's manual | Guidance for FLW's to conduct effective Parent Activity Meets and be able to promote caregivers to create an appropriate learning environment at home from an early childhood developmental lens. | Anganwadi Supervisors and ASHA Facilitators | FLW's |
| | • Key messaging sheet | Core training messages for nurturing care. Messages focus on pregnant women, children 0-6 months, 7 months- 2 years, 7 months- 6 years. | Anganwadi Supervisors and ASHA Facilitators | FLW's |
| | • Sector Meeting Guidelines | Key messages around importance of ECE, importance of creating a learning environment at home, participative methodology, Domains of ELDS, Strengthening Parent activity meets, | Anganwadi Supervisors and ASHA Facilitators | FLW's |

## Communication Package

| STATE | DESCRIPTOR | REVIEW |
|---|---|---|
| Maharashtra | • Parenting guide for caregiver - birth to 3 <br> • Job aid for frontline | **Relevance- Communication Package**  As increase in knowledge along with development of the right attitude has tremendous potential to catalyse positive change in practice, the intervention is aligned to parental needs to empower |

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| | workers- birth to 3 years<br>• English Activity Bank for Frontline workers - birth to 3 years (Manual for Play and Communication)<br>• ECE materials ICDS UNICEF- 3 to 6<br>• MCP Card | and equip them with the knowledge, attitude and practices aligned to nurturing care focused on empowering mothers, and to some extent fathers, family and community. This is visible and articulated in the communication vignettes and guidance shared in the parenting guide, manual for play and communication as well as the guidance provided for home visits, mothers' meetings, Palak Melawa (caregiver community fair).<br><br>Elaborate focus has been observed on comprehensive development through stimulating physical, cognitive, social and emotional development in children using context and culturally relevant play and communication. Also, the intervention is tailored to stages from prenatal to infancy to preschool and transition to school providing the needed support from 0-6 years of age. This addresses the need for parents to feel more empowered through specific parenting skills across domains, ages and stages of development and hence be responsive to children's developmental needs. The content specifically intends to improve parents' knowledge and practices related to caregiving, nutrition and child health and is also aligned to what is ensuing in the Anganwadi Centres (AWC's) in the context of 3-6 years. Leveraging available platforms and the communication and training content wherein fathers are seen as key recipients alongwith mothers, is good step from Mother centred to parent centred approach to raising children in keeping with research on paternal involvement as a crucial link to positive parenting. Tools like the Mother Child Protection (MCP) card, is used as a counselling tool for positive parenting focusing on children below 3 years. This is complemented with communication cards to counsel parents for creating a positive learning environment at home for children age 3-6 years.<br><br>Focus has also been given on father's role in caregiving and communication materials and training kits developed have ensured messaging reiterates the same. Gender is seen as an overarching focus through the material reviewed however a separate focus on emphasis on the implications of some gender different practices would be good to foreground. The material reviewed is equitable in reach across gender, ethnicity, class, geographic location and messaging has accounted for the same.<br><br>Also, Information elicited in the communication packages focus on changing cultural beliefs and attitudes towards parenting with a key focus on what, why and how of responsive parenting. More focus on gender linked biases as well as keener focus on Social Emotional Learning to help parents respond well to challenging behaviours and break patterns of inappropriate disciplining practices, would be good. |
| Rajasthan | • Sabrang Positive Parenting Kit | **Relevance- Communication Package** |

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|---|---|---|
| | Cards (for 3-6 year olds)<br>• Parent Activity Meet Capsules- April -Nov-2018 (for 3-6 olds)<br>• First 1000 day guidance and material | Increase in knowledge alongwith development of the right attitude has tremendous potential to catalyse positive change in practice, the intervention hence is aligned to parental needs to empower and equip them with the knowledge, attitude and practices aligned to nurturing care focused on empowering mothers essentially.<br><br>The communication package is based on the Early Learning Development Standards (ELDS) that have been developed and standardized through a scientific evidence-based process. The important domains of physical, language, cognitive, creative and socio-emotional development were a focus to develop the content for 3-6 years in a participatory manner to bring in greater relevance to the context. Also, the intervention is tailored to stages from prenatal to infancy to preschool providing the needed support from 0-6 years of age. For 0-3, a more basic messaging model has been followed while for 3-6 a more intense participatory methodology has been adopted to develop the parent reference cards- SABRANG. This addresses the need for parents to feel more empowered through specific parenting skills across domains, ages and stages of development and hence be responsive to children's developmental needs. The content specifically intends to improve parents' knowledge and practices related to caregiving, nutrition and child health and is also aligned to what is ensuing in the Anganwadi Centres (AWC's) in the context of 3-6 years.<br><br>The material reviewed aims to communicate gender equitable opportunities through responsive parenting. Focus has been given on father's role in caregiving through the material to build change in beliefs and practices. |

## Training materials

The intervention is a twin track approach to build the capacity of ICDS and health system functionaries, including frontline workers to raise awareness and build the capacity of parents and caregivers on providing nurturing care, positive parenting and early stimulation which in turn will positively influence the development trajectory of children. Increased capacity of frontline workers (e.g., social workers, health workers, teachers, childcare workers) to deliver quality interventions for ECD is a focus. The training materials follow a comprehensive approach with respect to the child's nutrition, health, growth and development to equip the FLW's with the knowledge, attitude and practice to feel confident themselves as well as be able to effectively empower the child's family and caregivers.

Once trained, existing service delivery platforms within the ICDS include mothers' meetings organized at the Anganwadi Centres, exclusive fathers meets, home visits by frontline functionaries and community events were used to reach out to parents and support them.
The material has a strong equity focus, ensuring that the process and the product are driven by the needs of the most vulnerable population. Districts have been selected targeting marginalized populations.

Gender focus is overarching e.g, Play and early learning is depicted and discussed to  learn to interact, play and communicate with those from the other gender. Key messages on ECD are targeting both mothers and fathers and other significant caregivers, emphasizing the importance of their involvement

in the care and development of the children – as well as in decision making. Gender socialization seems to begin early with value education, gendered toys for boys and girl. This is also addressed during parent and caregiver meetings with frontline workers.

| STATE | DESCRIPTOR | REVIEW |
|-------|-----------|--------|
| Maharashtra | • Training manuals Cycle 1-5 | **Relevance- Training Material**<br>Training materials have been developed on positive parenting. They are being used to enhance the knowledge and skills of programme functionaries to mobilize communities and families to promote responsive parenting and early learning. For developing training materials, the existing national and global packages/guidelines/training modules related to parenting /care for development were mapped, reviewed and contextualized for the current programme. In Maharashtra training is imparted in five cycles, each cycle consists of five days training for the master trainers (Anganwadi Supervisors-AWS, ASHA Facilitator, Block Coordinator). For the frontline functionaries five cycles of three days, one day per month for three consecutive months in one cycle, therefore, fifteen rounds of monthly training for a day each. A cascade model is followed wherein The Civil Society Organisation (CSO) team trains the master trainers who in turn train the frontline functionaries.<br><br>Information elicited in the training materials focus on changing cultural beliefs and attitudes towards parenting with a key focus on what, why and how of responsive parenting. Training sessions through a well-structured flow included pertinent content and methodologies. Experiential learning, role plays, case studies etc., were used as well as involved the active participation of the AWWs rather than acting as passive learners, facilitators of the sector meeting provided active learning situations to the participants and facilitate the learning process and Sector meeting were conducted in an open and democratic environment which allows the participants to voice their experiences and opinions to also help them experience an equitable environment. In addition to innovative training methodology, community events like Palak Melawa (fairs for caregivers) based on early childhood development (ECD) care continuum have been effectively leveraged. Through these fairs, the larger community has been made aware, especially fathers, about positive parenting practices that can be adopted in the home environment and their role. The training material equips the FLW's to conduct the parent meets, home visits and community fairs more effectively with an overarching focus on responsive parenting. Training uses games, activities and demonstrations on how to conduct a mothers' meetings and home visits. Learning is further reinforced through supportive supervision by Anganwadi Supervisors and ASHA (mentors.<br><br>However, a focused discussion around gender and equity challenges was not seen clearly articulated in the training materials. |

| | | More focus on gender linked biases as well as keener focus on Social Emotional Learning to help parents respond well to challenging behaviours and break patterns of inappropriate disciplining practices, would be good. |
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| Rajasthan | • Positive Parenting Module (AWW's Effective communication with caregivers)<br>• AWW's manual<br>• Key messaging sheet<br>• Sector Meeting Guidance<br>• Training Module | **Relevance-Training Material**<br><br>Information elicited in the communication packages and training materials focus on changing cultural beliefs and attitudes towards parenting with a key focus on what, why and how of responsive parenting. Participatory methodologies were used to adapt to context and culture and build upon positive parenting practices as well as address some of the cultural beliefs and attitudes towards parenting.<br><br>Training in Rajasthan laid emphasis on gentle disciplining and gender equity through reflective enquiry. However, strategies to engage fathers more in sessions and caregiving need to be delved in further. |

## Other reports/aspects

*Relevance- Strategy*

About 85 percent of a child's brain network is wired in the first 5 years of life. While genes determine when brain circuits are formed, experience shapes the unfolding of the connections among neurons[94]. Young children need nurturing care from the start. The most formative experiences of young children come from nurturing care received from parents, other family members, caregivers, and community-based services. Nurturing Care is characterised by a stable environment that promotes children's health and nutrition, protects children from threats, and gives them opportunities for early learning, through affectionate interactions and relationships. Benefits of such care are life-long, and include improved health, wellbeing, and ability to learn and earn. Also, childhood development is a maturational process resulting in an ordered progression of perceptual, motor, cognitive, language, socio-emotional, and self- regulation skills. Thus, the acquisition of skills through the lifecycle builds on the foundational capacities established in early childhood. Each are necessary for nurturing care. Nurturing care reduces the detrimental effects of disadvantage on brain structure and function which, in turn, improves children's health, growth, and development[95]. Support and responsiveness, with a foundation in early bonding, are expressed through social and emotional relationships, building trust and attachment and behavioural interactions such as hugging, holding and loving physical contact[96]. Responsive parenting includes prompt response to a child's behaviour that is appropriate to the child's needs and developmental phase[97]. Responsive feeding practices have been positively associated with young children's nutrition status[98].

94 Mustard 2000, 2007; Centre on the Developing Child at Harvard University 2007; Shonkoff and Phillips 2000

95 Black, MM, Walker, SP, Fernald, LCH..., and for the Lancet Early Childhood Development Series Steering Committee. Early childhood development coming of age: science through the life course. (published online Oct 4.) Lancet. 2016.

96 Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. Basic Books.

97 Eshel, Neir & Daelmans, Bernadette & Cabral de Mello, Meena & Martines, Jose. (2006). Responsive parenting: interventions and outcomes. Bulletin of the World Health Organisation.

98 Yousafzai, Aisha K, Rasheed, Munira A.,Bhutta Zulfiqar A. (2013). Annual Research Review: Improved nutrition – a pathway to resilience

The strategy was to build on government programme priorities, including POSHAN (Prime Minister's Overarching Scheme for Holistic Nourishment) Abhiyaan to utilize and increase regularity and quality of the three platforms of home visits, monthly mother meets (including meets with fathers) and community meets to improve interactions between FLW's and caregivers. Also, the strategy of cascade supportive mentoring and supervision was there with the Block coordinator, Supervisors and FLW's forming the cohesive triad of the same. Training uses games, activities and demonstrations on responsive feeding, play and communication with children, how to conduct meetings and visits like mothers' meetings and home visits etc. Learning is further reinforced through supportive supervision by Anganwadi Supervisors and ASHA (Accredited Social Health Activist) mentors.

The continuous involvement of beneficiaries in project design, implementation and monitoring has also been an effective strategy such as, consultative process with FLW's and Caregivers were used in development of the materials and example of which is addition of relevant messages regarding excessive screen time on the request of field supervisors in Maharashtra; another pertinent example is that the approach was refined as per ground realities such as scheduling mothers meet as per ages of children, separate fathers meets and utilizing folk media and Palak Melawas (community based parent festivals) to garner community support for ECD.

**Relevance - Alignment to State ECE Curriculum**

Overall, the goal of this intervention is for children aged 0–6 years to benefit from an integrated package of ECD interventions with a focus on positive parenting (which ensures responsive feeding, psychosocial stimulation and learning activities) towards enhanced brain development, improved infant and young child feeding, and school readiness. This is aligned to India's National ECCE Policy ratified in 2013, which focuses on the importance of parental involvement in the care and development of children. This strategy (promoting parental involvement) for ensuring quality early childhood development is recognised globally as one of the most effective ones with lifelong implications. Early childhood development is a key aspect of UNICEF ICO's new country programme (2018-2022) and Maharashtra is one of the focus states for this intervention. Both states have used the state curricula as a base to build the intervention.

Training manuals, monitoring tools and communication package for improved parenting is in place in both the states. State governments are scaling up different components of the package. The e-learning course comprising of 21 modules on ECE has been developed at the national level and is currently available with the MWCD for further dissemination during sector meetings of anganwadi workers in coming months. Furthermore, UNICEF has developed a resource kit on responsive parenting based on a review of materials developed in Maharashtra and Rajasthan. This resource kit includes a flipbook with 40 odd illustrated cards, in which the messages are developed using every alphabet of Hindi language which will enable easy recall of messages. A floor game has been designed for frontline workers to use during their sessions. In addition, a set of films depicting positive parenting practices with children of different age groups and a training film for frontline workers focusing on conducting home visits have been developed. These national prototypes will be shared with other states which plan to implement similar programmes in their states. To complement the existing communication tools in Maharashtra, UNICEF developed a deck of playing cards for use by the anganwadi workers to promote learning through play for children between 3-6 years. The anganwadi worker uses these cards during home visits to reinforce key messages with parents on the use of local materials for play and the activities that can be done as part of daily routine.

| STATE | DESCRIPTOR | REVIEW |
|---|---|---|
| Maharashtra | **ECE materials ICDS UNICEF- 3 to 6 *Parenting_Baseline Study Report *State level Baseline report *Proposal and donor reports *Progress reports | **Relevance - State ECE Curriculum**<br><br>POSHAN Abhiyaan, the flagship programme of the Ministry of Women and Child Development (MWCD), Government of India ensures convergence with various programmes including Anganwadi Services and lays emphasis on the first 1000 days of the child. For 0-3 years, Maharashtra has adopted an incremental Learning Approach (ILA) that Government of India is currently promoting through the National Nutrition Mission. ILA is a system which uses opportunities in the form of existing supervisory interactions at different levels, through which practical and guided learning may be accomplished. It builds learning incrementally to enable the frontline functionaries to internalize the learning, develop skills and take necessary actions. Different tools such as a family retained Mother Child Protection (MCP) card and the communication cards for promoting learning at home for children aged 3-6 years are used to promote learning. The MCP card is a family retained tool, which frontline functionaries and parents use to track delivery of services and developmental milestones and seek referral in case of developmental delays. Training uses games, activities and demonstrations on how to conduct a mothers' meetings and home visits. Learning is further reinforced through supportive supervision by Anganwadi Supervisors and ASHA (Accredited Social Health Activist) mentors. Training packages have been designed to be transacted in phases. In Maharashtra training is imparted in five cycles, each cycle consists of five days training for the master trainers and three days for the frontline functionaries - one day per month for three consecutive months. A cascade model is followed, the Civil Society Organisation (CSO) team trains the master trainers who in turn train the frontline functionaries. Based on the feedback provided by the supervisors, the training of frontline workers has improved the quality of mother's meetings and home visits. The mothers' meetings are now planned for a counselling tool for different age groups of children. Tools like the Mother Child Protection (MCP) card, is used as positive parenting focusing on children below 3 years.<br>This is complemented with communication cards to counsel parents for creating a positive learning environment at home for children age 3-6 years. Further to improve Early Childhood Education (ECE) services at the AWC, supervisors are being trained to implement state ECE curriculum and on the use of ECE Quality Assessment tool. The manuals for parents are also aligned to the state ECE curriculum- *Aakar* to reinforce some key learning at home through play and communication and equip parents better to provide a responsive and positive learning environment at home.<br><br>Further, in Maharashtra, Government has also initiated training of doctors and nurses to integrate stimulation and nurturing care into pediatric care in public health institutions at district-level. But this |

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| | | was not part of the current ECD intervention and as such is out of the scope of the current end-line evaluation. |
| Rajasthan | *State level Baseline report *Human Interest stories *Parenting Baseline Study Report *Proposal and donor reports | The communication package is based on the Early Learning Development Standards (ELDS) that have been developed and standardized through a scientific evidence-based process. Key components of the intervention are being scaled up by the Government. It has approved state-wide scale up of the parenting communication package for children age 3-6 years, through the 61,000 anganwadi centres. The communication package developed for the intervention consisting of 22 parenting cards (SABRANG) focuses on improving early learning through positive parenting practices at home. |

### *Effectiveness – Inputs/Activity Implementation as per plan- Usefulness of Tools and Standards*

The programme was conceptualized in two phases (1) Preparatory (2) Implementation – intensification, scaling and consolidation.

In 2019, as per preparatory plans, the thrust was on the consolidation of learnings and practices towards scaling up the programme. Currently, the frontline functionaries (anganwadi workers and ASHAs) across all 5,000 anganwadis prioritized using existing platforms regularly - home visits, meetings at the AWC and community-based meets for engaging with parents.

In the consolidation phase three key activities were undertaken, first was the strengthening of supportive supervision by establishing a system for FLW's through (a) sector-level meetings for reinforcing learning, addressing implementation challenges faced by the frontline functionaries (b) handholding and onsite support to the frontline functionaries for planning and improving the quality of service delivery including home visits, monthly meetings and community events and (c) quality assurance activities by the field supervisors with support from CSO partners to monitor progress and refine inputs. In both the states, monthly sector meetings have become forums for monthly planning, capacity building of anganwadi workers and for sharing best practices. In Rajasthan, the state government has developed an annual calendar for these meetings along with a monitoring mechanism. This will be integrated into the state monitoring system. In Maharashtra, a monitoring checklist was developed to review frontline functionaries' interactions with the caregivers which aided in the refining of the training of frontline workers to make the interactions more effective. In addition, in Maharashtra, 42 field supervisors were trained on an ECE Quality Assessment Tool, who used it for mentoring anganwadi workers to improve the quality of the ECE programmes at their centres. As a result, the supervisors are able to offer need-based solutions such as organizing the space within the anganwadi centre for ECE activities and supporting anganwadi workers to plan and implement developmentally appropriate activities for children 3-6-year-old.

The second activity was use of Learning Hubs as demonstration sites in Rajasthan to promote ECD along the entire age continuum of 0-6-years. Select anganwadi centres were developed as learning hubs and demonstrated desired practices on parental engagement. They also provided peer-to-peer support to six to eight adjoining anganwadi centres. Currently, 60 anganwadi centres are functioning as learning hubs in one district. These will, in turn, facilitate scaling up the programme.

The third activity is the Capacity building and scale-up wherein various steps have been initiated in Maharashtra and Rajasthan.  The state governments, with support from UNICEF, have worked to strengthen the quality of ECE programmes in anganwadi centres. to ensure that anganwadi workers first have the capacity to implement developmentally appropriate ECE programmes before they can effectively carry out a responsive parenting programme to guide parents on reinforcing their children's development and learning. In Maharashtra, 200 state-level master trainers have trained 3,036 field supervisors on the new ECE curriculum to strengthen the programme across 97,377 anganwadi centres in the state. In Rajasthan 1,600 state resource group members and master trainers were trained on ECE who further trained 63,000 anganwadi workers and 38,000 mentor teachers from primary schools. Furthermore, 320 core trainers from ICDS and the Department of Health trained as ECD champions are supporting scaling up of the programme, which includes:

- District-wide implementation of ECD intervention focusing on children below 3-years in seven districts, including 4 aspirational districts and 2 urban corporations.
- Training of frontline workers has been initiated in 16 tribal districts on the MCP card

Also, to ensure effectiveness, parents, caregivers and service providers have been engaged in the planning and implementation processes.  The behaviour change communication utilizing existing contact points has been designed in such a way that each household with a pregnant woman or a child in 0-6 years age-group will be reached at least once each month through the frontline workers.  In addition, the workers were trained to provide customized messages through these platforms based on the need of each household.  The three platforms for behaviour change communication also complement each other; while home visiting aims to empower parents and other caregivers at the household level, mothers' meetings utilize peer-group approach and Palak Melawa tries to build a positive community norm.

*Effectiveness – Inputs/Activity Implementation as per plan - Bottlenecks in Implementation*
The intervention builds on the national and state government priorities and is delivered through the current programme structures. As state governments have been closely associated with programme strategy development and implementation, the risk of the interventions not being sustained is minimal. Rather the learnings from the programme will inform the implementation of HBYC and improved ECE services at the anganwadi centres, while also promoting responsive parenting.

*Effectiveness – Inputs/Activity Implementation as per plan- Timely corrective action*
The approach adopted for implementation was continuously refined on the basis of feedback from the frontline workers to adjust it to meet their and the communities' requirements. The adjustments included scheduling mothers' meetings according to the age of children, organizing meetings with fathers as per their availability late in evenings or on holidays and utilizing folk media and Palak melwas (community-based parents' festivals) to garner larger support for ECD. In Maharashtra poor participation from fathers in monthly meetings was reported because of their reluctance to attend meetings with the mothers and inconvenient schedules of these meetings. Anganwadi workers were supported to re-schedule the meetings at a time convenient to the fathers to participate. In Palghar and Pune, 1025 sessions were organized for fathers, in which 4228 fathers attended. Following this dedicated session, there was an increase in the participation of fathers in the monthly sessions. Participation of fathers in monthly meetings in Rajasthan continues to be a challenge, primarily because of unavailability of fathers due to migration. However, during home visits, all caregivers in the family were provided messages on ECD.

## Annexure 5: Baseline evaluation report summary

Given the critical role played by positive parenting and the gap in knowledge with regards to parenting and the use of available services, a study was conducted to find evidence on what positive parenting practices, promotions or interventions are needed. "The Principal Objective of the study was to examine how raising children (both boys and girls) is understood among different stakeholders and what sources of parenting support exist for parents."[99] The baseline tried to capture knowledge, attitudes and practices (KAP) of the front-line workers (FLWs), mainly Anganwadi Workers (AWWs) and ASHAs, regarding early childhood care and development.

The study used mixed methods research, including quantitative surveys and Dyads with FLWs. The study was conducted in the Udaipur and Durgapur districts of Rajasthan and Aurangabad, Pune, Yavatmal and Palghar districts of Maharashtra, in specific blocks within these districts where the intervention had been planned. 600 CAPI based interviews and 14 dyads were conducted with AWWs and ASHAs, maintaining a 75:25 proportion at the state level, for each state. Responses were recorded and analysed in the domain of roles and responsibilities of the ASHAs and AWWs, underlying demographics, trainings received, knowledge about ECD methods & practices and interaction with parents; the results for which are summarised below.

The primary demographics indicated that a higher proportion of ASHAs were younger and had completed secondary (38%) and higher education (31%) than their AWW counterparts. Also, most of the FLWs included in the study were from tribal communities (majority belonging to their village of work) given that the ICDS study blocks were predominantly tribal. In addition, 95% of AWWs and 97% of ASHAs have access to mobile phones, but only 24% and 28% respectively have access to the internet. Television with cable/DTH was reported to be the primary source of information, with 73% of FLWs having access to it. The study also assessed the knowledge and behaviour of FLWs on-field.

The services provided to different target groups overlap between ASHAs and AWWs. Both reported that the most common service provided to children in the age group 0-6 was immunisation or health check. AWWs additionally provided supplementary nutrition and preschool education for the 2-6 child age group. With regards to pregnant women, the majority of AWWs distributed supplementary nutrition and provided immunisation and health check (82%). For the ASHAs, the trend was similar, in that health check topped the list of services provided, followed by the provision of IFA tablets. For mothers of children, AWWs continued to report provision of supplementary nutrition (80%) as a critical service disseminated while for ASHAs health education topped the list (60%) followed by immunisation & health checks (58%) and referral services (57%). In turn, all AWWs and most (97%) of ASHAs reported conducting monthly group meetings with mothers in Anganwadi centers. The topics discussed in the meetings comprised of maternal health and nutrition, complementary feeding, the importance of diet diversity for mothers and exclusive breastfeeding. Only 7% and 3% of the AWWs and ASHAs, respectively, have reported having held meetings with fathers in their area every month. They reported that the topics of discussion were mostly centered on feeding the child and health and nutrition for mothers.

The second focus area is the training of FLWs, wherein 85% of AWWs and 83% of ASHAs reported receiving job course training. It was found that a lesser proportion of rural FLWs reported receiving the training compared to their urban and tribal counterparts. On similar lines, 91% of AWWs and

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99 Report of Findings: Baseline with AWW and ASHA in Rajasthan and Maharashtra, UNICEF and Kantar Public

96% of ASHAs received in-service training. Most of the FLWs reported positive feedback on the last training that they attended. Payment for participation and transportation arrangement were rated poorly among both groups. In addition, FLWs reported that there were insufficient training time and a lack of practical sessions. Another positive highlight in this domain was that 93% of AWWs and 98% of ASHAs reported receiving mentoring support, majorly from their supervisors, followed by their trainers and government doctors. ANM and supervisors were also reported to be significant sources of information on parenting issues the FLWs were unable to address themselves. A greater percentage of ASHAs (84%) compared to AWWs (64%) reported conduction of monthly sectoral meetings wherein the key activities included reporting, documentation, and briefing on upcoming activities.

Another crucial area studied during baseline was FLWs knowledge on ECD methods and practices. Both AWWs and ASHAs reported having good knowledge of eating requirements for pregnant women, consumption of IFA tablets and the importance of rest. In contrast, knowledge of the importance of non-abusive environment and avoidance of hard work were low. FLWs reported 'home visits' as a significant occasion for interaction with pregnant women, wherein the discussion centered around the dietary intake and IFA or calcium tablets consumption. The major challenge faced by them in this interaction was the influence of family members and lack of coherence and understanding by the recipient. FLWs' knowledge on stimulation was also found to be inadequate (less than 50% of AWWs and ASHAs had knowledge of the same). FLWs, at the same time, performed better in the case of methods of stimulating the child than the meaning of the same, with 93% of FLWs reporting that they counsel mothers on methods of stimulation.

The knowledge of FLWs on the importance and methods of playing with the child were found to be adequate. An important point that came out in this area was the assistance provided to stressed mothers, with more than 60% in both groups reporting providing counselling for the same. In turn, FLWs knowledge on early childhood learning for young children and the importance of parent-child bonding was appreciable.

Gender and family perceptions among the FLWs were found to be mainly progressive, with only about 15% of them agreeing to give preference to male children when breastfeeding and a similar figure agreeing to have a shorter breastfeeding period for the girl child. These proportions were higher among the tribal AWWs and rural ASHAs. A positive trend was noted with reference to confidence levels when interacting with women, men and children on various topics such as the importance of playing with children, early learnings, and safe environments for children, among both AWWs and ASHAs.

The study found variation in access to and dispersal of information among the FLWs across the different geographies. In addition, variation was also found between ASHAs and AWWs, although in most cases their interests were found to be similarly aligned. The study investigated the interaction of the FLWs with the target groups, keeping in mind the dynamics of family and community life, social beliefs and practices of parenting, including gender stereotypes and norms. Finally, the study aided in understanding the existing situation and some potential platforms available for future expansion.

**Blocks covered during baseline in Maharashtra**

| State | District | Block | Type |
|---|---|---|---|
| Maharashtra | Aurangabad | Aurangabad 1 | Rural |
| Maharashtra | Aurangabad | Kannad | Rural |
| Maharashtra | Aurangabad | Khultabad | Rural |
| Maharashtra | Aurangabad | Paithan | Rural |
| Maharashtra | Yavatmal | Babulgaon | Rural |
| Maharashtra | Yavatmal | Digras | Rural |
| Maharashtra | Yavatmal | Zari | Rural |
| Maharashtra | Yavatmal | Ghatanji | Tribal |
| Maharashtra | Yavatmal | Pandharkawada | Tribal |
| Maharashtra | Yavatmal | Ralegaon | Tribal |
| Maharashtra | Pune | Pimpri 2 | Rural/Urban |
| Maharashtra | Pune | Hadapsar | Rural/Urban |
| Maharashtra | Pune | Kothrud | Urban |
| Maharashtra | Pune | Pimpri Chinchwad | Urban |
| Maharashtra | Pune | Pune Central | Urban |
| Maharashtra | Pune | Shivaji Nagar | Urban |
| Maharashtra | Palghar | Manor | Tribal |

**Blocks covered during baseline in Rajasthan**

| State | District | Block | Type |
|---|---|---|---|
| Rajasthan | Udaipur | Badgaon | Rural |
| Rajasthan | Udaipur | Bhinder | Rural |
| Rajasthan | Udaipur | Girwa | Tribal |
| Rajasthan | Udaipur | Gogunda | Rural |
| Rajasthan | Udaipur | Jhadol | Tribal |
| Rajasthan | Udaipur | Kherwara | Tribal |
| Rajasthan | Udaipur | Kotada | Tribal |
| Rajasthan | Udaipur | Lasaria | Tribal |
| Rajasthan | Udaipur | Mavli | Tribal |
| Rajasthan | Udaipur | Salumber | Tribal |
| Rajasthan | Udaipur | Udaipur City | Urban |
| Rajasthan | Dungarpur | Aaspur | Tribal |
| Rajasthan | Dungarpur | Bicchiwara | Tribal |
| Rajasthan | Dungarpur | Chikhali | Tribal |

| Rajasthan | Dungarpur | Dungarpur | Tribal |
|-----------|-----------|-----------|--------|
| Rajasthan | Dungarpur | Gamri Ahada | Tribal |
| Rajasthan | Dungarpur | Sagwara | Tribal |
| Rajasthan | Dungarpur | Simalwara | Tribal |

**Note**: All the planned intervention blocks from both the states as mentioned in tables above were sampled during baseline evaluation.

## Annexure 6: Quantitative sampling plan for endline evaluation

***Sampling during baseline evaluation***:

During the baseline evaluation, the study team conducted 600 FLW surveys (450 AWWs + 150 ASHAs) with the allocation in each intervention district as follows:

| Activities | Rajasthan | | Maharashtra | | | | Total |
|---|---|---|---|---|---|---|---|
| | Dungarpur | Udaipur | Aurangabad | Palghar | Pune | Yavatmal | |
| AWW interviews | 75 | 75 | 75 | 75 | 75 | 75 | 450 |
| ASHA interviews | 25 | 25 | 25 | 25 | 25 | 25 | 150 |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 600 |

As can be observed, the study team during baseline allocated the sample equally to all the intervention districts during baseline evaluation. All the blocks that were planned to be included in the project were included in the sampling. Systematic random sampling was used to sample the AWCs per block.

Further, the sampling was done to calculate the desired ratio from a given block in each district as follows:

- To calculate the Class Interval (CI) the total number of AWCs in each block were divided by the required ratio (primary sample + 100% buffer).
- Once the CI was calculated, a random start (RS) was generated between the starting serial number (S No.) and the CIs No. (S No. + CI value - 1).
- The RS, thus became the first sampled AWC.
- The next selection of AWC was done by adding RS + CI.
- This was done until a required number of sampled AWCs were achieved in each block of the district.

Once the AWCs were sampled, the respective AWWs were interviewed. AWWs and ASHA were sampled in 75:25 ratio i.e., ASHAs from every fourth AWW selected.

***Sampling for end-line evaluation:***

For purposes of this assessment, a ***two-stage cluster random sampling*** was used i.e., clustering at district and block level powered to provide state-level estimates. The evaluation team ensured to select FLWs from all the eligible intervention blocks (where the intervention was at least for a year) within a district. The team used systematic random sampling to select Anganwadi Centers (AWCs) from a block ensuring the representativeness of geographic typology (rural/urban/tribal). Once the sample of AWCs was arrived, the evaluation team sourced the list of AWWs within those selected AWCs from the UNICEF/ CDPO office. The sample was selected to be reflective of the underlying population of FLWs (proportionate to the FLW population in each intervention district and within each district, proportionate to FLW population in each intervention block). It is to be noted that the endline evaluation did not follow up the same FLWs (cohort) selected during baseline and as such during endline evaluation, the FLW sampling was re-done.

**Eligibility criteria:** FLWs from areas (blocks) where parenting intervention covering children 0-6 years has been implemented for ***at least one year***.

## *Sample size calculation*

The current evaluation is a cross-sectional one and hence, we used the **one-sample formula** to arrive at the sample size (N). The formula for calculating the sample size for cross-sectional studies is:

$$N = \frac{D * Z^2 * P * Q}{E^2}$$

Where, D is the design effect (1.5) – to account for two-stage clustering
    P= proportion of outcome indicator (0.5)
    Q=1-P
    Z= α=the z-score corresponding to a 95% significance level (1.96)
    E= maximum error allowed (5%)

To obtain the maximum sample size, we chose the proportion of outcome indicator (P) to be 0.5 (i.e., 50%). Design effect (D) was set to value 1.5 to account for two-stage cluster design and maximum error (E) allowed was 5%. We have used a 95% significance level (z=1.96) to calculate the sample size.

The required sample size in each state, based on the above values, was 576 respondents. During sample size calculations, it was envisaged that due to remote data collection strategy (in view of COVID-19), the non-response rate would be on higher side. Therefore, evaluation team considered a buffer of 100% (as was done during baseline) to account for potential non-response. The desired sample size for each state to provide state-level estimates (after rounding-off) was about 600 participants. To ensure the comparability of results with baseline, we divided the total sample between AWWs and ASHA in 75:25 ratio as was done in the baseline. We sampled the ASHAs from every fourth AWW selected. Therefore, in each state, the evaluation team sampled 450 AWWs and 150 ASHAs.

*Table 7: End-line quantitative assessment sampling*

| State | Required sample size (design effect D = 1.5) | Desired sample size to provide a state-level estimate (round-off) | Number of AWWs and ASHAs (75:25) |
|---|---|---|---|
| Maharashtra | 576 | 600 | AWWs – 450<br>ASHAs – 150 |
| Rajasthan | 576 | 600 | AWWs – 450<br>ASHAs – 150 |
| **Total** | | **1200** | **AWWs – 900**<br>**ASHAs – 300** |

### 3.7.1.1. Sampling strategy – Quantitative FLW survey

Since the intervention was adopted to cater to the needs of the local contexts in both the intervention states (Maharashtra and Rajasthan), the evaluation team proposed a suitable sampling strategy to reflect the state-specific contexts in the evaluation design.

### Maharashtra

**Definition of eligible respondent**: FLWs (AWWs/ASHAs) from blocks where parenting intervention covering children 0-6 years has been implemented for ***at least one year***

The sampling strategy for the selection of respondents for FLW survey in Maharashtra is presented below:
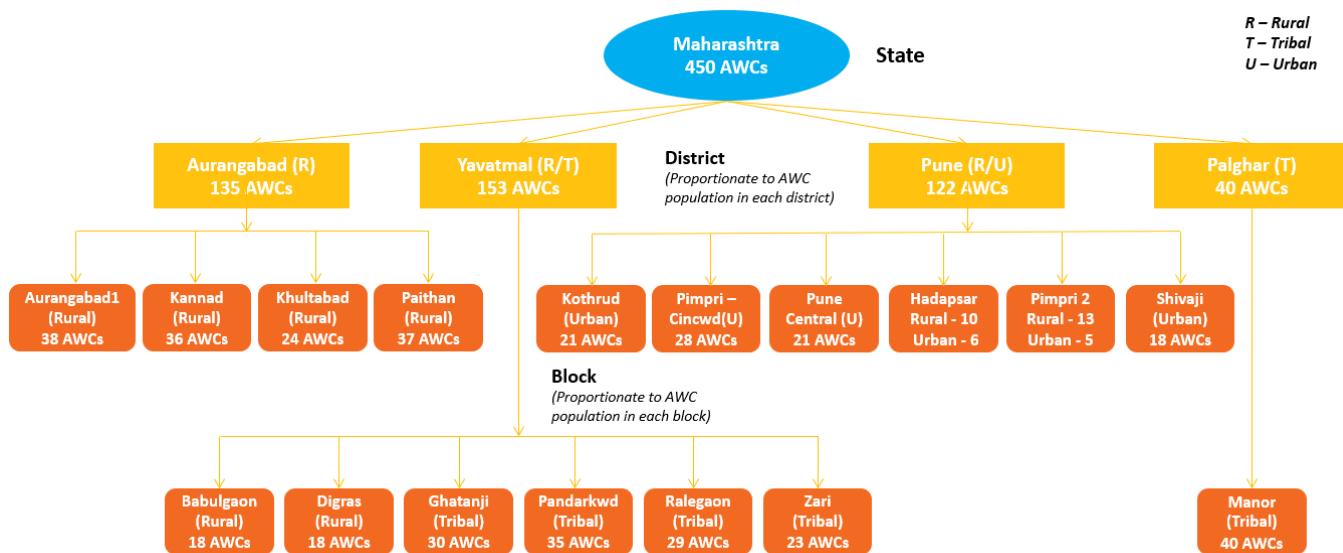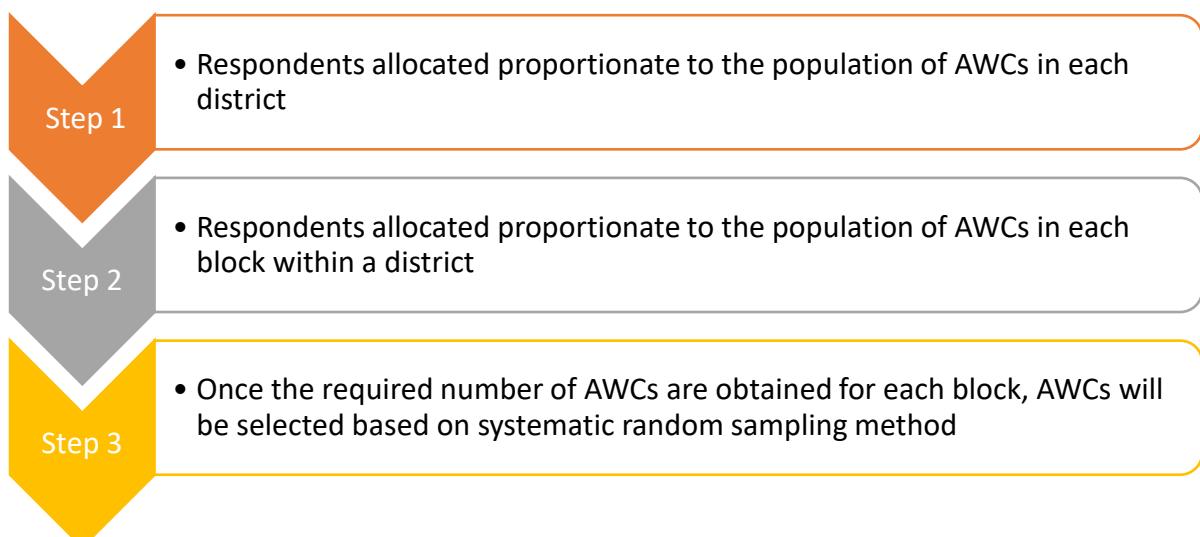


*Figure 23: Sampling strategy for Maharashtra state*

The steps followed for the sampling has been presented below:

| Step 1 | • Respondents allocated proportionate to the population of AWCs in each district |
| --- | --- |
| Step 2 | • Respondents allocated proportionate to the population of AWCs in each block within a district |
| Step 3 | • Once the required number of AWCs are obtained for each block, AWCs will be selected based on systematic random sampling method |

Once the required number of AWCs in each block within a district is determined, the evaluation team followed the below-mentioned steps to select the respondents:

- Under each block, the list of AWCs were sorted by – '***Sector***' name in alphabetical order
- All the AWCs in the block were allotted a serial number starting from 1
- A buffer of 100% AWCs was added to the primary sample in each block
- To calculate Class Interval (CI), the total number of AWCs in each block was divided by the required ratio (primary sample + 100% buffer)
- Once the CI was calculated, a Random Start (RS) was generated between the starting serial number (S.No.) and the Class Interval (CI) S.No.
- The Random Start (RS) was the first sampled AWC
- The subsequent selection of AWCs was done by adding the RS + CI
- This process was done until the required number of sampled AWCs are achieved in each block of the district

## Rajasthan

**Definition of eligible respondent**: FLWs (AWWs/ASHAs) from blocks where parenting intervention covering children 0-6 years has been implemented for ***at least one year***

The sampling strategy for the selection of respondents for FLW survey in Rajasthan is presented
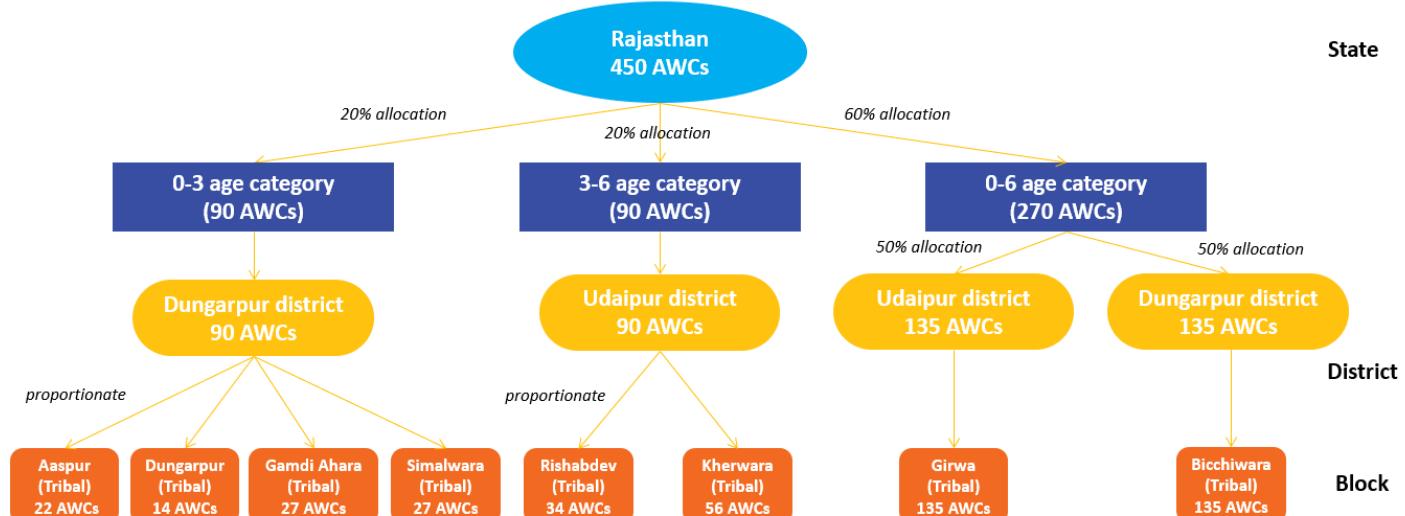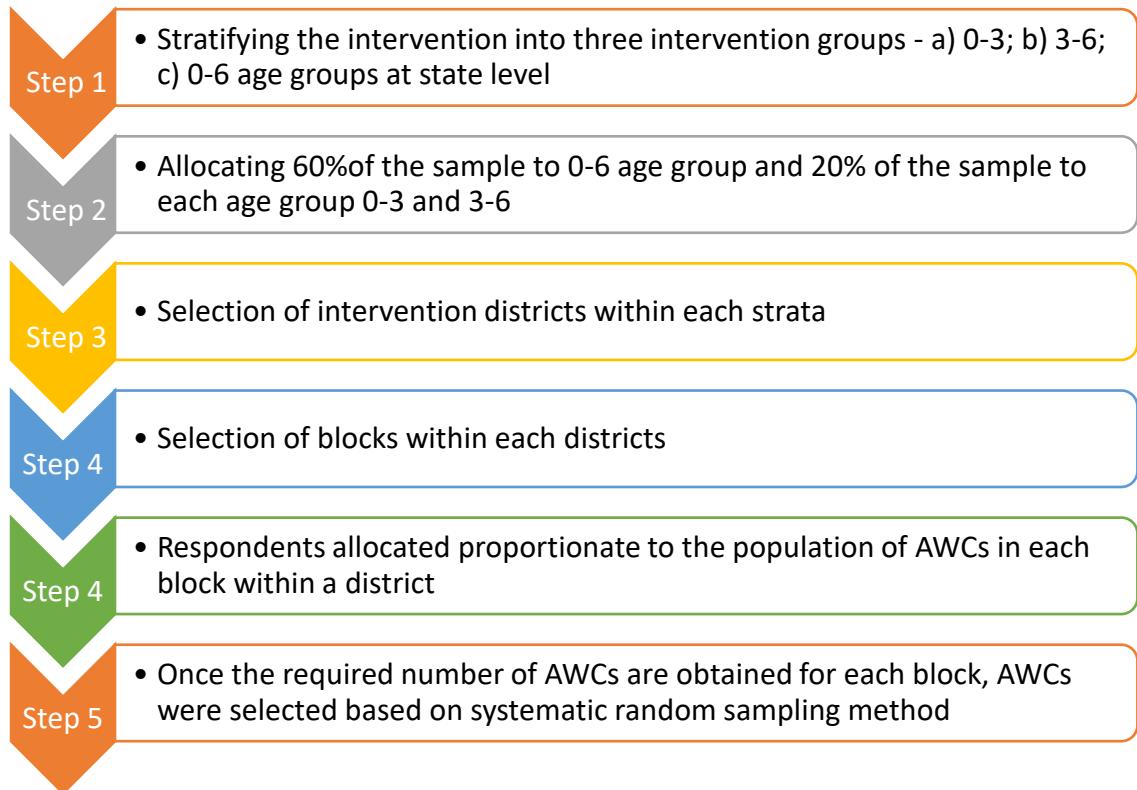


*Figure 24: Sampling strategy for Rajasthan state*

below:

The steps followed for the sampling has been presented below:

**Step 1**
- Stratifying the intervention into three intervention groups - a) 0-3; b) 3-6; c) 0-6 age groups at state level

**Step 2**
- Allocating 60%of the sample to 0-6 age group and 20% of the sample to each age group 0-3 and 3-6

**Step 3**
- Selection of intervention districts within each strata

**Step 4**
- Selection of blocks within each districts

**Step 4**
- Respondents allocated proportionate to the population of AWCs in each block within a district

**Step 5**
- Once the required number of AWCs are obtained for each block, AWCs were selected based on systematic random sampling method

*Note: As there were programmatic level differences between blocks, the evaluation team adjusted the sampling strategy accounting for the differences in the implementation strategy for various sub-groups. Further, as the mandate of the project was 0-6 intervention, upon discussion with the UNICEF program team, majority (60%) of the sample was allocated to 0-6 age category and the rest 40% of the sample was allocated equally between 0-3 and 3-6 age category.*

Once the required number of AWCs in each block within a district was determined, the evaluation team followed the below-mentioned steps to select the respondents:

- Under each block, the list of AWCs were sorted by – '**Sector**' name in alphabetical order
- All the AWCs in the block were allotted a serial number starting from 1
- A buffer of 100% AWCs were added to the primary sample in each block
- To calculate Class Interval (CI), the total number of AWCs in each block were divided by the required ratio (primary sample + 100% buffer)
- Once the CI was calculated, a Random Start (RS) was generated between the starting serial number (S.No.) and the Class Interval (CI) S.No.
- The Random Start (RS) was the first sampled AWC
- The subsequent selection of AWCs was done by adding the RS + CI
- This process was done until the required number of sampled AWCs are achieved in each block of the district

# Annexure 7: Stakeholder map

## Rajasthan

*Table 8: Stakeholder map - Rajasthan*

| STAKEHOLDER MAP – RAJASTHAN | | | | |
|---|---|---|---|---|
| **Government** | | **UNICEF** | **CSO Partner** | **Community** |
| **ICDS department** | **NHM** | UNICEF India | Unnati Sansthan | Parents (mothers & fathers) /Primary caregivers |
| Ministry of Women and Child Welfare (MWCD) | Ministry of Health and Family Welfare (MoHFW) | UNICEF Rajasthan | | Children (0-6 age) |
| Department of Women and Child Development (DWCD) | Department of Health and Family Welfare (DHFW) | | | Family members |
| • Deputy Director, ICDS<br>• Chief Executive Officer | District Health Officer | | | Community members (PRIs, village leaders, SHG members) |
| Child Development Project Officer (CDPO) | | | | |
| Anganwadi Supervisor/ Lady Supervisor | ASHA facilitator | | | |
| • Anganwadi Worker (AWWs)<br>• Anganwadi helpers | ASHA Sevikas | | | |

## Snapshot of roles and responsibilities

| Stakeholder | Role in the Project |
|---|---|
| Integrated Child Development Services (ICDS) | ICDS is the main government entity responsible for the nutrition and primary education services to the children in the country. For the current project, ICDS supported in terms of making the human resources (AWW supervisors, AWWs) available for the capacity building purposes on nurturing care and responsive parenting, providing high-level inputs and guidance.<br><br>In Rajasthan, the government itself rolled out the project (without CSO partner support) in select blocks of Dungarpur district. |
| Ministry of Health and Family Welfare (MoHFW) | MoHFW is the main government entity responsible for the delivering health related services to the pregnant women/ mothers/ children in the country. For the current project, MoHFW supported in terms of making the human resources (ASHAs) available for the capacity building purposes on nurturing care and responsive parenting, providing high level inputs and guidance |

| United Nations Children's Fund (UNICEF) | UNICEF is the lead technical and resource stakeholder, with primary role in project design, organising technical and financial support for project delivery. The role involved advocacy with different national and state partners. |
|---|---|
| CSO partner/s | The major role of CSO partners was in identifying the needs of the parents/caregivers in the community on nurturing care and responsive parenting, design communication tools, training materials, advocacy with the local government officials, organizing and delivering the trainings for AWW supervisors/FLWs, building the capacities of AWW supervisors/FLWs, providing support in terms of handholding the FLWs during Home Visits, CBEs, parents meeting. Unlike Maharashtra where the CSO partners only trained the master trainers, in Rajasthan, in the CSO supported blocks, the CSO itself organized and delivered the training to both AWW supervisor and FLWs. |
| AWW supervisors | AWWs supported the AWWs in handholding on the ground during Home Visits, CBEs, parents meeting, AWCs with supportive supervision |
| FLWs (AWWs/ASHAs) | FLWs (AWWs/ASHAs) are key stakeholders in transferring the right messages on nurturing care and responsive parenting to the parents/caregivers on the ground via various community platforms such as – home visits, community-based events, parents meetings. |
| Community | Parents/Caregivers have been at the heart of the project as ultimate beneficiaries. |

## **Maharashtra**

*Table 9: Stakeholder map - Maharashtra*

| STAKEHOLDER MAP – MAHARASHTRA | | | | |
|---|---|---|---|---|
| Government | | UNICEF | CSO Partner | Community |
| **ICDS department** | **NHM** | UNICEF India | Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sewagram | Parents (mothers & fathers) /Primary caregivers |
| Ministry of Women and Child Welfare (MWCD) | Ministry of Health and Family Welfare (MoHFW) | UNICEF Maharashtra | Gram Mangal | Children (0-6 age) |
| Department of Women and Child Development (DWCD) | Department of Health and Family Welfare (DHFW) | | | Family members |
| • Deputy Director, ICDS<br>• Chief Executive Officer<br>• Divisional Commissioner, ICDS | • District Health Officer (DHO)<br>• District Community Mobilizer (DCM) | | | Community members (PRIs, village leaders, SHG members) |
| Child Development Project Officer (CDPO) | Medical Officer | | | |
| Anganwadi Supervisor/ Lady Supervisor | ASHA facilitator | | | |

| • Anganwadi Worker (AWWs)<br>• Anganwadi helpers | ASHA Sevikas | | | |
|---|---|---|---|---|

**Snapshot of roles and responsibilities**

| Stakeholder | Role in the Project |
|---|---|
| Integrated Child Development Services (ICDS) | ICDS is the main government entity responsible for the nutrition and primary education services to the children in the country. For the current project, ICDS supported in terms of making the human resources (AWW supervisors, AWWs) available for the capacity building purposes on nurturing care and responsive parenting, providing high-level inputs and guidance |
| Ministry of Health and Family Welfare (MoHFW) | MoHFW is the main government entity responsible for the delivering health related services to the pregnant women/ mothers/ children in the country. For the current project, MoHFW supported in terms of making the human resources (ASHAs) available for the capacity building purposes on nurturing care and responsive parenting, providing high level inputs and guidance |
| United Nations Children's Fund (UNICEF) | UNICEF is the lead technical and resource stakeholder, with primary role in project design, organising technical and financial support for project delivery. The role involved advocacy with different national and state partners. |
| CSO partner/s | The major role of CSO partners was in identifying the needs of the parents/caregivers in the community on nurturing care and responsive parenting, design communication tools, training materials, advocacy with the local government officials, organizing the trainings for master trainers, building the capacities of master trainers, providing support in terms of handholding the FLWs during Home Visits, CBEs, parents meeting. |
| Master trainers | Master trainers (AWW supervisors, ASHA facilitators) have been key in rolling out the trainings received from CSO partners to the FLWs, handholding the FLWs on the ground during Home Visits, CBEs, parents meeting |
| FLWs (AWWs/ASHAs) | FLWs (AWWs/ASHAs) are key stakeholders in transferring the right messages on nurturing care and responsive parenting to the parents/caregivers on the ground via various community platforms such as – home visits, community-based events, parents meetings. |
| Community | Parents/Caregivers have been at the heart of the project as ultimate beneficiaries. |

## Annexure 8: Aligning ToC with KEQs

An outline of ToC was available in the ToR. Based on the available ToC and preliminary discussions with UNICEF state teams, the Evaluation Team constructed a broad ToC. This retrospectively constructed ToC is very descriptive and thus far from exhaustive programme theory. The evaluation team was not able to map pathways i.e. from activities to outputs or from outputs to outcomes as it required wider consultations and inputs from programme teams which was out of the scope of current evaluation. Resultantly, the assumptions associated with the specific pathways are not listed. The Evaluation Team have provided broad assumptions for instance at activity, output, outcome level.

Wherever possible, an attempt has been made to align the outputs and outcomes with the agreed KEQs/ sub questions.

| KEQs | Sub questions (focus Qs w.r.t. ToC) | ToC component (activity/ output/ immediate outcome) | ToC Assumptions |
|---|---|---|---|
| EQ5: To what extent were the inputs or activities of the intervention delivered as planned, specifically: development of communication materials, training materials, training of FLWs? | • Were the tools and standards developed to gauge programme quality and child development and learning useful?<br>• What were the bottlenecks in terms of implementation, and why?<br>• Was timely corrective action taken, when issues emerged? | **Activities**<br>• Capacity building of master trainers (ICDS officials and resource persons from CSOs) on responsive parenting care (early stimulation; responsive feeding)<br>• Training of FLWs (AWWs & ASHAs) on responsive parenting care and safety (monthly sector meetings) by master trainers/CSO Partner<br>• Supportive supervision for FLWs – providing hands on mentoring support during home visits/ CBE on pregnancy, childcare and early stimulation | • Training materials are developed on time; training schedule is followed as planned<br>• FLWs are available for trainings<br>• Institutional (govt) support exists<br>• AWW supervisors are motivated to provide hand-holding support to FLWs |
| | • To what extent were the FLWs able to use the communication materials/tools in communicating with parents at the various platforms? | **Output**<br>• FLWs use tools available/ newly developed (Sabrang cards/ Samvedansheel Palakatv and MCP cards) to orient parents/caregivers in the community (through community meetings, PAM, mother's meeting)<br>• FLWs orient the parents/caregivers in the community on positive parenting (early stimulation and responsive feeding) | • Communication tools are available with FLWs<br>• FLWs are motivated to orient the parents/ caregivers in the community |

| KEQs | Sub questions (focus Qs w.r.t. ToC) | ToC component (activity/ output/ immediate outcome) | ToC Assumptions |
|---|---|---|---|
| EQ7: To what extent was the training able to build the skills and capacity of FLWs to counsel and support parents/caregivers on parenting care? | • To what extent there was change in knowledge, attitude and perceptions of FLWs on the role of parenting on ECD? | **Output**<br>• Improved capacities of ICDS functionaries and ASHAs; Improved knowledge, skills, practices of FLWs on ECD/responsive parenting | FLWs are motivated to improve their learnings and practices |
| | • Did the training lead to intended changes in communication style and behaviour of FLWs when engaging with parents/caregivers?<br>• Did the training build the skills of FLWs to counsel the fathers of children? | **Output**<br>• Enhanced confidence of FLWs to interact with community members (particularly fathers)/ demonstrate the messages<br>• FLWs orient the parents/caregivers in the community on positive parenting (early stimulation and responsive feeding)<br><br>**Immediate Outcome**<br>• Improved quality of counselling and interactions of FLWs with community | FLWs are motivated to improve their learnings and practices |
| EQ9: To what extent were existing platforms used effectively to reach caregivers for counselling? (e.g. Anganwadi centres and home visits) | • To what extent FLWs optimally utilized the contacts points (Mothers meeting, PAM, community meetings, home visits) that they have with parents/ caregivers for delivering quality of ECD services? | **Immediate Outcome**<br>• Enhanced utilization of existing resources (Sabrang cards, Samvedansheel palakatv, MCP cards, home visit registers) and platforms by FLWs to orient parents/caregivers on ECD related aspects | • Available tools are used effectively<br>• Institutional (govt) support exists |
| EQ10: To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes? | • To what extent effective coordination and collaboration with existing govt. programmes and interventions were made during the implementation? | **Immediate Outcome**<br>• Enhanced utilization of existing resources (Sabrang cards, Samvedansheel palakatv, MCP cards, home visit registers) and platforms by FLWs to orient parents/caregivers on ECD related aspects | • Available tools are used effectively<br>• Institutional (govt) support exists |

# Annexure 9: Evaluation Matrix

*Table 10: Evaluation Matrix*

| Criteria and Evaluation Questions | Suggested sub-questions | Measures | Data sources and data collection methods |
|---|---|---|---|
| **Relevance** | | | |
| **EQ1: To what extent is the parenting programme delivered by FLWs in the community (hereafter 'the intervention') relevant to the caregivers in selected districts of Maharashtra and Rajasthan?** | **SEQ1.1**: What needs of parents/ caregivers are being addressed and how well?<br><br>**SEQ1.2**: Are other relevant caregivers in the household also being addressed? | • Parents/caregivers/govt officials/CSO partners views around priority needs for children's development and how the intervention caters to those needs; perceptions around the relevance of intervention in addressing those needs | • Review of communication packages, training materials<br>• KIIs with district and block officials of government dept, UNICEF staff, CSO partners<br>• IDIs with parents/caregivers |
| | **SEQ1.3**: To what extent does the intervention factor in gender aspects?<br><br>**SEQ 1.4**: Are the gender aspects responsive to the context and UNICEF's gender programming ambitions? | • Parents/caregivers awareness on gender-related aspects in childcare<br>• Stakeholders (govt, UNICEF, CSO partners) views and evidences as to the coherence of project objectives and strategies to gender-related aspects like gender and culture relevant communication<br>• Assessing the inclusive nature of FLW job aids such as whether the training and materials provided support for addressing gender e.g. father's involvement, girl child and boy child equality in care, support for mothers at home. | • Review of communication packages, training materials<br>• KIIs with UNICEF staff, CSO partners<br>• IDIs with Parents/caregivers |
| | **SEQ 1.5**: To what extent does the intervention factor in equity aspects?<br><br>**SEQ 1.6**: Are the equity aspects responsive to the context and UNICEF's equity programming ambitions? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences as to the coherence of project objectives and strategies to equity-related aspects like geographies and population targeted based on high vulnerability context<br>• Assessing the inclusive nature of FLW job aids such as whether the | • Review of communication packages, training materials<br>• KIIs with UNICEF staff, CSO partners |

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| | | training and materials provided support for FLW to counsel on nurturing care in case of children with disability, whether it supports FLWs to better support hard-to-reach households or households in very vulnerable situations. | |
| **EQ2: To what extent is the training that FLWs receive to deliver the intervention relevant and adequate for the target population (parents/caregivers of child)?** | **SEQ 2.1**: Did the training address ways to change cultural beliefs and attitudes around parenting? | • Perceptions of FLWs towards how the training aided them to address cultural beliefs and attitudes (which hinder child development) among parents/caregivers | • Review of communication packages, training materials<br>• KIIs with block level govt officials, Master trainers & CSO partners<br>• IDIs with FLWs |
| | **SEQ 2.2**: Did the training address the gender and equity-based challenges the frontline worker experiences? | • Perceptions of FLWs towards how the training aided them to address gender and equity-based challenges among parents/caregivers | • Review of communication packages, training materials<br>• KIIs with block level govt officials, Master trainers & CSO partners<br>• IDIs with FLWs |
| **EQ3: To what extent is the intervention aligned to the broader objectives of the project?** | **SEQ 3.1**: How relevant is the strategy (promoting parental involvement) for ensuring quality early childhood development? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences as to the coherence of project objectives and strategies with national/state ECD/ECE priorities and strategies e.g., promotion of father involvement in ECD, supportive role of mother-in-law/grandmother and other family members and community. | • Review of project documents, literature and policy documents and guidance<br>• KIIs with officials of government dept (state/district/block), UNICEF staff & CSO implementing partners |
| | **SEQ 3.2**: How do the envisaged activities and outputs improve quality of counselling and communication support to parents/caregivers? | • Stakeholders (govt, UNICEF, CSO partners) perceptions and evidences on the pathways of change (how they expect activities and outputs to contribute towards improving quality of counselling and communication support to parents/caregivers) | • Review of project documents<br>• KIIs with UNICEF staff & CSO implementing partners, master trainers<br>• IDIs with FLWs |
| **EQ4: To what extent is the** | **SEQ 4.1**: To what extent the intervention is | • Stakeholders (govt, UNICEF, CSO partners) views and evidences as to | • Desk review (review of project documents, |

| intervention aligned to the priorities of the government and other partners, specifically the Early Childhood Development strategies and plans? * | aligned to the state ECE curriculum? *<br><br>SEQ 4.2: What are the existing activities that are being planned or carried out by the government and other partners under ECD in the two States? *<br><br>SEQ 4.3: How is the intervention aligned with these activities? What are aspects of similarity/overlap? What are aspects of difference/divergence? *<br><br>SEQ 4.4: Any collaborative efforts and coordination with other partners for convergence? * | the coherence of project objectives and strategies with national/state ECD/ECE priorities and strategies; enquiring ongoing/planned activities and how these activities align with current intervention; any plans of forging partnerships | communication packages, training materials, literature)<br>• KIIs with officials of government dept (state/district/block), UNICEF staff<br>• KIIs with CSO implementing partners |
|---|---|---|---|
| *Effectiveness* | | | |
| **EQ5: To what extent were the inputs or activities of the intervention delivered as planned, specifically: development of communication materials, training materials, training of FLWs?** | **SEQ 5.1**: Were the tools and standards developed to gauge project quality and child development and learning useful?<br><br>**SEQ 5.2**: What were the bottlenecks in terms of implementation, and why?<br><br>**SEQ 5.3**: Was timely corrective action taken, when issues emerged? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on plan (intended) vs delivered trainings; factors leading to delays; identifying bottlenecks in implementation; strategies and interventions that did not work and why, and lessons learnt for possible corrective action/replication | • Review of progress reports of project<br>• KIIs with CSO implementing partners<br>• KIIs with block level govt officials, UNICEF staff, CSO partners, master trainers |
| | **SEQ 5.4**: To what extent were the FLWs able to use the communication materials/tools in communicating with parents at the various platforms? | • FLWs views and evidences on their comfort and confidence levels in using communication materials with parents (identifying difficulties if any); exploring which platforms are used / not used commonly and why/why not? | • KIIs with CSO implementing partners<br>• KIIs with officials of government dept, UNICEF staff<br>• IDIs with FLWs<br>• Case studies |
| **EQ6: What was the quality of the training to FLWs, in terms of** | **SEQ 6.1**: What did FLWs like about the training (all training | • FLWs views and evidences on the quality of training delivered to them (likes & dislikes); | • Review of communication materials, training materials |

| content, structure and delivery medium? | programmes), what did they find useful?<br><br>**SEQ 6.2**: What did FLWs dislike about the training, what did they not find so useful and why?<br><br>**SEQ 6.3**: What suggestions do FLWs have for improvements?<br><br>**SEQ 6.4**: Whether messaging in the communication package customized to gender and vulnerable groups? | which component of training they feel is most useful and why; capturing suggestions they have; perceptions regarding inclusive nature of the communication packages (gender and vulnerable groups) | • KIIs with block level officials, CSO partners, master trainers<br>• IDIs with FLWs |
|---|---|---|---|
| **EQ7: To what extent was the training able to build the skills and capacity of FLWs to counsel and support parents/caregivers on parenting care?** | **SEQ 7.1**: To what extent there was change in knowledge, attitude and perceptions of FLWs on the role of parenting on ECD?<br><br>**SEQ 7.2**: What factors influenced in building the skills and capacities of FLWs?<br><br>   o Factors around: implementation modality, quality of master trainers, gender of master trainers, socio-demographic characteristics of FLWs, etc. | • Stakeholders (govt, CSO partners) views and evidences on how intervention contributed to change in KAP of FLWs; best way/s to impart training; lessons learnt; challenges<br>• Pre-post analysis of KAP levels of FLWs; views and evidences from FLWs on quality of training imparted; challenges; support received from line-managers, other stakeholders | • Quantitative survey with FLWs<br>• KIIs with CSO implementing partners<br>• KIIs with district and block officials of ICDS, CSO partner, master trainer<br>• Case studies |
| | **SEQ 7.3**: Did the training lead to intended changes in communication style and behaviour of FLWs when engaging with parents/caregivers?<br><br>**SEQ 7.4**: Did the training build the skills | • Stakeholders (govt, CSO partners) views and evidences on how intervention contributed to change in communication style and behaviour of FLWs; challenges<br>• Analysing FLW interactions with | • KIIs with CSO implementing partners<br>• KIIs with block level officials, CSO partners, master trainers<br>• IDIs with FLWs<br>• Case studies |

| | of FLWs to counsel the fathers of children? | parents/caregivers; their confidence levels, adapting messages suitable to target group (mother/father/other family members etc); demonstration capabilities; effective utilization of job aids<br>• Perception of FLWs on how they see the change in their communication style and behaviour and how project contributed to the same | |
|---|---|---|---|
| **EQ8: To what extent did FLWs effectively transfer their learnings to the parents/caregivers on parenting care and creating a learning environment at home?** | **SEQ 8.1**: Were specific strategies adopted to reach out to parents/caregivers across gender and various vulnerable groups?<br><br>*(FLWs reaching out to fathers, challenges faced, suggestions for reaching out to fathers and other caregivers)*<br><br>**SEQ 8.2**: What were the barriers and challenges faced by FLWs in the effective transfer of knowledge to parents/caregivers? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on how FLWs used the learnings in the community; strategies FLWs adopt to reach parents of vulnerable groups; barriers and challenges faced; lessons learnt<br>• FLWs views and evidences on how they use the learnings in the community; strategies they adopt to reach parents of vulnerable groups; barriers and challenges faced | • IDIs with FLWs<br>• KIIs with CSO implementing partners, master trainers<br>• IDIs with parents/caregivers |
| **EQ9: To what extent were existing platforms used effectively to reach caregivers for counselling? (e.g. Anganwadi centres and home visits)** | **SEQ 9.1**: To what extent FLWs optimally utilized the contacts points (Mothers meeting, PAM, community meetings, home visits) that they have with parents/caregivers for delivering quality of ECD services?<br><br>**SEQ 9.2**: What problems and challenges hindered FLWs for not utilizing the contact points effectively? | • FLWs views and evidences on how they utilize existing institutional platforms to reach out to parents/caregivers to deliver ECD services; which platform is most common; which platform is most effective; reaching out to fathers, did they manage to reach out, what were the barriers and challenges, what are their suggestions for reaching out to fathers and other caregivers? | • IDIs with FLWs<br>• KIIs with block level officials of government dept, CSO partner, master trainers<br>• IDIs with parents |

| **Efficiency** | | | |
|---|---|---|---|
| **EQ10: To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes?** | **SEQ 10.1**: To what extent effective coordination and collaboration with existing govt. programmes and interventions were made during the implementation? * | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on the adequacy of current human resources/capacities; exiting gaps in the required number of staff; cope up strategies in areas where there are no staff currently; convergence and alignment with other ongoing interventions/programmes | • KIIs with district/block officials of government dept<br>• KIIs with CSO implementing partners, UNICEF staff members |
| **EQ11: How the existing government platforms for continuing education and training has been used to bring efficiency?** | **SEQ 11.1**: To what extent the sector meeting and ICDS supervisor visits has been leveraged for project efficiency? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on utilization of sector meetings and efficient use of monitoring visits of supervisors | • KIIs with block officials of government dept<br>• KIIs with CSO implementing partners, UNICEF staff members |
| **Sustainability** | | | |
| **EQ12: Is the intervention and implementation modality scalable to other areas of the state?** | **SEQ 12.1**: To what extent the models for promoting parental involvement (communication package, training modules, capacity building and monitoring) adopted in the project, scalable to other districts?<br><br>**SEQ 12.2**: What are the issues and challenges in design or implementation if any, that need to be addressed before scaling up the interventions? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on the scalability of the intervention); issues and challenges and how they can be addressed for effective scale-up; replication of inclusive nature of the intervention (gender and equity aspects) | • KIIs with officials of government dept (state/district)<br>• KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members |
| **EQ13: Are any of the positive results of the** | **SEQ 13.1**: What are the positive results and which of these results are likely to be sustained? Why? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on sustenance of positive results (likely/unlikely to | • KIIs with officials of government dept (district/block) |

| | | | |
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| **intervention likely to be sustained?** | **SEQ 13.2**: Are any areas of the intervention clearly unsustainable? What lessons can be learned from such areas?<br><br>**SEQ 13.3**: What are the major factors that influenced the achievement or non-achievement of sustainability of the intervention? | sustain and why?); major factors influencing the sustainability of the intervention; how these can be addressed | • KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members |
| **EQ14: To what extent there is government ownership to sustain the focus on parenting care for improved ECD services?** | **SEQ 14.1**: What are the specific components in which the state government would continue the focus on parenting care for improved ECD services?<br><br>**SEQ 14.2**: To what extent the sub-district, district and state-level officials of ICDS and Health have been involved in the project intervention? | • Stakeholders (govt, UNICEF, CSO partners) views and evidences on future strategies, focus areas and how it aligns with current programme components; involvement of government stakeholders at different levels in the current intervention | • KIIs with officials of government dept (state/district)<br>• KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members |

# Annexure 10: Primary Data Collection and Quality Assurance

## a. Primary Data Collection

The COVID-19 pandemic impacted the normal ways of work immensely. During the time of evaluation, there was uncertainty as to when the situation would return to normal. Since the on-field data collection was not possible in current pandemic circumstances, the evaluation team collected the required data remotely via **telephonic survey**. During telephonic survey, the trained interviewers contacted and gathered the information from the respondents over telephones/cellular phones.

### Primary data collection team recruitment, training, pilot orientation and placement

**Engagement of Appropriate Study team**: The evaluation team mobilized and engaged qualified and experienced study team (separately both for quantitative and qualitative study) from the empanelled list for undertaking the survey. The supervisors and investigators who could speak the local language or having past experience of conducting studies in the study States were recruited.

**Team structure and detailed responsibility**



Besides the data collection team (DCOR), Athena staff also supported in conducting select state and district level KIIs.

### Activities before data collection

**Translation of Questionnaires and Topic Guides:** We translated all the study instruments into the local languages (Hindi and Marathi). The quality assurance of the translation was made before administering the questionnaires and topic guides for the testing.

**Recruitment of the Data Collection Team:** The following key processes were adopted for the recruitment of the data collection team.

- The data collection team comprised of only female researchers.
- The quantitative survey team included 20 enumerators and the qualitative survey team comprised of 8 enumerators. Two supervisors per state were deployed.

- The female researchers empanelled/associated with DCOR from the relevant study areas were screened and suitable candidates were identified for data collection.
- Emphasis was given to those researchers who had prior experience of conducting surveys/studies (especially who conducted phone surveys).
- Researchers possessing a hold over the local language and the context of the study states were selected. Separate teams were placed in each state for the quantitative and qualitative data collection.

**Training of main data collection team**

- The training was conducted remotely over Zoom as per the agenda.
- Keeping the number of researchers in mind, the training was organised over a week.
- Separate training sessions were conducted for the teams, one for the FLW survey team and another for the qualitative team.
- The training sessions were undertaken in Hindi language. The training sessions were recorded for the later reference of the participants.

## Pilot testing

**Field Testing of Questionnaires and Topic Guides:** Before the training, pilot testing of both quantitative and qualitative study instruments was conducted by the study team.

Soon after the testing, team conducted the de-briefing sessions to capture takeaways from the same, which were used to make necessary modifications in the questionnaires and topic guides.

The pilot-testing of the tools helped the team to:

a) Make the design, language, logic, response options, etc. contextually relevant.
b) Helped in grounding of evaluation team members on the questionnaires and topic guides
c) Helped in developing the CAPI applications and build logic checks and skips in the applications.
d) Minimized the scope of changes in the questionnaires and topic guides during actual data collection.

## Actual data collection process

**FLW Survey**

- The respondents' (Frontline Workers) valid contact numbers were obtained from UNICEF state teams/CSO partners.
- The respondents were interviewed by the enumerators, over telephone/cellular phone.
- Before the actual interview, the respondent was contacted by the investigator to inform regarding the evaluation and invite them to participate in the interview. If the respondent consented to participate in the interview, a suitable date and time was agreed taking the respondent's comfort and availability into consideration.
- Before the start of actual interview on the agreed date and time, investigator reconfirmed the availability of the respondent just before the start of the interview. If the respondent was not in a position to share information comfortably at that time, the interview was rescheduled at a mutually convenient time.

- The verbal consent of the respondent for the interview was taken over phone just before the interview.
- While conducting the interviews with the FLWs over phone, the data was fed directly into CAPI by the interviewer.
- Prior consent was obtained from the respondent to record the interview. Only if the respondent provided the consent, the interview was recorded. If the respondent did not provide consent to be recorded but provided consent for interview, then investigator moved ahead with the interview without recording.

## Key Informant Interviews (KIIs) - stakeholders

- The KII participants' valid contact numbers were obtained from UNICEF.
- The respondent was interviewed by the facilitator over telephone/cellular phone.
- The interview was scheduled according to the respondent's convenience.
- The verbal consent of the respondent for the interview was taken over phone just before the interview.
- The key informant interviews were recorded with prior consent and later transcribed by listening to the audio files.
- Prior consent was obtained from the respondent to record the interview. Only if the respondent provided the consent, the interview was recorded. If the respondent did not provide consent to be recorded but provided consent for interview, then investigator did not move ahead with the interview without recording (as there is no note taker to take the notes).

## In-Depth Interviews (IDIs) - FLWs

- Team conducted the master trainer interviews (KIIs) before conducting the FLWs IDIs
- Evaluation team sourced recommendations from the interviewed master trainers (lady supervisor/ASHA facilitator) to identify 3 FLWs (AWWs and ASHAs each) who are active in delivering services to HHs with children less than 6 years within their sector
- From the list of 3 recommended FLWs, one was selected randomly
- Once the FLWs were identified, their contact numbers were obtained from the master trainers
- The identified FLWs were interviewed by the facilitators over telephone/cellular phone.
- After the interview with the selected FLWs (recommended by master trainer) was done, the evaluation team requested the interviewed FLW to identify 3 FLWs (AWWs and ASHAs each) who generally face issues in the community in the delivery of services to HHs with children below 6 years of age
- From the list of 3 FLWs recommended, one was selected randomly for the interview
- In total, data collection team conducted 2 AWW and 2 ASHA IDIs in each selected sector (i.e., sector of interviewed master trainer)
- The interview was scheduled according to the FLW's convenience.
- The verbal consent of the FLW for the interview was taken over phone just before the interview.
- The in-depth interviews were recorded and later transcribed by listening to the audio files.
- Prior consent was obtained from the FLW to record the interview. Only if the FLW provided the consent, the interview was recorded. If the FLW did not provide consent to

be recorded but provided consent for the interview, then investigator did not move ahead with the interview (as there was no note taker to take the notes).

**In-Depth Interviews (IDIs) – parents/caregivers**

- Evaluation team asked the AWW interviewed to recommend three enthusiastic parents and three parents who have not been receiving/ willing to receive any services related to their child in their community (mother and father each). The social category, distance from AWC, gender of the child for each nominated parent were noted
- Phone numbers of the nominated parents were obtained from AWW
- From among the list of 3 mothers and 3 fathers recommended as active parents and 3 mothers and 3 fathers recommended as resistive parents, one mother and one father were selected from each group randomly
- The selected parents (from nominated list) were contacted by team and were included in the IDI
- In case AWW mentioned that there was no family within her village who do not take up any services, then the interviewed active parents were requested to identify three parents (recommendations for mother was sourced from interviewed mother and for father likewise) who have not been receiving/ willing to receive any services related to their child in their community
- The sampled parents/caregivers were contacted prior to the interview to obtain consent and fix a suitable date and time for the interview
- The respondent was interviewed by the facilitator over telephone/cellular phone.
- The interview was scheduled according to the respondent's convenience.
- At the scheduled time one facilitator interviewed the participant over phone.
- The verbal consent of the respondent for the interview was taken before commencing the interview.
- The in-depth interviews were recorded and later transcribed by listening to the audio files.
- Prior consent was obtained from the respondent to record the interview. Only if the respondent provided the consent, the interview was recorded. If the respondent did not provide consent to be recorded but provided consent for interview, then investigator did not move ahead with the interview without recording (as there was no note taker to take the notes)

## b. Quality Assurance Mechanisms

**Development of CAPI application for electronic data collection**: The CAPI version of the questionnaire was developed after the paper version of the same is pilot tested and finalised. Team deployed an IT Expert for developing the android application software which was installed and used on android operating system-based tablets during data collection. Open Data Kits (ODK) data collection software was used for developing the CAPI application, which is an android based open source data collection tool developed by Google. The software was supported by a backend server, a mobile client, 'ODK collect' for data collection and ODK Aggregate as a server application to generate basic graphs, visualize data using maps and to export data in CSV files.

- **Developing tools software:** The ODK software with its Xforms technology was used to design the data collection forms. The finalized FLW questionnaire was converted into

data collection survey forms, through XLS Form syntax in Excel. Data entry errors were minimized by programming acceptable data value ranges, skips, and error messages into the data collection forms.

- **Pre-testing:** We adopted a two-stage pre-test of the ODK survey application. In the first stage the mobile tools were circulated to the core study team to test for its validity and consistency. Then, the tool was tested during pilot testing of FLW survey tool jointly by the core survey team and IT expert.

- **Devices/Type of mobiles:** The assessment forms developed using ODK platform were downloaded into android tablets of data collection team with ODK Collect mobile app. The ODK Collect is a mobile container, which serves for forms download, filling, and submitting to the server.

- **Database creation and management:** Database was created using MySQL Server for the systematic storage of collected data in a readily analyzable form. The data dictionary/code book was developed to define column attributes, specify the range of allowable values, and standardize data coding (e.g, yes = 1, no = 0). Data entry errors were minimized by programming acceptable data value ranges and error messages into the data collection software. Additional cleaning and editing of data for outliers and inconsistencies were performed on an ongoing basis during the data collection phase.

- **Security and confidentiality:** ODK application used for data collection was protected using passwords. Interviewers were needed to login to the system to access the surveys and to upload data. All uploaded data were stored under password protection and only authorized personnel had access to the password(s). All data were transmitted electronically from the mobile ODK application via secured SSL connection to the server. The data were extracted in csv files for analysis.

- **Use of CAPI**: Data collection using CAPI helped to reduce errors in data collection and data entry to a great extent. The ODK application was developed with all logic and validation checks. There were mandatory field and validation controls to prompt the enumerator to check the survey forms before saving or uploading in the application. This helped to get data on real time basis to track and assess the quality of data collected in the field.

- **Data validation**: Each evening the data published by the teams were run through a validation system in the server – which highlighted blank fields, data entry errors, etc.

- Further, UNICEF constituted an Evaluation Reference Group (ERG) to ensure quality assurance of the evaluation. ERG supported the evaluation by providing strategic direction and technical inputs and bringing critical issues to the notice of the Evaluation agency.

## Limitation of conducting interviews over phone/remotely

| Sl. no | Limitation | Mitigation strategy |
|--------|-----------|---------------------|
| 1. | Multiple technical issues arose during telephonic interviews like bad network signal strength, faulty handset, lack of charge in the battery etc. | Prior to the interview, the enumerators dialed and requested the participants to attend the interview in a network area of good strength and to keep the battery fully charged. |

| 2. | Some contact numbers obtained were not correct, reachable and/or invalid | Evaluation team coordinated with UNICEF state teams/CSO partners to obtain the updated contact of FLWs to the best extent possible |
|---|---|---|
| 3. | In a telephonic interview, fatigue can creep in much faster leading to inefficient interaction at the later part of the interview. | Prior to the interview, the enumerators made all possible attempts to build up a good rapport with the respondent, made her understand the value of her responses, and conducted the interview in an engaging manner so as to keep the respondent engaged for long. |
| 5. | The lack of non-verbal engagements by the interviewer as well as the interviewee during a telephonic interview might lead to sub-optimal communication | |
| 6. | In the physical absence of an interviewer, the respondent may exhibit systematic response bias | |
| 7. | FLWs willingness to participate in the telephonic surveys | Evaluation team with the support from UNICEF/ CSO partners made all possible attempts to garner support of FLW supervisors at block (CDPO, Lady Supervisors) to seek their help in persuading FLWs to cooperate with the survey team by explaining them the importance of the study. Also, as a mitigation measure, evaluation team included a buffer of 100% for FLW quantitative survey to account for the potential non-response rate. |

# Annexure 11: Remote Data Collection, Challenges and Mitigation Measures

## Strategy for Remote Data Collection

Initially, the evaluation team planned to collect all the primary data in-person on the field. But, due to unexpected circumstances created by the COVID-19 pandemic, in-person on the field data collection was not possible. Therefore, the evaluation team in consultation with UNICEF Country and State offices decided to collect all the primary data remotely (via phone survey).

Following the decision to collect all the primary data remotely, the evaluation team adapted the study tools and evaluation design (in consultation with UNICEF ICO and state offices) to account for possible risks involved in the remote data collection strategy. The following necessary revisions/ adjustments were made during the inception phase to adapt the evaluation to remote data collection strategy –

- The FLW quantitative tool which was quite lengthier was trimmed down to optimal level with an objective to complete the interview via phone survey within 30-35 minutes

- Additional line of evidence – *IDIs with FLWs* was added to qualitative answer the questions dropped during the FLW quantitative tool trimming process

- Further, the FGDs planned with parents/caregivers (0-3 and 3-6 child) was replaced with IDIs

- The evaluation team in consultation with UNICEF ICO and state offices created a matrix mapping quantitative and qualitative lines of evidence with KEQs/SEQs to strategically spread the information across the respondents which helped in tailoring the study tools to each respondent strategically

## a. Pilot testing of study tools

The draft study tools adapted to remote data collection strategy were rigorously tested twice during **Pilot 1** (24th – 26th Aug 2020) and **Pilot 2** (14th – 16th Oct 2020).

Pilot 1

Pilot testing - 1 of study tools (FLW quantitative survey tool, FLW IDI guide, and parents/caregivers IDI guides) was conducted from 24th – 26th August 2020. A total of 15 interviews were conducted (refer to *Annexure 2* for more details). The following risks were identified, and the appropriate mitigation measures were suggested –

### i. FLW Survey

| Potential issue | Mitigation plan/ recommendation | Support required from UNICEF |
|---|---|---|
| • The trimmed version of the FLW quant tool taking a longer time than expected (AWW tool ~ 60 mins and ASHA tool ~ 45-50 mins) | Relook into the tool once again to identify some additional non-priority questions to be dropped | Review the recommendations from the evaluation team in dropping the non-priority questions |
| • Contact numbers – invalid, wrong, switched off/ not reachable | Source updated contact numbers from the program team. Use an 'Odd' and 'Even' sampling strategy to | UNICEF to support in sourcing the valid contact numbers (or) recheck the available phone numbers and update the same wherever possible. |

| | |
|---|---|
| | mitigate the potential lower response rates. | |
| • Network issue/ Background noise | Data collection team to ensure that the respondents are in the area of good signal strength and also request the respondent during the appointment calls to ensure that they are located in the area of decent signal strength. Further, team to request the respondent to be located in a peaceful area for smooth discussion. | |
| • FLWs not providing consent to participate (as they have not received any information from their line manager/superiors) | Inform the state, district, block, sector-level officials regarding the evaluation and urge them to pass on this information to their respective staff and encourage FLWs to participate in the interview | UNICEF to support in obtaining official support letter from government in two states and support in informing the state, district, block, and sector level officials regarding the evaluation via their network (potentially program team and CSO partners) |
| • Organizing /scheduling the interviews | Be flexible in organizing early morning or late evening interviews to account for the availability of FLWs | - |
| • FLWs finding it difficult to distinguish the different trainings received | • To the extent possible probe for the type of training received<br>• Use locally used terms for trainings FLWs generally receive such as ILA, ECCE | UNICEF to recommend locally used terms for ILA, ECCE, ECD trainings to be included in the probes in the FLW tool |
| • FLWs unable to identify the position/role of the person who provided the training | As per the suggestion of program team, probe by asking FLWs if the trainer was from ICDS, health department or private organization. Add relevant options in the FLW quant tool | |

## ii.    Parents/ caregiver IDIs

| Potential issue | Mitigation plan/ recommendation |
|---|---|
| • Organizing /scheduling the interviews | Be flexible in organizing early morning or late evening interviews to account for the availability of parents |
| • The time frame of services provided by FLWs | Add a note in the qualitative IDI guides to probe for services received/ meetings attended before COVID (before Mar 2020). |
| • Asking FLWs to list/ recommend parents – potential biases | To avoid the risk of select bias in selecting parents from the list recommended by AWWs, the data collection team to ask the AWWs to indicate the social category of the parents and probe for the distance of the parent's location from the AWC. |

After Pilot – 1, the evaluation team had a debriefing call with the UNICEF ICO. Further to the discussion, the FLW quantitative tool was further trimmed down and the specific questions dropped from the FLW quant tool were added in the FLW IDI tool. Necessary updates were made

in the Hindi/ Marathi translations related to the technical terms. One of the key findings from Pilot – 1 was invalid/ switched off status of FLW's contact numbers. In this context, Pilot – 2 was planned to further deep-dive into testing core technical terms local translations, closely monitor the time duration for each tool, and check the validity of the contact numbers.

**Pilot 2**

Pilot – 2 was conducted from 14th – 16th Oct 2020 covering 8 FLWs. Additionally, about 135 FLWs contact numbers from select blocks were dialed in for validity checks. The main findings from Pilot -2 were –

- The FLW quantitative survey time duration was within optimal levels (AWWs ~ 40-45 mins and ASHAs ~ 35- 40 mins)
- The updated translations for key technical terms was more easily understandable for FLWs when compared to previous translation of these terms
- The clear statement added before the start of the interview that all the discussions will pertain to the period before COVID-19 (Mar 2020) helped in avoiding any confusion related to the period of discussion.
- The invalid/ switched-off/ not reachable cases were quite high

Following Pilot – 2, the evaluation team again had a de-briefing call with UNICEF ICO. In view of high invalid/ non-contactable numbers, it was decided that UNICEF ICO would ask the respective state teams to support in re-checking the available contact numbers and provide updated contact numbers to the best extent possible.

## Main Data Collection – Risks and Mitigation Measures

- The strategy to dial in the numbers which are *switched off/ out of network area/ not reachable/ unanswered* for seven times over three days helped in reaching out to the respondents and fixing the interviews to push the response rate up
- Wherever the team was not able to reach out to odd-numbered respondents, the team relied on even-numbered respondents. This strategy as well aided in pushing the response rate.
- Team was flexible in fixing calls in the evenings at the respondent's convenience (specifically with respondents from tribal blocks). This flexible nature of the team aided in encouraging respondents to participate in the interview.
- In few blocks in Rajasthan and Maharashtra, an additional sample was needed to be supplied as the team was unable to meet the target sample for that block with odd and even-numbered samples combined, as in these blocks, we mostly had old contact numbers (most of which were not reachable) and had less/no updated contact numbers for those blocks.
- In some sectors where there were a large number of unreachable contacts, in such sectors, the team requested the FLWs whom they managed to interview to help them source the updated contact numbers of uncontactable FLWs from their respective sectors. This helped in reaching out to more FLWs.
- Few FLWs who provided us a date for the interview did not pick the call even after multiple attempts. In such cases, the team relied on the even-numbered sample for their replacement. Similarly, during parent's IDIs as well, few parents who provided an

appointment did not pick the call thereafter even after multiple attempts. In such cases as well, the team relied on the extra sample recommended by the AWWs.

## Outcome of Quality Checks

### A. High-Frequency Checks (HFCs)

1. **To detect errors**:

   a) **Survey coding**: Responses to questions with skip patterns were analysed and it was observed that all the skip patterns in the CAPI were working correctly

   b) **Missing data**: Quality checks were done to identify if there are completely blank rows (or) questions that were skipped more than others (or) if there are questions that no respondent answered. Three missing rows were observed which were blank. These were the interviews that were initiated but since the respondent had to drop due to some emergency, the interview was ended and conducted later. These three blank rows will be removed in the final cleaning process.

   c) **Categorical variables**: Quality checks were done to identify if there are interviewers whose interview data shows high 'don't know'/ 'No' / 'nothing'. The analysis shows that such responses were minimal (less than 2% for most of the questions).

   d) **Too many similar responses**: We ran an analysis to identify if there are questions where most of the respondents answered in the same way. This was not the case across the variables except for one variable on the mother's meeting where most of the responses were 'yes'. But this was not the case with 'father's meeting' where the responses were a mix of options.

   e) **Outliers**: As all the open-ended questions were qualitative and there were no quantitative open-ended questions in the FLW survey, identifying outliers was irrelevant

   f) **Respondent IDs**: We have PSU codes as the unique identifier in the FLW survey. Quality checks were done to identify if there were duplicates in the unique identifier (PSU code), blank or invalid IDs. Although no blank and invalid unique IDs were detected, overall, about 2% of AWWs and 1.5% of ASHA responses had duplicate IDs. These IDs were noted by the team and conveyed to DCOR for follow-up. These specific duplicates were followed-up and traced by the supervisors and the correct IDs were identified.

2. **To monitor survey progress and track respondents**

   a) **Survey duration**: The time taken for each interview was analysed. The average time duration for the AWW interview was around 41 minutes and for ASHAs the average time duration was around 32 minutes. Outliers were detected in terms of abnormally high or low time durations in about 3 percent of the cases. These cases were tracked and rectified.

   b) **Monitoring progress**: We internally have set up an online monitoring excel sheet which is updated once every two days. This helped us monitor the progress of the no. of interviews being conducted and to identify areas where the survey was moving slowly

### B. Back-Checks (BCs)

A short-structured questionnaire (*refer Annexure 5*) was used for checking the quality of the FLW survey data that systematically back-checked the information from already interviewed FLWs. This was done by re-interviewing some FLWs randomly by the supervisors and checking the results with what was collected by the interviewer. We included only static questions in the back-check tool the responses to which would not change regardless of the interview (e.g. type of respondent, PSU area, religion, social category, date of birth, marital status). Back-checks helped reduce two types of problems that could potentially affect the accuracy of the survey data.

1. First, back-checks were used to check that the interviewer actually interviewed the selected FLWs or not. Sometimes interviewers either inadvertently locate the wrong FLWs or they may deliberately interview an FLW, thus making it easier to finish their work quickly.
2. Second, to estimate the extent of errors which the investigators could have made

The back-check questionnaires were filled in by the supervisors. The back-checked data was then matched with the original response from the main dataset. In total, about 8 percent of the total responses were back-checked. Below, we provide a snapshot of the extent of error observed in each question included in the back-check.

| Q.No | Question | Error rate (in %) |
|---|---|---|
| PSU Code | Is the PSU Code entered correct? | 1.96% |
| Type of respondent | Is the respondent AWW? | 0% |
| | Is the respondent ASHA? | 0% |
| 101 | What is your name? | 0.98% |
| 103 | What is your Date of Birth? | 4.9% |
| 104 | What religion do you follow? | 0.98% |
| 105 | Which social category do you belong to? | 5.88% |
| 106 | Marital Status | 0% |
| 107 | What is the highest level of education that you have attained? | 2.94% |
| 506A | Did you receive any communication material/ tool to counsel parents/caregivers on positive parenting and early childhood development in the past two years? | 1.96% |

An effort was made to conduct the back-checking on the same day of the interview (or) at least on the following day, which helped to estimate the error rates and update the team accordingly.

## C.  Spot-Checks (SCs)

The supervisor observed each interviewer multiple times throughout the course of data collection. Each interviewer was listened during the first two days of data collection so that any errors made consistently are identified and rectified immediately. Additional observations of each interviewer's performance were made during the rest of the data collection period on a rotational basis. All the supervisors observed at least one interview per day of each field investigator during the course of the data collection.

During the interviews, the supervisor listened to the interviewer being on the same call. This way, they checked if the investigator interprets the respondent correctly and follows the proper skip

patterns. The supervisor made notes of problem areas and points to be discussed later with the interviewer. The supervisor did not intervene during the course of the interview and ensured to conduct herself in such a manner as not to make the interviewer or respondent nervous or uneasy. After each observation, the field supervisor and interviewer discussed the interviewer's performance. Overall, about 15 percent of the interviews were spot-checked.

The supervisors met daily with the interviewers at the end of the day via conference call to discuss the quality of their work and progress made. During these team meetings, the supervisor pointed out the mistakes discovered during the observation of interviews. In most cases, mistakes were corrected immediately and the interviewing style was improved by pointing out and discussing errors during these meetings. The supervisor discussed the examples of actual mistakes identified during spot checks. Also, during the meetings, they encouraged the interviewers to talk about any situations they encountered during the data collection with the larger team for cross-learning. The group discussed whether or not the situation was handled properly, and how similar situations should be handled in the future. Team members learned a lot from one another in these meetings.

## Lessons learnt

We had some excellent lessons to learn from the remote data collection strategy we deployed for the current endline evaluation. Some of the key lessons learnt are –

- The detailed planned during the inception phase to adapt the whole evaluation to the remote data collection strategy was pivotal for the successful data collection

- Clear identification of potential risks via two rounds of rigorous pilot testing of study tools aided immensely in terms of –

  o Strategically tailoring study tools to specific respondents to execute each tool within 30 mins

  o Think through the possible mitigation measures which are pragmatic and practical in application

  o Have a plan B in case Plan A is not successful ('Odd' and 'Even' & additional sampling strategy)

  o Evidencing the need to re-check the available contact numbers and update the same

- Informing the government officials at different levels (block, district, and state) via UNICEF state offices and CSO partners, and supporting letter from the state government aided in garnering support from the government

- **Odd-Even sample**: The Odd-Even sampling strategy helped in mitigating potential risks of low response rate by substituting the primary sample (ODD) with secondary sample (EVEN) in case the primary sample is not reachable

- **Dialing respondents at different times:** The strategy to dial-in the switched-off/ not reachable/ out of network area contacts seven times over a period of three days aided in pushing the response rate up

- **Flexibility of team in organizing the interviews:** The flexible nature of the data collection team in fixing the interviews early morning/ late evenings at the respondent's

convenience (specifically with respondents from tribal blocks) assisted in including more respondents in the interviews

- **Additional sampling (resampling):** In some blocks where the team was unable to meet the target sample for that block with odd and even-numbered samples combined, the additional sample (resampling) aided in filling the gap

- **Continuous coordination with CSO partners**: For blocks where the supervisors/ FLWs were not providing the consent/ willing to participate in the survey, the data collection closely coordinated with the respective CSO partners to leverage their local connections with block/district level officials in convincing the supervisors/ FLWs to participate in the study

## Analysis of sample covered from 'Odd' and 'Even' Sample & no. of attempts

Overall, 87.7% of the sample was achieved from the original sampled list and the remaining (12.3%) was achieved from the additional sample list (resampling). Both the original sampled list and the additional list had 'Odd' and 'Even' sample. The tables below present an overall analysis of the number of attempts made for each category (AWW/ ASHA) in two states.

| | | Odd or even | | | | | |
|---|---|---|---|---|---|---|---|
| | | Odd | | Even | | Total | |
| | | Count | Column N % | Count | Column N % | Count | Column N % |
| Number of attempts conducted for AWW interview in Rajasthan | 1 Attempt | 42 | 15.3% | 32 | 18.2% | 74 | 16.4% |
| | 2 Attempts | 115 | 41.8% | 70 | 39.8% | 185 | 41.0% |
| | 3 Attempts | 44 | 16.0% | 27 | 15.3% | 71 | 15.7% |
| | 4 Attempts | 37 | 13.5% | 25 | 14.2% | 62 | 13.7% |
| | 5 Attempts | 23 | 8.4% | 12 | 6.8% | 35 | 7.8% |
| | 6 Attempts | 9 | 3.3% | 4 | 2.3% | 13 | 2.9% |
| | 7 Attempts | 5 | 1.8% | 6 | 3.4% | 11 | 2.4% |
| | Total | 275 | 100.0% | 176 | 100.0% | 451 | 100.0% |

| | | Odd or even | | | | | |
|---|---|---|---|---|---|---|---|
| | | Odd | | Even | | Total | |
| | | Count | Column N % | Count | Column N % | Count | Column N % |
| Number of attempts conducted for AWW interview in Maharastra | 1 Attempt | 60 | 19.3% | 29 | 17.1% | 89 | 18.5% |
| | 2 Attempts | 152 | 48.9% | 97 | 57.1% | 249 | 51.8% |
| | 3 Attempts | 29 | 9.3% | 7 | 4.1% | 36 | 7.5% |

| | | 31 | 10.0% | 19 | 11.2% | 50 | 10.4% |
|---|---|---|---|---|---|---|---|
| | 4 Attempts | 31 | 10.0% | 19 | 11.2% | 50 | 10.4% |
| | 5 Attempts | 17 | 5.5% | 4 | 2.4% | 21 | 4.4% |
| | 6 Attempts | 8 | 2.6% | 3 | 1.8% | 11 | 2.3% |
| | 7 Attempts | 14 | 4.5% | 11 | 6.5% | 25 | 5.2% |
| | Total | 311 | 100.0% | 170 | 100.0% | 481 | 100.0% |

| | | Odd or even | | | | | |
|---|---|---|---|---|---|---|---|
| | | Odd | | Even | | Total | |
| | | Count | Column N % | Count | Column N % | Count | Column N % |
| Number of attempts conducted for ASHA interview in Rajasthan | 1 Attempt | 15 | 17.0% | 16 | 30.2% | 31 | 22.0% |
| | 2 Attempts | 30 | 34.1% | 22 | 41.5% | 52 | 36.9% |
| | 3 Attempts | 19 | 21.6% | 5 | 9.4% | 24 | 17.0% |
| | 4 Attempts | 7 | 8.0% | 6 | 11.3% | 13 | 9.2% |
| | 5 Attempts | 10 | 11.4% | 4 | 7.5% | 14 | 9.9% |
| | 6 Attempts | 5 | 5.7% | 0 | 0.0% | 5 | 3.5% |
| | 7 Attempts | 2 | 2.3% | 0 | 0.0% | 2 | 1.4% |
| | Total | 88 | 100.0% | 53 | 100.0% | 141 | 100.0% |

| | | Odd or even | | | | | |
|---|---|---|---|---|---|---|---|
| | | Odd | | Even | | Total | |
| | | Count | Column N % | Count | Column N % | Count | Column N % |
| Number of attempts conducted for ASHA interview in Maharastra | 1 Attempt | 27 | 21.1% | 11 | 33.3% | 38 | 23.6% |
| | 2 Attempts | 48 | 37.5% | 17 | 51.5% | 65 | 40.4% |
| | 3 Attempts | 25 | 19.5% | 3 | 9.1% | 28 | 17.4% |
| | 4 Attempts | 9 | 7.0% | 1 | 3.0% | 10 | 6.2% |
| | 5 Attempts | 10 | 7.8% | 1 | 3.0% | 11 | 6.8% |
| | 6 Attempts | 6 | 4.7% | 0 | 0.0% | 6 | 3.7% |
| | 7 Attempts | 3 | 2.3% | 0 | 0.0% | 3 | 1.9% |
| | Total | 128 | 100.0% | 33 | 100.0% | 161 | 100.0% |

# Annexure 12: Evaluation team composition and roles

| Name | Proposed position | Gender | Staff/Consultant | No. of person days | Key roles and responsibilities |
|---|---|---|---|---|---|
| Monisha Singh Diwan | Team Leader | Female | Consultant – Athena | 31 | • Overall, responsible for delivery of entire gamut of tasks and deliverables<br>• Provide a nuanced understanding of ECD domain to the team for incorporation in the design and analysis<br>• Lead the team in providing thematic area related nuances for planning and delivering the assignment<br>• Responsible for providing technical direction to the assignment: Inputs for designing the study, instruments, and analysis<br>• Ensure timely and quality delivery<br>• Provide thought leadership<br>• Conduct state level KIIs – govt officials, UNICEF staff (Maharashtra)<br>• Provide gender/equity lens to the evaluation |
| Francis Rathinam | Evaluation Expert | Male | Staff – Athena | 27 | • Play a leadership role (evaluation and learning aspects) in conjunction with the Team Leader<br>• Responsible for leading 'specific evaluation and learning outputs'<br>• Provide management backstopping<br>• Lead study designs and methods<br>• Provide inputs on designing the study, instruments and analysis<br>• Contribute in the review of ToC<br>• Guide the team during the analysis stage and report writing<br>• Lead/ oversee evaluation & learning consultations |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | • Conduct state level KIIs – govt officials, UNICEF staff (Rajasthan) |
| Bilal Afroz | Quantitative researcher | Male | Staff – Athena | 33 | • Support Team Leader and Evaluation expert in quality and timely delivery<br>• Ensure coordination of team members<br>• Tracking of deliverables, timelines, inputs from team members and submission to UNICEF<br>• Responsible for quantitative data analysis – FLW survey data<br>• Provide support in study designs and survey instruments<br>• Support in conducting select district level KIIs |
| Manoj Parida | Survey Manager | Male | Consultant – Athena | 36 | • Overall management of field data collection, teams<br>• Ensure timely and quality data collection<br>• Conduct data validation during field data collection<br>• Share weekly updates on the progress of data collection and sample achieved<br>• Data management/ security |
| Research Associates (2) | Support personnel | Female | Consultant – Athena | - | • Support in quantitative & qualitative analysis, and report writing |

## Annexure 13: Analysis Approach

| Criteria and Evaluation Questions | Suggested sub-questions | Data sources and data collection methods | Analysis approach |
|---|---|---|---|
| **Relevance** | | | |
| **EQ1: To what extent is the parenting programme delivered by FLWs in the community (hereafter 'the intervention') relevant to the caregivers in selected districts of Maharashtra and Rajasthan?** | **SEQ1.1**: What needs of parents/ caregivers are being addressed and how well?<br><br>**SEQ1.2**: Are other relevant caregivers in the household also being addressed? | • Review of communication packages, training materials<br>• KIIs with district and block officials of government dept, UNICEF staff, CSO partners<br>• IDIs with parents/caregivers | **Qualitative**<br>• Manual review of communication packages/training materials<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on the needs of parents/caregivers being addressed by the intervention |
| | **SEQ1.3**: To what extent does the intervention factor in gender aspects?<br><br>**SEQ 1.4**: Are the gender aspects responsive to the context and UNICEF's gender programming ambitions? | • Review of communication packages, training materials<br>• KIIs with UNICEF staff, CSO partners<br>• IDIs with Parents/caregivers | **Qualitative**<br>• Manual review of communication packages/training materials<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on the inclusive nature of intervention (gender aspects) |
| | **SEQ 1.5**: To what extent does the intervention factor in equity aspects?<br><br>**SEQ 1.6**: Are the gender aspects responsive to the context and UNICEF's equity | • Review of communication packages, training materials<br>• KIIs with UNICEF staff, CSO partners | **Qualitative**<br>• Manual review of communication packages/training materials<br>• Content/comparative analysis of transcripts |

| | | | |
|---|---|---|---|
| | programming ambitions? | | developed from notes taken during KIIs <br> • Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on the inclusive nature of intervention (equity aspects) |
| **EQ2: To what extent is the training that FLWs receive to deliver the intervention relevant and adequate for the target population?** | **SEQ 2.1**: Did the training address ways to change cultural beliefs and attitudes around parenting? | • Review of communication packages, training materials <br> • KIIs with block level govt officials, Master trainers & CSO partners <br> • IDIs with FLWs | **Qualitative** <br> • Manual review of communication packages/training materials <br> • Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs <br> • Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on whether and how the training addressed cultural beliefs and attitudes around responsive parenting |
| | **SEQ 2.2**: Did the training address the gender and equity-based challenges the frontline worker experiences? | • Review of communication packages, training materials <br> • KIIs with block level govt officials, Master trainers & CSO partners <br> • IDIs with FLWs | **Qualitative** <br> • Manual review of communication packages/training materials <br> • Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs <br> • Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on whether and how the trainings aided FLWs in addressing gender and equity challenges |
| **EQ3: To what extent is the intervention** | **SEQ 3.1**: How relevant is the strategy (promoting parental involvement) for ensuring quality | • Review of project documents, literature and policy | **Qualitative** <br> • Manual review of project related documents, policy documents and guidance |

| aligned to the broader objectives of the project? | early childhood development? | documents and guidance<br>• KIIs with officials of government dept (state/district/block), UNICEF staff & CSO implementing partners | • Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on relevance of the intervention strategy |
|---|---|---|---|
| | • **SEQ 3.2**: How do the envisaged activities and outputs improve quality of counselling and communication support to parents/caregivers? | • Review of project documents<br>• KIIs with UNICEF staff & CSO implementing partners, master trainer<br>• IDIs with FLWs | **Qualitative**<br>• Manual review of project related documents<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to programme effects on FLWs ways of counselling |
| **EQ4: To what extent is the intervention aligned to the priorities of the government and other partners, specifically the Early Childhood Development strategies and plans?** | **SEQ 4.1**: To what extent the intervention is aligned to the state ECE curriculum?<br><br>**SEQ 4.2**: What are the existing activities that are being planned or carried out by the government and other partners under ECD in the two States?<br><br>**SEQ 4.3**: How is the intervention aligned with these activities? What are aspects of similarity/overlap? What are aspects of difference/divergence?<br><br>**SEQ 4.4**: Any collaborative efforts and coordination with other partners for convergence? | • Desk review (review of project documents, communication packages, training materials, literature)<br>• KIIs with officials of government dept (state/district/block), UNICEF staff<br>• KIIs with CSO implementing partners | **Qualitative**<br>• Literature review<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on existing government programmes, alignment of current intervention with these govt programmes, alignment with state ECE curriculum, convergence for impact |

| Effectiveness | | | |
|---|---|---|---|
| **EQ5: To what extent were the inputs or activities of the intervention delivered as planned, specifically: development of communication materials, training materials, training of FLWs?** | **SEQ 5.1**: Were the tools and standards developed to gauge project quality and child development and learning useful?<br><br>**SEQ 5.2**: What were the bottlenecks in terms of implementation, and why?<br><br>**SEQ 5.3**: Was timely corrective action taken, when issues emerged? | • Review of progress reports of project<br>• KIIs with CSO implementing partners<br>• KIIs with block level govt officials, UNICEF staff, CSO partners, master trainers | <u>**Qualitative**</u><br>• Manual review of project related documents<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on progress against planned activities, challenges faced, corrective actions taken |
| | **SEQ 5.4**: To what extent were the FLWs able to use the communication materials/tools in communicating with parents at the various platforms? | • KIIs with CSO implementing partners<br>• KIIs with officials of government dept, UNICEF staff<br>• IDIs with FLWs<br>• Case studies | <u>**Qualitative**</u><br>• Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs<br>• Organize, interpret and synthesis qualitative findings to understand points of agreement and contention among different stakeholders on the use of communication tools developed as a part of the intervention (particularly Sabrang cards in Rajasthan & Samvendansheel palakatv in Maharashtra)<br>• Documenting the case-studies to highlight the use of communication materials/tools by FLWs in the community |
| **EQ6: What was the quality of the training to FLWs, in terms of content, structure and delivery medium?** | **SEQ 6.1**: What did FLWs like about the training (all training programmes), what did they find useful?<br><br>**SEQ 6.2**: What did FLWs dislike about the training, what did they not find so useful and why? | • Review of communication materials, training materials<br>• KIIs with block level officials, CSO partners, master trainers<br>• IDIs with FLWs | <u>**Qualitative**</u><br>• Manual review of communication packages and training materials<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs |

| | | | |
|---|---|---|---|
| | **SEQ 6.3**: What suggestions do FLWs have for improvements?<br><br>**SEQ 6.4**: Whether messaging in the communication package customized to gender and vulnerable groups? | | |
| **EQ7: To what extent was the training able to build the skills and capacity of FLWs to counsel and support parents/caregivers on parenting care?** | **SEQ 7.1**: To what extent there was change in knowledge, attitude and perceptions of FLWs on the role of parenting on ECD?<br><br>**SEQ 7.2**: What factors influenced in building the skills and capacities of FLWs?<br><br>    o   Factors around: implementation modality, quality of master trainers, gender of master trainers, socio-demographic characteristics of FLWs, etc. | • Quantitative survey with FLWs<br>• KIIs with CSO implementing partners<br>• KIIs with district and block officials of ICDS, CSO partner, master trainer<br>• Case studies | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to likely effect of programme on KAP of FLWs<br>• Documenting the case-studies to highlight the story of an active FLW<br><br>**Quantitative**<br>• Pre-post analysis of indicators related to KAP to analyse the changes in the levels of KAP of FLWs<br>• Pearson's Chi-square tests for proportions (to test statistical significance), generate frequency tables, cross tabulations<br>• *Sub-group analysis*: State wise/type of area (rural/urban/tribal)/ FLW type/Age categories/ education level/social group of FLWs<br>• *Source*: Baseline & End-line FLW survey<br><br>*A list of indicators on KAP of FLWs (from quant tool) is provided in a separate table below to answer this EQ* |
| | **SEQ 7.3**: Did the training lead to intended changes in | • KIIs with CSO implementing partners | **Qualitative**<br>• Content/comparative analysis of transcripts |

| | communication style and behaviour of FLWs when engaging with parents/caregivers?<br><br>**SEQ 7.4**: Did the training build the skills of FLWs to counsel the fathers of children? | • KIIs with block level officials, CSO partners, master trainers<br>• IDIs with FLWs<br>• Case studies | developed from notes taken during KIIs/IDIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to likely changes in communication style and behavior of FLWs due to trainings provided<br>• Documenting the case-studies to highlight the story of an active FLW |
|---|---|---|---|
| **EQ8: To what extent did FLWs effectively transfer their learnings to the parents/caregivers on parenting care and creating a learning environment at home?** | **SEQ 8.1**: Were specific strategies adopted to reach out to parents/caregivers across gender and various vulnerable groups?<br><br>*(FLWs reaching out to fathers, challenges faced, suggestions for reaching out to fathers and other caregivers)*<br><br>**SEQ 8.2**: What were the barriers and challenges faced by FLWs in the effective transfer of knowledge to parents/caregivers? | • IDIs with FLWs<br>• KIIs with CSO implementing partners, master trainers<br>• IDIs with parents/caregivers | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs/IDIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to likely changes in ways of FLWs interact with community, strategies adopted to reach various groups, challenges faced by FLWs in the community |
| **EQ9: To what extent were existing platforms used effectively to reach caregivers for counselling? (e.g. Anganwadi centres and home visits)** | **SEQ 9.1**: To what extent FLWs optimally utilized the contacts points (Mothers meeting, PAM, community meetings, home visits) that they have with parents/caregivers for delivering quality of ECD services?<br><br>**SEQ 9.2**: What problems and challenges hindered FLWs for not utilizing the contact points effectively? | • IDIs with FLWs<br>• KIIs with block level officials of government dept, CSO partner, master trainers<br>• IDIs with parents | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to utilization of existing contact points, barriers in effective utilization of existing institutional platforms, challenges in reaching out to fathers |

| Efficiency | | | |
|---|---|---|---|
| **EQ10: To what extent was the intervention efficient in making the best possible use of available resources to achieve its outcomes?** | **SEQ 10.1**: To what extent effective coordination and collaboration with existing govt. programmes and interventions were made during the implementation? | • KIIs with district/block officials of government dept<br>• KIIs with CSO implementing partners, UNICEF staff members | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on sufficiency of human and other resources, collaborations made with existing government programme to deepen the reach and impact of the intervention |
| **EQ11: How the existing government platforms for continuing education and training has been used to bring efficiency?** | **SEQ 11.1**: To what extent the sector meeting and ICDS supervisor visits has been leveraged for project efficiency? | • KIIs with block officials of government dept<br>• KIIs with CSO implementing partners, UNICEF staff members | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to efficient utilization of sector meetings to train the FLWs |
| Sustainability | | | |
| **EQ12: Is the intervention and implementation modality scalable to other areas of the state?** | **SEQ 12.1**: To what extent the models for promoting parental involvement (communication package, training modules, capacity building and monitoring) adopted in the project, scalable to other districts?<br><br>**SEQ 12.2**: What are the issues and challenges in design or implementation if any, that need to be addressed before | • KIIs with officials of government dept (state/district)<br>• KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to scalability of the intervention, issues and challenges to be addressed before scale-up |

| | scaling up the interventions? | | |
|---|---|---|---|
| **EQ13: Are any of the positive results of the intervention likely to be sustained?** | **SEQ 13.1**: What are the positive results and which of these results are likely to be sustained? Why?<br><br>**SEQ 13.2**: Are any areas of the intervention clearly unsustainable? What lessons can be learned from such areas?<br><br>**SEQ 13.3**: What are the major factors that influenced the achievement or non-achievement of sustainability of the intervention? | • KIIs with officials of government dept (district/block)<br>• KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related to sustainability of positive results, unsustainable areas/components of the programme, factors aiding or impeding sustainability |
| **EQ14: To what extent there is government ownership to sustain the focus on parenting care for improved ECD services?** | **SEQ 14.1**: What are the specific components in which the state government would continue the focus on parenting care for improved ECD services?<br><br>**SEQ 14.2**: To what extent the sub-district, district and state-level officials of ICDS and Health have been involved in the project intervention? | • KIIs with officials of government dept (state/district)<br>• KIIs with CSO implementing partners<br>• KIIs with UNICEF staff members | **Qualitative**<br>• Content/comparative analysis of transcripts developed from notes taken during KIIs<br>• Organize, interpret and synthesis qualitative data to understand points of agreement and contention among different stakeholders on perceptions related likely government support for the scale up of the programme, involvement of various levels of institutional human resources to make the model sustainable |

## _Triangulation of findings_

Triangulation of findings generated through different lines of evidences (qualitative and quantitative) was be done wherever possible to deepen and widen the understanding which improved the findings. It facilitated validation of data through cross verification from different sources and helped in assessing and strengthening contribution narrative thereby increasing the confidence in the findings.

We provide an example below to demonstrate how triangulation was used during analysis stage –

**Example:**

| Sub-Evaluation Question (SEQ) – 7.1 | Data sources |
|---|---|
| **SEQ7.1**: To what extent there was change in knowledge, attitude and perceptions of FLWs on the role of parenting on ECD? | • Quantitative survey with FLWs<br>• KIIs with CSO implementing partners<br>• KIIs with district officials/block officials of ICDS |

- Firstly, the results of key KAP indicators from quantitative FLW survey endline were compared with baseline data to assess changes in KAP levels of FLWs
- Then, the qualitative findings related to the perceptions (on changes related to KAP of FLWs) of different stakeholder groups (govt officials and CSO partners) were compared to determine areas of agreement as well as areas of divergence.
- Finally, the key emerging findings from qualitative analysis (on areas of agreement or divergence) were paired with associated quantitative survey findings to determine if both the qualitative and quantitative sources draw similar conclusions.
- If both the qualitative and quantitative sources drew similar conclusions, then the confidence in the findings/results was considered to be higher which strengthens contribution narrative. If both qualitative and quantitative sources drew diverging conclusions, then this was considered as a weak evidence of change

# Annexure 14: List of personnel met during KIIs

## Maharashtra

| S.No. | KII Respondent | Type of Respondent | Level *(State/District/ Block/Sector)* | Details |
|---|---|---|---|---|
| 1 | Nutrition Specialist | UNICEF | State | UNICEF Maharashtra state office |
| 2 | Education Specialist | UNICEF | State | UNICEF Maharashtra state office |
| 3 | Education Officer | UNICEF | State | UNICEF Maharashtra state office |
| 4 | Professor, Department of Community Health, MGIMS | CSO | State | MGIMS, Sewagram |
| 5 | Project Coordinator, MGIMS | CSO | State | MGIMS, Sewagram |
| 6 | Director, Gram Mangal | CSO | State | |
| 7 | Project Coordinator, Gram Mangal | CSO | State | |
| 8 | Commissioner, ICDS | State govt. official | State | Maharashtra |
| 9 | Assistant Commissioner, ICDS | State govt. official | State | Maharashtra |
| 10 | District Community Health Officer (DCHO) | District govt. official | District | District – Aurangabad |
| 11 | DCM | District govt. official | District | District – Yavatmal |
| 12 | District CEO | District govt. official | District | District -Yavatmal |
| 13 | Deputy CEO – WCD | District govt. official | District | District – Aurangabad |
| 14 | District Health Officer | District govt. official | District | District – Aurangabad |
| 15 | Deputy Divisional Commissioner, ICDS | District govt. official | District | District – Pune |
| 16 | Deputy CEO | District govt. official | District | District – Palghar |
| 17 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Ralegaon District – Yavatmal |
| 18 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Hadapsar 2 District - Pune |
| 19 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Pimpri 2 District - Pune |
| 20 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Pune Centre District - Pune |
| 21 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Manor District - Palghar |

| 22 | AWW Supervisor | Sector govt. official | Sector | Block – Babhulgaon<br>District – Yavatmal |
| 23 | AWW Supervisor | Sector govt. official | Sector | Block – Digras (2)<br>District – Yavatmal |
| 24 | AWW Supervisor | Sector govt. official | Sector | Block – Ghatanji<br>District – Yavatmal |
| 25 | AWW Supervisor | Sector govt. official | Sector | Block – Aurangabad 1<br>District – Aurangabad |
| 26 | AWW Supervisor | Sector govt. official | Sector | Block – Kannad<br>District – Aurangabad |
| 27 | AWW Supervisor | Sector govt. official | Sector | Block – Paithan<br>District – Aurangabad |
| 28 | AWW Supervisor | Sector govt. official | Sector | Block – Khultabad<br>District – Aurangabad |
| 29 | AWW Supervisor | Sector govt. official | Sector | Block – Pimpri 2<br>District – Pune |
| 30 | AWW Supervisor | Sector govt. official | Sector | Block – Pimpri Chinchwad<br>District – Pune |
| 31 | AWW Supervisor | Sector govt. official | Sector | Block – Pune Central<br>District – Pune |
| 32 | AWW Supervisor | Sector govt. official | Sector | Block – Manor (3)<br>District – Palghar |

## Rajasthan

| S.No. | KII Respondent | Type of Respondent | Level (State/District/ Block/Sector) | Details |
|---|---|---|---|---|
| 1 | Nutrition Specialist | UNICEF | State | UNICEF Rajasthan state office |
| 2 | Nutrition Officer | UNICEF | State | UNICEF Rajasthan state office |
| 2 | Education Specialist | UNICEF | State | UNICEF Rajasthan state office |
| 3 | Education Officer | UNICEF | State | UNICEF Rajasthan state office |
| 4 | Director, Unnati Sansthan | CSO | State | Unnati Sansthan, Udaipur |
| 5 | Deputy Director – ICDS | District govt. official | District | District: Dungarpur |
| 6 | Child Development Project Officer (CDPO) | Block govt. official | Block | Block – Bicchiwara<br>District – Dungarpur |
| 7 | AWW Supervisor | Sector govt. official | Sector | Block – Girwa (4)<br>District – Udaipur |
| 8 | AWW Supervisor | Sector govt. official | Sector | Block – Rishabhdev (2)<br>District – Udaipur |
| 9 | AWW Supervisor | Sector govt. official | Sector | Block – Kherwara (2)<br>District – Udaipur |
| 10 | AWW Supervisor | Sector govt. official | Sector | Block – Bicchiwara (4)<br>District – Dungarpur |
| 11 | AWW Supervisor | Sector govt. official | Sector | Block – Dungarpur (3)<br>District – Dungarpur |

## Annexure 15: List of documents reviewed

**Communication Packages/training materials/project documents**

1. Parenting guide for caregiver - birth to 6 years
2. Job aid for frontline workers- birth to 3 years
3. English Activity Bank for Frontline workers - birth to 3 years (Manual for Play & Communication)
4. ECE materials ICDS UNICEF- 3 to 6 (Responsive Caregiving Programme Part 1, 2, 3)
5. MCP Card
6. Sabrang Positive Parenting Kit Cards (for 3-6-year-old)
7. Parent Activity Meet Capsules April -Nov-2018 (for 3-6 old)
8. First 1000 day guidance and material
9. Training manuals for Facilitators - Cycle 1-5
10. Positive Parenting Module (AWW's Effective communication with caregivers)
11. AWW's manual
12. Key messaging sheet
13. Sector Meeting Guidelines

**Policies, guidelines, online resources and websites**

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9. Survive, Thrive, Transform – The Global Strategy for Women's, Children's and Adolescents' Health (2016 – 2030). New York: United Nations; 2015
10. Transforming our World: The 2030 Agenda for Sustainable Development. New York: United Nations; 2015
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54. Information and data on Training and Monitoring from CSO partner MGIMS in Aurangabad & Yavatmal; and CSO partner Gram Mangal in Pune & Palghar

## Annexure 16: Endline evaluation study tools

Attached as separate document.

# Annexure 17: FLW survey analysis tables and graphs
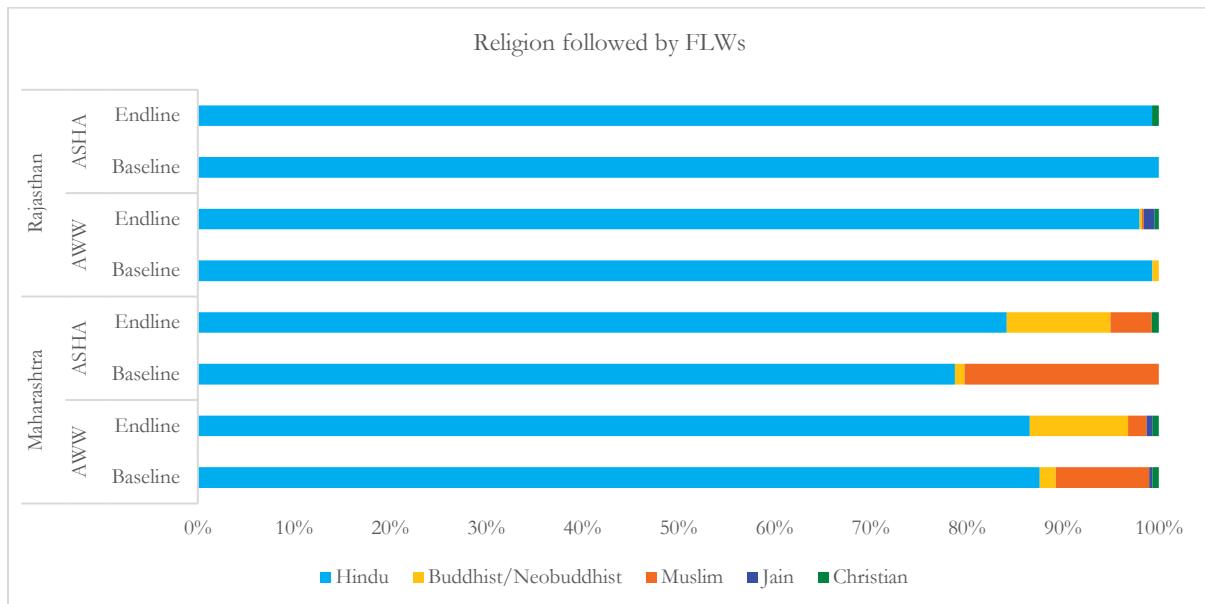


*Figure 25: Religion followed by FLWs*
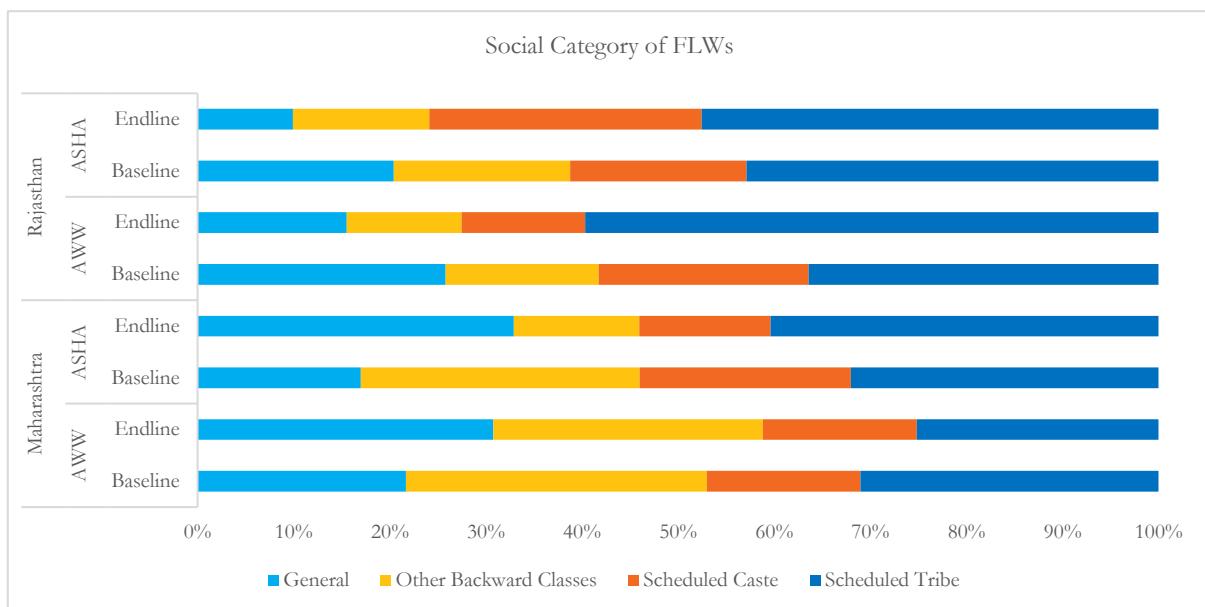


*Figure 26: Social Category of FLWs*

## Education level of FLWs
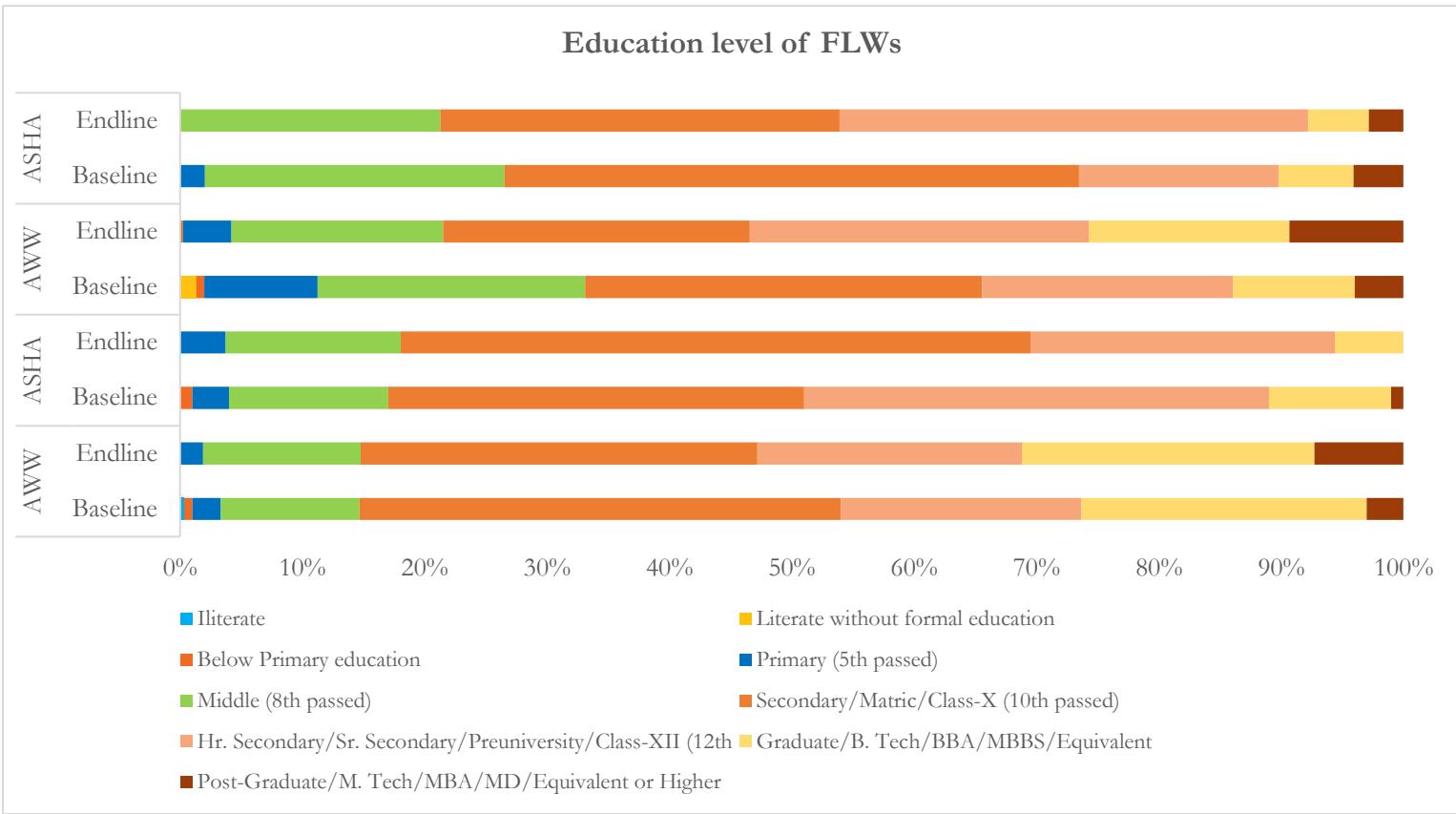


*Figure 27: Education levels of FLWs*

## Knowledge and practices of FLWs: FLW survey analysis tables and graphs
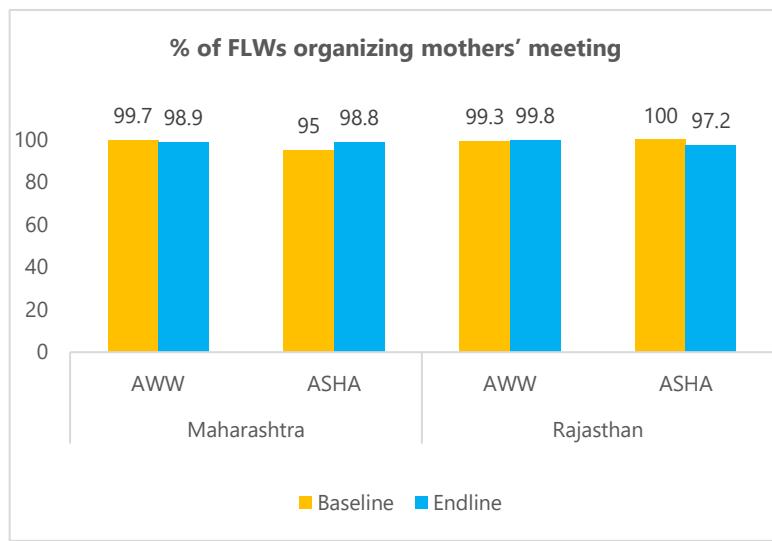


*Figure 28: Percentage of FLWs organizing mothers' meeting*

*Table 11: Percentage of FLWs organizing mothers' meetings in Maharashtra*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q211 Do you use to hold mothers' meeting in your area before COVID-19? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 98 | 100 | 100 | 98 | 100 | 99 | 80 | 100 | 100 | - | 99 | 98 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

*Table 12: Percentage of FLWs organizing mothers' meetings in Rajasthan*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q211 Do you use to hold mothers' meeting in your area before COVID-19? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 100 | 96 | 100 | - | 99 | 100 | 100 | 100 | 100 | - | 96 | 97 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |
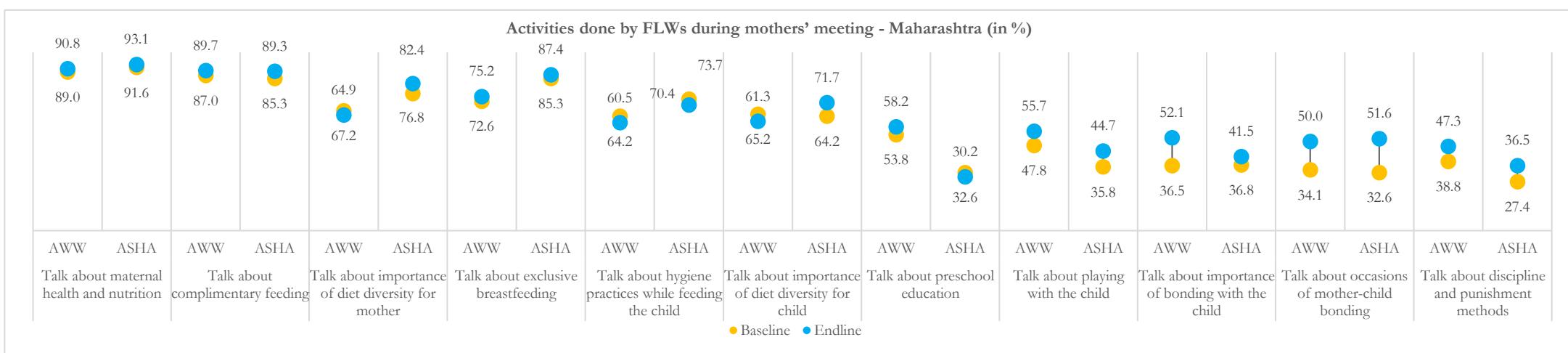
*Figure 29: Activities done by FLWs during mothers' meetings in Maharashtra (in %)*

Table 13: Activities done by FLWs during mothers' meetings in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q217 What do you do use to do in these meetings with mothers? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Talk about maternal health and nutrition | 57 | 98 | 111 | 85 | 94 | 91 | 17 | 32 | 38 | - | 95 | 91 |
| Talk about complimentary feeding | 70 | 95 | 95 | 88 | 89 | 92 | 15 | 29 | 37 | - | 92 | 86 |
| Talk about importance of diet diversity for mother | 45 | 85 | 71 | 69 | 72 | 51 | 20 | 29 | 24 | - | 87 | 76 |
| Talk about exclusive breastfeeding | 56 | 88 | 73 | 71 | 80 | 71 | 18 | 26 | 37 | - | 92 | 81 |
| Talk about hygiene practices while feeding the child | 48 | 72 | 72 | 67 | 69 | 41 | 19 | 25 | 26 | - | 76 | 62 |
| Talk about importance of diet diversity for child | 46 | 83 | 66 | 63 | 72 | 55 | 18 | 30 | 13 | - | 82 | 62 |
| Talk about preschool education | 52 | 67 | 35 | 62 | 59 | 54 | 1 | 23 | 7 | - | 34 | 24 |
| Talk about playing with the child | 41 | 67 | 35 | 56 | 61 | 48 | 3 | 27 | 4 | - | 59 | 22 |
| Talk about importance of bonding with the child | 22 | 58 | 29 | 50 | 60 | 43 | 7 | 23 | 5 | - | 47 | 33 |
| Talk about occasions of mother-child bonding | 18 | 55 | 29 | 53 | 52 | 44 | 6 | 22 | 3 | - | 58 | 41 |
| Talk about discipline and punishment methods | 19 | 59 | 38 | 48 | 49 | 44 | 1 | 20 | 5 | - | 37 | 37 |
| N | 74 | 102 | 123 | 128 | 208 | 140 | 20 | 33 | 42 | - | 96 | 63 |
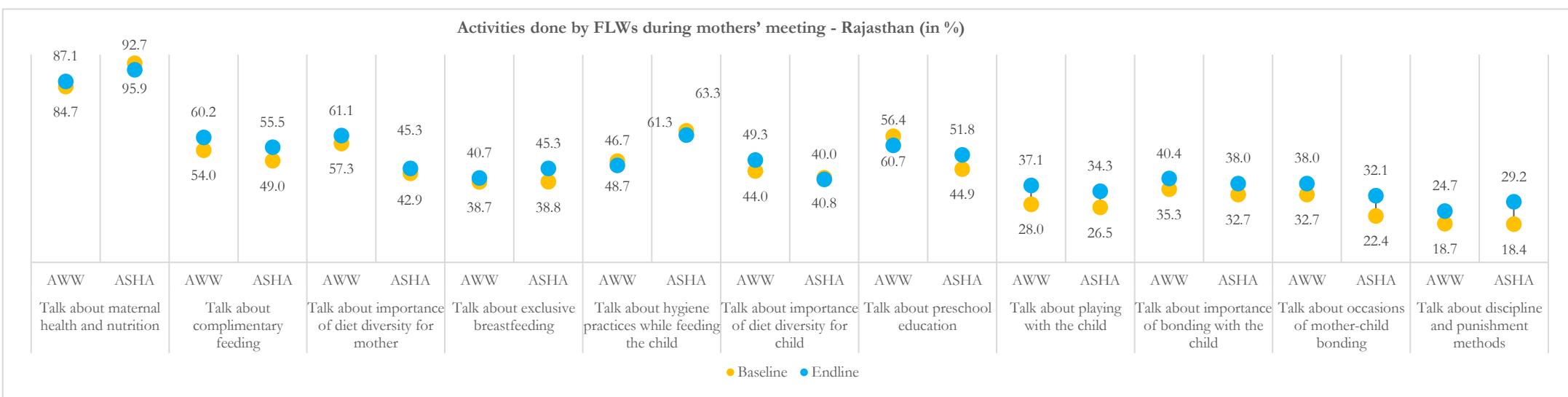
*Figure 30: Activities done by FLWs during mothers' meetings in Rajasthan (in %)*

Table 14: Activities done by FLWs during mothers' meetings in Rajasthan (in %)

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q217 What do you do use to do in these meetings with mothers? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Talk about maternal health and nutrition | 5 | 22 | 100 | - | 90 | 86 | 1 | 8 | 38 | - | 91 | 94 |
| Talk about complimentary feeding | 2 | 11 | 68 | - | 60 | 60 | 1 | 4 | 19 | - | 53 | 58 |
| Talk about importance of diet diversity for mother | 2 | 10 | 74 | - | 51 | 65 | 0 | 2 | 19 | - | 41 | 49 |
| Talk about exclusive breastfeeding | 0 | 3 | 55 | - | 45 | 39 | 0 | 0 | 19 | - | 43 | 48 |
| Talk about hygiene practices while feeding the child | 2 | 8 | 63 | - | 45 | 47 | 1 | 3 | 27 | - | 63 | 59 |
| Talk about importance of diet diversity for child | 5 | 4 | 57 | - | 56 | 47 | 0 | 1 | 19 | - | 53 | 28 |
| Talk about preschool education | 2 | 14 | 75 | - | 60 | 55 | 0 | 2 | 20 | - | 56 | 48 |
| Talk about playing with the child | 0 | 2 | 40 | - | 46 | 34 | 0 | 0 | 13 | - | 34 | 35 |
| Talk about importance of bonding with the child | 2 | 2 | 49 | - | 45 | 39 | 0 | 1 | 15 | - | 38 | 38 |
| Talk about occasions of mother-child bonding | 2 | 5 | 42 | - | 36 | 39 | 0 | 1 | 10 | - | 35 | 29 |
| Talk about discipline and punishment methods | 0 | 1 | 27 | - | 30 | 23 | 0 | 0 | 9 | - | 27 | 32 |
| N | 5 | 26 | 119 | - | 128 | 322 | 1 | 8 | 40 | - | 68 | 69 |
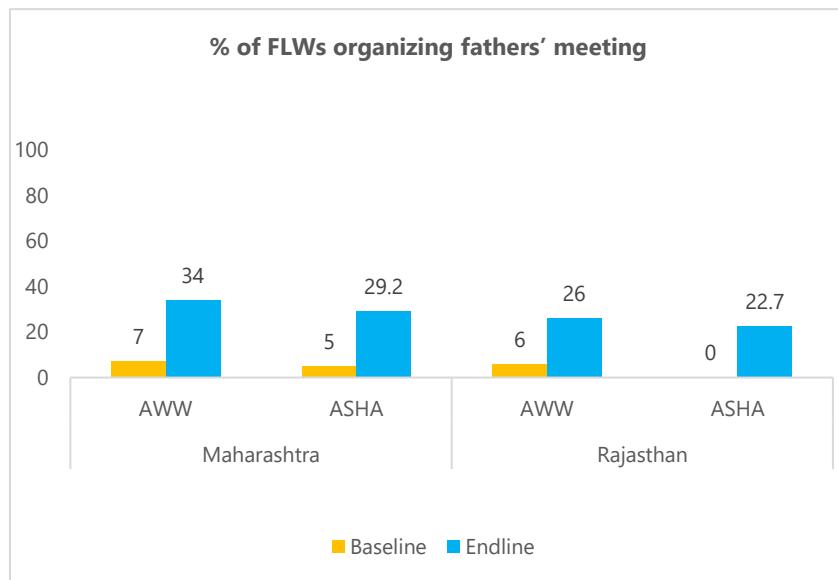
*Figure 31: Percentage of FLWs organizing fathers' meetings*

*Table 15: Percentage of FLWs organizing fathers' meetings in Maharashtra*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q219 Do you hold fathers' meeting in your area? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 3 | 4 | 12 | 30 | 38 | 32 | 0 | 9 | 5 | - | 29 | 30 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

*Table 16: Percentage of FLWs organizing fathers' meetings in Rajasthan*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q219 Do you hold fathers' meeting in your area? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 0 | 0 | 8 | - | 39 | 20 | 0 | 0 | 0 | - | 30 | 16 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |
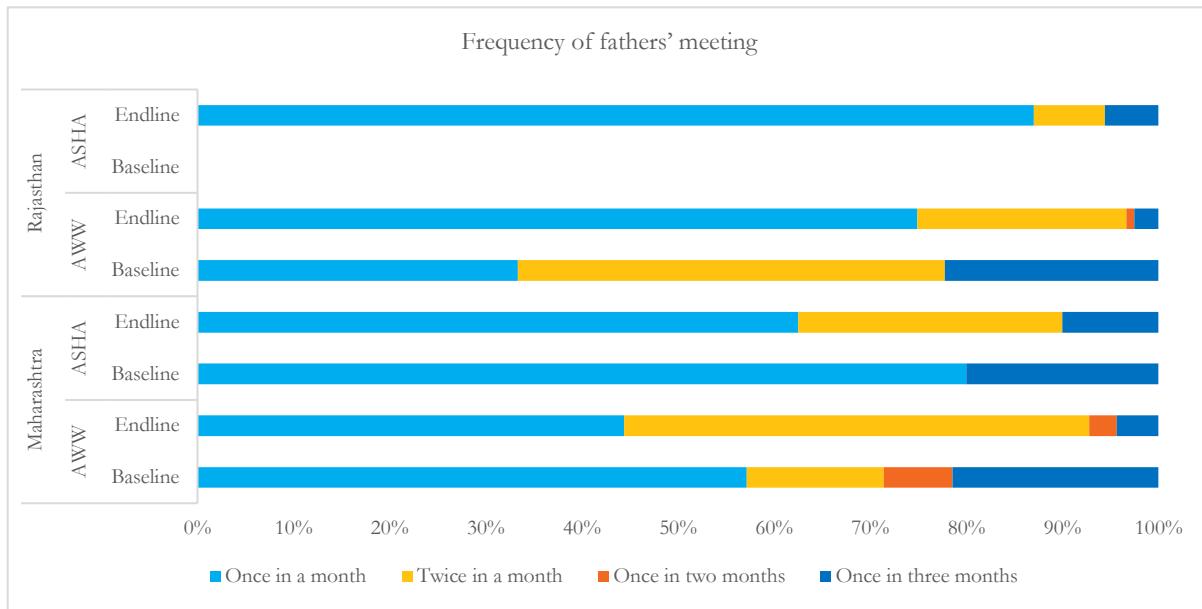
*Figure 32: Frequency of fathers' meeting*

*Table 17: Frequency of fathers' meetings in Maharashtra*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q222 How often do you conduct fathers' meeting in your area? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Once in a month | 0 | 25 | 47 | 33 | 40 | 48 | - | 67 | 100 | - | 61 | 63 |
| Twice in a month | 0 | 25 | 7 | 46 | 44 | 46 | - | 0 | 0 | - | 29 | 16 |
| Once in two months | 0 | 25 | 0 | 5 | 3 | 4 | - | 0 | 0 | - | 0 | 0 |
| Once in three months | 0 | 0 | 20 | 5 | 5 | 2 | - | 33 | 0 | - | 7 | 10 |
| Once in six months | 100 | 25 | 20 | 3 | 0 | 0 | - | 0 | 0 | - | 3 | 11 |
| Not fixed | 0 | 0 | 6 | 8 | 1 | 0 | - | 0 | 0 | - | 3 | 0 |
| **N** | **2** | **4** | **15** | **39** | **78** | **46** | **-** | **3** | **2** | **-** | **28** | **19** |

*Table 18: Frequency of fathers' meetings in Rajasthan*

| Rajasthan | AWW | | | | ASHA | |
|---|---|---|---|---|---|---|
| Q222 How often do you conduct fathers' meeting in your area? | Baseline | | Endline | | Endline Only | |
| | Rural | Tribal | Rural | Tribal | Rural | Tribal |
| Once in a month | - | 33 | 56 | 79 | 81 | 73 |
| Twice in a month | - | 45 | 28 | 15 | 5 | 27 |
| Once in two months | - | 0 | 4 | 0 | 0 | 0 |
| Once in three months | - | 22 | 2 | 1 | 5 | 0 |
| Once in six months | - | 0 | 0 | 0 | 0 | 0 |
| Not fixed | - | 0 | 8 | 5 | 9 | 0 |
| **N** | **-** | **9** | **50** | **67** | **21** | **11** |

**Activities done by FLWs during fathers' meeting – Maharashtra (in %)**
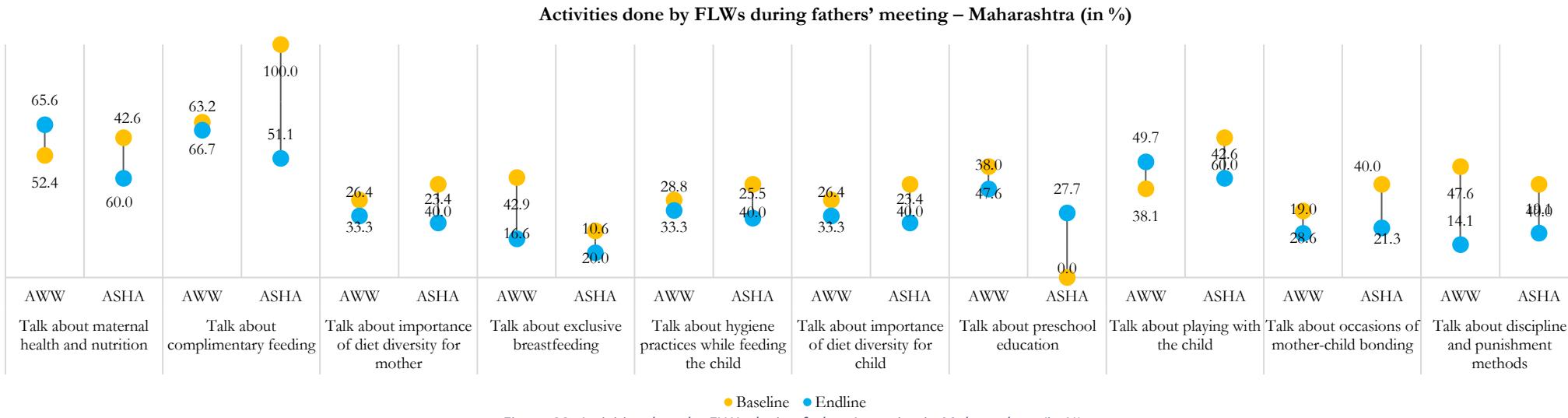


*Figure 33: Activities done by FLWs during fathers' meeting in Maharashtra (in %)*

*Table 19: Activities done by FLWs during fathers' meeting in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q226 What do you do in these meetings with fathers? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Talk about complimentary feeding | 1 | 2 | 11 | 64 | 67 | 57 | - | 3 | 2 | - | 57 | 42 |
| Talk about maternal health and nutrition | 0 | 3 | 8 | 46 | 76 | 17 | - | 3 | 0 | - | 25 | 68 |
| Talk about importance of diet diversity for mother | 0 | 2 | 8 | 15 | 36 | 20 | - | 2 | 1 | - | 21 | 26 |
| Talk about preschool education | 2 | 2 | 6 | 28 | 49 | 28 | - | 0 | 0 | - | 36 | 16 |
| Talk about hygiene practices while feeding the child | 0 | 1 | 6 | 18 | 32 | 33 | - | 2 | 0 | - | 39 | 5 |
| Talk about discipline and punishment methods | 2 | 3 | 5 | 10 | 14 | 17 | - | 1 | 1 | - | 29 | 5 |
| Talk about playing with the child | 2 | 1 | 5 | 41 | 62 | 37 | - | 3 | 0 | - | 61 | 16 |
| Talk about importance of diet diversity for child | 0 | 2 | 8 | 31 | 49 | 48 | - | 2 | 0 | - | 71 | 21 |
| Talk about exclusive breastfeeding | 0 | 2 | 7 | 10 | 19 | 17 | - | 1 | 0 | - | 7 | 16 |
| Talk about occasions of father-child bonding | 1 | 1 | 4 | 18 | 26 | 9 | - | 1 | 1 | - | 29 | 11 |
| N | 2 | 4 | 15 | 39 | 78 | 46 | - | 3 | 2 | - | 28 | 19 |

## Activities done by FLWs during fathers' meeting – Rajasthan (in %)
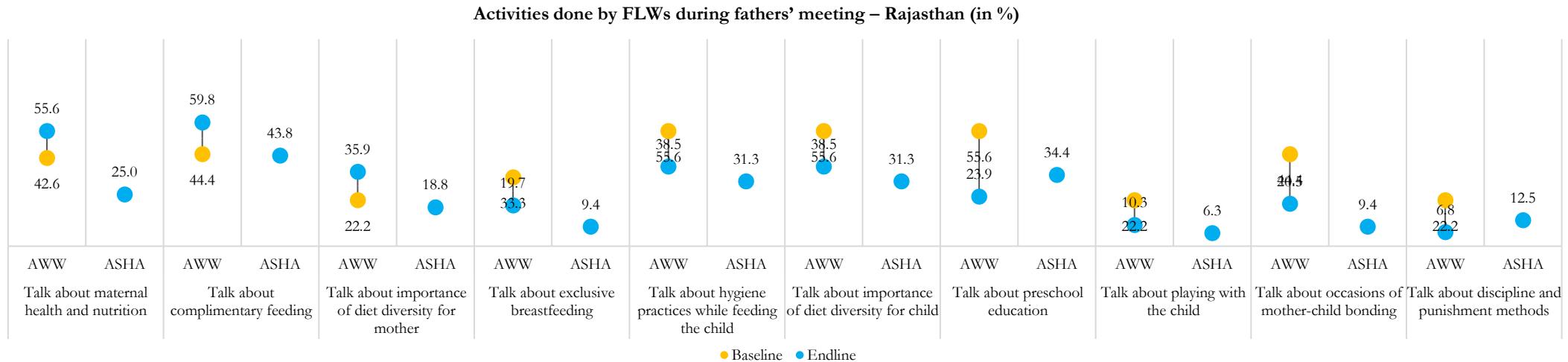


*Figure 34: Activities done by FLWs during fathers' meetings in Rajasthan (in %)*

*Table 20: Activities done by FLWs during fathers' meetings in Rajasthan (in %)*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q226 What do you do in these meetings with fathers? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Talk about complimentary feeding | - | 60 | 60 | - | 52 | 27 |
| Talk about maternal health and nutrition | - | 68 | 51 | - | 24 | 27 |
| Talk about importance of diet diversity for mother | - | 34 | 37 | - | 24 | 9 |
| Talk about preschool education | - | 20 | 27 | - | 43 | 18 |
| Talk about hygiene practices while feeding the child | - | 28 | 46 | - | 19 | 55 |
| Talk about discipline and punishment methods | - | 10 | 5 | - | 0 | 36 |
| Talk about playing with the child | - | 8 | 12 | - | 5 | 9 |
| Talk about importance of diet diversity for child | - | 44 | 34 | - | 33 | 27 |
| Talk about exclusive breastfeeding | - | 20 | 19 | - | 10 | 9 |
| Talk about occasions of father-child bonding | - | 34 | 10 | - | 5 | 18 |
| N | - | 50 | 67 | - | 21 | 11 |
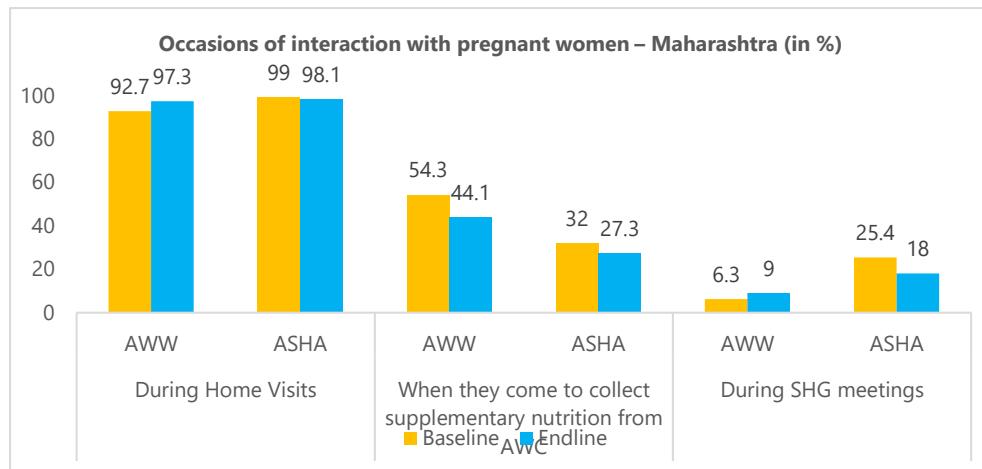
*Figure 35: Occasions of interaction with pregnant women in Maharashtra (in %)*

*Table 21: Occasions of interaction with pregnant women in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q407 What are the various occasions you interact with pregnant women in your area? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| During home visit | 100 | 92 | 89 | 97 | 96 | 99 | 100 | 100 | 98 | - | 97 | 100 |
| When they come to collect supplementary nutrition from AWC | 33 | 70 | 54 | 43 | 59 | 24 | 16 | 42 | 33 | - | 31 | 22 |
| During SHG meetings | 1 | 13 | 4 | 31 | 23 | 24 | 8 | 15 | 5 | - | 245 | 8 |
| Never | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | - | 0 | 0 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **64** |
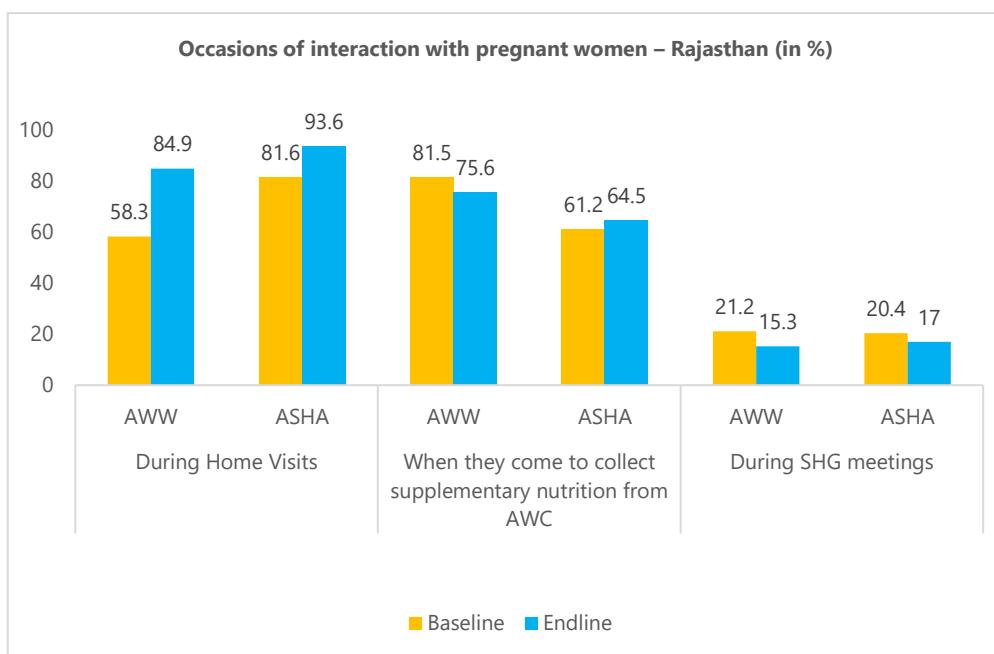
*Figure 36: Occasions of interaction with pregnant women in Rajasthan (in %)*

*Table 22: Occasions of interaction with pregnant women in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q407 What are the various occasions you interact with pregnant women in your area? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| During home visit | 100 | 48 | 59 | - | 94 | 81 | 0 | 88 | 83 | - | 50 | 58 |
| When they come to collect supplementary nutrition from AWC | 80 | 81 | 82 | - | 69 | 78 | 100 | 38 | 65 | - | 40 | 34 |
| During SHG meetings | 40 | 15 | 22 | - | 12 | 17 | 0 | 0 | 25 | - | 11 | 9 |
| Never | 0 | 0 | 2 | - | 0 | 1 | 0 | 0 | 0 | - | 0 | 0 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 131 | 116 |

**FLWs providing counselling to pregnant women - Maharashtra (in %)**
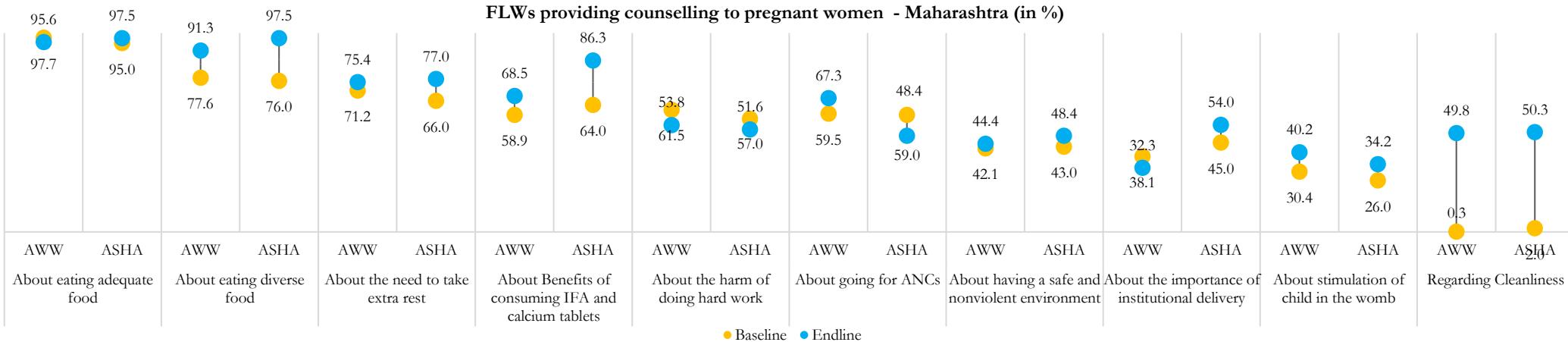


*Figure 37: FLWs providing counselling to pregnant women in Maharashtra (in %)*

*Table 23: FLWs providing counselling to pregnant women in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q408 What do you counsel the pregnant women during such interactions? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| About eating adequate food | 99 | 98 | 97 | 95 | 94 | 99 | 100 | 100 | 88 | - | 96 | 100 |
| About eating diverse food | 80 | 82 | 72 | 84 | 94 | 94 | 76 | 85 | 69 | - | 97 | 98 |
| About the need to take extra rest | 61 | 81 | 69 | 62 | 83 | 77 | 56 | 94 | 50 | - | 75 | 80 |
| About Benefits of consuming IFA and calcium tablets | 51 | 75 | 51 | 70 | 64 | 75 | 72 | 76 | 50 | - | 84 | 98 |
| About the harm of doing hard work | 47 | 75 | 60 | 53 | 51 | 58 | 36 | 67 | 62 | - | 57 | 44 |
| About going for ANCs | 44 | 80 | 52 | 76 | 70 | 55 | 48 | 79 | 50 | - | 65 | 23 |
| About having a safe and nonviolent environment | 29 | 67 | 30 | 47 | 48 | 38 | 36 | 64 | 31 | - | 54 | 41 |
| About the importance of institutional delivery | 43 | 49 | 26 | 24 | 39 | 30 | 44 | 61 | 33 | - | 62 | 42 |
| About stimulation of child in the womb | 16 | 56 | 18 | 41 | 49 | 26 | 8 | 58 | 12 | - | 45 | 17 |
| Regarding Cleanliness | 0 | 0 | 1 | 37 | 59 | 49 | 0 | 0 | 5 | - | 51 | 50 |
| **N** | **75** | **102** | **122** | **131** | **208** | **141** | **25** | **33** | **42** | **-** | **97** | **64** |
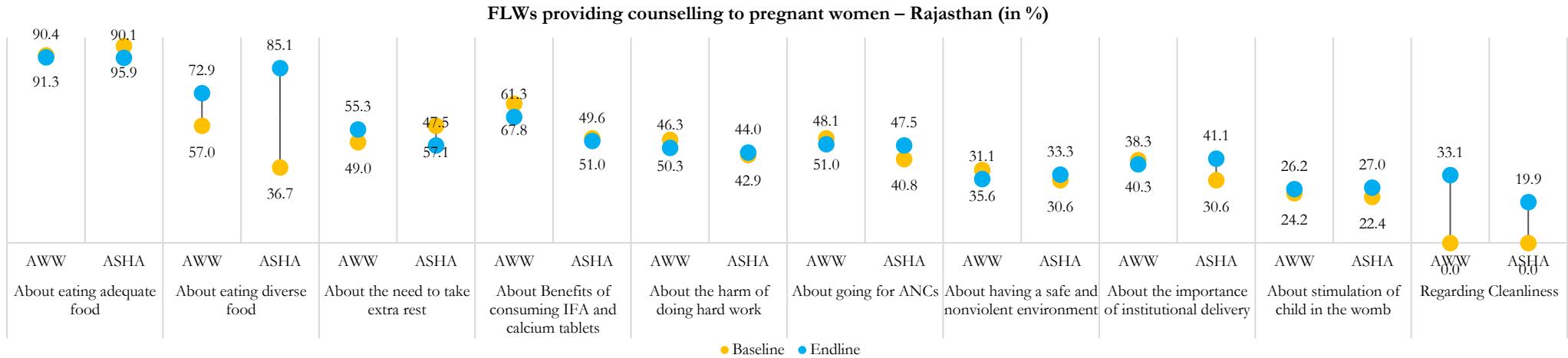
Figure 38: FLWs providing counselling to pregnant women in Rajasthan (in %)

Table 24: FLWs providing counselling to pregnant women in Rajasthan (in %)

| Rajasthan | AWW | | | | | | ASHA | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q408 What do you counsel the pregnant women during such interactions? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| About eating adequate food | 100 | 89 | 91 | - | 91 | 90 | 100 | 88 | 98 | - | 90 | 90 |
| About eating diverse food | 20 | 48 | 61 | - | 78 | 71 | 100 | 13 | 40 | - | 85 | 86 |
| About the need to take extra rest | 0 | 33 | 55 | - | 58 | 54 | 100 | 38 | 60 | - | 47 | 49 |
| About Benefits of consuming IFA and calcium tablets | 100 | 59 | 68 | - | 72 | 57 | 0 | 25 | 58 | - | 62 | 37 |
| About the harm of doing hard work | 60 | 22 | 56 | - | 43 | 48 | 0 | 25 | 48 | - | 47 | 41 |
| About going for ANCs | 20 | 19 | 60 | - | 63 | 42 | 100 | 25 | 43 | - | 51 | 44 |
| About having a safe and nonviolent environment | 60 | 7 | 41 | - | 30 | 32 | 0 | 0 | 38 | - | 31 | 36 |
| About the importance of institutional delivery | 20 | 15 | 47 | - | 33 | 40 | 100 | 13 | 33 | - | 38 | 44 |
| About stimulation of child in the womb | 20 | 0 | 30 | - | 26 | 26 | 100 | 0 | 25 | - | 27 | 27 |
| Regarding Cleanliness | 0 | 0 | 0 | - | 32 | 34 | 0 | 0 | 0 | - | 14 | 26 |
| N | 5 | 27 | 117 | - | 129 | 318 | 1 | 8 | 40 | - | 71 | 70 |

**FLWs reporting things a pregnant women should do for healthy development of unborn child - Maharashtra (in %)**
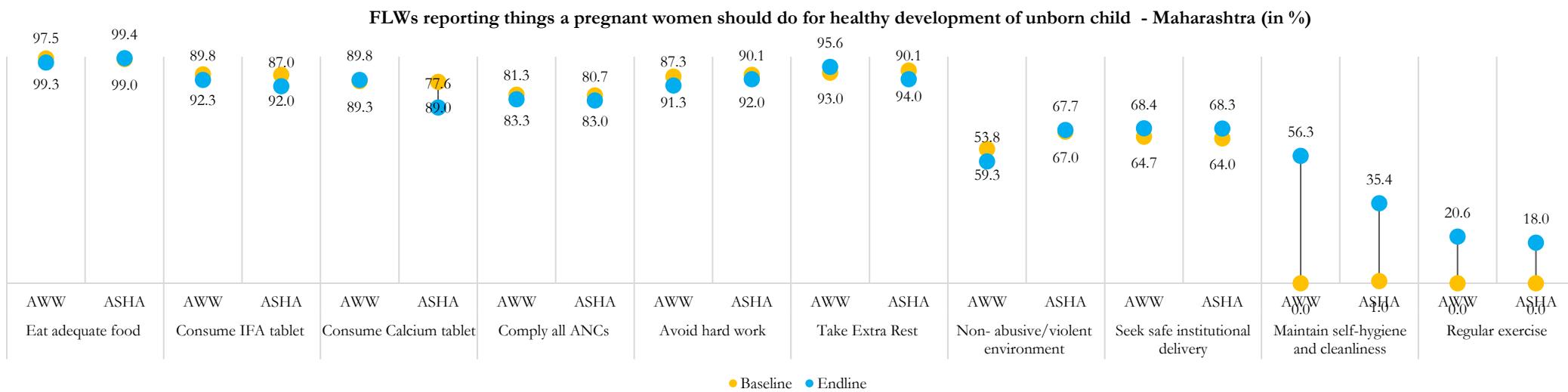


*Figure 39: FLWs reporting things pregnant women should do for healthy development of unborn child in Maharashtra (in %)*

**FLWs reporting things a pregnant women should do for healthy development of unborn child - Rajasthan (in %)**
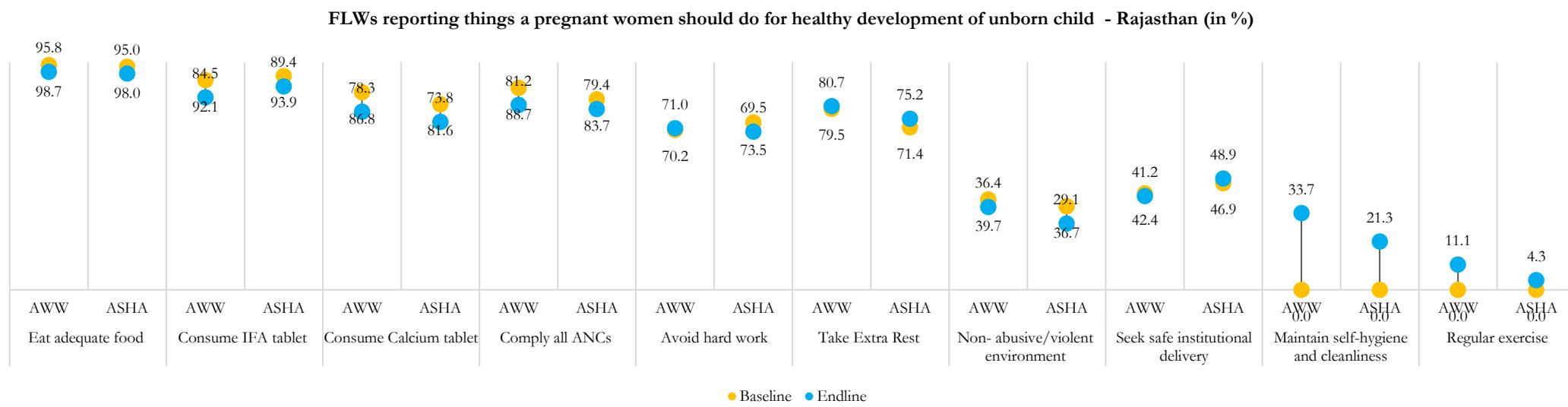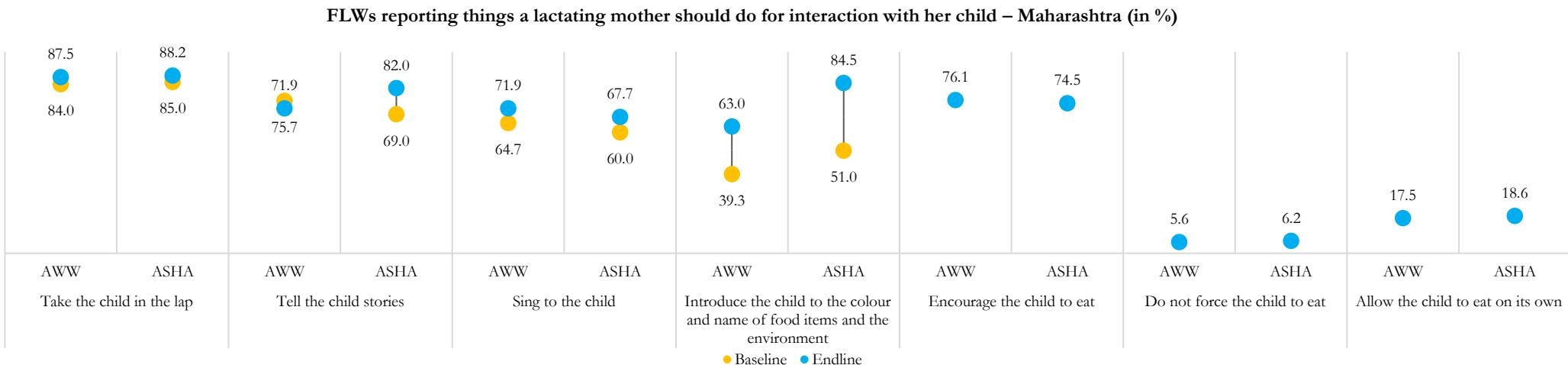


*Figure 40: FLWs reporting things pregnant women should do for healthy development of unborn child in Rajasthan (in %)*

**FLWs reporting things a lactating mother should do for interaction with her child – Maharashtra (in %)**



*Figure 41: FLWs reporting things a lactating mother should do for interaction with her child in Maharashtra (in %)*

Table 25: FLWs reporting things a lactating mother should do for interaction with her child in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q420 What all should a lactating mother do for interaction (stimulation) with her child while complimentary feeding the child? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Take the child in the lap | 92 | 91 | 73 | 87 | 89 | 85 | 92 | 97 | 71 | - | 90 | 86 |
| Tell the child stories | 60 | 95 | 69 | 55 | 76 | 81 | 56 | 82 | 67 | - | 78 | 88 |
| Sing to the child | 77 | 84 | 41 | 65 | 70 | 81 | 80 | 79 | 33 | - | 67 | 69 |
| Introduce the child to the colour and name of food items and the environment | 28 | 62 | 28 | 57 | 65 | 66 | 36 | 85 | 33 | - | 81 | 89 |
| Don't Know/Can't Say | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 2 | - | 0 | 0 |
| Nothing | 0 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | - | 1 | 0 |
| Encourage the child to eat | - | - | - | 82 | 81 | 64 | - | - | - | - | 73 | 77 |
| Do not force the child to eat | - | - | - | 2 | 7 | 7 | - | - | - | - | 1 | 14 |
| Allow the child to eat on its own | - | - | - | 18 | 15 | 21 | - | - | - | - | 22 | 14 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **64** |

**FLWs reporting things a lactating mother should do for interaction with her child – Rajasthan (in %)**
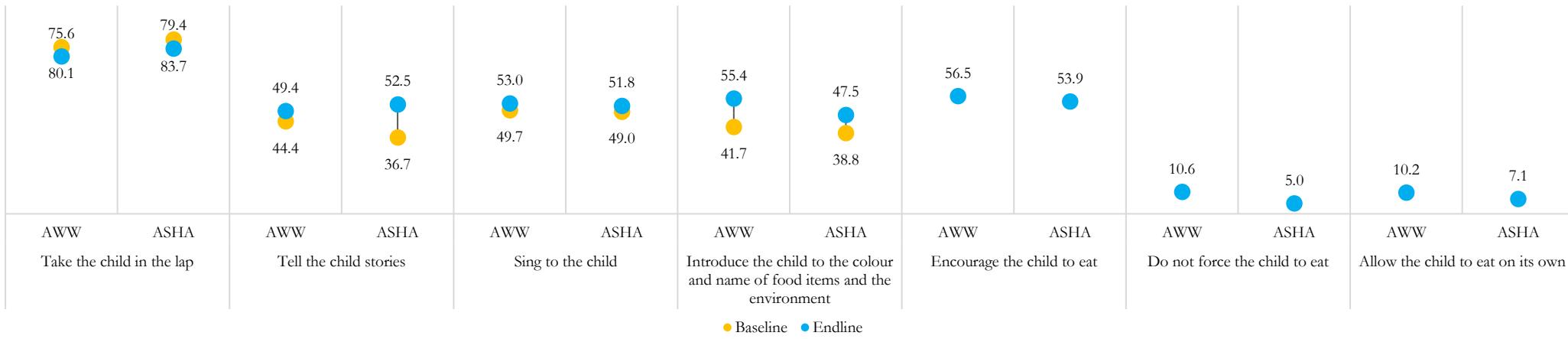


*Figure 42: FLWs reporting things a lactating mother should do for interaction with her child in Rajasthan (in %)*

*Table 26: FLWs reporting things a lactating mother should do for interaction with her child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q420 What all should a lactating mother do for interaction (stimulation) with her child while complimentary feeding the child? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Take the child in the lap | 80 | 63 | 84 | - | 67 | 79 | 100 | 50 | 90 | - | 80 | 79 |
| Tell the child stories | 100 | 30 | 45 | - | 50 | 49 | 0 | 25 | 40 | - | 48 | 57 |
| Sing to the child | 60 | 30 | 54 | - | 57 | 52 | 0 | 38 | 53 | - | 56 | 47 |
| Introduce the child to the colour and name of food items and the environment | 80 | 11 | 47 | - | 59 | 54 | 0 | 25 | 43 | - | 52 | 43 |
| Encourage the child to eat | - | - | - | - | 70 | 51 | - | - | - | - | 63 | 47 |
| Do not force the child to eat | - | - | - | - | 9 | 11 | - | - | - | - | 10 | 0 |
| Allow the child to eat on its own | - | - | - | - | 12 | 10 | - | - | - | - | 11 | 3 |
| Don't Know/Can't Say | 0 | 15 | 6 | - | 6 | 6 | 0 | 13 | 3 | - | 0 | 0 |
| Nothing | 0 | 7 | 1 | - | 1 | 0 | 0 | 13 | 3 | - | 1 | 11 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |
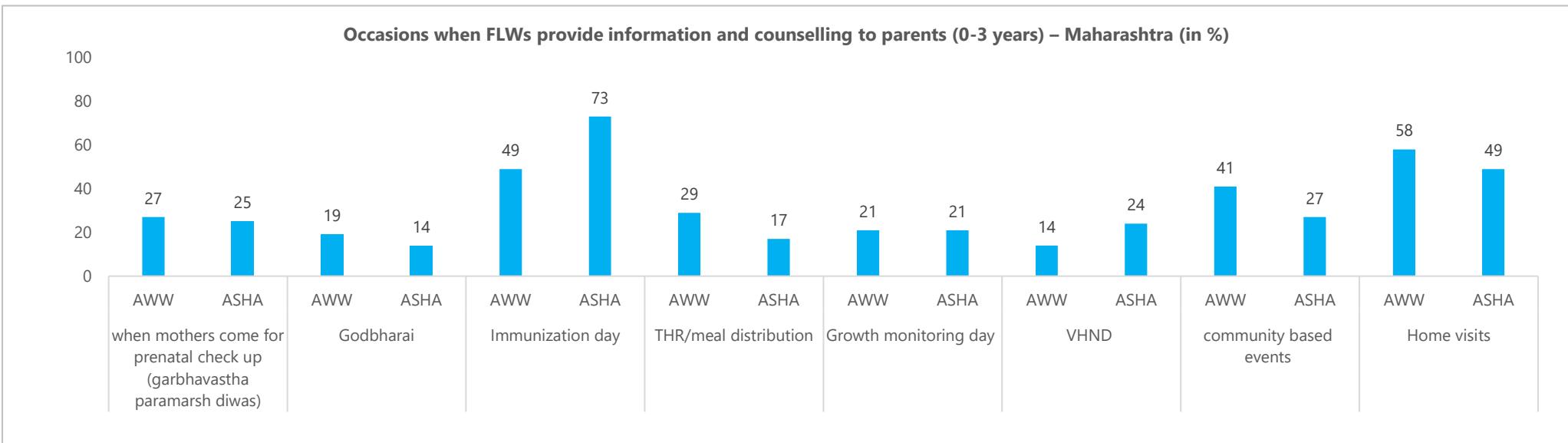
*Figure 43: Occasions when FLWs provide information and counselling to parents (0-3 years) in Maharashtra (in %)*

*Table 27: Occasions when FLWs provide information and counselling to parents (0-3 years) in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q201b When do you provide information and counselling support to parents of children aged 0-3 years? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| When mothers come for prenatal check up (garbhavastha paramarsh diwas) | 30 | 63 | 36 | - | 30 | 17 |
| Godbharai | 22 | 52 | 17 | - | 22 | 3 |
| Immunization day | 45 | 107 | 82 | - | 73 | 73 |
| THR/meal distribution | 37 | 89 | 14 | - | 26 | 5 |
| Growth monitoring day | 31 | 62 | 6 | - | 33 | 3 |
| VHND | 21 | 41 | 7 | - | 24 | 25 |
| Community based events | 48 | 75 | 72 | - | 33 | 17 |
| Home Visits | 105 | 155 | 77 | - | 60 | 56 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |
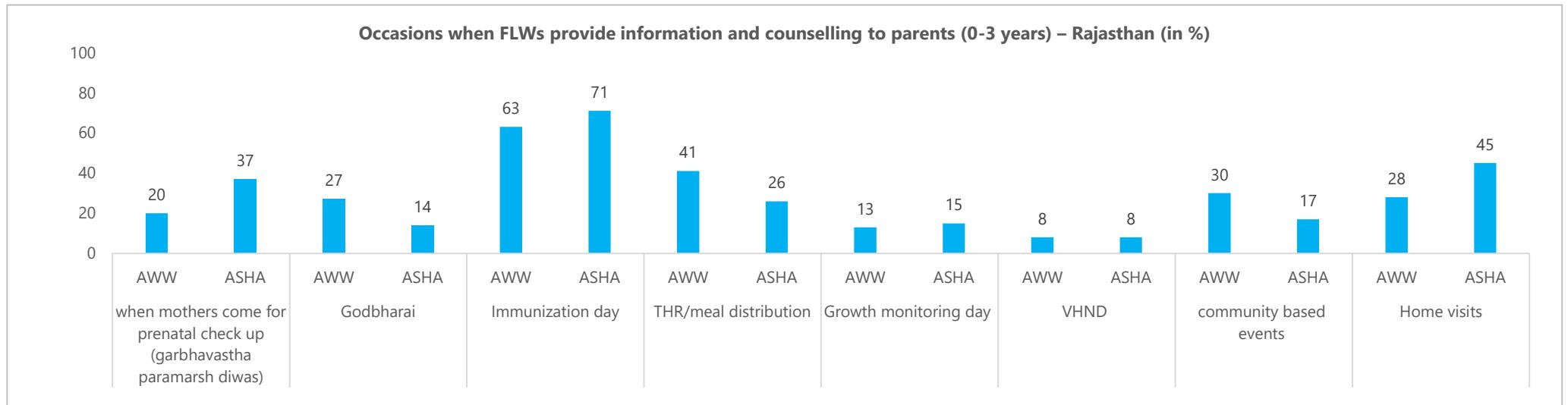
*Figure 44: Occasions when FLWs provide information and counselling to parents (0-3 years) in Rajasthan (in %)*

*Table 28: Occasions when FLWs provide information and counselling to parents (0-3 years) in Rajasthan (in %)*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q201b When do you provide information and counselling support to parents of children aged 0-3 years? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| When mothers come for prenatal check up (garbhavastha paramarsh diwas) | - | 15 | 75 | - | 32 | 41 |
| Godbharai | - | 41 | 82 | - | 24 | 4 |
| Immunization day | - | 85 | 199 | - | 73 | 69 |
| THR/meal distribution | - | 44 | 140 | - | 21 | 31 |
| Growth monitoring day | - | 22 | 35 | - | 10 | 20 |
| VHND | - | 22 | 14 | - | 13 | 3 |
| Community based events | - | 46 | 90 | - | 21 | 13 |
| Home Visits | - | 66 | 147 | - | 47 | 66 |
| N | - | 129 | 322 | - | 71 | 70 |

**Occasions when FLWs provide information and counselling to parents (3-6 years) – Maharashtra (in %)**

| | | | | | |
|---|---|---|---|---|---|
| AWW | AWW | AWW | AWW | AWW | AWW |
| immunization day | THR/meal distribution | Growth monitoring day | VHND | Community based events | Monthly meeting (ECCE day/ PAM meeting) |
| 26 | 46 | 18 | 15 | 31 | 70 |
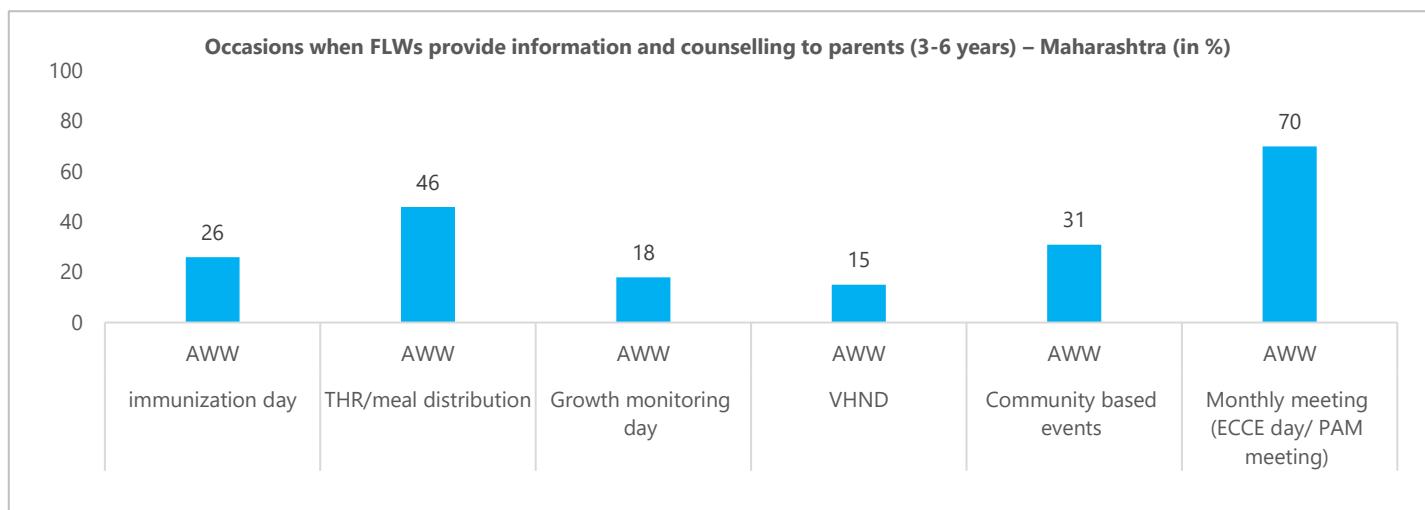
*Figure 45: Occasions when FLWs provide information and counselling to parents (3-6 years) in Maharashtra (in %)*

**Occasions when FLWs provide information and counselling to parents (3-6 years) – Rajasthan (in %)**

| | | | | | |
|---|---|---|---|---|---|
| AWW | AWW | AWW | AWW | AWW | AWW |
| immunization day | THR/meal distribution | Growth monitoring day | VHND | Community based events | Monthly meeting (ECCE day/ PAM meeting) |
| 26 | 28 | 11 | 5 | 32 | 68 |
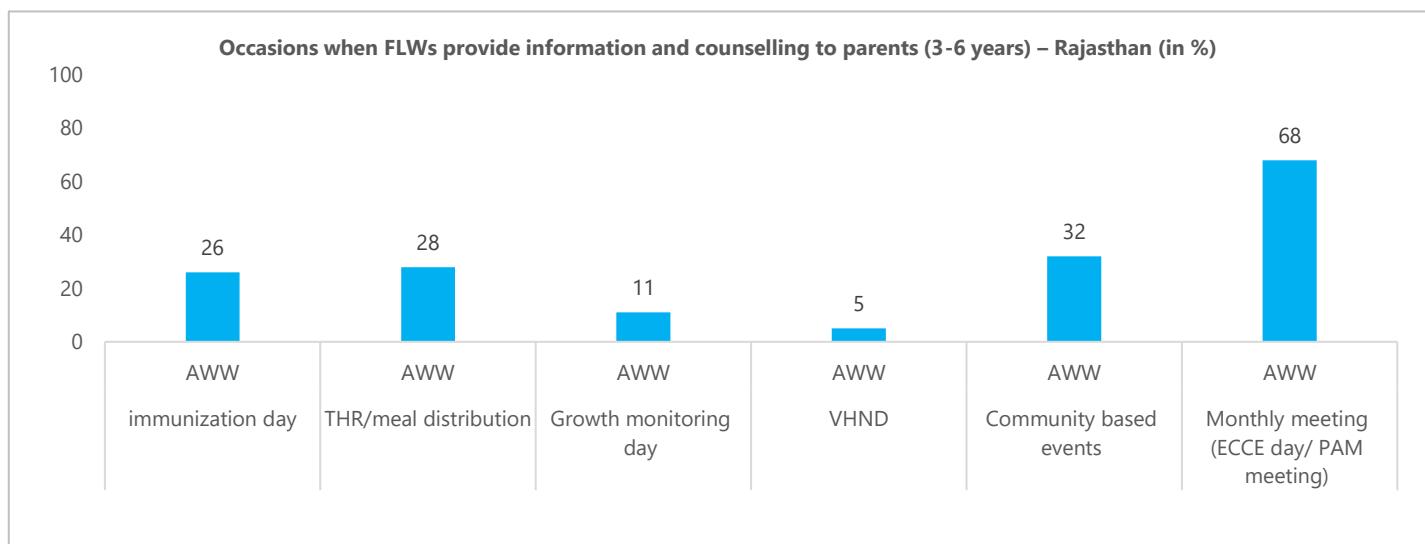
*Figure 46: Occasions when FLWs provide information and counselling to parents (3-6 years) in Rajasthan (in %)*

**FLWs providing counselling to parents of 0-3 years child – Maharashtra (in %)**
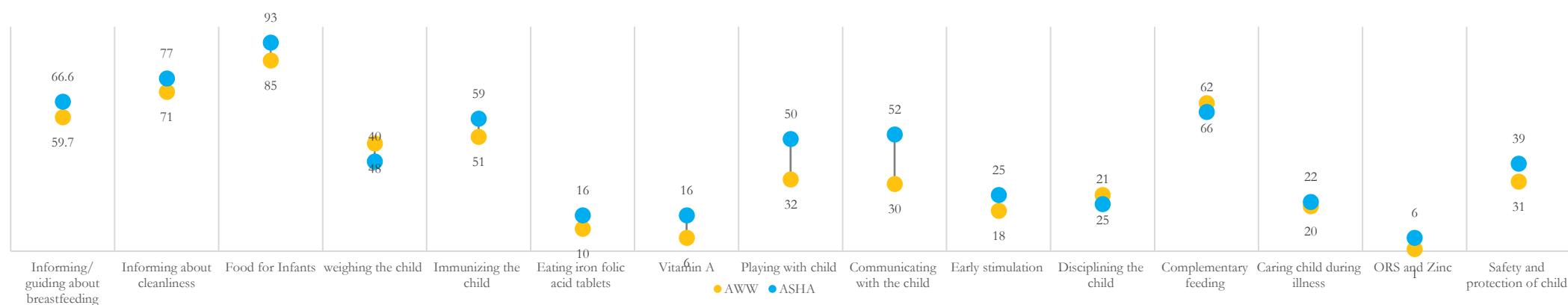


*Figure 47: FLWs providing counselling to parents of 0-3 years child in Maharashtra (in %)*

*Table 29: FLWs providing counselling to parents of 0-3 years child in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q201c what do you provide information or counselling on?** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Informing/ guiding about breastfeeding | 71 | 63 | 45 | - | 63 | 72 |
| Informing about cleanliness | 63 | 69 | 80 | - | 72 | 84 |
| Food for Infants | 89 | 88 | 79 | - | 95 | 89 |
| Weighing the child | 45 | 55 | 40 | - | 41 | 39 |
| Immunizing the child | 63 | 56 | 34 | - | 70 | 42 |
| Eating iron folic acid tablets | 11 | 14 | 4 | - | 21 | 9 |
| Vitamin A | 9 | 8 | 1 | - | 22 | 6 |
| Playing with child | 21 | 43 | 28 | - | 61 | 34 |
| Communicating with the child | 21 | 38 | 25 | - | 59 | 42 |
| Early stimulation | 20 | 26 | 4 | - | 39 | 3 |
| Disciplining the child | 21 | 34 | 15 | - | 24 | 17 |
| Complementary feeding | 65 | 64 | 71 | - | 54 | 75 |
| Caring child during illness | 21 | 22 | 14 | - | 24 | 19 |
| ORS and Zinc | 3 | 0 | 0 | - | 9 | 2 |
| Safety and protection of child | 22 | 31 | 41 | - | 43 | 33 |
| None | 0 | 0 | 0 | - | 0 | 0 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |

**FLWs providing counselling to parents of 0-3 years child – Rajasthan (in %)**
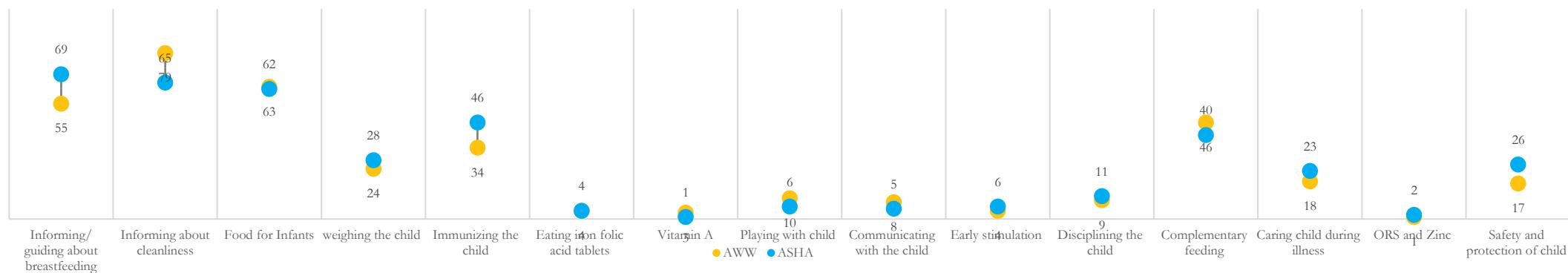


*Figure 48: FLWs providing counselling to parents of 0-3 years child in Rajasthan (in %)*

Table 30: FLWs providing counselling to parents of 0-3 years child in Rajasthan (in %)

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q201c what do you provide information or counselling on? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Informing/ guiding about breastfeeding | - | 68 | 50 | - | 73 | 64 |
| Informing about cleanliness | - | 82 | 78 | - | 61 | 70 |
| Food for Infants | - | 69 | 61 | - | 66 | 59 |
| Weighing the child | - | 19 | 26 | - | 31 | 26 |
| Immunizing the child | - | 37 | 32 | - | 48 | 44 |
| Eating iron folic acid tablets | - | 5 | 4 | - | 3 | 4 |
| Vitamin A | - | 2 | 3 | - | 0 | 1 |
| Playing with child | - | 8 | 11 | - | 4 | 7 |
| Communicating with the child | - | 9 | 7 | - | 3 | 7 |
| Early stimulation | - | 7 | 3 | - | 6 | 7 |
| Disciplining the child | - | 11 | 8 | - | 4 | 17 |
| Complementary feeding | - | 45 | 46 | - | 39 | 40 |
| Caring child during illness | - | 23 | 15 | - | 25 | 20 |
| ORS and Zinc | - | 0 | 1 | - | 1 | 3 |
| Safety and protection of child | - | 8 | 21 | - | 24 | 27 |
| None | - | 1 | 0 | - | 0 | 1 |
| **N** | **-** | **129** | **322** | **-** | **71** | **70** |

**FLWs reporting activities parents can do to bond with a baby of 0-6 months – Maharashtra (in %)**



Figure 49: FLWs reporting activities parents can do to bond with a baby of 0-6 months in Maharashtra (in %)

Table 31: FLWs reporting activities parents can do to bond with a baby of 0-6 months in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q451 What are the activities parents can do to bond with the baby of 0-6 months old? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Hold the baby close to them | 87 | 94 | 69 | 93 | 84 | 84 | 96 | 94 | 76 | - | 93 | 84 |
| Playing with the child | 77 | 75 | 58 | 73 | 82 | 71 | 68 | 94 | 71 | - | 92 | 80 |
| Sing to the baby | 60 | 85 | 41 | 76 | 73 | 68 | 64 | 91 | 26 | - | 70 | 55 |
| Rock the baby gently | 51 | 68 | 46 | 68 | 62 | 61 | 52 | 85 | 48 | - | 70 | 67 |
| Strive for eye contact | 52 | 50 | 30 | 54 | 63 | 49 | 48 | 67 | 29 | - | 67 | 38 |
| Talk to the baby | 36 | 64 | 37 | 80 | 85 | 93 | 32 | 70 | 21 | - | 94 | 100 |
| Copy child movements | 23 | 35 | 15 | 39 | 42 | 47 | 24 | 48 | 17 | - | 44 | 45 |
| Don't Know/Can't Say | 0 | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 0 | - | 2 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

**FLWs reporting activities parents can do to bond with a baby of 0-6 months –Rajasthan (in %)**
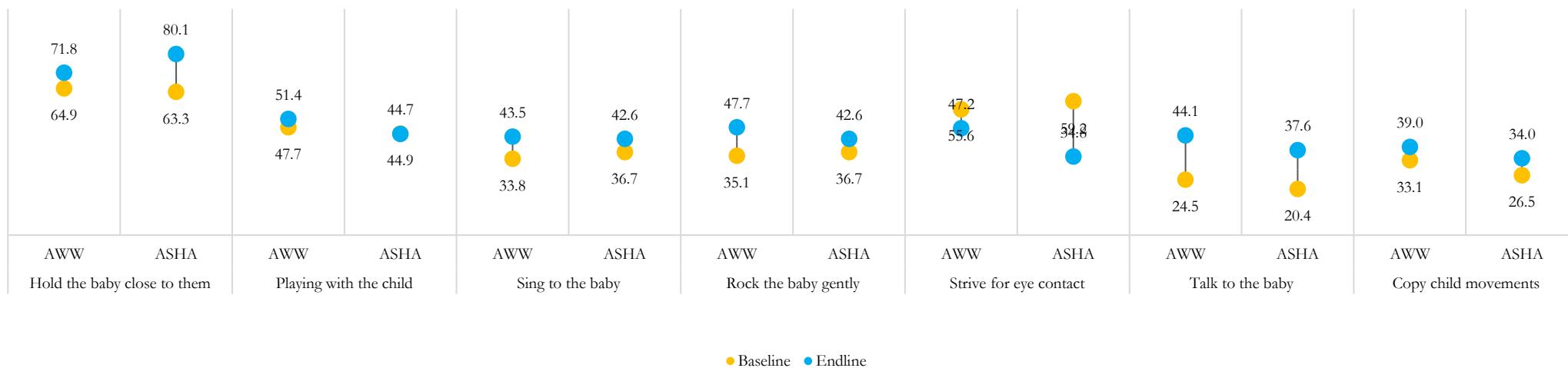


*Figure 50: FLWs reporting activities parents can do to bond with a baby of 0-6 months in Rajasthan (in %)*

*Table 32: FLWs reporting activities parents can do to bond with a baby of 0-6 months in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q451 What are the activities parents can do to bond with the baby of 0-6 months old? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Hold the baby close to them | 60 | 44 | 70 | - | 74 | 71 | 100 | 25 | 70 | - | 79 | 81. |
| Playing with the child | 100 | 30 | 50 | - | 53 | 51 | 100 | 25 | 48 | - | 41 | 49 |
| Sing to the baby | 40 | 11 | 39 | - | 43 | 44 | 0 | 38 | 38 | - | 45 | 40 |
| Rock the baby gently | 20 | 19 | 39 | - | 40 | 51 | 0 | 38 | 38 | - | 54 | 39 |
| Strive for eye contact | 100 | 37 | 58 | - | 57 | 43 | 100 | 50 | 60 | - | 39 | 30 |
| Talk to the baby | 20 | 15 | 27 | - | 56 | 39 | 0 | 25 | 20 | - | 35 | 40 |
| Copy child movements | 20 | 19 | 37 | - | 46 | 36 | 0 | 0 | 33 | - | 34 | 34 |
| Don't Know/Can't Say | 0 | 30 | 5 | - | 3 | 7 | 0 | 13 | 3 | - | 0 | 7 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |

**FLWs reporting ways through which a baby bonds with its caregiver – Maharashtra (in %)**
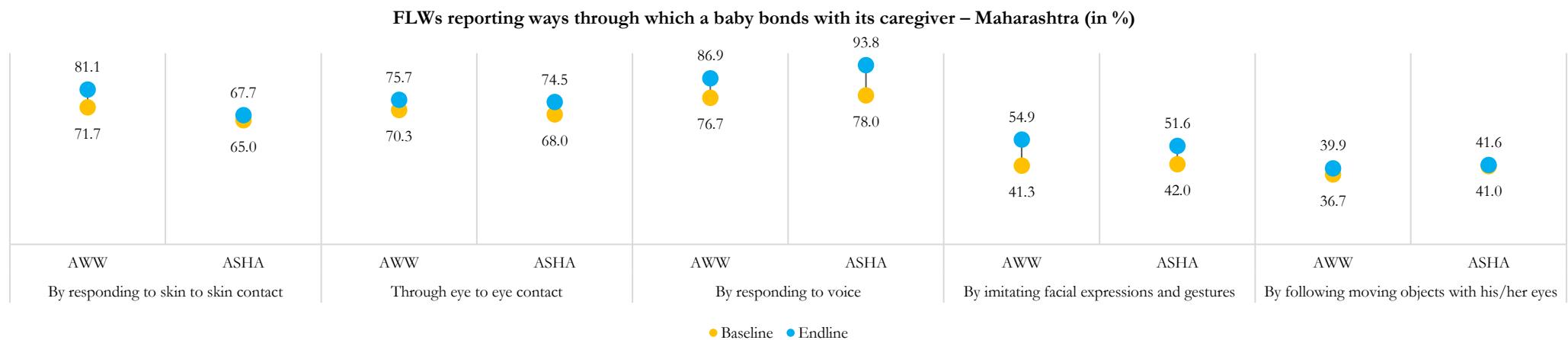


Figure 51: FLWs reporting ways through which a baby bonds with its caregiver in Maharashtra (in %)

Table 33: FLWs reporting ways through which a baby bonds with its caregiver in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q450 What are the ways through which a baby bonds with its caregiver? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| By responding to skin to skin contact | 76 | 84 | 59 | 83 | 81 | 79 | 64 | 91 | 45 | - | 74 | 58 |
| Through eye to eye contact | 87 | 88 | 46 | 76 | 76 | 76 | 88 | 85 | 43 | - | 75 | 73 |
| By responding to voice | 80 | 87 | 66 | 89 | 80 | 95 | 76 | 94 | 67 | - | 91 | 98 |
| By imitating facial expressions and gestures | 20 | 73 | 28 | 59 | 47 | 63 | 12 | 82 | 29 | - | 46 | 59 |
| By following moving objects with his/her eyes | 33 | 56 | 23 | 47 | 42 | 30 | 28 | 82 | 17 | - | 44 | 38 |
| Don't Know/Can't Say | 0 | 1 | 5 | 1 | 1 | 0 | 0 | 0 | 2 | - | 1 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

**FLWs reporting ways through which a baby bonds with its caregiver – Rajasthan (in %)**
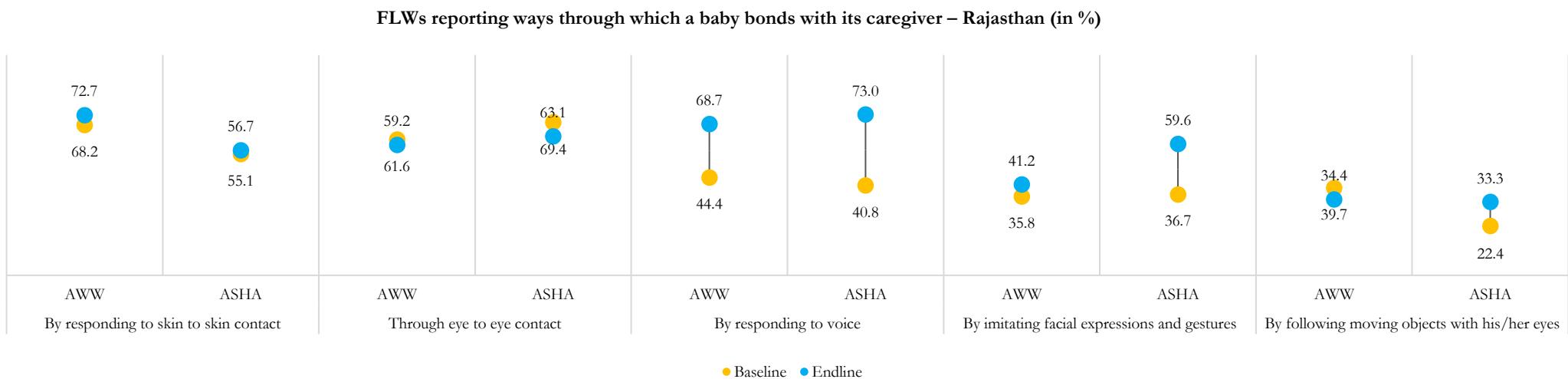


*Figure 52: FLWs reporting ways through which a baby bonds with its caregiver in Rajasthan (in %)*

*Table 34: FLWs reporting ways through which a baby bonds with its caregiver in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q450 What are the ways through which a baby bonds with its caregiver? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| By responding to skin to skin contact | 80 | 44 | 73 | - | 77 | 71 | 100 | 38 | 58 | - | 51 | 63 |
| Through eye to eye contact | 100 | 52 | 62 | - | 57 | 60 | 100 | 38 | 75 | - | 61 | 66 |
| By responding to voice | 40 | 22 | 50 | - | 78 | 65 | 100 | 25 | 43 | - | 82 | 64 |
| By imitating facial expressions and gestures | 40 | 11 | 41 | - | 45 | 40 | 0 | 38 | 38 | - | 59 | 60 |
| By following moving objects with his/her eyes | 60 | 7 | 46 | - | 49 | 29 | 0 | 13 | 25 | - | 24 | 29 |
| Don't Know/Can't Say | 0 | 30 | 7 | - | 5 | 6 | 0 | 13 | 0 | - | 4 | 3 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |
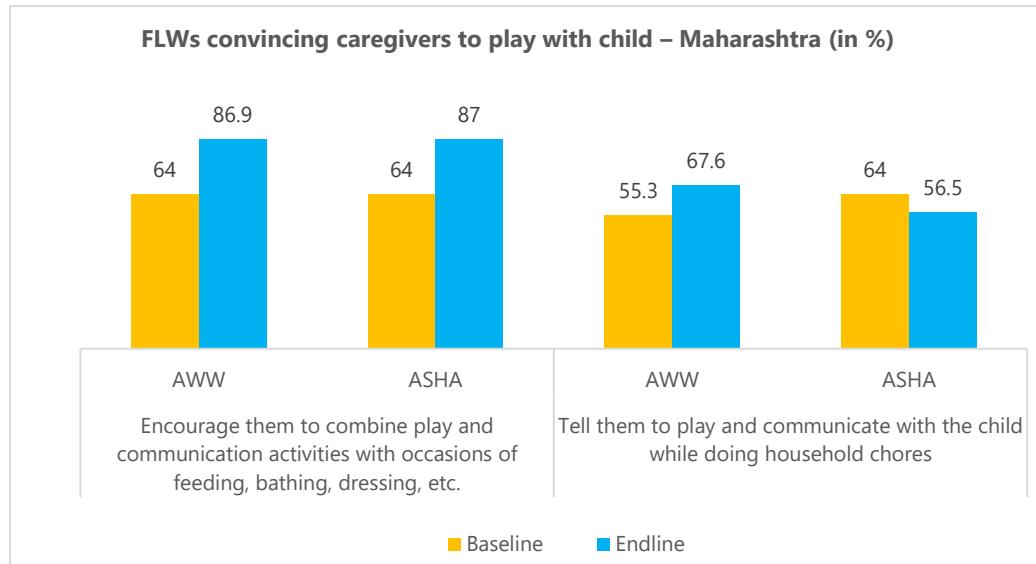
Figure 53: FLWs convincing caregivers to play with child in Maharashtra (in %)

Table 35: FLWs convincing caregivers to play with child in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q435 How do you convince the caregivers to play with the child? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Encourage them to combine play and communication activities with occasions of feeding, bathing, dressing, etc. | 76 | 79 | 44 | 92 | 80 | 92 | 64 | 91 | 43 | - | 83 | 94 |
| Tell them to play and communicate with the child while doing household chores | 60 | 59 | 50 | 63 | 76 | 60 | 76 | 70 | 52 | - | 59 | 53 |
| Don't Know/Can't Say | 0 | 0 | 14 | 2 | 1 | 1 | 0 | 0 | 2 | - | 0 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |
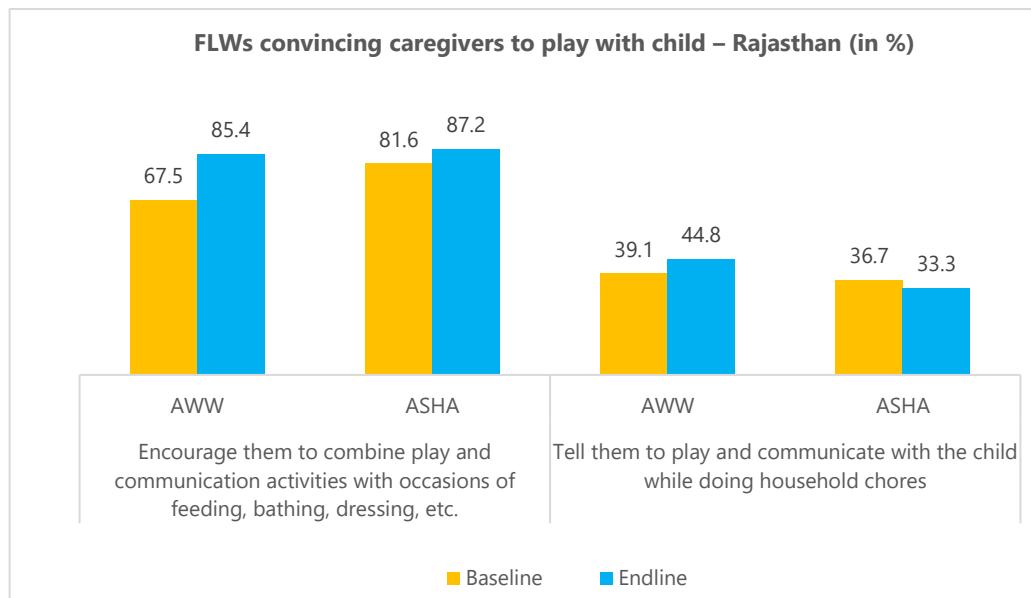
*Figure 54: FLWs convincing caregivers to play with child in Rajasthan (in %)*

*Table 36: FLWs convincing caregivers to play with child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q435 How do you convince the caregivers to play with the child?** | **Baseline** | | | **Endline** | | | **Baseline** | | | **Endline** | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Encourage them to combine play and communication activities with occasions of feeding, bathing, dressing, etc. | 80 | 56 | 70 | - | 84 | 86 | 100 | 63 | 85 | - | 92 | 83 |
| Tell them to play and communicate with the child while doing household chores | 60 | 41 | 38 | - | 40 | 47 | 0 | 50 | 35 | - | 31 | 36 |
| Don't Know/Can't Say | 0 | 19 | 10 | - | 4 | 3 | 0 | 13 | 8 | - | 4 | 7 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |
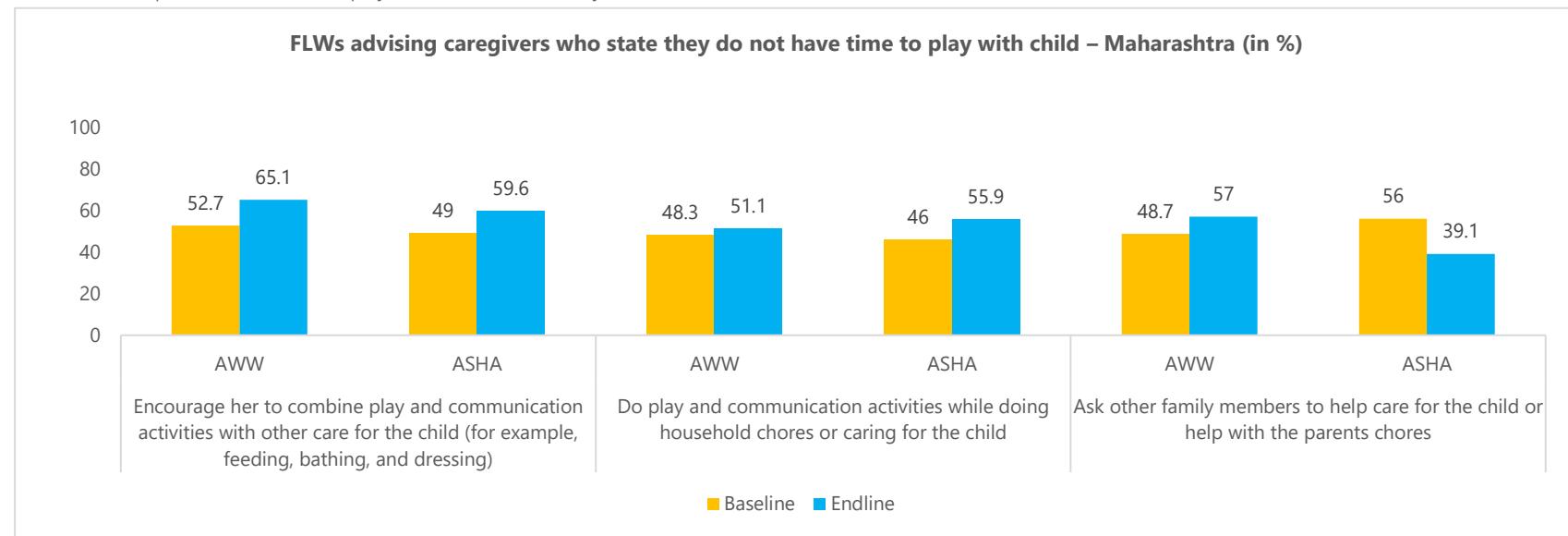
Figure 55: FLWs advising caregivers who state they do not have time to play with child in Maharashtra (in %)

Table 37: FLWs advising caregivers who state they do not have time to play with child in Maharashtra (in %)

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q437 If a caregiver comes to you and states that she/he does not have time to play with the child, what would be your advice? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Encourage her to combine play and communication activities with other care for the child (for example, feeding, bathing, and dressing) | 61 | 69 | 34 | 59 | 63 | 75 | 44 | 67 | 38 | - | 65 | 52 |
| Do play and communication activities while doing household chores or caring for the child | 41 | 60 | 44 | 45 | 55 | 51 | 52 | 76 | 43 | - | 55 | 58 |
| Ask other family members to help care for the child or help with the parents chores | 63 | 58 | 32 | 66 | 56 | 49 | 64 | 64 | 21 | - | 63 | 38 |
| Nothing | 0 | 1 | 10 | 1 | 1 | 1 | 0 | 0 | 7 | - | 1 | 2 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |
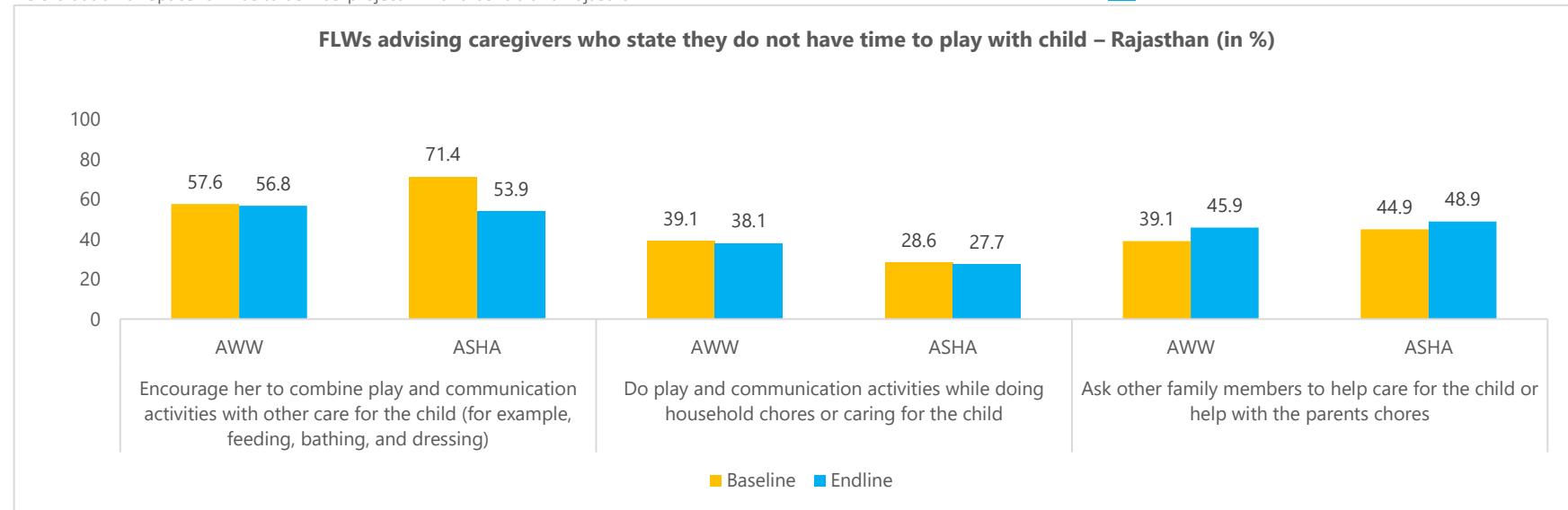
Figure 56: FLWs advising caregivers who state they do not have time to play with child in Rajasthan (in %)

Table 38: FLWs advising caregivers who state they do not have time to play with child in Rajasthan (in %)

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q437 If a caregiver comes to you and states that she/he does not have time to play with the child, what would be your advice? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Encourage her to combine play and communication activities with other care for the child (for example, feeding, bathing, and dressing) | 60 | 26 | 65 | - | 68 | 53 | 100 | 63 | 73 | - | 45 | 63 |
| Do play and communication activities while doing household chores or caring for the child | 20 | 41 | 39 | - | 33 | 40 | 0 | 25 | 50 | - | 54 | 44 |
| Ask other family members to help care for the child or help with the parents' chores | 80 | 33 | 39 | - | 45 | 46 | 0 | 13 | 33 | - | 34 | 21 |
| Nothing | 0 | 26 | 10 | - | 2 | 4 | 0 | 13 | 5 | - | 4 | 4 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |
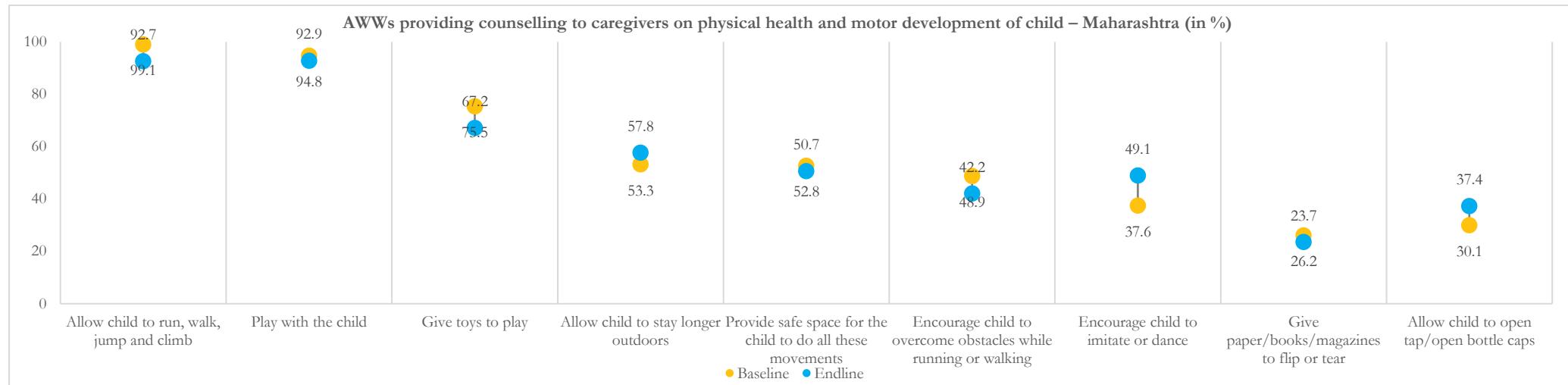
Figure 57: AWWs providing counselling to caregivers on physical health and motor development of child in Maharashtra (in %)

Table 39: AWWs providing counselling to caregivers on physical health and motor development of child in Maharashtra (in %)

| Maharashtra | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q492 What do you counsel or tell them to do for the physical health and motor development of children of 3-6 years? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Allow child to run, walk, jump and climb | 91 | 85 | 59 | 93 | 91 | 95 |
| Play with the child | 56 | 90 | 68 | 95 | 92 | 92 |
| Give toys to play | 37 | 84 | 48 | 66 | 70 | 64 |
| Allow child to stay longer outdoors | 44 | 62 | 21 | 66 | 54 | 55 |
| Provide safe space for the child to do all these movements | 36 | 55 | 31 | 69 | 44 | 44 |
| Encourage child to overcome obstacles while running or walking | 28 | 65 | 30 | 51 | 36 | 44 |
| Encourage child to imitate or dance | 23 | 47 | 17 | 51 | 53 | 42 |
| Give paper/books/magazines to flip or tear | 11 | 37 | 11 | 19 | 26 | 25 |
| Allow child to open tap/open bottle caps | 7 | 49 | 11 | 41 | 37 | 36 |
| Don't know/Can't say | 0 | 0 | 2 | 0 | 2 | 2 |
| N | 75 | 102 | 122 | 131 | 208 | 142 |
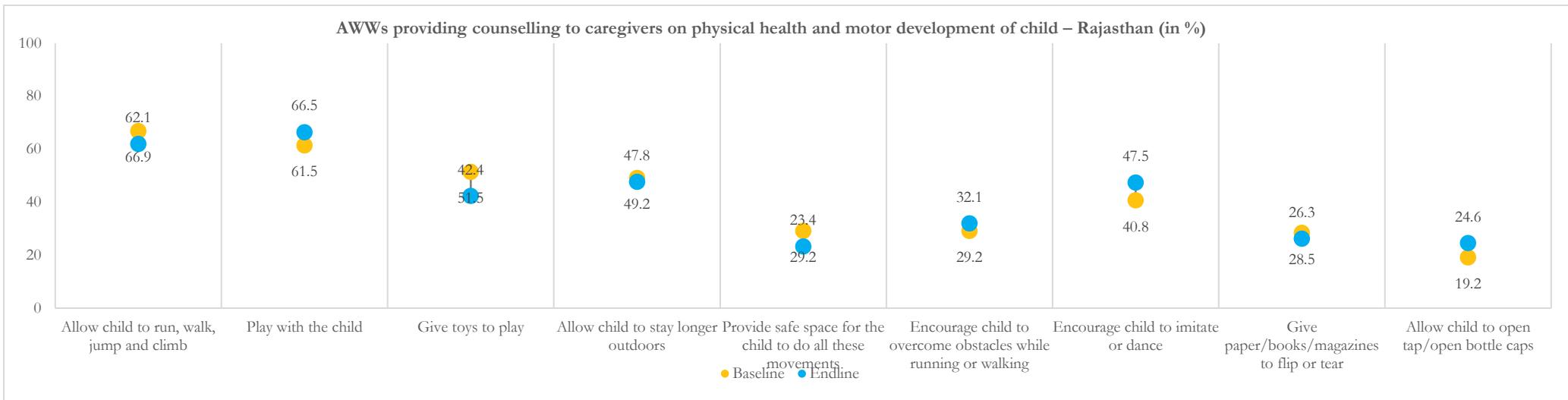
*Figure 60: AWWs providing counselling to caregivers on physical health and motor development of child in Rajasthan (in %)*

*Table 40: AWWs providing counselling to caregivers on physical health and motor development of child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | |
| Q492 What do you counsel or tell them to do for the physical health and motor development of children of 3-6 years? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Allow child to run, walk, jump and climb | 80 | 43 | 71 | - | 79 | 55 |
| Play with the child | 80 | 57 | 62 | - | 70 | 65 |
| Give toys to play | 100 | 57 | 48 | - | 37 | 45 |
| Allow child to stay longer outdoors | 60 | 38 | 51 | - | 33 | 54 |
| Provide safe space for the child to do all these movements | 20 | 14 | 33 | - | 23 | 24 |
| Encourage child to overcome obstacles while running or walking | 0 | 14 | 34 | - | 36 | 31 |
| Encourage child to imitate or dance | 40 | 24 | 44 | - | 49 | 47 |
| Give paper/books/magazines to flip or tear | 20 | 14 | 32 | - | 30 | 25 |
| Allow child to open tap/open bottle caps | 0 | 0 | 24 | - | 23 | 25 |
| Don't know/Can't say | 0 | 0 | 2 | - | 5 | 13 |
| **N** | **5** | **21** | **104** | **-** | **128** | **320** |
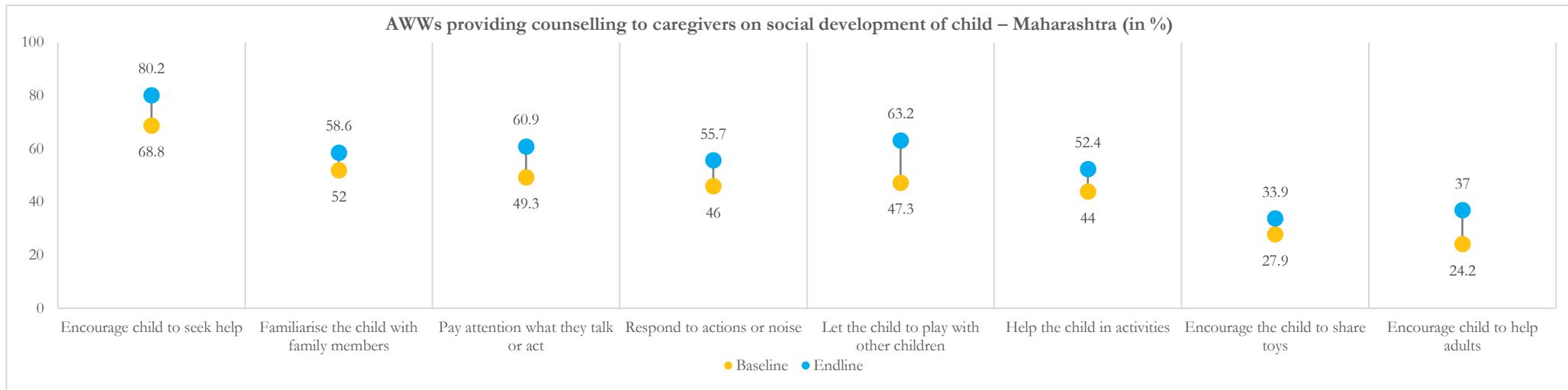
*Figure 61: AWWs providing counselling to caregivers on social development of child in Maharashtra (in %)*

*Table 41: AWWs providing counselling to caregivers on social development of child in Maharashtra (in %)*

| Maharashtra | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q494 What do you counsel or tell them to do for the social development of children of children of 3-6 years? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Encourage child to seek help | 85 | 77 | 52 | 88 | 79 | 75 |
| Familiarise the child with family members | 43 | 74 | 39 | 57 | 59 | 59 |
| Pay attention what they talk or act | 44 | 71 | 34 | 71 | 50 | 68 |
| Respond to actions or noise | 52 | 62 | 29 | 57 | 57 | 52 |
| Let the child to play with other children | 35 | 71 | 35 | 70 | 66 | 54 |
| Help the child in activities | 29 | 62 | 38 | 70 | 46 | 47 |
| Encourage the child to share toys | 8 | 51 | 20 | 49 | 31 | 24 |
| Encourage child to help adults | 11 | 38 | 21 | 39 | 31 | 44 |
| Don't know/Can't say | 0 | 4 | 2 | 2 | 13 | 5 |
| **N** | **75** | **101** | **122** | **131** | **208** | **142** |
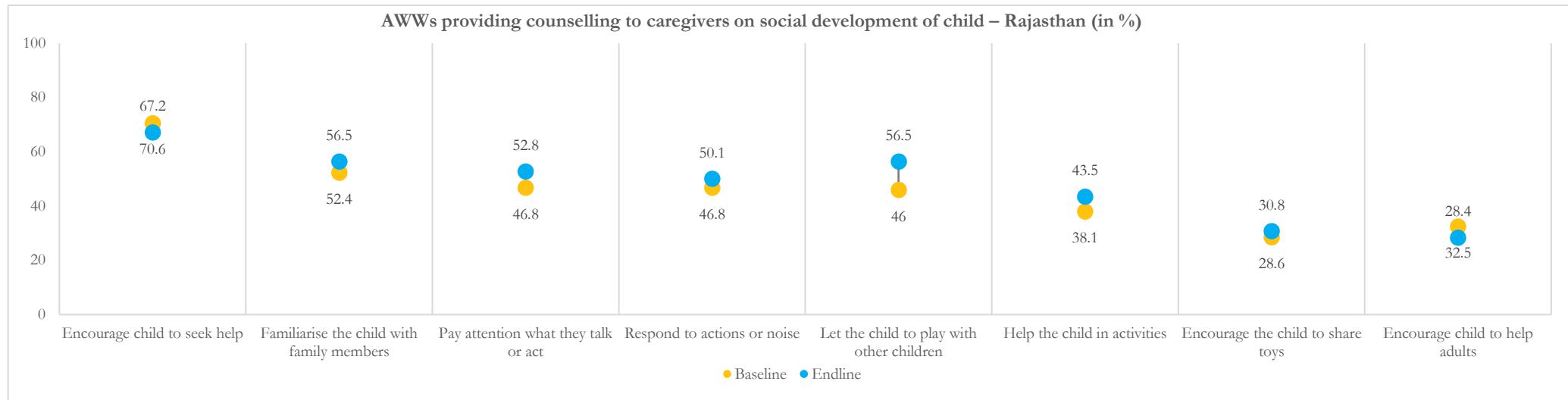
*Figure 62: AWWs providing counselling to caregivers on social development of child in Rajasthan (in %)*

*Table 42: AWWs providing counselling to caregivers on social development of child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | |
|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | |
| Q494 What do you counsel or tell them to do for the social development of children of 3-6 years? | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Encourage child to seek help | 60 | 71 | 71 | - | 76 | 64 |
| Familiarise the child with family members | 80 | 29 | 56 | - | 56 | 57 |
| Pay attention what they talk or act | 40 | 38 | 49 | - | 63 | 49 |
| Respond to actions or noise | 60 | 29 | 50 | - | 47 | 52 |
| Let the child to play with other children | 40 | 48 | 46 | - | 55 | 57 |
| Help the child in activities | 60 | 38 | 37 | - | 53 | 40 |
| Encourage the child to share toys | 40 | 14 | 31 | - | 32 | 30 |
| Encourage child to help adults | 0 | 5 | 40 | - | 30 | 28 |
| Don't know/Can't say | 0 | 0 | 2 | - | 14 | 22 |
| N | 5 | 21 | 100 | - | 129 | 322 |

**AWWs providing counselling to caregivers on emotional development of child – Maharashtra (in %)**

| Category | Baseline | Endline |
|----------|----------|---------|
| Let the child to play roles such as mother, teacher, etc. | 64.3 | 71.9 |
| Allow child to take decisions while playing | 55.2 | 61.1 |
| Answer child s questions | 55.2 | 62.2 |
| Encourage child to support other children who are crying or sad | 44.8 | 52.4 |
| Encourage child to talk about his/her own emotions | 43.1 | 76.3 |
| Encourage child to do things alone | 43.4 | 42 |
| Appreciate child for doing or completing work or activities | 36.4 | 61.3 |
| Encourage child to do new things or activities | 29.6 | 51.8 |
| Help child to do new things or activities | 31.3 | 41.8 |
| Include child in everyday activities and cheer them constantly | 25.3 | 29.7 |
| Cheer and praise the child for their achievements | 25.6 | 40.1 |

*Figure 63: AWWs providing counselling to caregivers on emotional development of child in Maharashtra (In %)*

**AWWs providing counselling to caregivers on emotional development of child – Rajasthan (in %)**

| Category | Baseline | Endline |
|----------|----------|---------|
| Let the child to play roles such as mother, teacher, etc. | 69.4 | 66.5 |
| Allow child to take decisions while playing | 63.6 | 61.9 |
| Answer child s questions | 54.5 | 60.3 |
| Encourage child to support other children who are crying or sad | 45.5 | 49.9 |
| Encourage child to talk about his/her own emotions | 43.8 | 60.3 |
| Encourage child to do things alone | 32.2 | 37.7 |
| Appreciate child for doing or completing work or activities | 38 | 52.5 |
| Encourage child to do new things or activities | 43 | 53 |
| Help child to do new things or activities | 33.1 | 37.9 |
| Include child in everyday activities and cheer them constantly | 33.9 | 27.3 |
| Cheer and praise the child for their achievements | 28.1 | 32.4 |

*Figure 64: AWWs providing counselling to caregivers on emotional development of child in Rajasthan (in %)*

*Table 43: AWWs providing counselling to caregivers on emotional development of child in Maharashtra and Rajasthan (In %)*

| Q496 What do you counsel or tell them to do for the emotional development of children of 3-6 years? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Let the child to play roles such as mother, teacher, etc. | 79 | 81 | 41 | 76 | 70 | 71 | 60 | 67 | 71 | - | 74 | 63 |
| Allow child to take decisions while playing | 43 | 77 | 45 | 68 | 64 | 51 | 80 | 57 | 64 | - | 66 | 60 |
| Answer child s questions | 33 | 86 | 43 | 58 | 64 | 63 | 60 | 43 | 57 | - | 67 | 58 |
| Encourage child to support other children who are crying or sad | 32 | 63 | 37 | 67 | 53 | 37 | 20 | 33 | 49 | - | 43 | 53 |
| Encourage child to talk about his/her own emotions | 41 | 60 | 30 | 85 | 68 | 80 | 60 | 19 | 48 | - | 69 | 57 |
| Encourage child to do things alone | 39 | 61 | 31 | 49 | 37 | 43 | 40 | 24 | 34 | - | 37 | 38 |
| Appreciate child for doing or completing work or activities | 40 | 54 | 19 | 59 | 63 | 62 | 40 | 24 | 41 | - | 60 | 50 |
| Encourage child to do new things or activities | 15 | 56 | 17 | 59 | 53 | 43 | 60 | 24 | 46 | - | 56 | 52 |
| Help child to do new things or activities | 17 | 62 | 14 | 57 | 30 | 46 | 0 | 5 | 41 | - | 44 | 35 |
| Include child in everyday activities and cheer them constantly | 19 | 45 | 13 | 46 | 24 | 23 | 0 | 24 | 38 | - | 30 | 26 |
| Cheer and praise the child for their achievements | 13 | 47 | 16 | 50 | 35 | 39 | 0 | 0 | 36 | - | 33 | 32 |
| Don't know/Can't say | 0 | 1 | 3 | 1 | 8 | 7 | 0 | 0 | 1 | - | 13 | 30 |
| **N** | **75** | **101** | **121** | **131** | **208** | **142** | **5** | **21** | **95** | **-** | **129** | **322** |

**AWWs providing counselling to caregivers on language and communication development of child – Maharashtra (in %)**
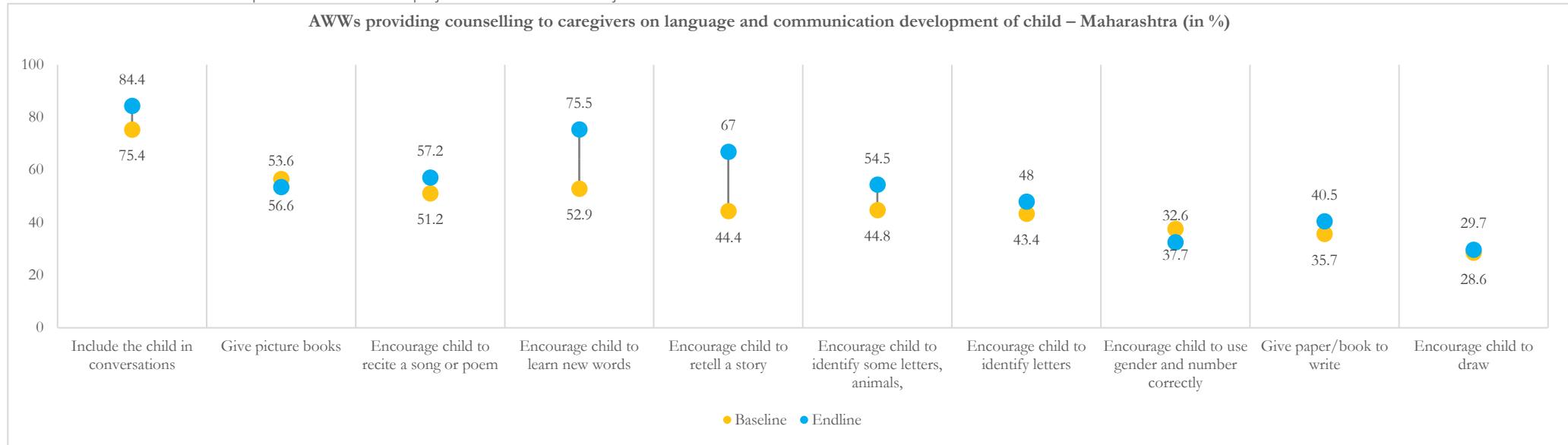


*Figure 65: AWWs providing counselling to caregivers on language and communication development of child in Maharashtra (in %)*

**AWWs providing counselling to caregivers on language and communication development of child – Rajasthan (in %)**
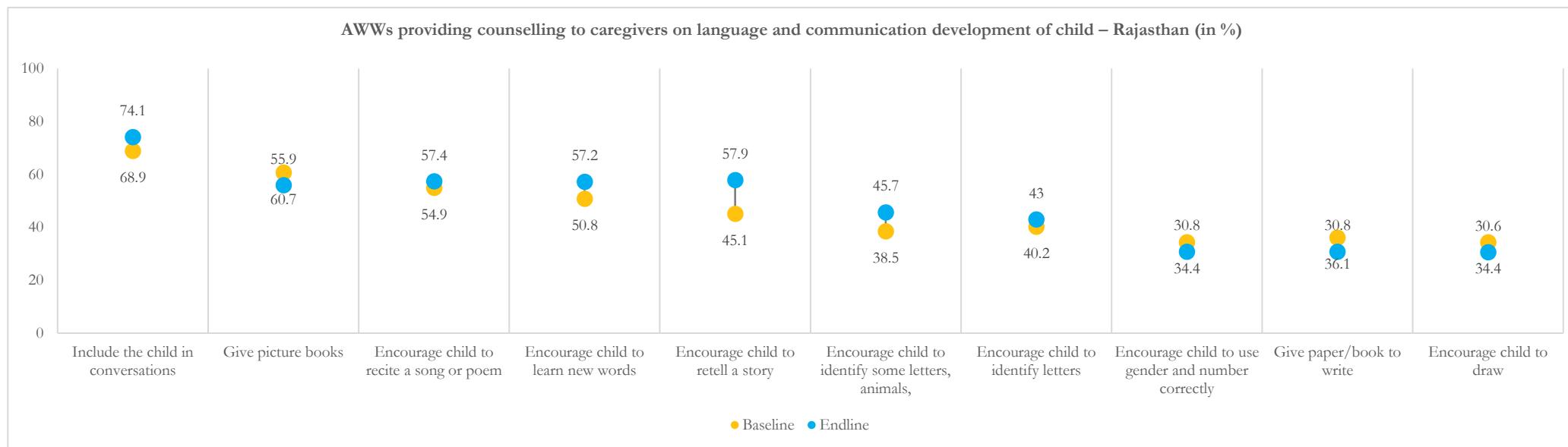


*Figure 66: AWWs providing counselling to caregivers on language and communication development of child in Rajasthan (in %)*

*Table 44: AWWs providing counselling to caregivers on language and communication development of child in Maharashtra and Rajasthan (in %)*

| Q500 What do you counsel or tell them to do for the language and communication development of children in the age group of 3-6 years? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Include the child in conversations | 84 | 84 | 63 | 91 | 87 | 75 | 80 | 62 | 70 | - | 85 | 70 |
| Give picture books | 51 | 76 | 44 | 55 | 52 | 54 | 60 | 43 | 65 | - | 56 | 56 |
| Encourage child to recite a song or poem | 44 | 82 | 30 | 68 | 54 | 52 | 60 | 38 | 58 | - | 57 | 58 |
| Encourage child to learn new words | 41 | 79 | 39 | 71 | 78 | 76 | 60 | 48 | 51 | - | 61 | 56 |
| Encourage child to retell a story | 29 | 60 | 41 | 70 | 63 | 70 | 80 | 24 | 48 | - | 62 | 56 |
| Encourage child to identify some letters, animals, | 29 | 71 | 33 | 51 | 49 | 66 | 40 | 14 | 44 | - | 48 | 45 |
| Encourage child to identify letters | 16 | 75 | 34 | 53 | 41 | 53 | 0 | 24 | 46 | - | 47 | 42 |
| Encourage child to use gender and number correctly | 36 | 54 | 25 | 30 | 38 | 28 | 20 | 14 | 40 | - | 28 | 32 |
| Give paper/book to write | 20 | 57 | 28 | 44 | 40 | 38 | 0 | 14 | 43 | - | 26 | 35 |
| Encourage child to draw | 16 | 54 | 16 | 38 | 25 | 30 | 20 | 10 | 41 | - | 30 | 31 |
| Don't know/Can't say | 0 | 0 | 2 | 0 | 2 | 1 | 0 | 5 | 0 | - | 4 | 7 |
| N | 75 | 100 | 122 | 131 | 208 | 142 | 5 | 21 | 96 | - | 129 | 322 |

**AWWs providing counselling to caregivers on cognitive development of child – Maharashtra (in %)**
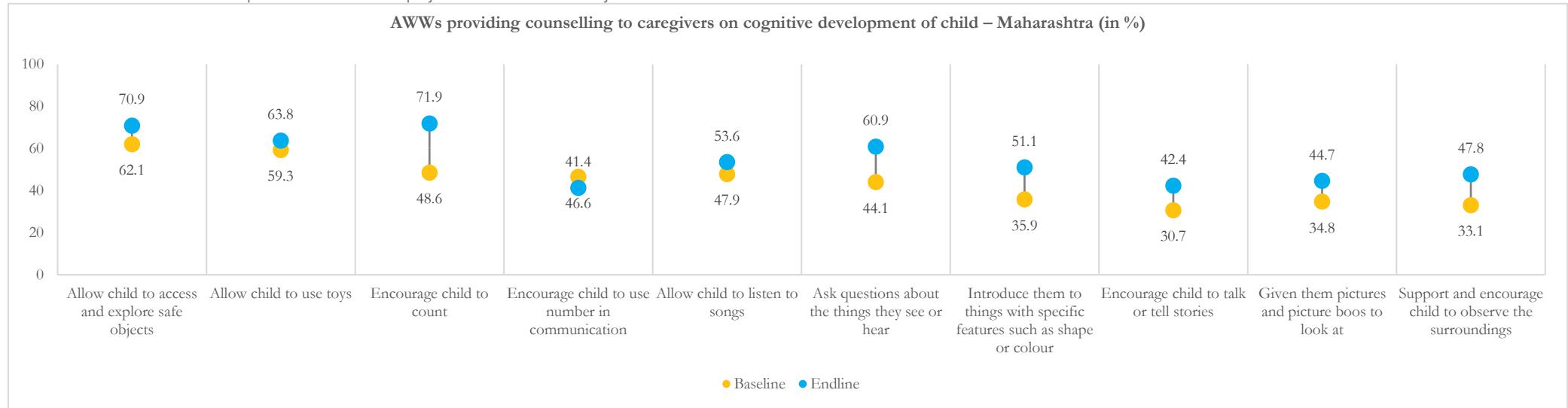


*Figure 67: AWWs providing counselling to caregivers on cognitive development of child – Maharashtra (in %)*

**AWWs providing counselling to caregivers on cognitive development of child – Rajasthan (in %)**
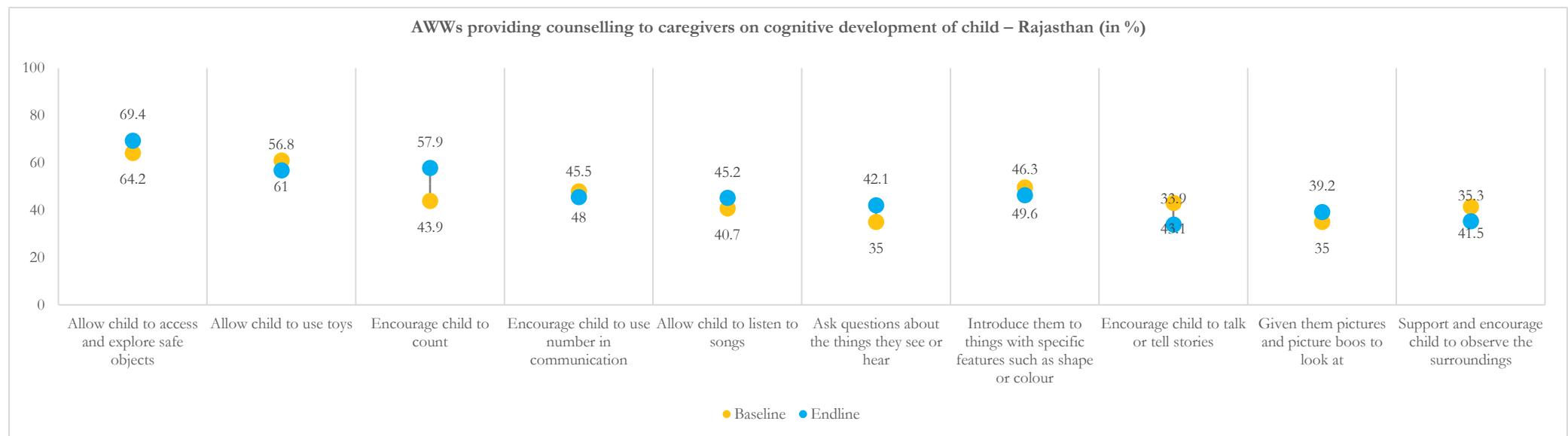


*Figure 68: AWWs providing counselling to caregivers on cognitive development of child in Rajasthan (in %)*

| Q502 What do you counsel or tell them to do for the cognitive development of children in the age group of 3-6 years? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Allow child to access and explore safe objects | 80 | 75 | 40 | 73 | 75 | 63 | 60 | 43 | 69 | - | 75 | 67 |
| Allow child to use toys | 41 | 88 | 47 | 73 | 62 | 58 | 80 | 48 | 63 | - | 48 | 60 |
| Encourage child to count | 35 | 80 | 31 | 78 | 71 | 68 | 20 | 30 | 48 | - | 59 | 58 |
| Encourage child to use number in communication | 44 | 69 | 29 | 47 | 45 | 30 | 60 | 30 | 52 | - | 47 | 45 |
| Allow child to listen to songs | 29 | 78 | 34 | 44 | 55 | 60 | 40 | 35 | 42 | - | 47 | 45 |
| Ask questions about the things they see or hear | 31 | 64 | 36 | 72 | 62 | 50 | 60 | 22 | 37 | - | 43 | 42 |
| Introduce them to things with specific features such as shape or colour | 36 | 54 | 21 | 47 | 41 | 70 | 60 | 26 | 55 | - | 48 | 46 |
| Encourage child to talk or tell stories | 27 | 51 | 16 | 40 | 43 | 44 | 20 | 22 | 49 | - | 41 | 31 |
| Given them pictures and picture boos to look at | 16 | 65 | 22 | 44 | 36 | 59 | 20 | 4 | 43 | - | 35 | 41 |
| Support and encourage child to observe the surroundings | 28 | 57 | 16 | 61 | 47 | 37 | 40 | 26 | 45 | - | 49 | 30 |
| Encourage child to dance along with the songs | 7 | 54 | 20 | 36 | 34 | 31 | 0 | 4 | 44 | - | 42 | 37 |
| Give then drawing materials | 19 | 52 | 15 | 21 | 14 | 33 | 0 | 13 | 35 | - | 26 | 18 |
| Encourage child to sing known songs | 1 | 43 | 15 | 30 | 37 | 27 | 0 | 4 | 38 | - | 30 | 36 |
| Don't know/Can't say | 1 | 2 | 10 | 1 | 6 | 1 | 0 | 4 | 0 | - | 7 | 12 |
| N | 75 | 99 | 116 | 131 | 208 | 142 | 5 | 23 | 95 | - | 129 | 322 |

*Table 45: AWWs providing counselling to caregivers on cognitive development of child in Maharashtra and Rajasthan (in %)*

**FLWs describing the home environment needed for child to grow well – Maharashtra (in %)**
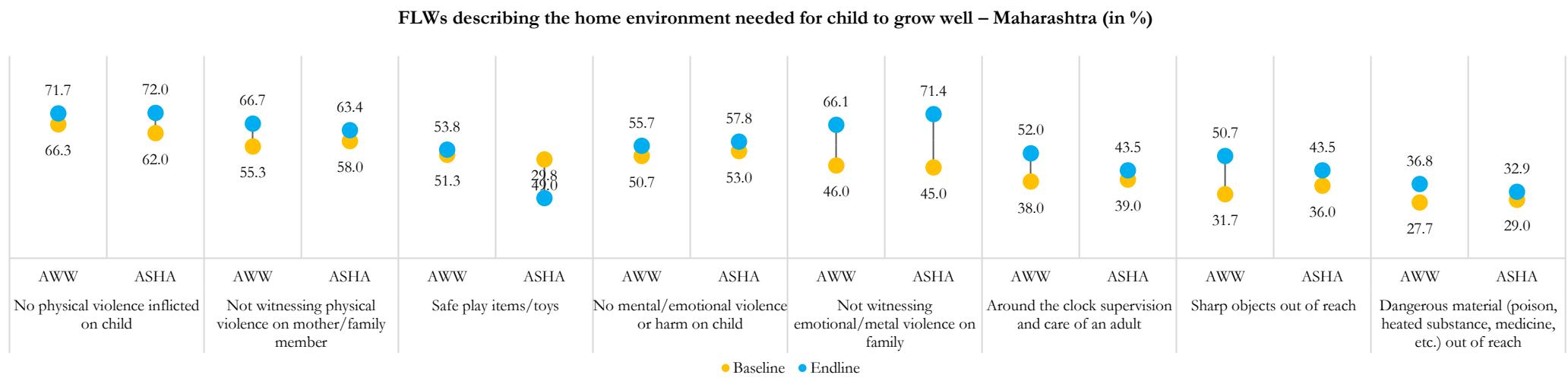


*Figure 69: FLWs describing the home environment needed for child to grow well in Maharashtra (in %)*

*Table 46: FLWs describing the home environment needed for child to grow well in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q507 How would you describe the home environment needed for child to grow well? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| No physical violence inflicted on child | 76 | 79 | 50 | 76 | 64 | 80 | 76 | 82 | 38 | - | 69 | 77 |
| Not witnessing physical violence on mother/family member | 41 | 81 | 42 | 75 | 68 | 57 | 48 | 82 | 45 | - | 75 | 45 |
| Safe play items/toys | 45 | 70 | 40 | 47 | 51 | 65 | 28 | 82 | 46 | - | 19 | 47 |
| No mental/emotional violence or harm on child | 47 | 65 | 41 | 76 | 69 | 18 | 48 | 76 | 38 | - | 79 | 25 |
| Not witnessing emotional/metal violence on family | 51 | 63 | 29 | 69 | 69 | 59 | 64 | 64 | 19 | - | 75 | 45 |
| Around the clock supervision and care of an adult | 31 | 61 | 24 | 63 | 50 | 45 | 40 | 70 | 14 | - | 51 | 33 |
| Sharp objects out of reach | 11 | 61 | 20 | 47 | 56 | 47 | 4 | 70 | 29 | - | 44 | 44 |
| Dangerous material (poison, heated substance, medicine, etc.) out of reach | 16 | 49 | 17 | 39 | 40 | 30 | 4 | 70 | 12 | - | 33 | 33 |
| Don't know/Can't say | 1 | 1 | 2 | 0 | 0 | 0 | 0 | 3 | 0 | - | 0 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

**FLWs describing the home environment needed for child to grow well – Rajasthan (in %)**
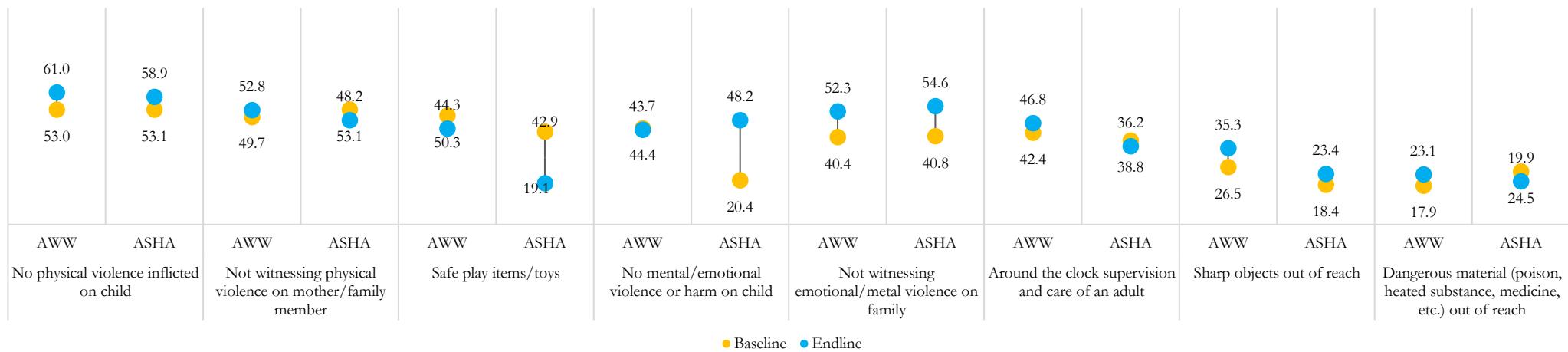


Figure 70: FLWs describing the home environment needed for child to grow well in Rajasthan (in %)

Table 47: FLWs describing the home environment needed for child to grow well in Rajasthan (in %)

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q507 How would you describe the home environment needed for child to grow well? | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| No physical violence inflicted on child | 80 | 37 | 55 | - | 62 | 61 | 100 | 38 | 55 | - | 58 | 60 |
| Not witnessing physical violence on mother/family member | 60 | 33 | 53 | - | 62 | 49 | 0 | 38 | 58 | - | 48 | 49 |
| Safe play items/toys | 60 | 44 | 51 | - | 38 | 35 | 0 | 25 | 48 | - | 13 | 26 |
| No mental/emotional violence or harm on child | 60 | 33 | 46 | - | 38 | 46 | 0 | 13 | 23 | - | 47 | 50 |
| Not witnessing emotional/metal violence on family | 40 | 15 | 46 | - | 38 | 46 | 100 | 25 | 43 | - | 56 | 53 |
| Around the clock supervision and care of an adult | 20 | 33 | 45 | - | 61 | 41 | 100 | 13 | 43 | - | 41 | 31 |
| Sharp objects out of reach | 20 | 15 | 29 | - | 36 | 35 | 0 | 13 | 20 | - | 23 | 24 |
| Dangerous material (poison, heated substance, medicine, etc.) out of reach | 0 | 4 | 22 | - | 22 | 24 | 100 | 25 | 23 | - | 21 | 19 |
| Don't know/Can't say | 0 | 19 | 5 | - | 0 | 5 | 0 | 13 | 3 | - | 3 | 4 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |
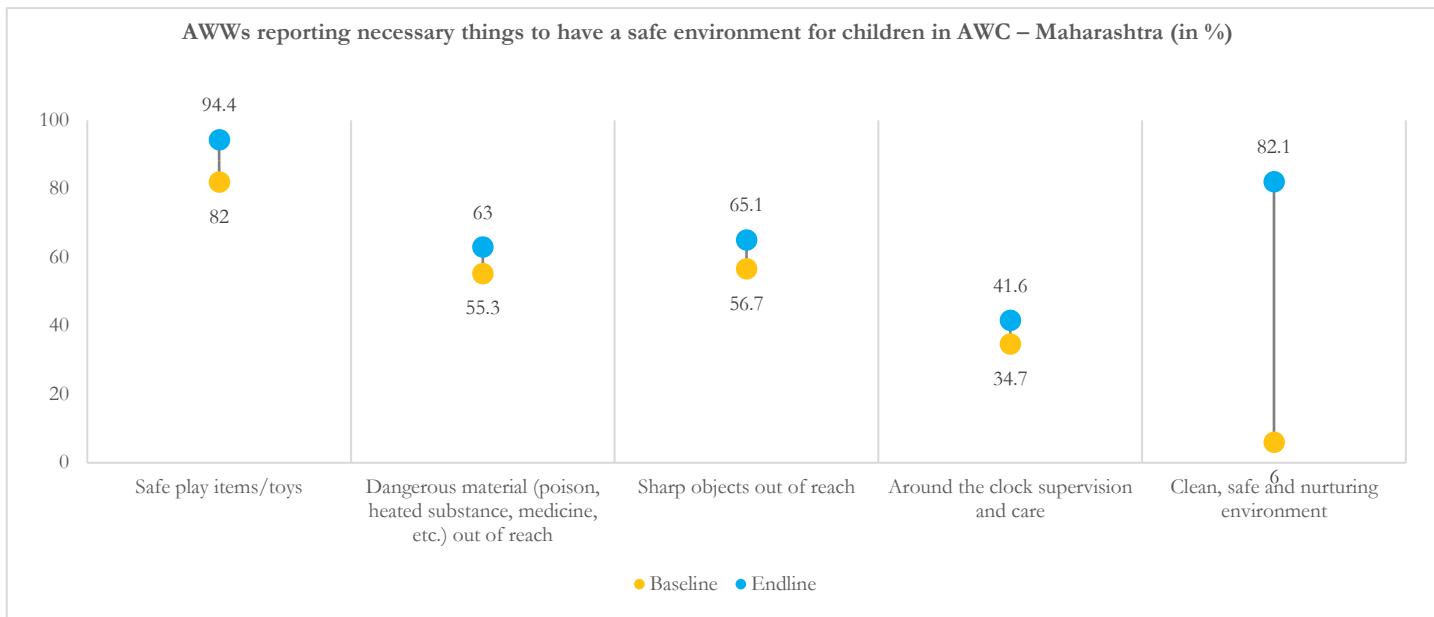
*Figure 71: AWWs reporting necessary things to have a safe environment for children in AWC in Maharashtra (in %)*

*Table 48: AWWs reporting necessary things to have a safe environment for children in AWC in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q508 What all is necessary to have a safe environment for children in the AWC? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Safe play items/toys | 88 | 89 | 72 | 95 | 93 | 96 | 64 | 94 | 64 | - | 97 | 100 |
| Dangerous material (poison, heated substance, medicine, etc.) out of reach | 47 | 80 | 40 | 67 | 63 | 59 | 60 | 85 | 38 | - | 65 | 55 |
| Sharp objects out of reach | 51 | 76 | 44 | 71 | 64 | 62 | 40 | 85 | 31 | - | 62 | 47 |
| Around the clock supervision and care | 36 | 55 | 17 | 46 | 44 | 35 | 32 | 67 | 12 | - | 40 | 50 |
| Clean, safe and nurturing environment | 4 | 7 | 7 | 73 | 79 | 95 | 0 | 3 | 14 | - | 88 | 98 |
| Don't know/Can't say | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 5 | - | 1 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |
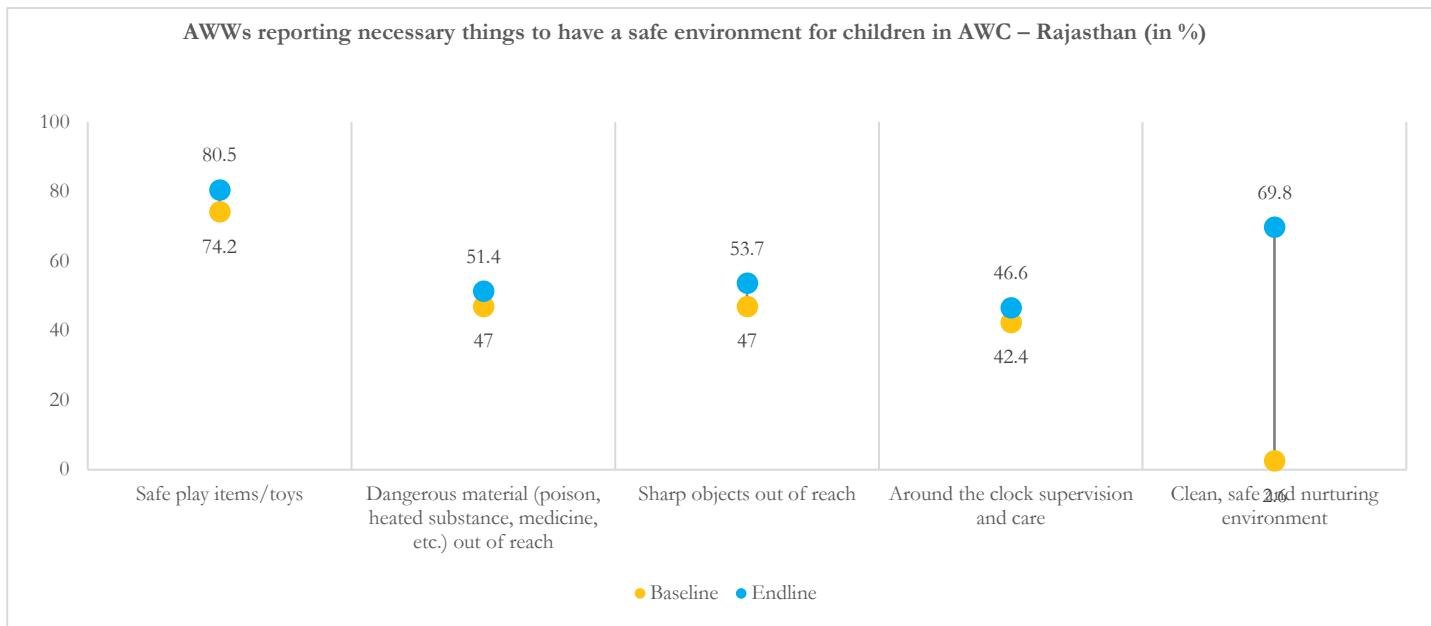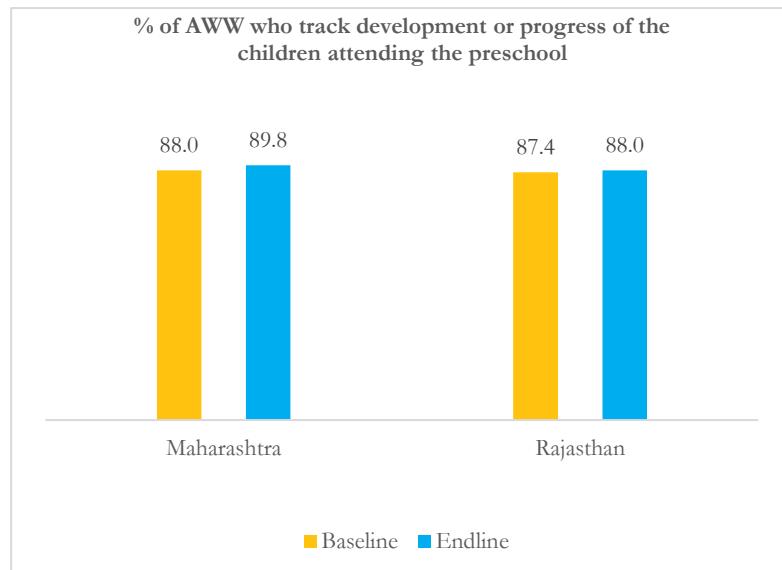
*Figure 72: AWWs reporting necessary things to have a safe environment for children in AWC in Rajasthan (in %)*

*Table 49: AWWs reporting necessary things to have a safe environment for children in AWC in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q508 What all is necessary to have a safe environment for children in the AWC? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Safe play items/toys | 80 | 59 | 77 | - | 78 | 82 | 100 | 75 | 63 | - | 85 | 81 |
| Dangerous material (poison, heated substance, medicine, etc.) out of reach | 60 | 30 | 50 | - | 50 | 52 | 100 | 50 | 63 | - | 42 | 61 |
| Sharp objects out of reach | 60 | 37 | 49 | - | 60 | 51 | 0 | 25 | 43 | - | 42 | 49 |
| Around the clock supervision and care | 0 | 30 | 47 | - | 52 | 44 | 100 | 25 | 35 | - | 30 | 41 |
| Clean, safe and nurturing environment | 0 | 4 | 3 | - | 59 | 74 | 0 | 0 | 0 | - | 72 | 74 |
| Don't know/Can't say | 0 | 11 | 3 | - | 4 | 3 | 0 | 13 | 5 | - | 1 | 4 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |

*Figure 73: Percentage of AWW who track development or progress of the children attending the preschool (in %)*

*Table 50: Percentage of AWW who track development or progress of the children attending the preschool in Maharashtra (in %)*

| Maharashtra | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q486 Do you track the development or progress of the children attending the preschool program in your centre? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 76 | 89 | 94 | 92 | 89 | 89 |
| N | 75 | 102 | 123 | 131 | 208 | 142 |

*Table 51: Percentage of AWW who track development or progress of the children attending the preschool in Rajasthan (in %)*

| Rajasthan | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q486 Do you track the development or progress of the children attending the preschool program in your centre? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 80 | 85 | 88 | - | 88 | 88 |
| N | 5 | 27 | 119 | - | 129 | 322 |
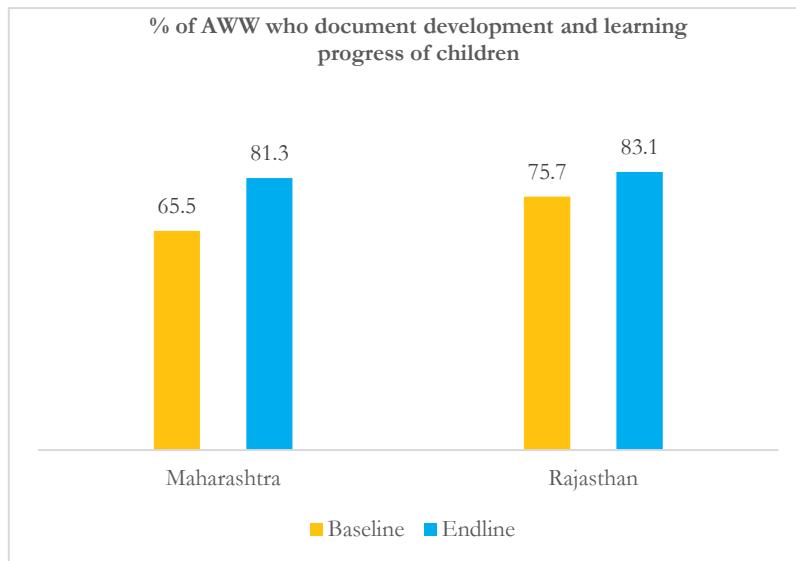
*Figure 74: Percentage of AWW who document development and learning progress of children (in %)*

*Table 52: Percentage of AWW who document development and learning progress of children in Maharashtra (in %)*

| Maharashtra | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q488 Do you document development and learning progress of children? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 23 | 75 | 79 | 79 | 83 | 80 |
| N | 57 | 91 | 116 | 120 | 185 | 127 |

*Table 53: Percentage of AWW who document development and learning progress of children in Rajasthan (in %)*

| Rajasthan | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q488 Do you document development and learning progress of children? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| | 50 | 70 | 78 | - | 88 | 81 |
| N | 4 | 23 | 105 | - | 113 | 284 |

**Activities done by AWWs as a part of preschool education – Maharashtra (in %)**



● Baseline   ● Endline
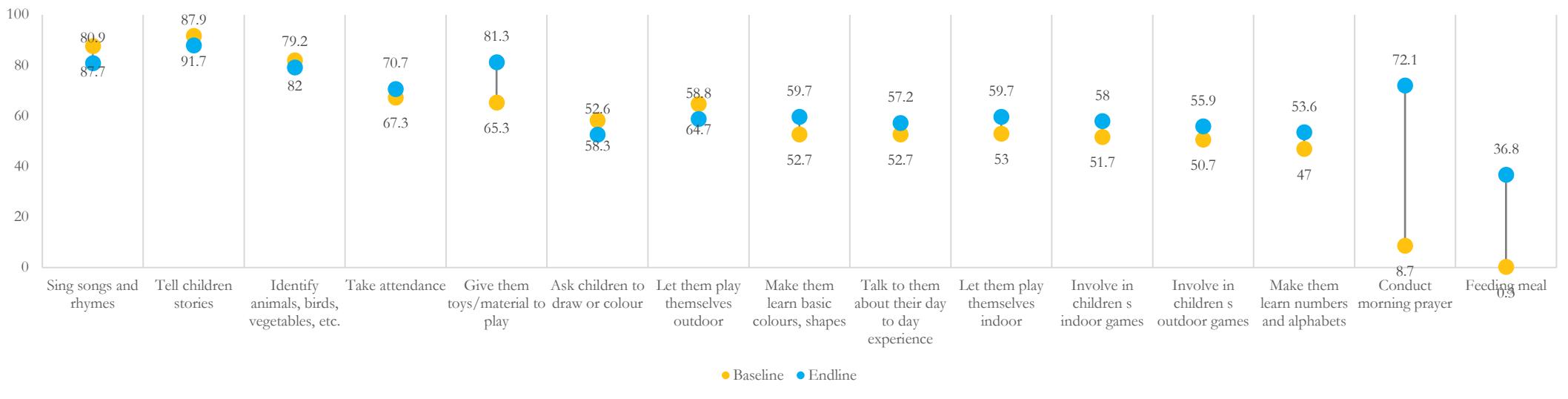
*Figure 75: Activities done by AWWs as a part of preschool education in Maharashtra (in %)*

**Activities done by AWWs as a part of preschool education – Rajasthan (in %)**



● Baseline   ● Endline
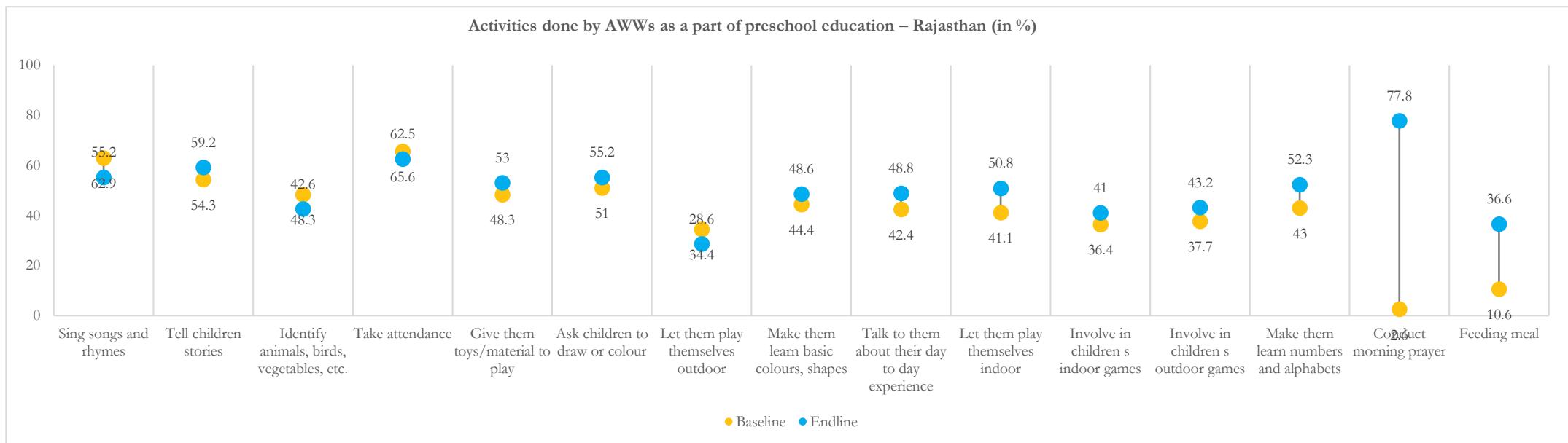
*Figure 76: Activities done by AWWs as a part of preschool education in Rajasthan (in %)*

*Table 54: Activities done by AWWs as a part of preschool education in Maharashtra and Rajasthan (in %)*

| Q473 What all activities do you carry out as a part of preschool education at your AWC? | Maharshtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Sing songs and rhymes | 88 | 98 | 79 | 83 | 80 | 80 | 80 | 48 | 66 | - | 66 | 51 |
| Tell children stories | 81 | 98 | 93 | 87 | 89 | 87 | 80 | 22 | 61 | - | 64 | 58 |
| Identify animals, birds, vegetables, etc. | 81 | 94 | 72 | 75 | 80 | 82 | 20 | 30 | 54 | - | 54 | 38 |
| Take attendance | 45 | 90 | 62 | 71 | 70 | 72 | 100 | 41 | 70 | - | 51 | 67 |
| Give them toys/material to play | 79 | 79 | 46 | 88 | 87 | 67 | 40 | 33 | 52 | - | 55 | 52 |
| Ask children to draw or colour | 67 | 74 | 41 | 54 | 55 | 47 | 20 | 44 | 54 | - | 63 | 52 |
| Let them play themselves outdoor | 76 | 75 | 50 | 63 | 65 | 47 | 20 | 26 | 37 | - | 29 | 29 |
| Make them learn basic colours, shapes | 47 | 70 | 42 | 53 | 64 | 60 | 40 | 22 | 50 | - | 57 | 45 |
| Talk to them about their day to day experience | 51 | 78 | 33 | 63 | 60 | 48 | 40 | 22 | 47 | - | 46 | 50 |
| Let them play themselves indoor | 47 | 79 | 35 | 62 | 64 | 51 | 40 | 33 | 43 | - | 49 | 52 |
| Involve in children s indoor games | 61 | 74 | 28 | 58 | 63 | 51 | 40 | 22 | 39 | - | 47 | 39 |
| Involve in children s outdoor games | 57 | 74 | 28 | 53 | 61 | 51 | 20 | 22 | 42 | - | 51 | 40 |
| Make them learn numbers and alphabets | 31 | 72 | 37 | 48 | 66 | 41 | 20 | 22 | 49 | - | 64 | 48 |
| Conduct morning prayer | 13 | 5 | 9 | 76 | 76 | 63 | 0 | 4 | 3 | - | 73 | 80 |
| Feeding meal | 0 | 0 | 1 | 52 | 40 | 18 | 0 | 4 | 13 | - | 43 | 34 |
| Don't Know/Can't Say | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | 2 | - | 0 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 5 | 27 | 119 | - | 129 | 322 |

**Activities done by AWWs to identify a child with special care at centre – Maharashtra (in %)**

- Baseline  ● Endline
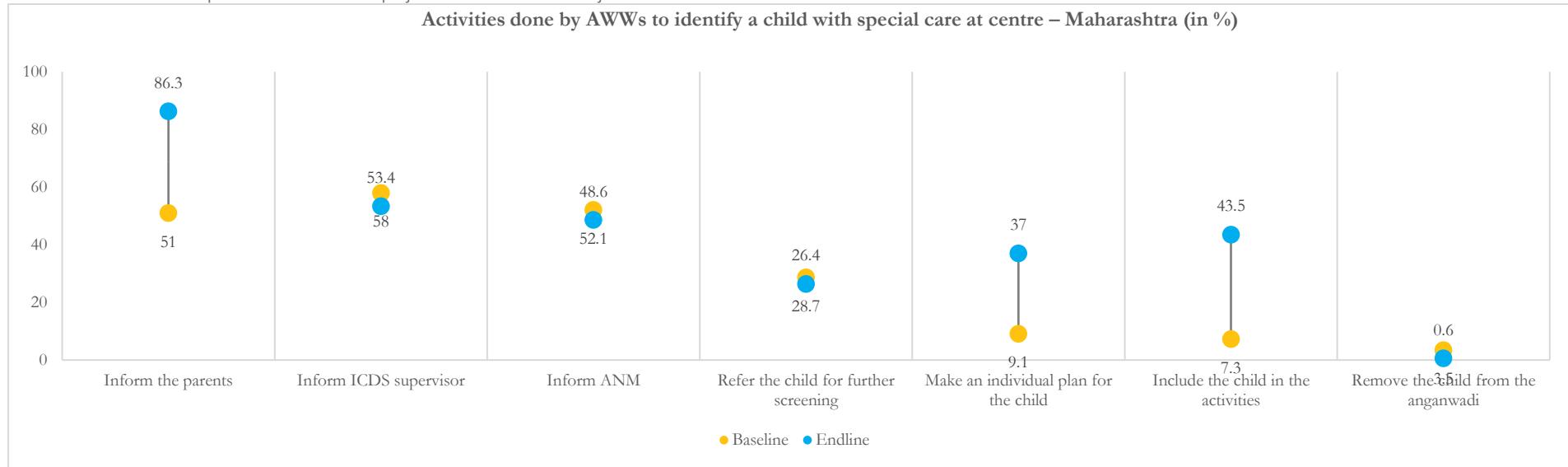
*Figure 77: Activities done by AWWs to identify a child with special care at centre in Maharashtra (in %)*

*Table 55: Activities done by AWWs to identify a child with special care at centre in Maharashtra (in %)*

| Maharashtra | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q489 What do you do if you identify a child with special care in your centre? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Inform the parents | 41 | 63 | 41 | 89 | 78 | 96 |
| Inform ICDS supervisor | 57 | 65 | 46 | 50 | 54 | 56 |
| Inform ANM | 23 | 72 | 48 | 41 | 49 | 55 |
| Refer the child for further screening | 36 | 17 | 31 | 25 | 27 | 26 |
| Make an individual plan for the child | 8 | 15 | 4 | 50 | 35 | 28 |
| Include the child in the activities | 9 | 8 | 5 | 71 | 38 | 26 |
| Remove the child from the anganwadi | 1 | 7 | 2 | 2 | 1 | 0 |
| Don't Know/Can't Say | 0 | 2 | 3 | - | - | - |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** |
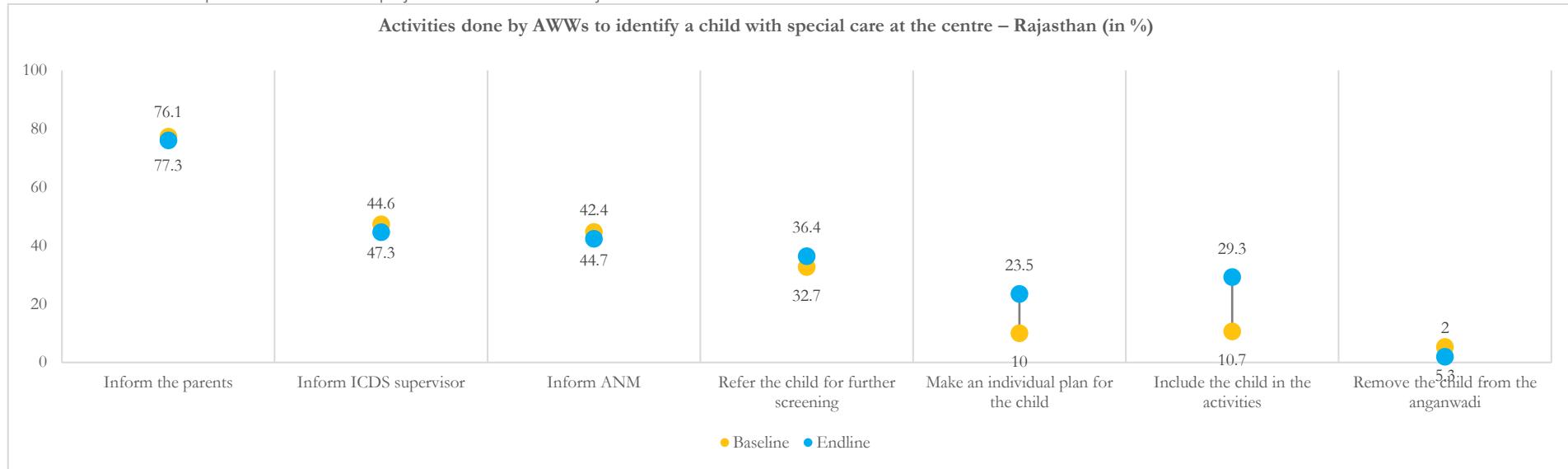
*Figure 78: Activities done by AWWs to identify a child with special care at the centre in Rajasthan (in %)*

*Table 56: Activities done by AWWs to identify a child with special care at the centre in Rajasthan (in %)*

| Rajasthan | AWW | | | | | |
|---|---|---|---|---|---|---|
| Q489 What do you do if you identify a child with special care in your centre? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Inform the parents | 80 | 74 | 77 | - | 87 | 72 |
| Inform ICDS supervisor | 20 | 15 | 55 | - | 47 | 44 |
| Inform ANM | 60 | 41 | 45 | - | 40 | 44 |
| Refer the child for further screening | 60 | 19 | 34 | - | 43 | 34 |
| Make an individual plan for the child | 20 | 4 | 11 | - | 15 | 27 |
| Include the child in the activities | 0 | 0 | 13 | - | 35 | 27 |
| Remove the child from the anganwadi | 0 | 0 | 7 | - | 0 | 3 |
| Don't Know/Can't Say | 0 | 11 | 5 | - | 2 | 3 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** |

**FLWs reporting identifiers to identify developmental delays among children of 0-3 years – Maharashtra (in %)**
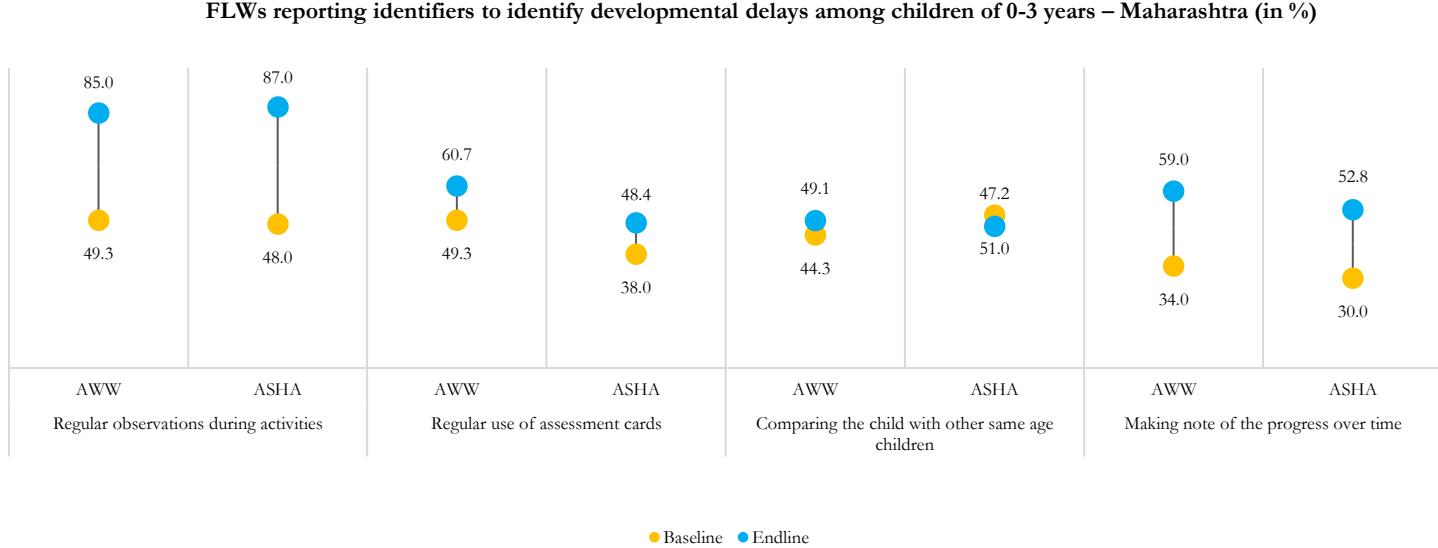


*Figure 79: FLWs reporting identifiers to identify developmental delays among children of 0-3 years in Maharashtra (in %)*

*Table 57: FLWs reporting identifiers to identify developmental delays among children of 0-3 years in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q548 How do you think one can identify developmental delays among children of 0-3 years? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Regular observations during activities | 40 | 69 | 39 | 89 | 84 | 84 | 48 | 52 | 45 | - | 87 | 60 |
| Regular use of assessment cards | 55 | 53 | 43 | 58 | 66 | 56 | 44 | 45 | 29 | - | 51 | 31 |
| Comparing the child with other same age children | 48 | 52 | 36 | 41 | 45 | 63 | 52 | 64 | 40 | - | 33 | 47 |
| Making note of the progress over time | 17 | 49 | 32 | 51 | 47 | 83 | 28 | 42 | 21 | - | 44 | 45 |
| Don't know/Can't say | 0 | 0 | 7 | 0 | 1 | 0 | 4 | 0 | 5 | - | 1 | 1 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **94** |

**FLWs reporting identifiers to identify developmental delays among children of 0-3 years – Rajasthan (in %)**



● Baseline ● Endline
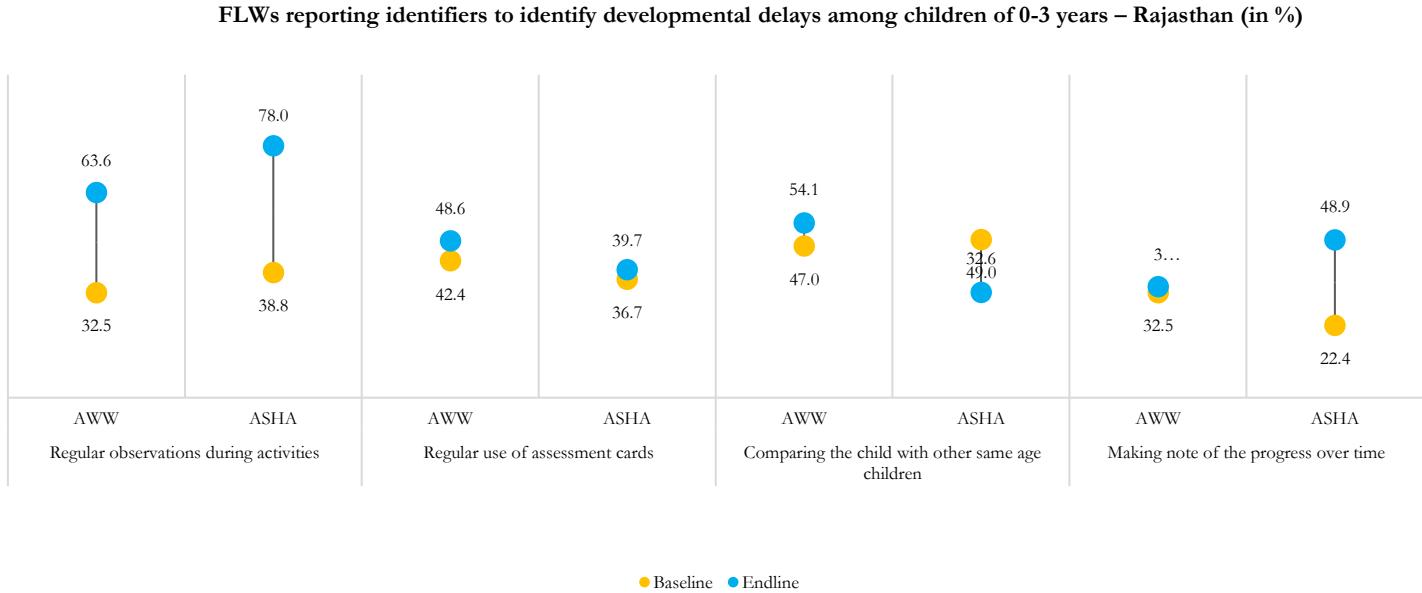
*Figure 80: FLWs reporting identifiers to identify developmental delays among children of 0-3 years in Rajasthan (in %)*

*Table 58: FLWs reporting identifiers to identify developmental delays among children of 0-3 years in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q548 How do you think one can identify developmental delays among children of 0-3 years? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Regular observations during activities | 40 | 37 | 44 | - | 74 | 60 | 0 | 50 | 35 | - | 79 | 77 |
| Regular use of assessment cards | 40 | 15 | 36 | - | 47 | 49 | 100 | 25 | 40 | - | 47 | 33 |
| Comparing the child with other same age children | 40 | 37 | 31 | - | 53 | 55 | 100 | 38 | 18 | - | 34 | 31 |
| Making note of the progress over time | 0 | 48 | 49 | - | 33 | 35 | 0 | 38 | 53 | - | 48 | 50 |
| Don't know/Can't say | 20 | 22 | 9 | - | 3 | 3 | 0 | 13 | 10 | - | 1 | 0 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **49** | **-** | **71** | **70** |

**FLWs reporting on checking if the child has difficulties in seeing – Maharashtra (in %)**
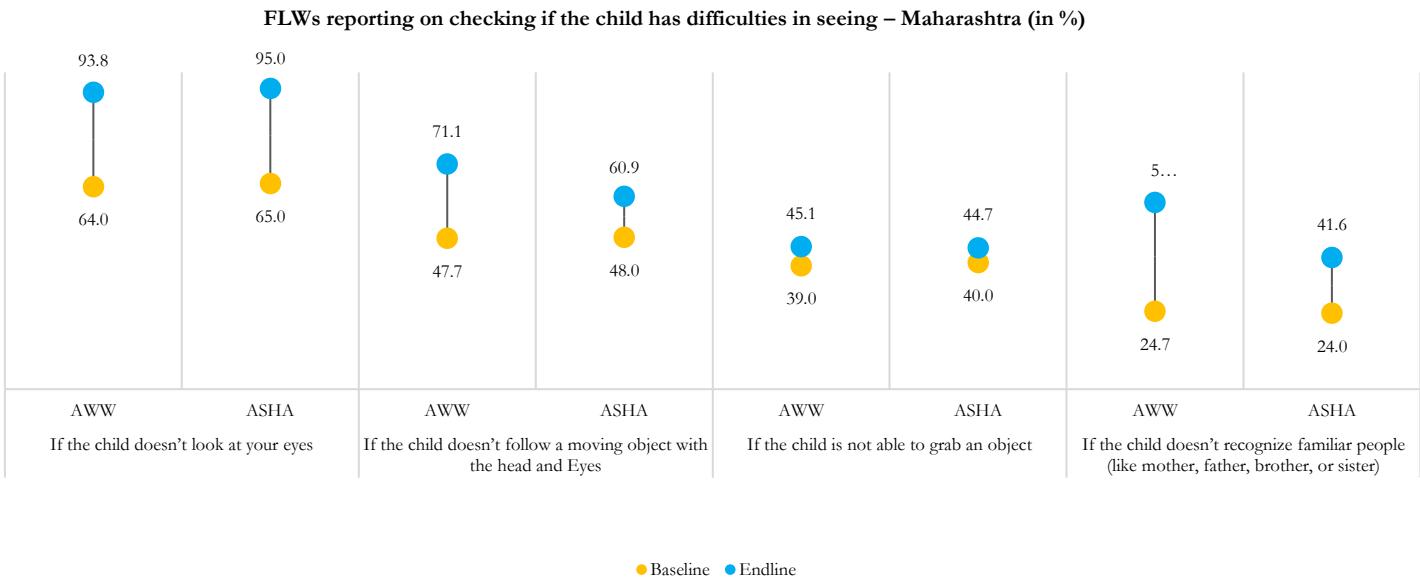


*Figure 81: FLWs reporting on checking if the child has difficulties in seeing in Maharashtra (in %)*

*Table 59: FLWs reporting on checking if the child has difficulties in seeing in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q549 How do you check if the child has difficulties in seeing? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| If the child doesn't look at your eyes | 77 | 69 | 52 | 89 | 94 | 98 | 80 | 79 | 45 | - | 92 | 100 |
| If the child doesn't follow a moving object with the head and Eyes | 43 | 59 | 41 | 66 | 79 | 65 | 44 | 61 | 40 | - | 63 | 58 |
| If the child is not able to grab an object | 33 | 58 | 27 | 36 | 52 | 43 | 12 | 76 | 29 | - | 40 | 52 |
| If the child doesn't recognize familiar people (like mother, father, brother, or sister) | 15 | 53 | 7 | 54 | 61 | 61 | 12 | 55 | 7 | - | 43 | 39 |
| Don't know/Can't say | 0 | 3 | 7 | 0 | 1 | 0 | 0 | 0 | 7 | - | 1 | 0 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 25 | 33 | 42 | - | 97 | 64 |

**FLWs reporting on checking if the child has difficulties in seeing – Rajasthan (in %)**
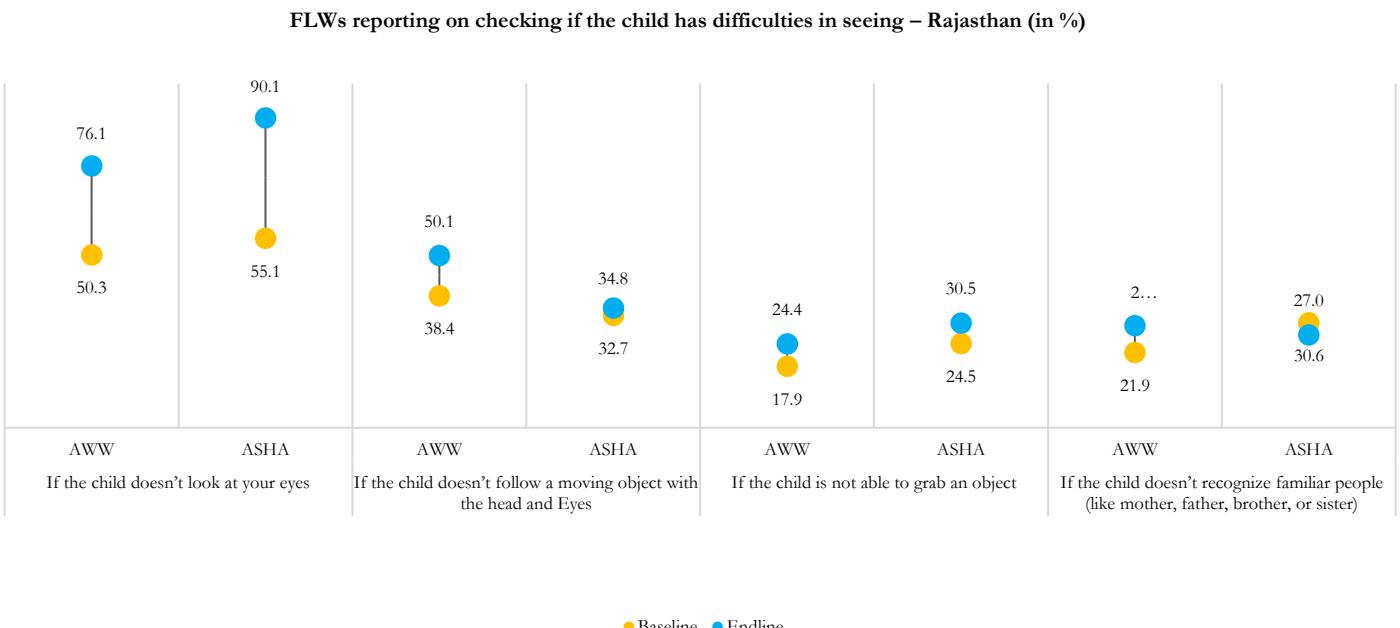


*Figure 82: FLWs reporting on checking if the child has difficulties in seeing in Rajasthan (in %)*

*Table 60: FLWs reporting on checking if the child has difficulties in seeing in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q549 How do you check if the child has difficulties in seeing?** | **Baseline** | | | **Endline** | | | **Baseline** | | | **Endline** | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| If the child doesn't look at your eyes | 60 | 37 | 53 | - | 92 | 70 | 100 | 50 | 55 | - | 93 | 87 |
| If the child doesn't follow a moving object with the head and Eyes | 40 | 44 | 37 | - | 61 | 46 | 0 | 38 | 33 | - | 39 | 30 |
| If the child is not able to grab an object | 40 | 19 | 17 | - | 14 | 29 | 100 | 38 | 20 | - | 30 | 31 |
| If the child doesn't recognize familiar people (like mother, father, brother, or sister) | 0 | 19 | 24 | - | 29 | 30 | 0 | 63 | 25 | - | 25 | 29 |
| Don't know/Can't say | 0 | 33 | 12 | - | 2 | 9 | 0 | 13 | 8 | - | 3 | 4 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |

**FLWs reporting on checking if the child has difficulties in hearing – Maharashtra (in %)**



*Figure 83: FLWs reporting on checking if the child has difficulties in hearing in Maharashtra (in %)*

*Table 61: FLWs reporting on checking if the child has difficulties in hearing in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q550 How do you check if the child has difficulties in hearing? | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| If the child doesn't turn his head to see someone behind him when the person speaks | 80 | 69 | 60 | 82 | 83 | 82 | 88 | 64 | 48 | - | 78 | 64 |
| If the child doesn't show any reactions to strong or loud Sounds | 55 | 70 | 46 | 70 | 65 | 69 | 52 | 91 | 62 | - | 79 | 70 |
| If child doesn't make a lot of different sounds (tata, dada, and baba) | 12 | 59 | 20 | 49 | 52 | 42 | 0 | 64 | 7 | - | 42 | 41 |
| Don't know/Can't say | 0 | 3 | 3 | 2 | 4 | 0 | 0 | 3 | 5 | - | 2 | 2 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **64** |

**FLWs reporting on checking if the child has difficulties in hearing – Rajasthan (in %)**
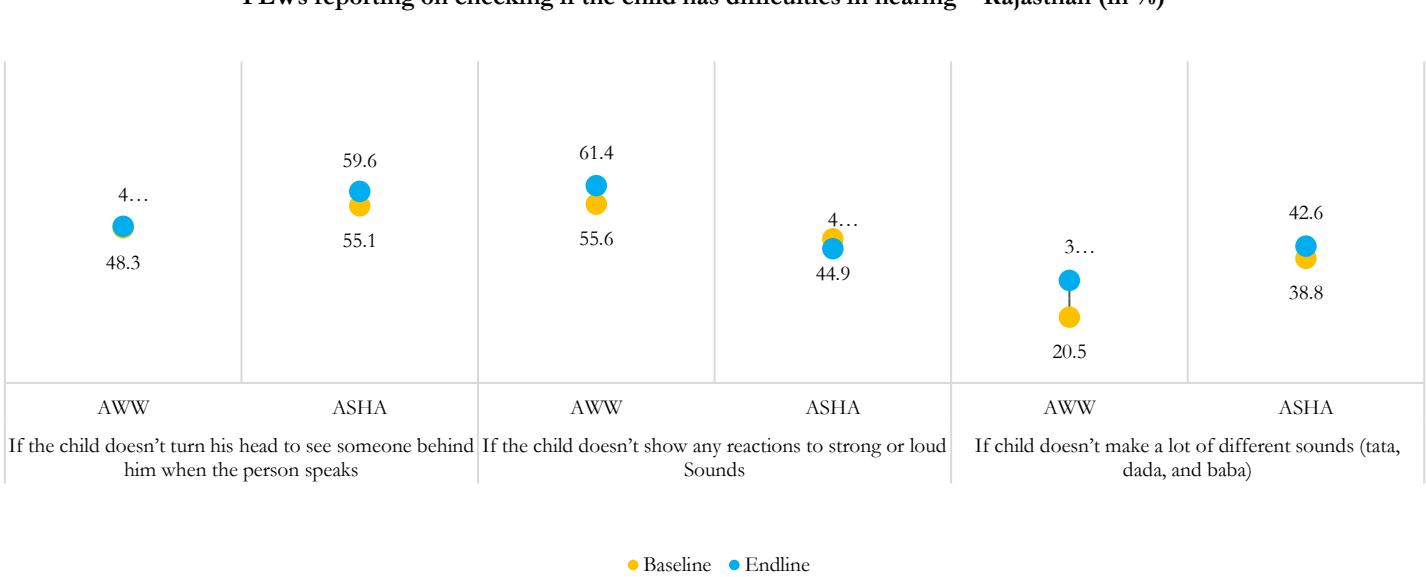


● Baseline   ● Endline

*Figure 84: FLWs reporting on checking if the child has difficulties in hearing in Rajasthan (in %)*

*Table 62: FLWs reporting on checking if the child has difficulties in hearing in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Q550 How do you check if the child has difficulties in hearing?** | **Baseline** | | | **Endline** | | | **Baseline** | | | **Endline** | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| If the child doesn't turn his head to see someone behind him when the person speaks | 80 | 33 | 50 | - | 57 | 45 | 0 | 50 | 58 | - | 59 | 60 |
| If the child doesn't show any reactions to strong or loud Sounds | 40 | 41 | 60 | - | 65 | 60 | 100 | 50 | 43 | - | 42 | 41 |
| If child doesn't make a lot of different sounds (tata, dada, and baba) | 0 | 30 | 19 | - | 38 | 30 | 100 | 50 | 35 | - | 48 | 37 |
| Don't know/Can't say | 0 | 26 | 8 | - | 5 | 14 | 0 | 13 | 8 | - | 1 | 9 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |
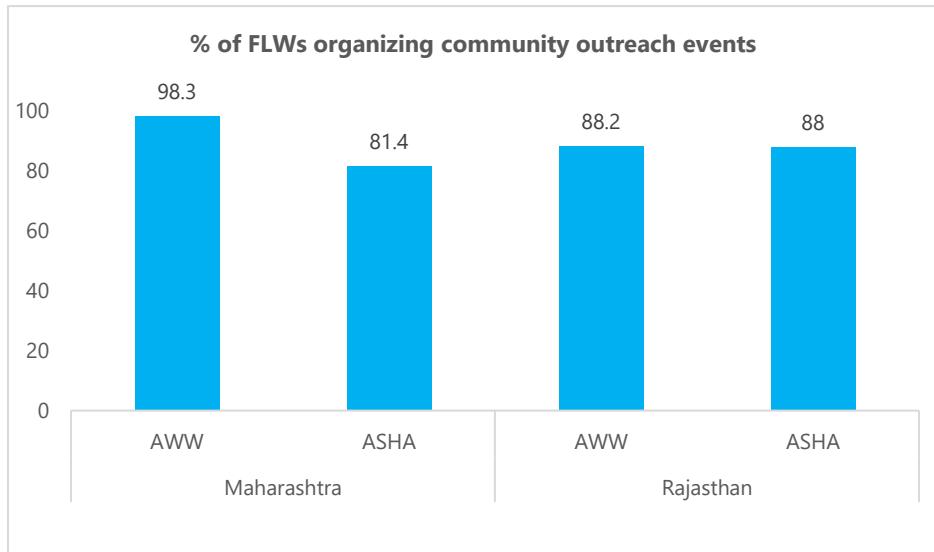
*Figure 85: Percentage of FLWs organizing community outreach events*

*Table 63: Percentage of FLWs organizing community outreach events in Maharashtra*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q228a Do you organize community outreach events in your village?** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Yes | 99 | 98 | 99 | - | 86 | 75 |
| No | 1 | 2 | 1 | - | 14 | 25 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |

*Table 64: Percentage of FLWs organizing community outreach events in Rajasthan*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q228a Do you organize community outreach events in your village?** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Yes | - | 94 | 86 | - | 92 | 84 |
| No | - | 6 | 14 | - | 9 | 16 |
| **N** | **-** | **129** | **322** | **-** | **71** | **70** |
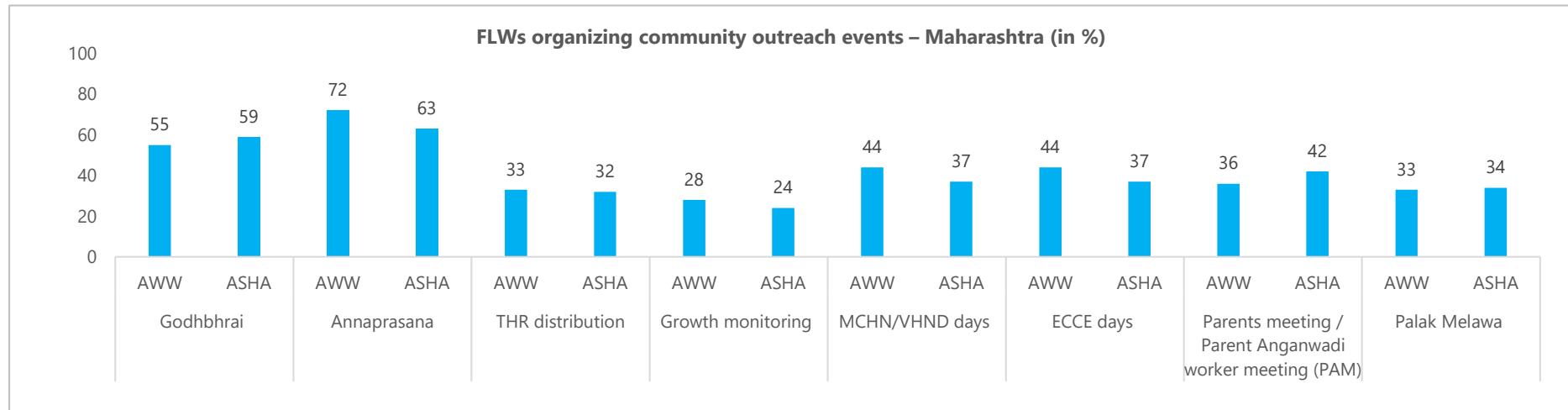
*Figure 86: FLWs organizing community outreach events in Maharashtra (in %)*

*Table 65: FLWs organizing community outreach events in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q228b If yes, then what all community outreach events do you conduct? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Godhbhrai | 41 | 62 | 58 | - | 71 | 38 |
| Annaprasana | 66 | 65 | 89 | - | 66 | 56 |
| THR distribution | 37 | 47 | 9 | - | 36 | 2 |
| Growth monitoring | 46 | 44 | 18 | - | 42 | 15 |
| MCHN/VHND days | 32 | 35 | 16 | - | 27 | 19 |
| ECCE days | 61 | 45 | 27 | - | 48 | 17 |
| Parents meeting / Parent Anganwadi worker meeting (PAM) | 38 | 46 | 19 | - | 57 | 17 |
| Palak Melawa | 33 | 36 | 28 | - | 29 | 44 |
| N | 130 | 203 | 140 | - | 83 | 48 |
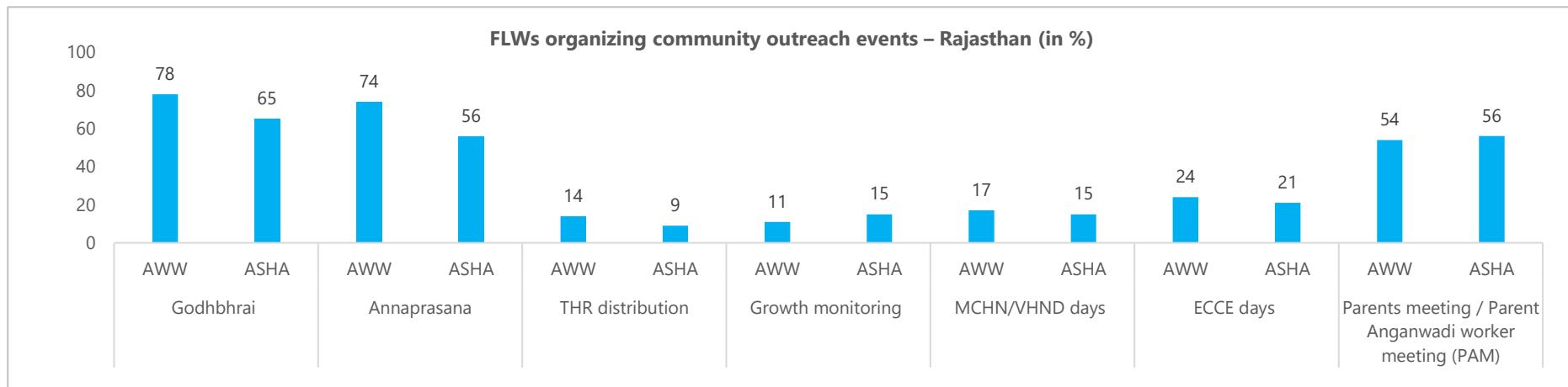
Figure 87: FLWs organizing community outreach events in Rajasthan (in %)

Table 66: FLWs organizing community outreach events in Rajasthan (in %)

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q228b If yes, then what all community outreach events do you conduct?** | **Endline Only** | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Godhbhrai | - | 86 | 75 | - | 86 | 41 |
| Annaprasana | - | 84 | 70 | - | 79 | 31 |
| THR distribution | - | 16 | 13 | - | 11 | 7 |
| Growth monitoring | - | 17 | 8 | - | 17 | 14 |
| MCHN/VHND days | - | 33 | 11 | - | 23 | 7 |
| ECCE days | - | 24 | 24 | - | 6 | 37 |
| Parents meeting / Parent Anganwadi worker meeting (PAM) | - | 57 | 52 | - | 46 | 66 |
| Palak Melawa | - | 0 | 0 | - | 0 | 0 |
| **N** | **-** | **121** | **277** | **-** | **65** | **59** |

**FLWs reporting useful platforms to counsel parents of 0-3 years child – Maharashtra (in %)**
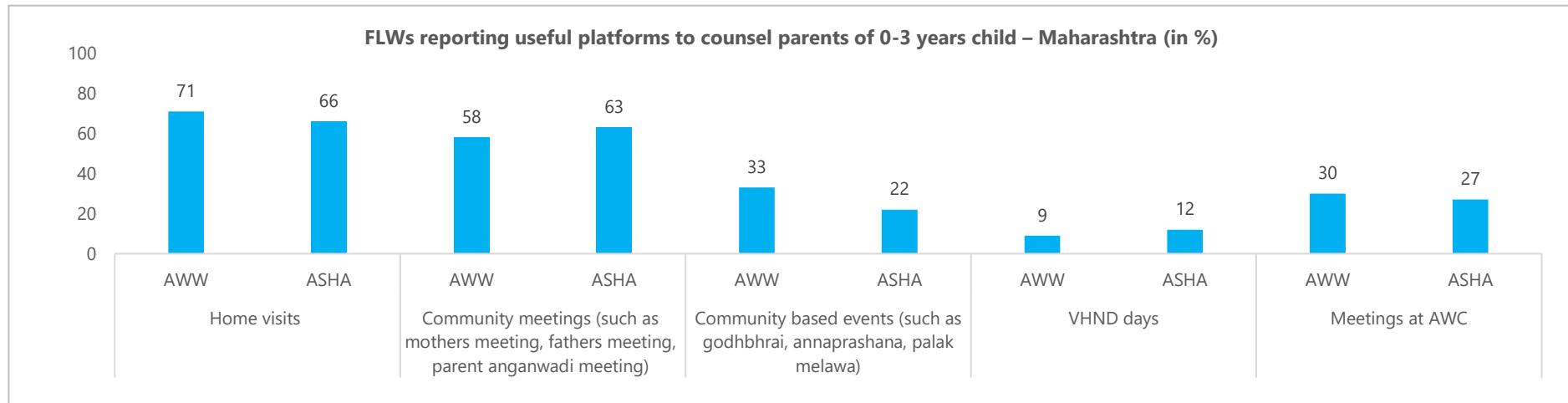
*Figure 88: FLWs reporting useful platforms to counsel parents of 0-3 years child in Maharashtra (in %)*

*Table 67: FLWs reporting useful platforms to counsel parents of 0-3 years child in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q458a In your view, which platforms are very useful in counselling parents/caregivers with 0-3 age child on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Home visits | 59 | 78 | 73 | - | 70 | 59 |
| Community meetings (such as mothers meeting, fathers meeting, parent anganwadi meeting) | 57 | 63 | 52 | - | 67 | 56 |
| Community based events (such as godhbhrai, annaprashana, palak melawa) | 41 | 35 | 22 | - | 32 | 8 |
| VHND days | 8 | 13 | 4 | - | 16 | 8 |
| Meetings at AWC | 17 | 30 | 41 | - | 19 | 41 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |
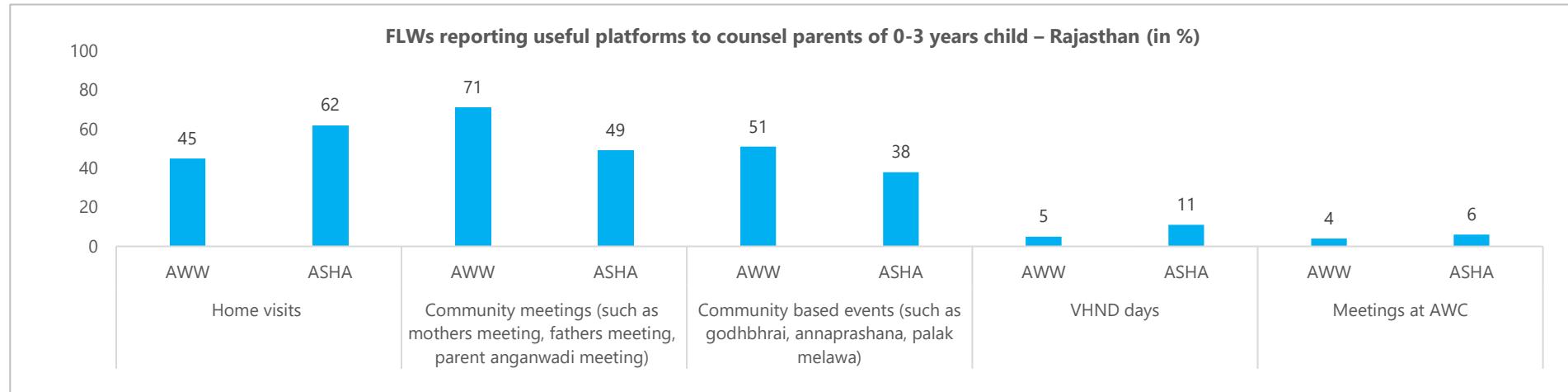
*Figure 89: FLWs reporting useful platforms to counsel parents of 0-3 years child in Rajasthan (in %)*

*Table 68: FLWs reporting useful platforms to counsel parents of 0-3 years child in Rajasthan (in %)*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q458a In your view, which platforms are very useful in counselling parents/caregivers with 0-3 age child on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Home visits | - | 43 | 45 | - | 48 | 76 |
| Community meetings (such as mothers meeting, fathers meeting, parent anganwadi meeting) | - | 69 | 71 | - | 48 | 50 |
| Community based events (such as godhbhrai, annaprashana, palak melawa) | - | 55 | 49 | - | 39 | 36 |
| VHND days | - | 8 | 4 | - | 11 | 10 |
| Meetings at AWC | - | 1 | 5 | - | 4 | 7 |
| N | - | 129 | 322 | - | 71 | 70 |

**FLWs reporting useful platforms to counsel parents of 3-6 years child – Maharashtra (in %)**
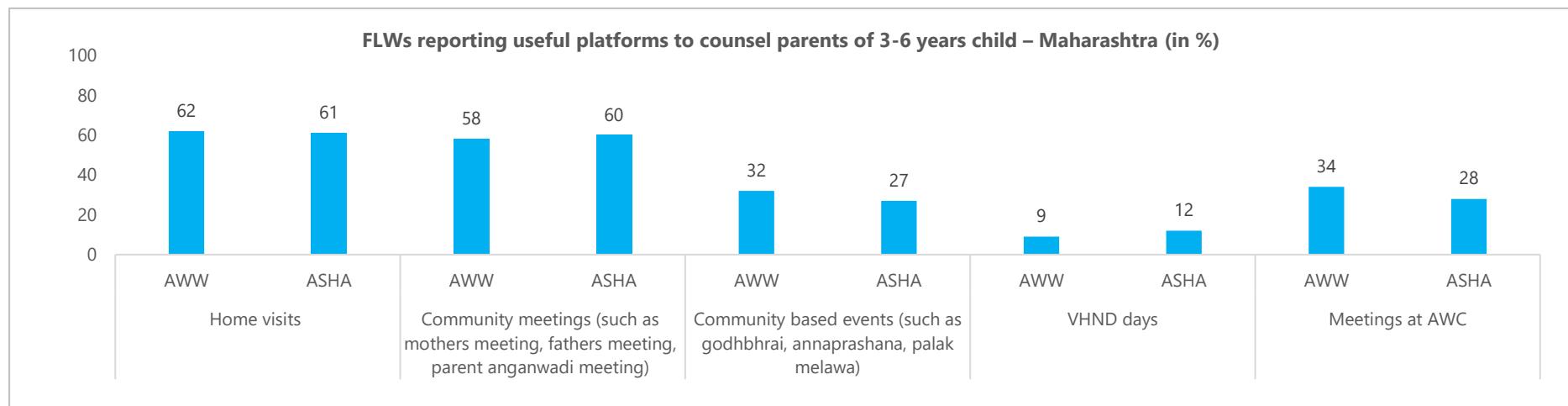
Figure 90: FLWs reporting useful platforms to counsel parents of 3-6 years child in Maharashtra (in %)

Table 69: FLWs reporting useful platforms to counsel parents of 3-6 years child in Maharashtra (in %)

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q458b In your view, which platforms are very useful in counselling parents/caregivers with 3-6 age child on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Home visits | 57 | 73 | 51 | - | 69 | 48 |
| Community meetings (such as mothers meeting, fathers meeting, parent anganwadi meeting) | 61 | 61 | 51 | - | 65 | 52 |
| Community based events (such as godhbhrai, annaprashana, palak melawa) | 40 | 35 | 22 | - | 36 | 14 |
| VHND days | 10 | 12 | 3 | - | 16 | 8 |
| Meetings at AWC | 17 | 33 | 51 | - | 18 | 44 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |
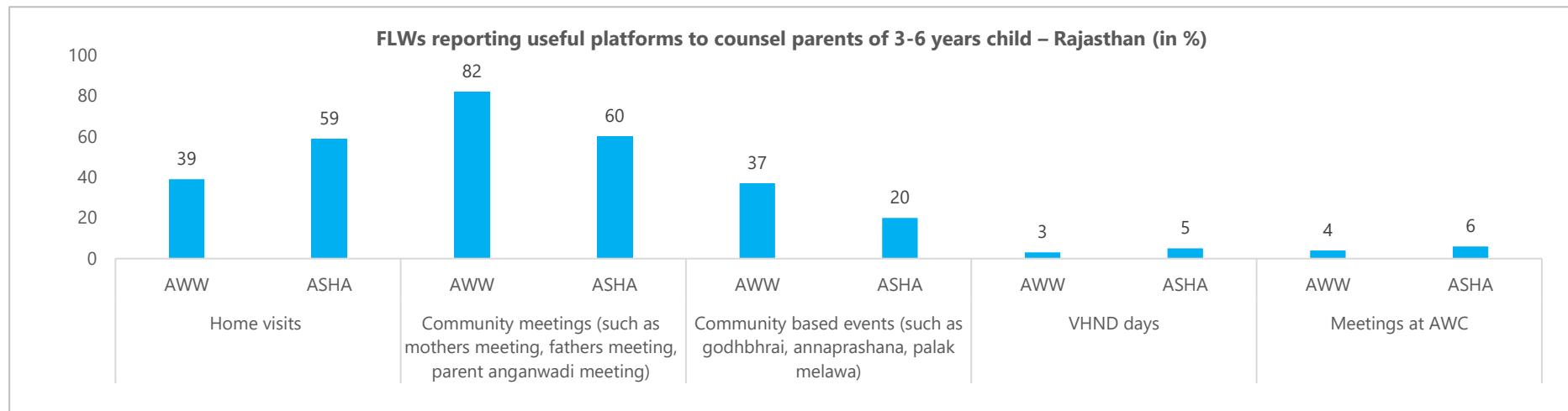
Figure 91: FLWs reporting useful platforms to counsel parents of 3-6 years child in Rajasthan (in %)

Table 70: FLWs reporting useful platforms to counsel parents of 3-6 years child in Rajasthan (in %)

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q458b In your view, which platforms are very useful in counselling parents/caregivers with 3-6 age child on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Home visits | - | 33 | 41 | - | 47 | 71 |
| Community meetings (such as mothers meeting, fathers meeting, parent anganwadi meeting) | - | 81 | 82 | - | 66 | 53 |
| Community based events (such as godhbhrai, annaprashana, palak melawa) | - | 38 | 37 | - | 24 | 16 |
| VHND days | - | 6 | 2 | - | 7 | 3 |
| Meetings at AWC | - | 2 | 4 | - | 7 | 6 |
| N | - | 129 | 322 | - | 71 | 70 |

# Attitude and Perceptions of FLWs: FLW survey analysis tables and graphs
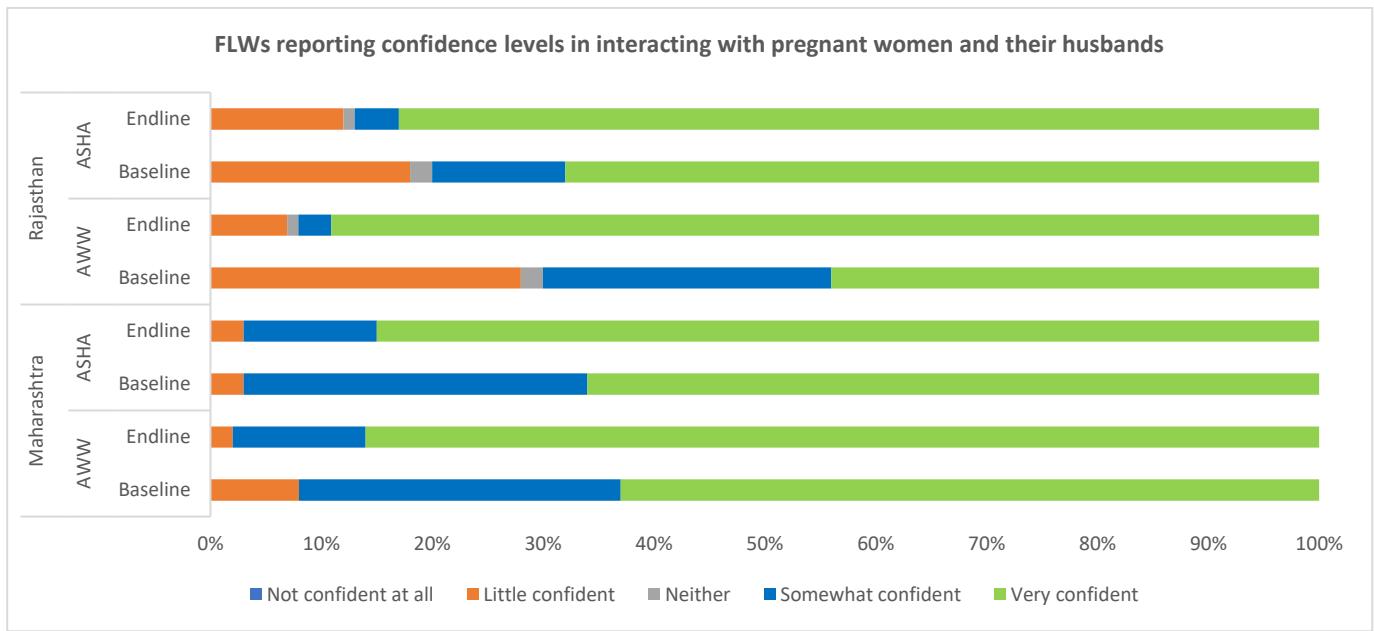


Figure 92: FLWs reporting confidence levels in interacting with pregnant women and their husbands
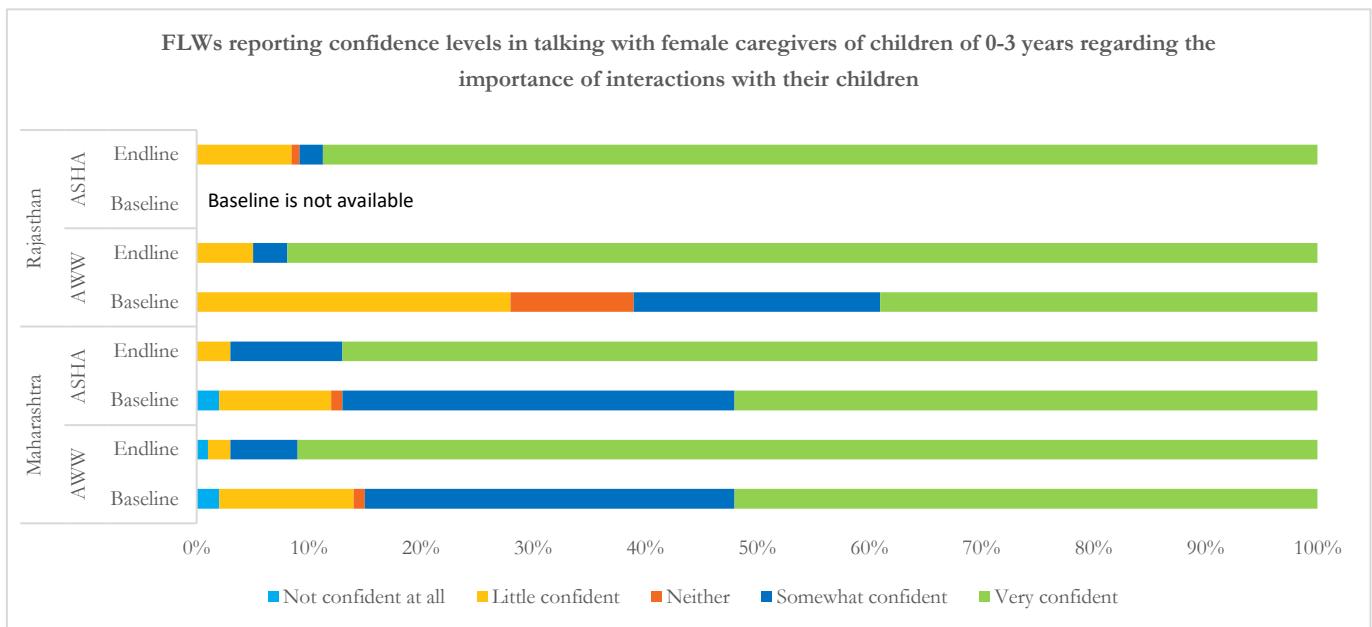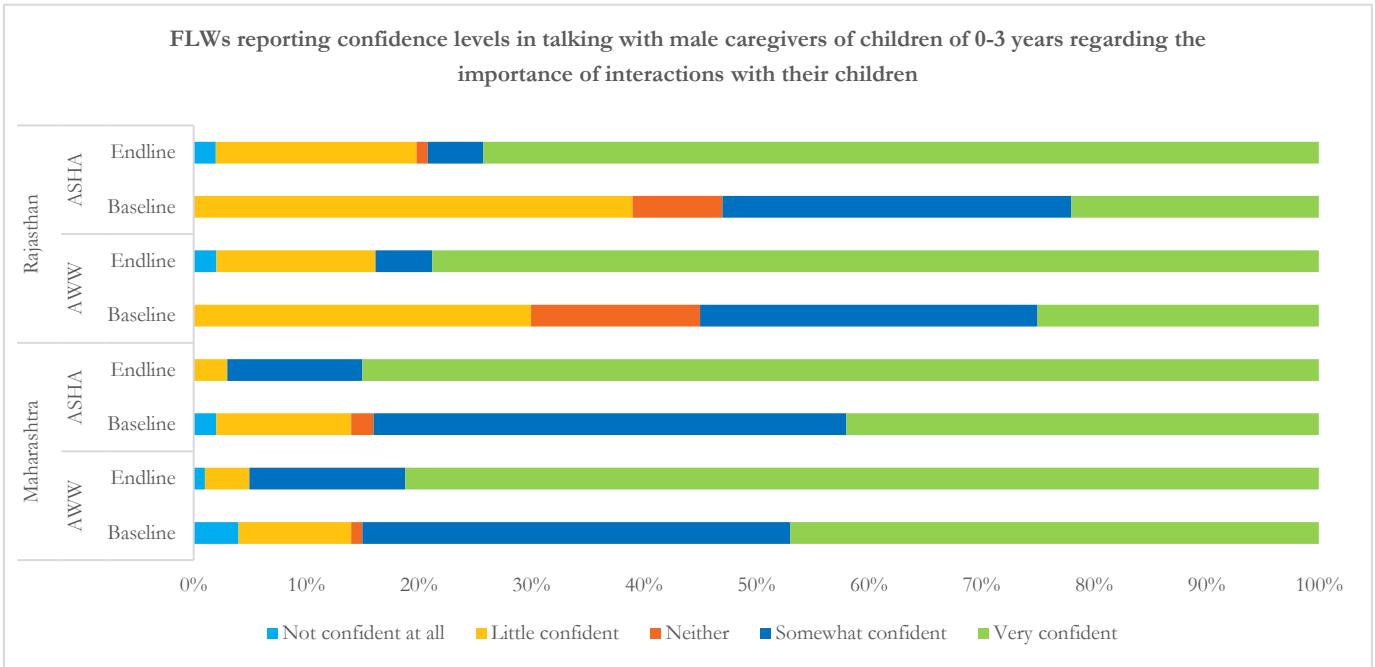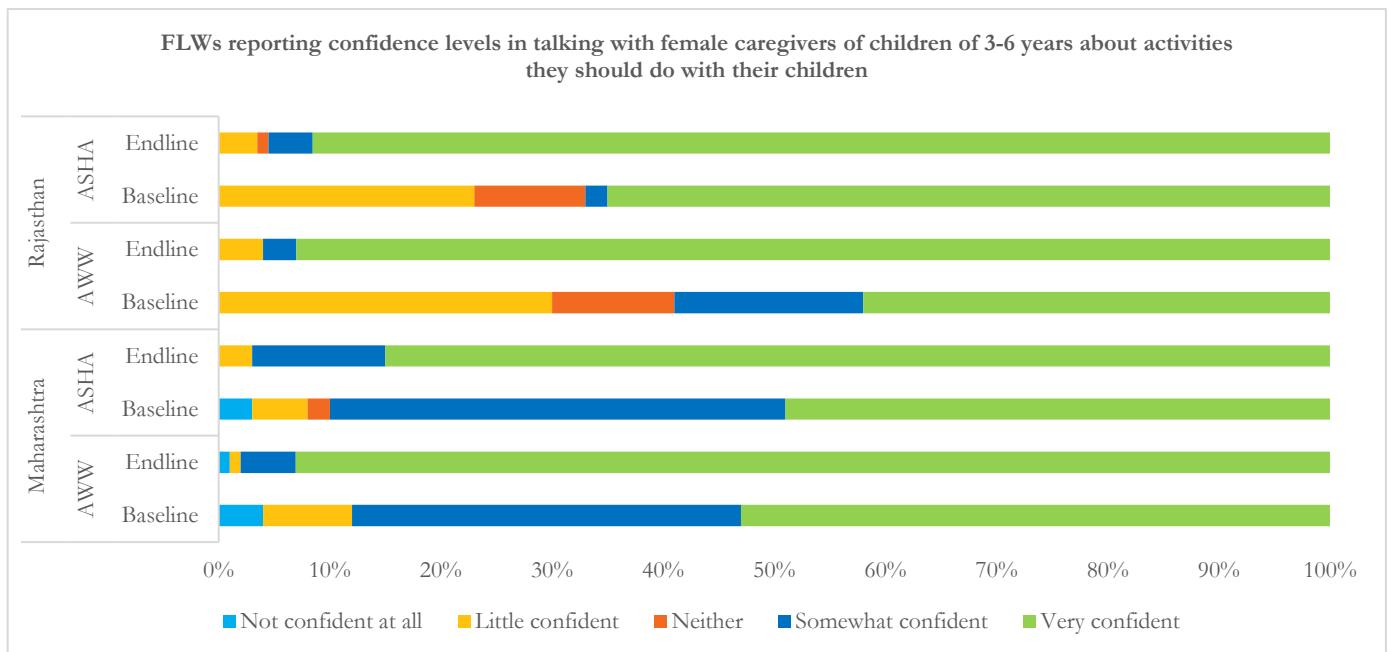


Figure 93: FLWs reporting confidence levels in talking with female caregivers of children of 0-3 years regarding the importance of interactions with their children

Figure 94: FLWs reporting confidence levels in talking with male caregivers of children of 0-3 years regarding the importance of interactions with their children



Figure 95: FLWs reporting confidence levels in talking with female caregivers of children of 3-6 years about activities they should do with their children
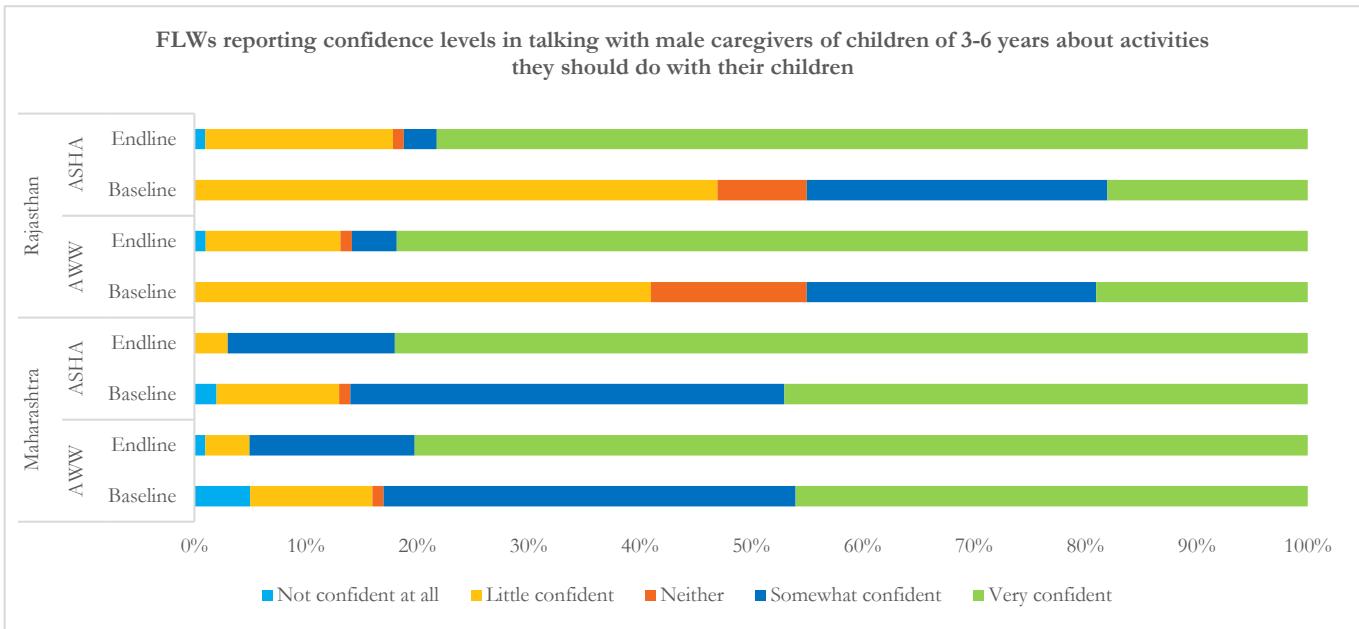
*Figure 96: FLWs reporting confidence levels in talking with male caregivers of children of 3-6 years about activities they should do with their children*
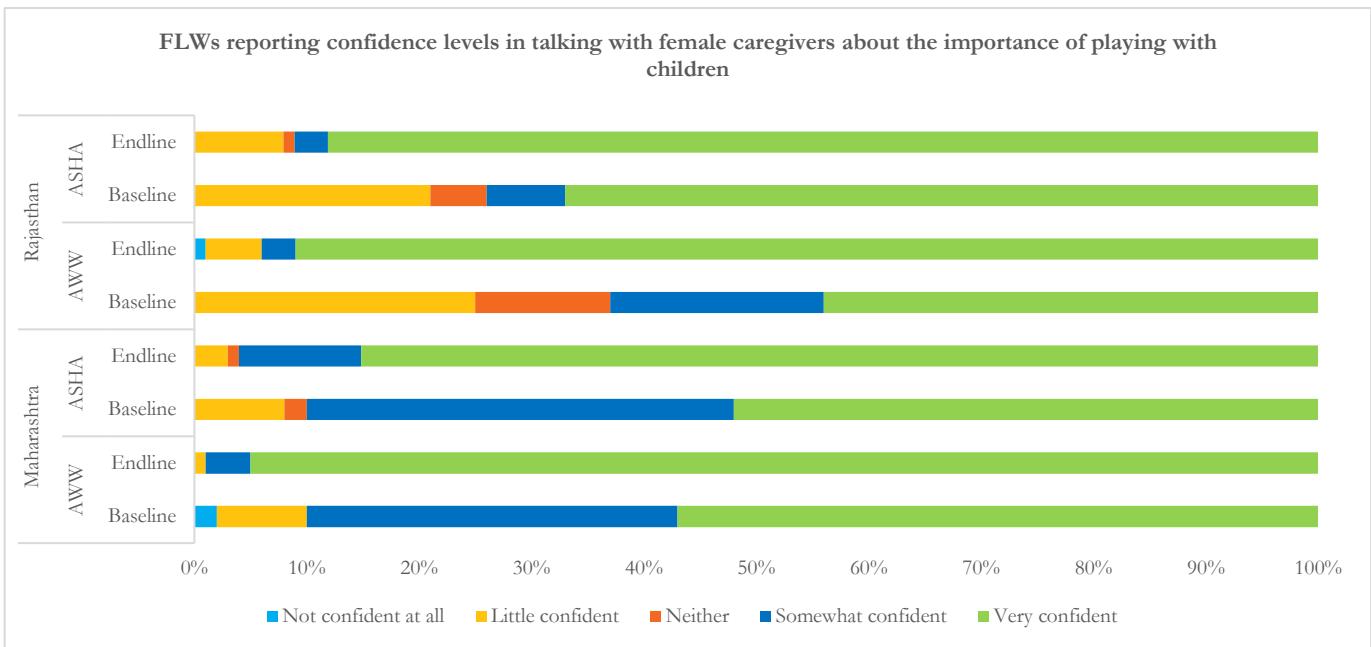


*Figure 97: FLWs reporting confidence levels in talking with female caregivers about the importance of playing with children*
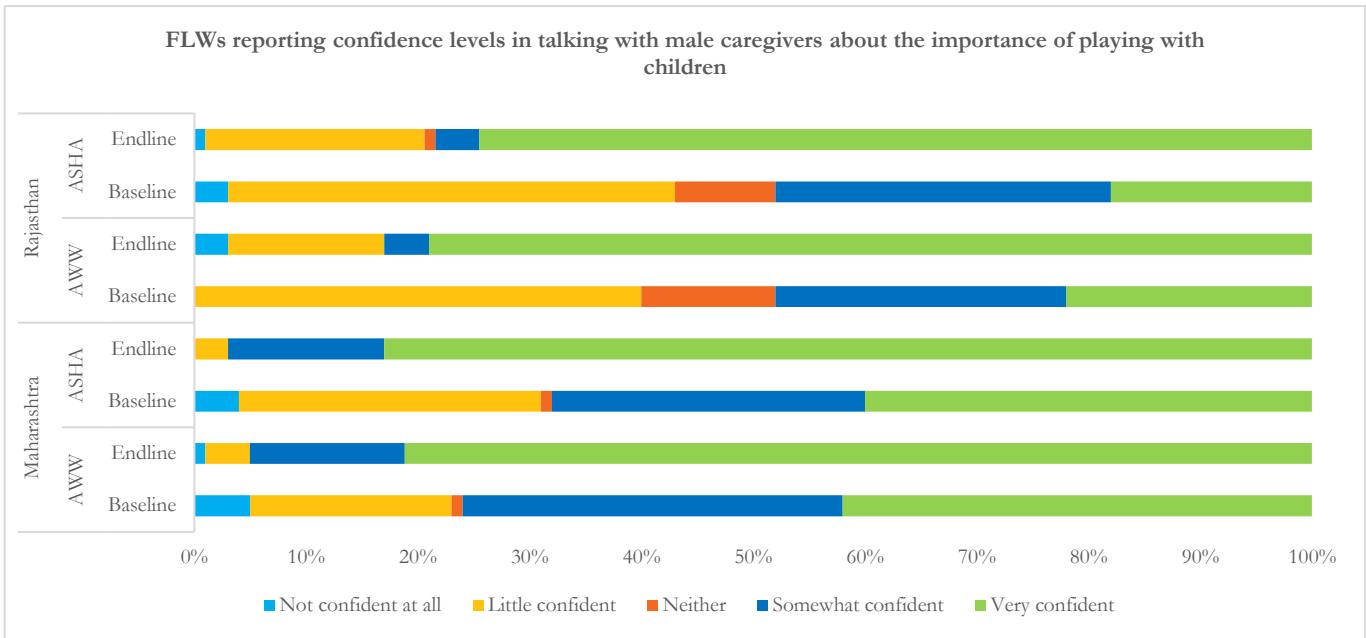
Figure 98: FLWs reporting confidence levels in talking with male caregivers about the importance of playing with children
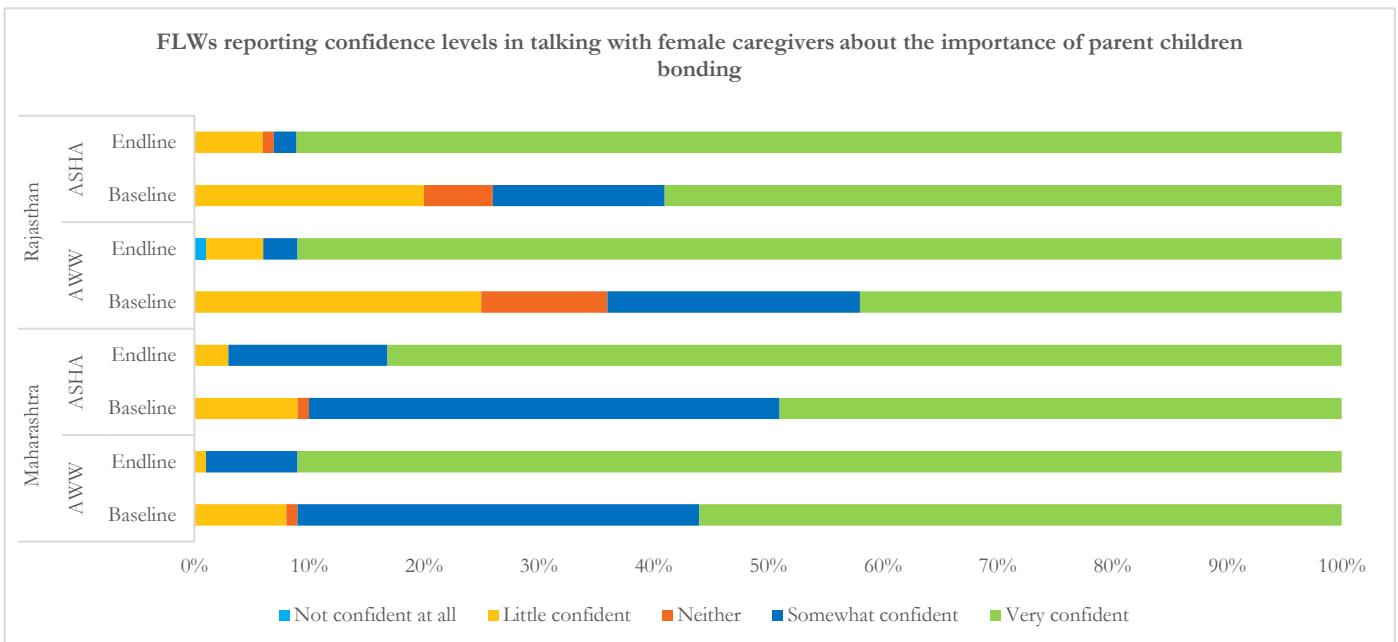


Figure 99: FLWs reporting confidence levels in talking with female caregivers about the importance of parent children bonding
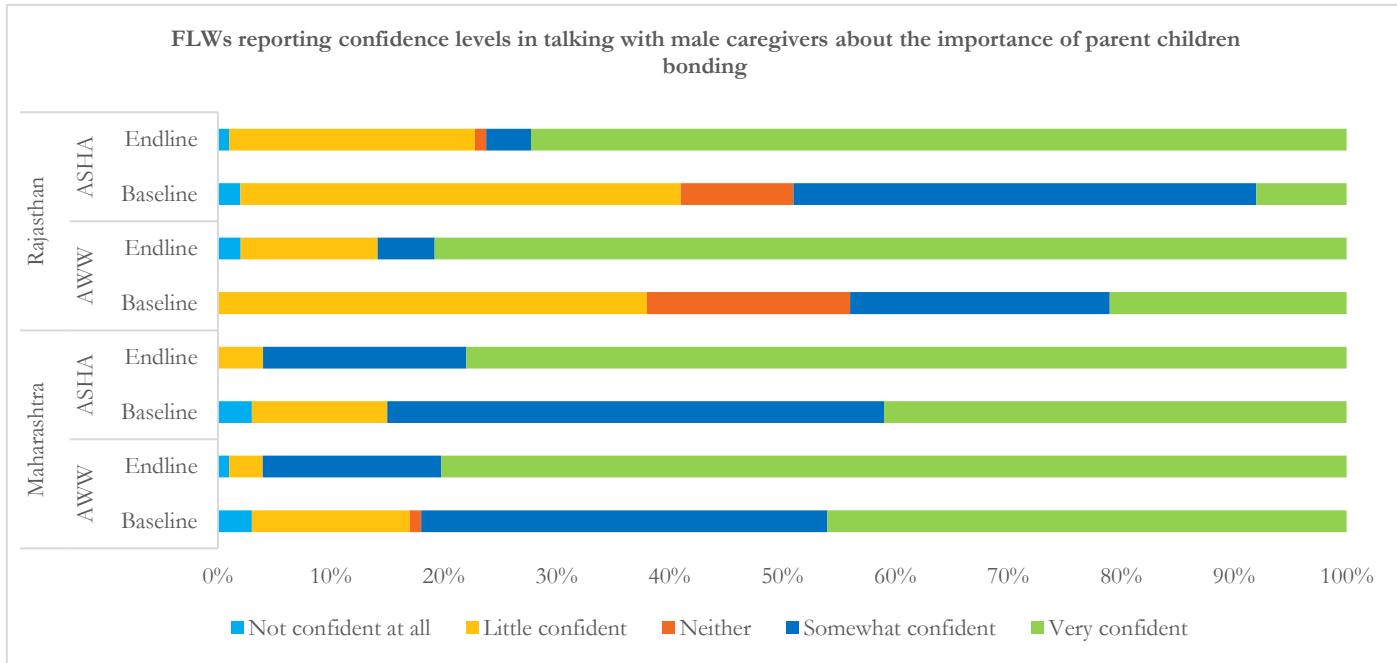
Figure 100: FLWs reporting confidence levels in talking with male caregivers about the importance of parent children bonding
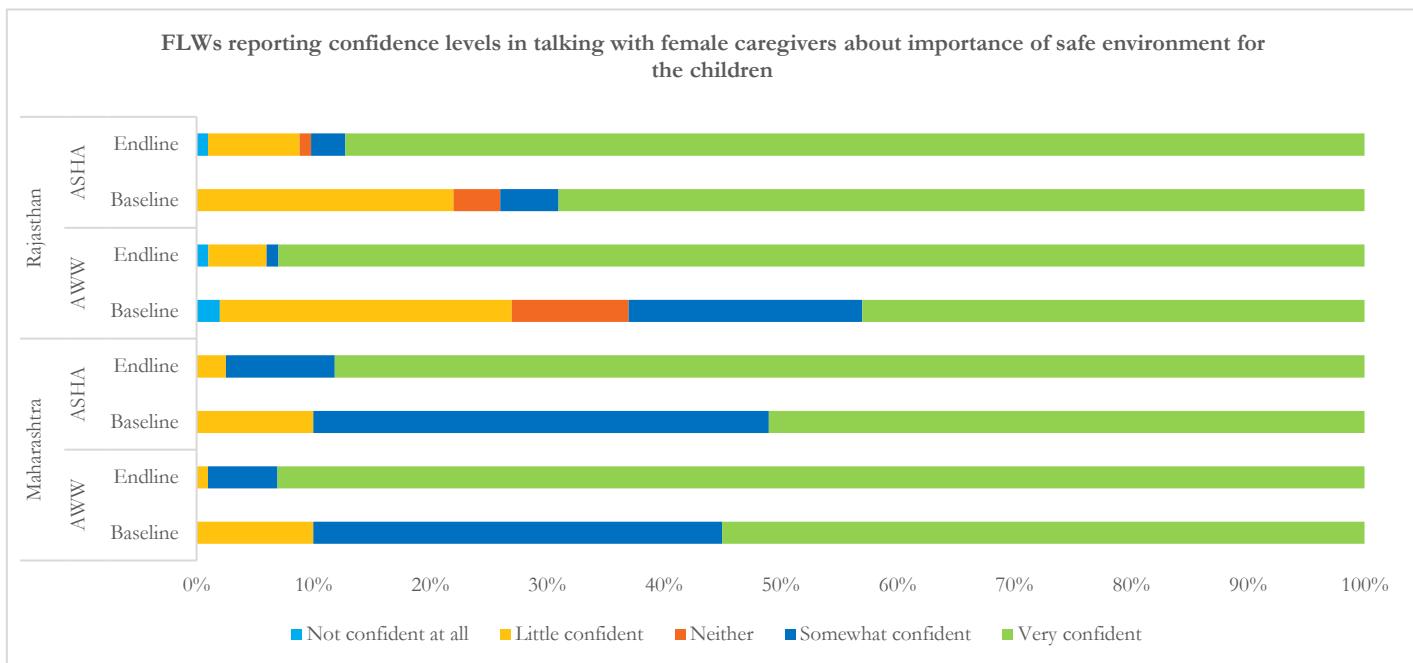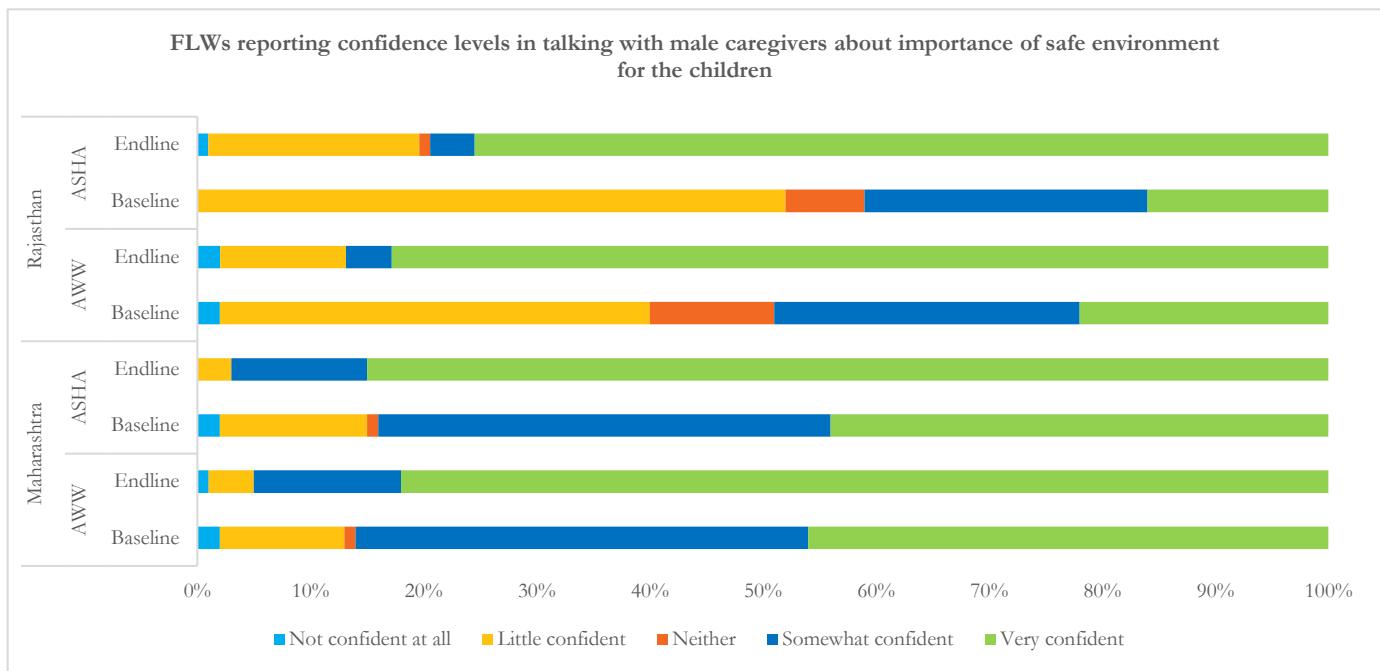


Figure 101: FLWs reporting confidence levels in talking with female caregivers about importance of safe environment for the children

*Figure 102: FLWs reporting confidence levels in talking with male caregivers about importance of safe environment for the children*

**FLWs reporting methods not suitable to punish boy child - Maharashtra (in %)**
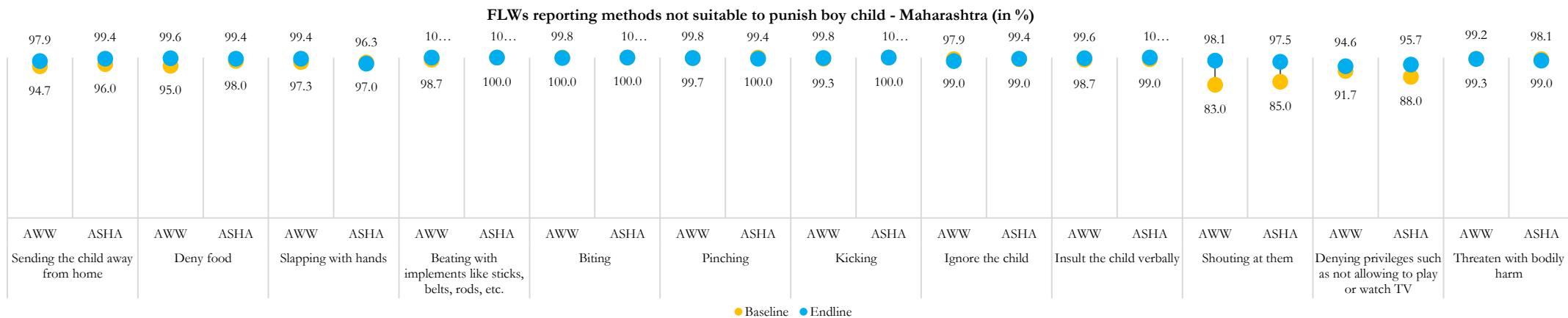


*Figure 103: FLWs reporting methods not suitable to punish boy child in Maharashtra (in %)*

*Table 71: FLWs reporting methods not suitable to punish boy child in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q523 Methods not considered suitable to punish a boy child | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Sending the child away from home | 100 | 96 | 90 | 99 | 96 | 99 | 96 | 97 | 95 | - | 99 | 100 |
| Deny food | 100 | 96 | 91 | 99 | 100 | 100 | 100 | 94 | 100 | - | 100 | 98 |
| Slapping with hands | 97 | 100 | 95 | 100 | 99 | 100 | 92 | 100 | 98 | - | 95 | 98 |
| Beating with implements like sticks, belts, rods, etc. | 100 | 100 | 97 | 100 | 100 | 100 | 100 | 100 | 100 | - | 100 | 100 |
| Biting | 100 | 100 | 100 | 100 | 100 | 99 | 100 | 100 | 100 | - | 100 | 100 |
| Pinching | 100 | 100 | 99 | 100 | 100 | 99 | 100 | 100 | 100 | - | 99 | 100 |
| Kicking | 100 | 100 | 98 | 100 | 100 | 99 | 100 | 100 | 100 | - | 100 | 100 |
| Ignore the child | 100 | 99 | 98 | 98 | 97 | 100 | 100 | 100 | 98 | - | 99 | 100 |
| Insult the child verbally | 99 | 99 | 98 | 100 | 100 | 99 | 100 | 100 | 98 | - | 100 | 100 |
| Shouting at them | 91 | 95 | 68 | 96 | 99 | 99 | 80 | 100 | 76 | - | 97 | 98 |
| Denying privileges such as not allowing to play or watch TV | 99 | 94 | 85 | 94 | 94 | 97 | 96 | 97 | 76 | - | 96 | 95 |
| Threaten with bodily harm | 100 | 100 | 98 | 100 | 99 | 99 | 100 | 100 | 98 | - | 97 | 100.0 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **64** |
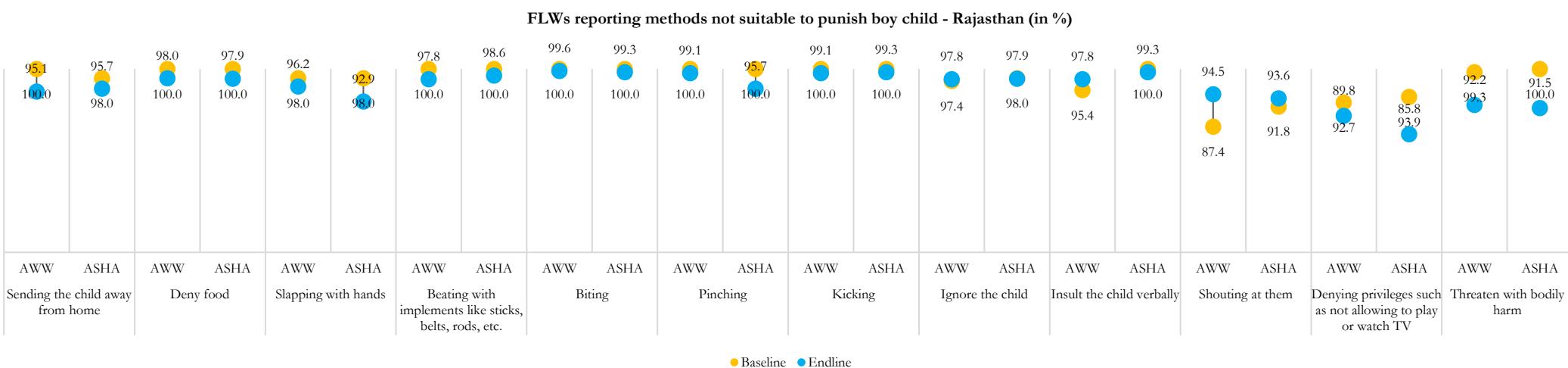
Figure 104: FLWs reporting methods not suitable to punish boy child in Rajasthan (in %)

*Table 72: FLWs reporting methods not suitable to punish boy child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| **Q523 Methods not considered suitable to punish a boy child** | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Sending the child away from home | 100 | 100 | 100 | - | 99 | 94 | 100 | 100 | 98 | - | 97 | 94 |
| Deny food | 100 | 100 | 100 | - | 99 | 98 | 100 | 100 | 100 | - | 99 | 97 |
| Slapping with hands | 100 | 96 | 98 | - | 99 | 95 | 100 | 88 | 100 | - | 97 | 89 |
| Beating with implements like sticks, belts, rods, etc. | 100 | 100 | 100 | - | 98 | 98 | 100 | 100 | 100 | - | 99 | 99 |
| Biting | 100 | 100 | 100 | - | 100 | 99 | 100 | 100 | 100 | - | 100 | 99 |
| Pinching | 100 | 100 | 100 | - | 100 | 99 | 100 | 100 | 100 | - | 99 | 93 |
| Kicking | 100 | 100 | 100 | - | 99 | 99 | 100 | 100 | 100 | - | 100 | 99 |
| Ignore the child | 100 | 100 | 97 | - | 99 | 97 | 100 | 100 | 98 | - | 100 | 96 |
| Insult the child verbally | 80 | 100 | 95 | - | 100 | 97 | 100 | 100 | 100 | - | 100 | 99 |
| Shouting at them | 80 | 100 | 85 | - | 98 | 93 | 100 | 100 | 90 | - | 97 | 90 |
| Denying privileges such as not allowing to play or watch TV | 80 | 100 | 92 | - | 93 | 89 | 100 | 100 | 93 | - | 89 | 83 |
| Threaten with bodily harm | 100 | 100 | 99 | - | 95 | 91 | 100 | 100 | 100 | - | 97 | 86 |
| **N** | **5** | **27** | **119** | **-** | **129** | **322** | **1** | **8** | **40** | **-** | **71** | **70** |

**FLWs reporting methods not suitable to punish girl child - Maharashtra (in %)**
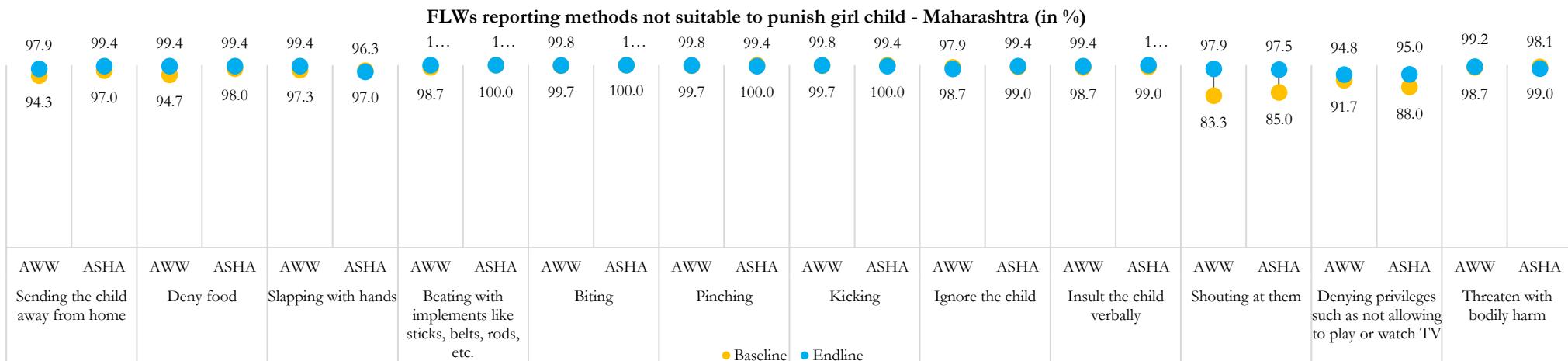


*Figure 105: FLWs reporting methods not suitable to punish girl child in Maharashtra (in %)*

*Table 73: FLWs reporting methods not suitable to punish girl child in Maharashtra (in %)*

| Maharashtra | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q523 Methods not considered suitable to punish a girl child | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Sending the child away from home | 100 | 96 | 89 | 99 | 96 | 99 | 96 | 97 | 98 | - | 99 | 100 |
| Deny food | 100 | 96 | 90 | 99 | 100 | 100 | 100 | 94 | 100 | - | 100 | 98 |
| Slapping with hands | 97 | 100 | 95 | 100 | 99 | 100 | 92 | 100 | 98 | - | 95 | 98 |
| Beating with implements like sticks, belts, rods, etc. | 100 | 100 | 97 | 100 | 100 | 100 | 100 | 100 | 100 | - | 100 | 100 |
| Biting | 100 | 100 | 99 | 100 | 100 | 99 | 100 | 100 | 100 | - | 100 | 100 |
| Pinching | 100 | 100 | 99 | 100 | 100 | 99 | 100 | 100 | 100 | - | 99 | 100 |
| Kicking | 100 | 100 | 99 | 100 | 100 | 99 | 100 | 100 | 100 | - | 100 | 100 |
| Ignore the child | 100 | 99 | 98 | 98 | 97 | 100 | 100 | 100 | 98 | - | 99 | 100 |
| Insult the child verbally | 99 | 100 | 98 | 100 | 99 | 99 | 100 | 100 | 98 | - | 100 | 100 |
| Shouting at them | 91 | 95 | 69 | 96 | 99 | 99 | 80 | 100 | 76 | - | 97 | 98 |
| Denying privileges such as not allowing to play or watch TV | 99 | 94 | 85 | 94 | 94 | 97 | 96 | 97 | 76 | - | 95 | 95 |
| Threaten with bodily harm | 100 | 100 | 97 | 100 | 99 | 99 | 100 | 100 | 98 | - | 97 | 100 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **25** | **33** | **42** | **-** | **97** | **64** |

**FLWs reporting methods not suitable to punish girl child – Rajasthan (in %)**
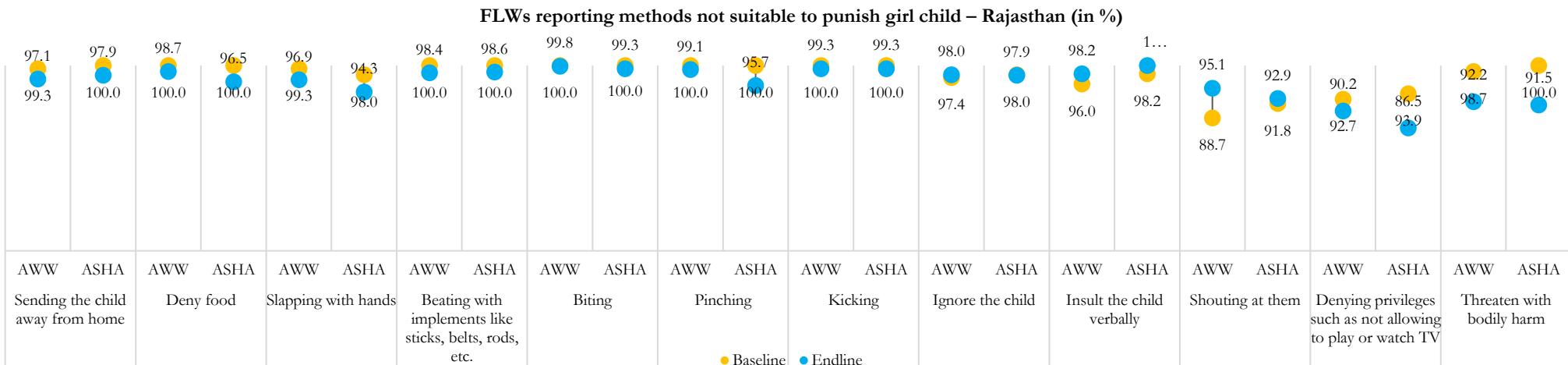


*Figure 106: FLWs reporting methods not suitable to punish girl child in Rajasthan (in %)*

*Table 74: FLWs reporting methods not suitable to punish girl child in Rajasthan (in %)*

| Rajasthan | AWW | | | | | | ASHA | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| Q523 Methods not considered suitable to punish a girl child | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Sending the child away from home | 100 | 96 | 100 | - | 99 | 96 | 100 | 100 | 100 | - | 99 | 97 |
| Deny food | 100 | 100 | 100 | - | 99 | 98 | 100 | 100 | 100 | - | 97 | 96 |
| Slapping with hands | 100 | 96 | 100 | - | 99 | 96 | 100 | 88 | 100 | - | 97 | 91 |
| Beating with implements like sticks, belts, rods, etc. | 100 | 100 | 100 | - | 99 | 98 | 100 | 100 | 100 | - | 100 | 97 |
| Biting | 100 | 100 | 100 | - | 100 | 100 | 100 | 100 | 100 | - | 100 | 99 |
| Pinching | 100 | 100 | 100 | - | 100 | 99 | 100 | 100 | 100 | - | 99 | 93 |
| Kicking | 100 | 100 | 100 | - | 99 | 99 | 100 | 100 | 100 | - | 100 | 99 |
| Ignore the child | 100 | 100 | 97 | - | 99 | 98 | 100 | 100 | 98 | - | 100 | 96 |
| Insult the child verbally | 80 | 100 | 96 | - | 100 | 98 | 100 | 100 | 100 | - | 100 | 99 |
| Shouting at them | 80 | 100 | 87 | - | 98 | 94 | 100 | 100 | 90 | - | 97 | 89 |
| Denying privileges such as not allowing to play or watch TV | 80 | 100 | 92 | - | 93 | 89 | 100 | 100 | 93 | - | 89 | 84 |
| Threaten with bodily harm | 100 | 100 | 98 | - | 95 | 91 | 100 | 100 | 100 | - | 97 | 86 |
| N | 5 | 27 | 119 | - | 129 | 322 | 1 | 8 | 40 | - | 71 | 70 |
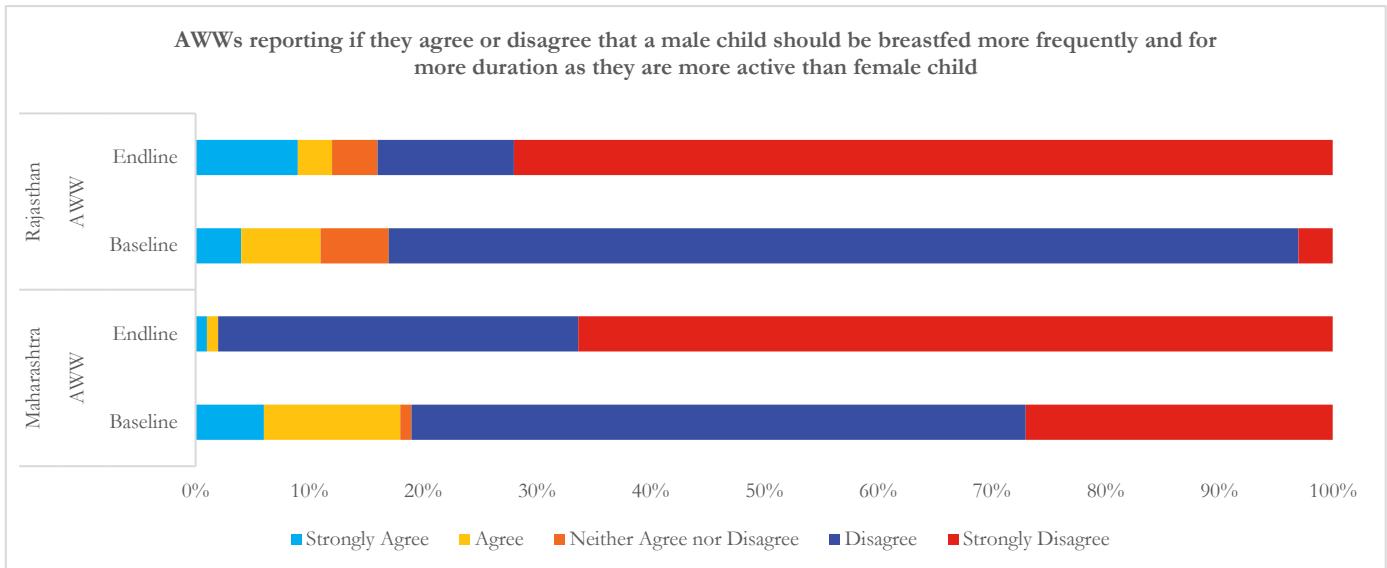
*Figure 107: AWWs reporting if they agree or disagree that a male child should be breastfed more frequently and for more duration as they are more active than female child*

*Table 75: AWWs reporting if they agree or disagree that a male child should be breastfed more frequently and for more duration as they are more active than female child*

| Q601 We have been told that a male child should be breastfed more frequently and for more duration as they are more active than female child in infant stage. Do you agree or disagree? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Strongly Agree | 11 | 4 | 5 | 0 | 0 | 1 | 20 | 4 | 3 | - | 6 | 10 |
| Agree | 3 | 5 | 24 | 1 | 0 | 2 | 0 | 11 | 6 | - | 1 | 4 |
| Neither Agree nor Disagree | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 22 | 3 | - | 4 | 4 |
| Disagree | 36 | 52 | 66 | 30 | 19 | 52 | 80 | 59 | 85 | - | 17 | 10 |
| Strongly Disagree | 50 | 39 | 2 | 69 | 81 | 45 | 0 | 4 | 3 | - | 72 | 72 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 5 | 27 | 119 | - | 129 | 322 |
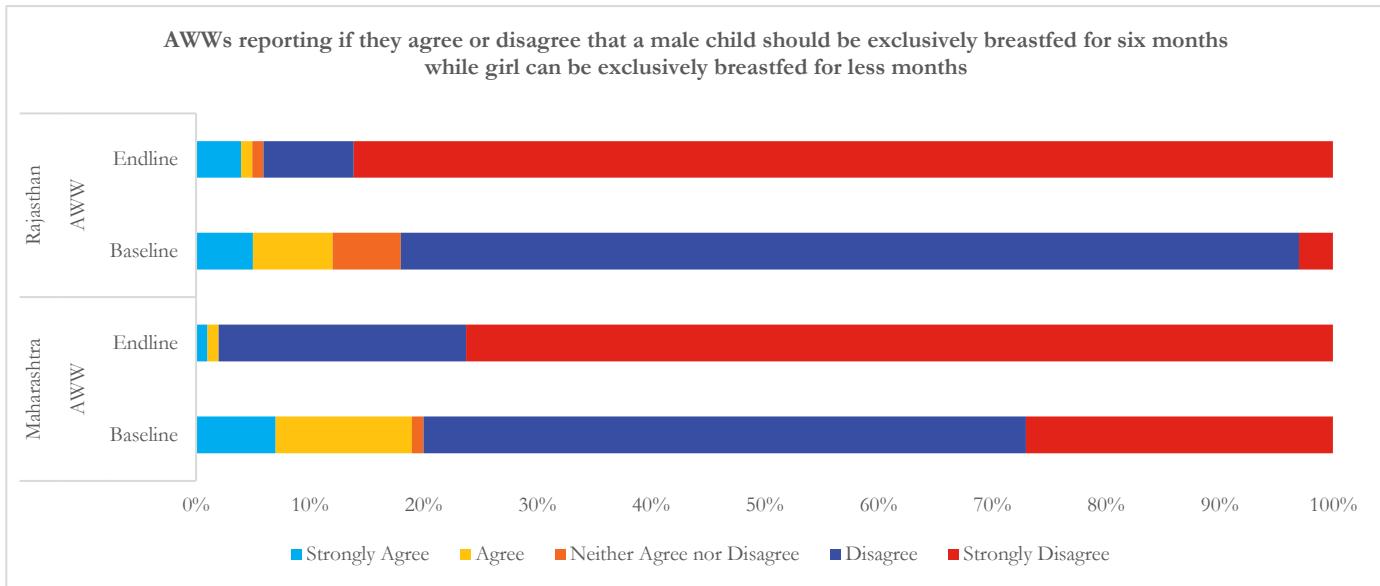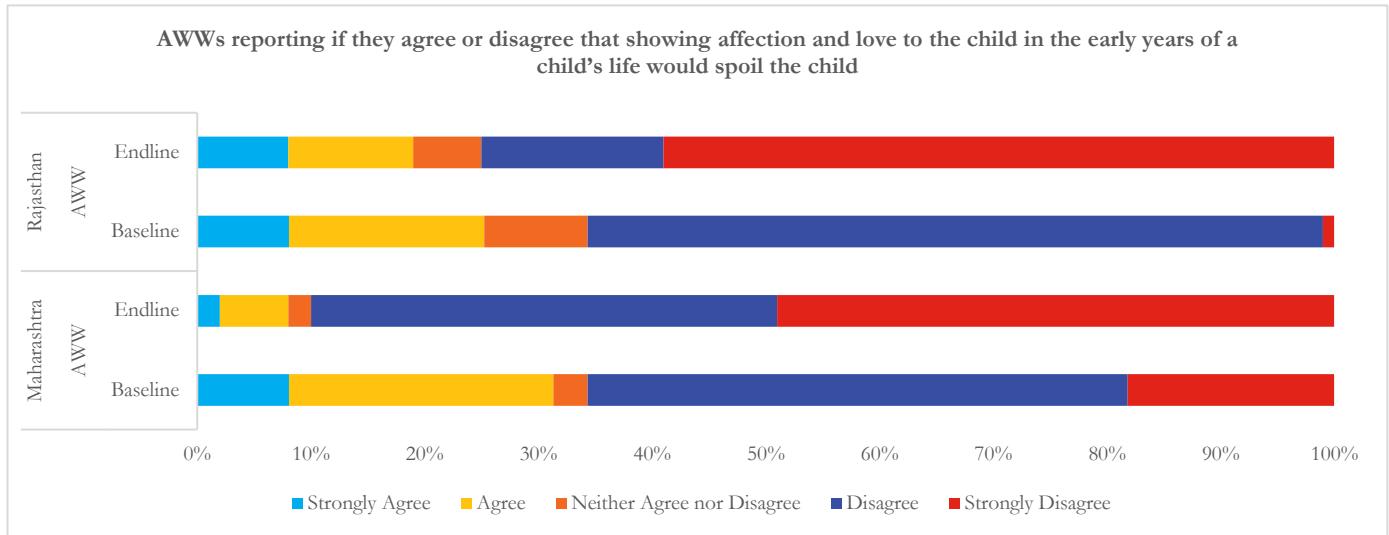
*Figure 108: AWWs reporting if they agree or disagree that a male child should be exclusively breastfed for six months while girl can be exclusively breastfed for less months*

*Table 76: AWWs reporting if they agree or disagree that a male child should be exclusively breastfed for six months while girl can be exclusively breastfed for less months*

| Q602 We were told that a boy should be exclusively breastfed for six months while a girl can be exclusively breastfed for less months. Do you agree that this is right? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Strongly Agree | 9 | 5 | 8 | 0 | 0 | 1 | 20 | 0 | 5 | - | 2 | 4 |
| Agree | 1 | 7 | 23 | 0 | 1 | 1 | 0 | 22 | 4 | - | 1 | 1 |
| Neither Agree nor Disagree | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 18 | 4 | - | 1 | 0 |
| Disagree | 39 | 48 | 66 | 19 | 9 | 46 | 80 | 56 | 84 | - | 11 | 7 |
| Strongly Disagree | 51 | 40 | 2 | 81 | 90 | 52 | 0 | 4 | 3 | - | 85 | 88 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **5** | **27** | **119** | **-** | **129** | **322** |

Figure 109: AWWs reporting if they agree or disagree that showing affection and love to the child in the early years of a child's life would spoil the child

Table 77: AWWs reporting if they agree or disagree that showing affection and love to the child in the early years of a child's life would spoil the child

| Q604 We were told that showing affection and love to the child in the early years of a child's life would spoil the child. Do you agree or disagree to that? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Strongly Agree | 15 | 2 | 10 | 2 | 3 | 0 | 20 | 4 | 8 | - | 4 | 10 |
| Agree | 13 | 13 | 38 | 5 | 6 | 8 | 40 | 11 | 18 | - | 6 | 12 |
| Neither Agree nor Disagree | 4 | 4 | 3 | 2 | 2 | 0 | 0 | 18 | 8 | - | 6 | 6 |
| Disagree | 43 | 52 | 45 | 45 | 26 | 60 | 40 | 63 | 65 | - | 27 | 12 |
| Strongly Disagree | 25 | 29 | 4 | 46 | 63 | 32 | 0 | 4 | 1 | - | 57 | 60 |
| N | 75 | 102 | 123 | 131 | 208 | 142 | 5 | 27 | 119 | - | 129 | 322 |
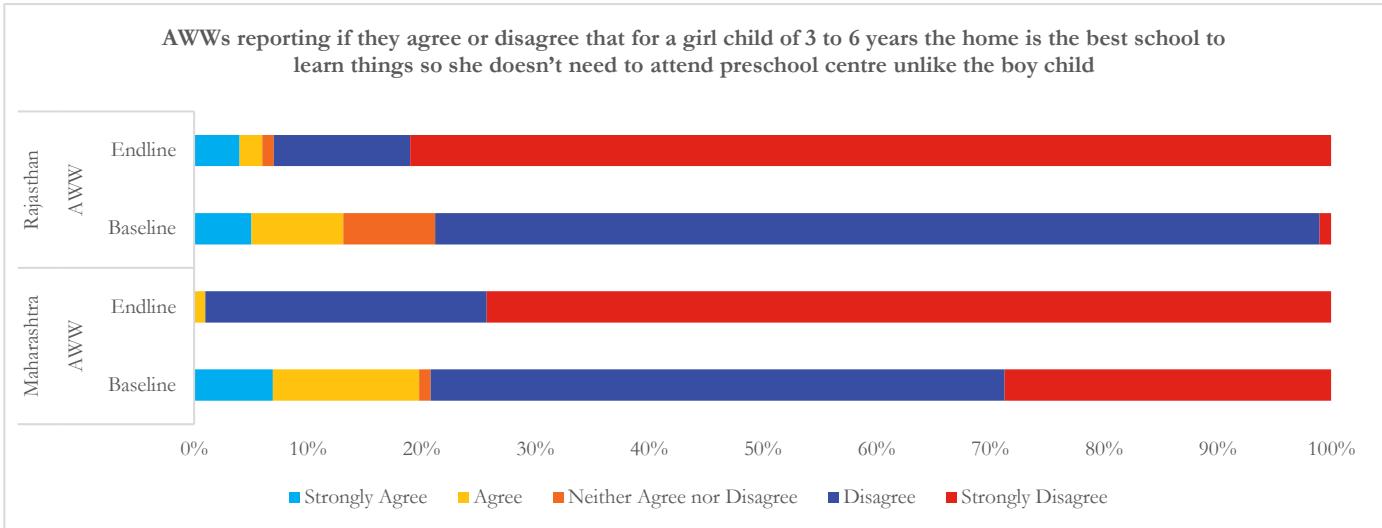
Figure 110: AWWs reporting if they agree or disagree that for a girl child of 3 to 6 years the home is the best school to learn things so she doesn't need to attend preschool centre unlike the boy child

Table 78: AWWs reporting if they agree or disagree that for a girl child of 3 to 6 years the home is the best school to learn things so she doesn't need to attend preschool centre unlike the boy child

| Q607 We have been told that for a girl child of 3 to 6 years the home is the best school to learn things, so she doesn't need to attend preschool centre unlike the boy child. Do you agree or disagree to that? | Maharashtra AWW | | | | | | Rajasthan AWW | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Baseline | | | Endline | | | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Strongly Agree | 11 | 3 | 8 | 0 | 0 | 0 | 20 | 4 | 5 | - | 2 | 5 |
| Agree | 1 | 5 | 26 | 0 | 0 | 1 | 0 | 7 | 9 | - | 2 | 3 |
| Neither Agree nor Disagree | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 22 | 5 | - | 1 | 1 |
| Disagree | 39 | 55 | 55 | 21 | 13 | 47 | 80 | 67 | 80 | - | 14 | 11 |
| Strongly Disagree | 49 | 37 | 9 | 79 | 87 | 52 | 0 | 0 | 1 | - | 81 | 80 |
| **N** | **75** | **102** | **123** | **131** | **208** | **142** | **5** | **27** | **119** | **-** | **129** | **322** |

**% of FLWs who received training on positive parenting and ECD in the past one year**
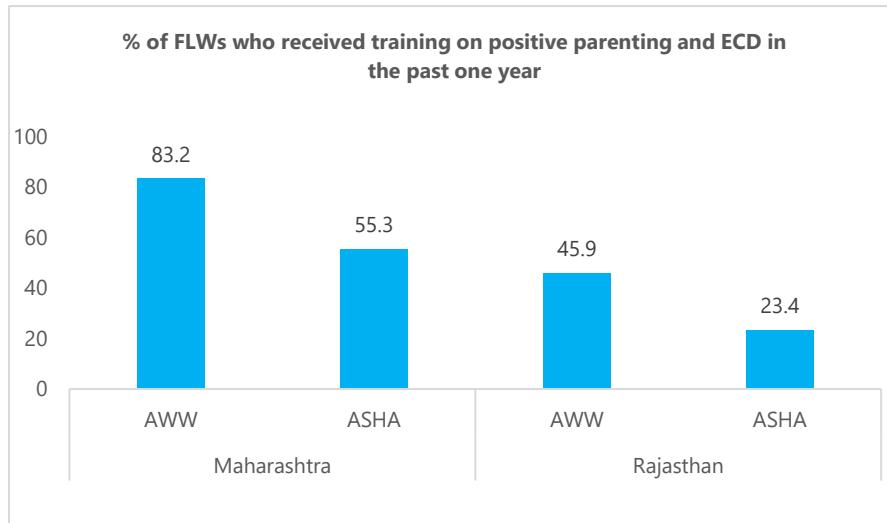


*Figure 111: Percentage of FLWs who received training on positive parenting and ECD in the past one year*

*Table 79: Percentage of FLWs who received training on positive parenting and ECD in the past one year in Maharashtra*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q304a Did you receive any training related to positive parenting and early childhood development in the past one year? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Yes | 94 | 80 | 78 | - | 51 | 63 |
| No | 6 | 20 | 23 | - | 50 | 38 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |

*Table 80: Percentage of FLWs who received training on positive parenting and ECD in the past one year in Rajasthan*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q304a Did you receive any training related to positive parenting and early childhood development in the past one year? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Yes | - | 54 | 43 | - | 16 | 31 |
| No | - | 47 | 57 | - | 85 | 69 |
| **N** | **-** | **129** | **322** | **-** | **71** | **70** |
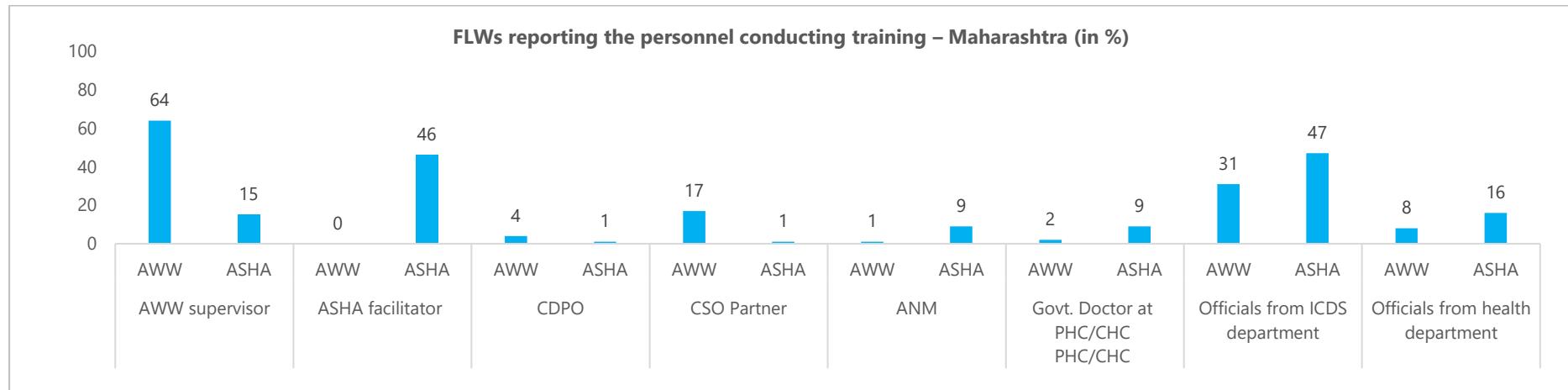
*Figure 112: FLWs reporting the personnel conducting training in Maharashtra (in %)*

*Table 81: FLWs reporting the personnel conducting training in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q304b Who conducted the training?** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| AWW supervisor | 64 | 72 | 52 | - | 16 | 13 |
| ASHA facilitator | 0 | 0 | 0 | - | 47 | 45 |
| CDPO | 3 | 4 | 3 | - | 2 | 0 |
| CSO Partner (MGIMS, Gram Mangal, Unnati) | 29 | 2 | 26 | - | 2 | 0 |
| ANM | 0 | 1 | 2 | - | 6 | 13 |
| Govt. Doctor at PHC/CHC | 2 | 2 | 0 | - | 10 | 8 |
| Officials from ICDS department | 19 | 42 | 29 | - | 45 | 50 |
| Officials from health department | 2 | 16 | 1 | - | 29 | 0 |
| Others | 13 | 14 | 20 | - | 14 | 28 |
| **N** | **123** | **167** | **110** | **-** | **49** | **40** |
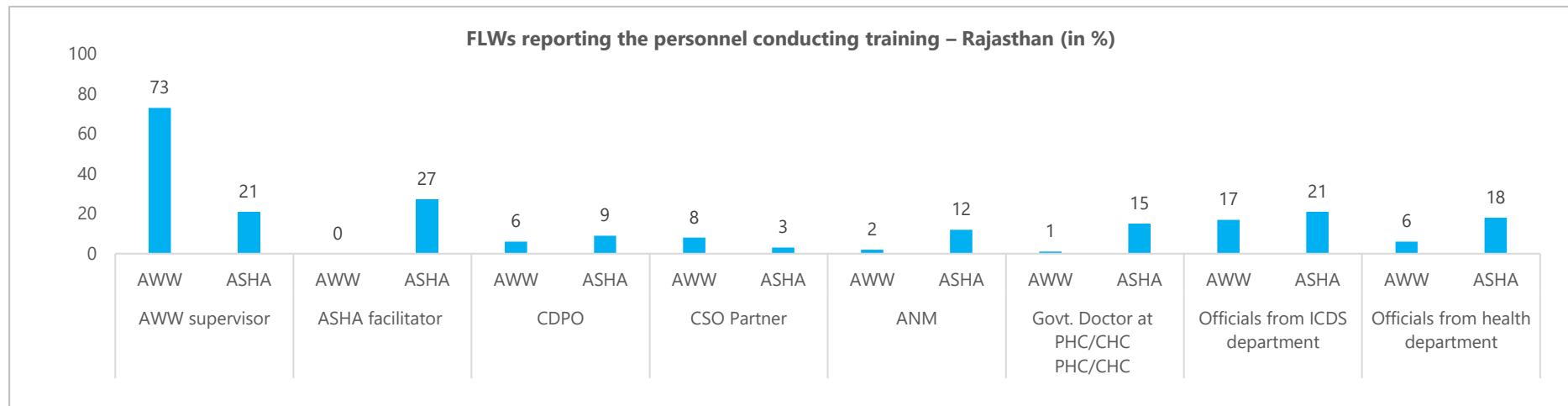
*Figure 113: FLWs reporting the personnel conducting training in Rajasthan (in %)*

*Table 82: FLWs reporting the personnel conducting training in Rajasthan (in %)*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q304b Who conducted the training?** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| AWW supervisor | - | 71 | 74 | - | 18 | 23 |
| ASHA facilitator | - | 0 | 0 | - | 55 | 14 |
| CDPO | - | 0 | 9 | - | 18 | 5 |
| CSO Partner (MGIMS, Gram Mangal, Unnati) | - | 12 | 6 | - | 0 | 5 |
| ANM | - | 4 | 1 | - | 9 | 14 |
| Govt. Doctor at PHC/CHC | - | 1 | 1 | - | 18 | 14 |
| Officials from ICDS department | - | 17 | 17 | - | 18 | 23 |
| Officials from health department | - | 4 | 7 | - | 27 | 14 |
| Others | - | 23 | 21 | - | 9 | 32 |
| **N** | **-** | **69** | **138** | **-** | **11** | **22** |
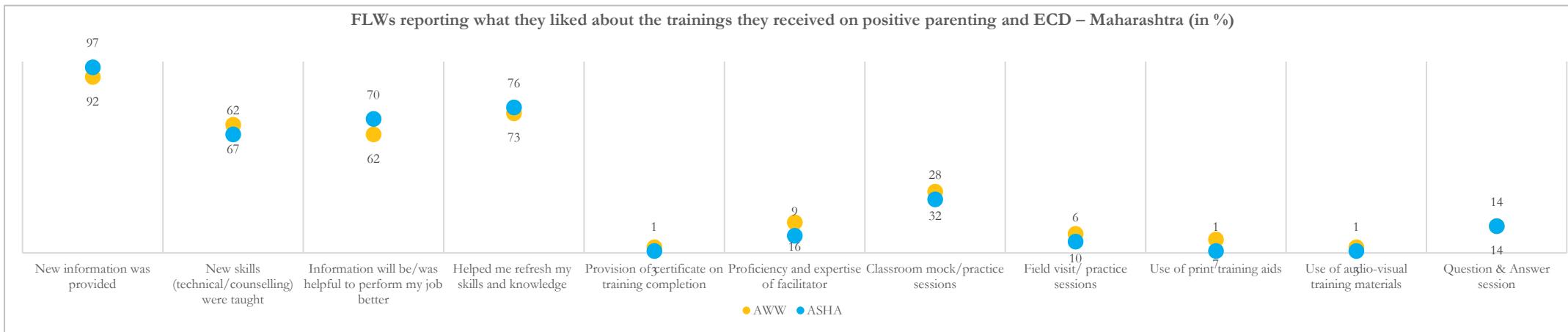
Figure 114: FLWs reporting what they liked about the trainings they received on positive parenting and ECD in Maharashtra (in %)

Table 83: FLWs reporting what they liked about the trainings they received on positive parenting and ECD in Maharashtra (in %)

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q305a What did you like about the trainings you received on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| New information was provided | 93 | 91 | 91 | - | 96 | 98 |
| New skills (technical/counselling) were taught | 76 | 71 | 49 | - | 82 | 38 |
| Information will be/was helpful to perform my job better | 72 | 66 | 46 | - | 78 | 60 |
| Helped me refresh my skills and knowledge | 73 | 66 | 83 | - | 78 | 75 |
| Provision of certificate on training completion | 3 | 4 | 2 | - | 2 | 0 |
| Proficiency and expertise of facilitator | 28 | 14 | 6 | - | 16 | 0 |
| Classroom mock/practice sessions | 46 | 36 | 9 | - | 39 | 15 |
| Field visit/ practice sessions | 16 | 8 | 5 | - | 6 | 5 |
| Use of print training aids | 10 | 8 | 3 | - | 2 | 0 |
| Use of audio-visual training materials | 3 | 3 | 3 | - | 0 | 3 |
| Question & Answer session | 12 | 21 | 6 | - | 25 | 0 |
| Nothing | 0 | 0 | 0 | - | 2 | 0 |
| N | 123 | 167 | 110 | - | 49 | 40 |
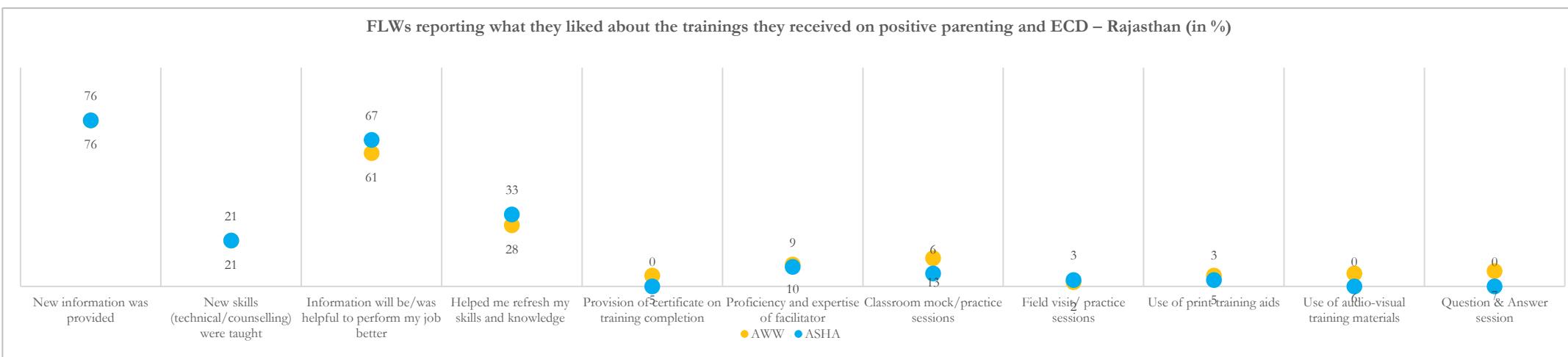
*Figure 115: FLWs reporting what they liked about the trainings they received on positive parenting and ECD in Rajasthan (in %)*

Table 84: FLWs reporting what they liked about the trainings they received on positive parenting and ECD in Rajasthan (in %)

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q305a What did you like about the trainings you received on positive parenting and early childhood development? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| New information was provided | - | 81 | 74 | - | 64 | 82 |
| New skills (technical/counselling) were taught | - | 20 | 21 | - | 18 | 23 |
| Information will be/was helpful to perform my job better | - | 67 | 58 | - | 64 | 68 |
| Helped me refresh my skills and knowledge | - | 32 | 26 | - | 36 | 32 |
| Provision of certificate on training completion | - | 3 | 7 | - | 0 | 0 |
| Proficiency and expertise of facilitator | - | 15 | 7 | - | 9 | 9 |
| Classroom mock/practice sessions | - | 16 | 11 | - | 0 | 9 |
| Field visit/ practice sessions | - | 1 | 3 | - | 9 | 0 |
| Use of print training aids | - | 6 | 5 | - | 9 | 0 |
| Use of audio-visual training materials | - | 13 | 2 | - | 0 | 0 |
| Question & Answer session | - | 13 | 4 | - | 0 | 0 |
| Nothing | - | 1 | 4 | - | 9 | 0 |
| N | - | 69 | 138 | - | 11 | 22 |

**FLWs reporting what they dis-liked about the trainings they received on positive parenting and ECD – Maharashtra (in %)**



*Figure 116: FLWs reporting what they dis-liked about the trainings they received on positive parenting and ECD in Maharashtra (in %)*

**FLWs reporting what they dis-liked about the trainings they received on positive parenting and ECD – Rajasthan (in %)**
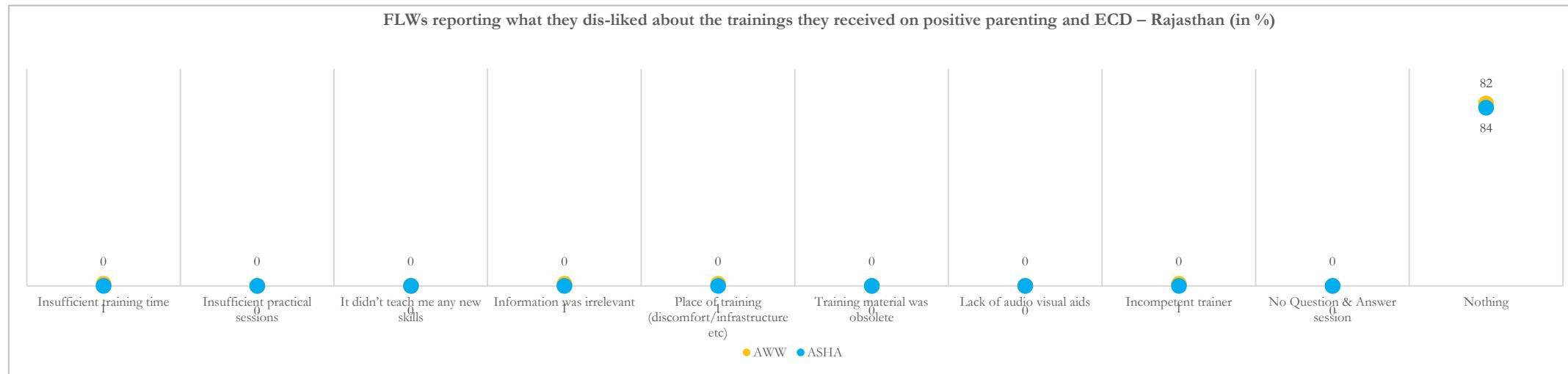


*Figure 117: FLWs reporting what they dis-liked about the trainings they received on positive parenting and ECD in Rajasthan (in %)*
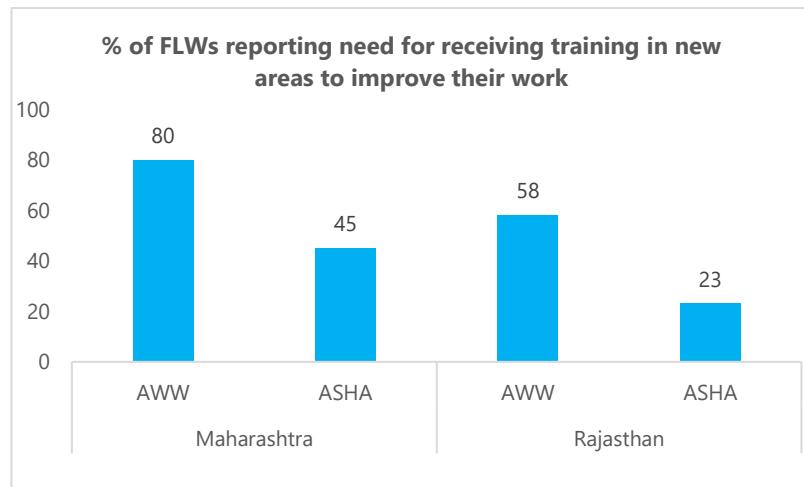
*Figure 118: Percentage of FLWs reporting need for receiving training in new areas to improve their work*

*Table 85: Percentage of FLWs reporting need for receiving training in new areas to improve their work in Maharashtra*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q306a Are there any new areas on which you would like to receive training on to improve your work? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Yes | 88 | 89 | 91 | - | 90 | 95 |
| No | 12 | 11 | 9 | - | 10 | 5 |
| **N** | **131** | **208** | **142** | **-** | **97** | **64** |

*Table 86: Percentage of FLWs reporting need for receiving training in new areas to improve their work in Rajasthan*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q306a Are there any new areas on which you would like to receive training on to improve your work? | Endline Only | | | | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| Yes | - | 69 | 60 | - | 55 | 76 |
| No | - | 31 | 40 | - | 45 | 24 |
| **N** | **-** | **129** | **322** | **-** | **71** | **70** |
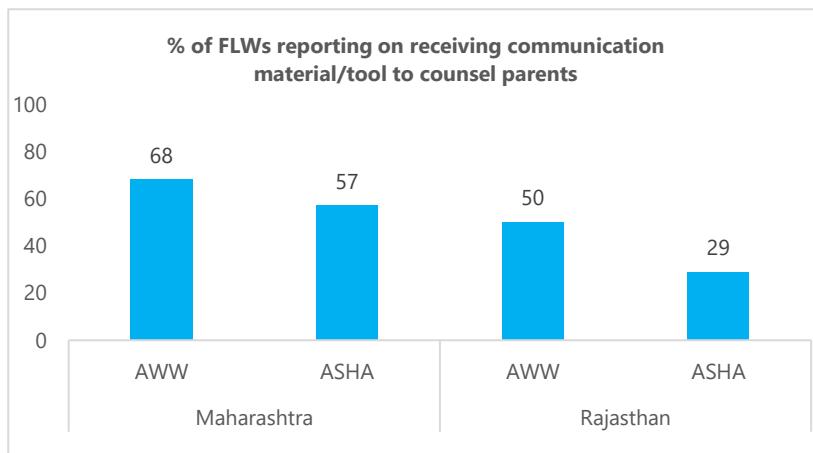


*Figure 119: % of FLWs reporting on receiving communication material/tool to counsel parents*
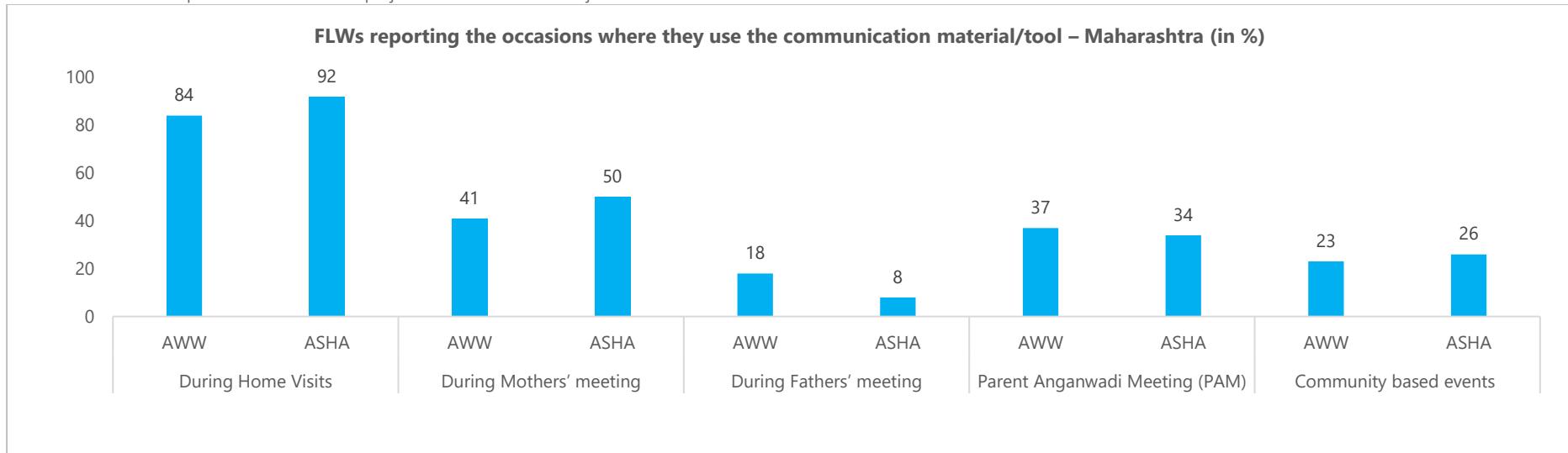
*Figure 120: FLWs reporting the occasions where they use the communication material/tool in Maharashtra (in %)*

*Table 87: FLWs reporting the occasions where they use the communication material/tool in Maharashtra (in %)*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q506b1 When do you generally use these communication material/tools to counsel parents/caregivers on positive parenting and early childhood development? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| During Home Visits | 82 | 82 | 90 | - | 92 | 93 |
| During Mothers' meeting | 31 | 64 | 23 | - | 70 | 27 |
| During Fathers' meeting | 16 | 25 | 10 | - | 13 | 2 |
| Parent Anganwadi Meeting (PAM) | 55 | 41 | 14 | - | 64 | 2 |
| Community based events | 34 | 20 | 13 | - | 49 | 2 |
| Others | 10 | 22 | 10 | - | 2 | 11 |
| **N** | **103** | **123** | **99** | **-** | **47** | **44** |
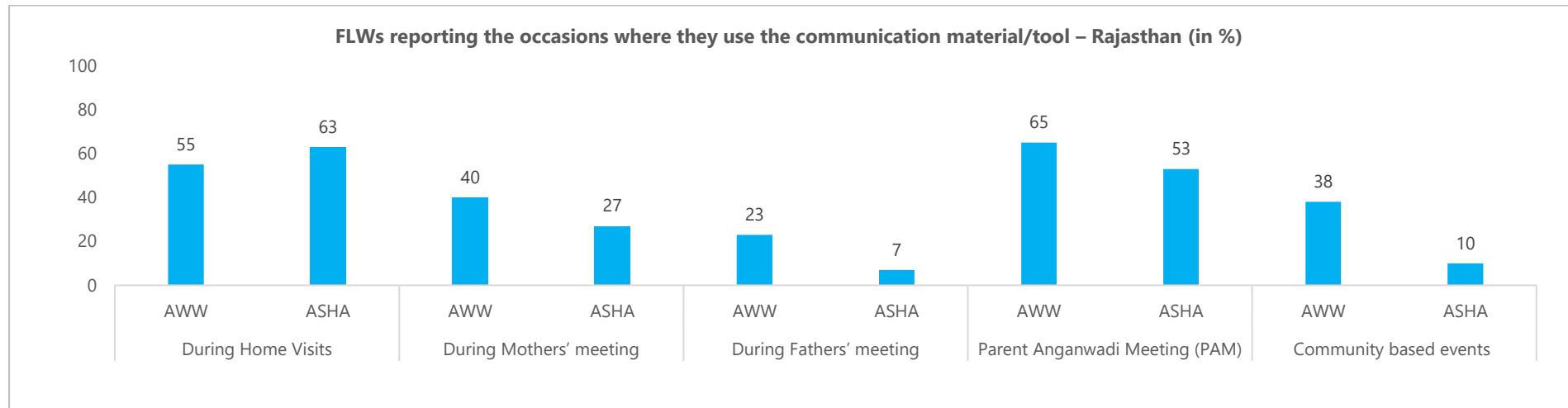
Figure 121: FLWs reporting the occasions where they use the communication material/tool in Rajasthan (in %)

Table 88: FLWs reporting the occasions where they use the communication material/tool in Rajasthan (in %)

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| Q506b1 When do you generally use these communication material/tools to counsel parents/caregivers on positive parenting and early childhood development? | Baseline | | | Endline | | |
| | Urban | Rural | Tribal | Urban | Rural | Tribal |
| During Home Visits | - | 50 | 61 | - | 56 | 71 |
| During Mothers' meeting | - | 42 | 39 | - | 25 | 29 |
| During Fathers' meeting | - | 17 | 30 | - | 6 | 7 |
| Parent Anganwadi Meeting (PAM) | - | 66 | 64 | - | 56 | 50 |
| Community based events | - | 40 | 36 | - | 13 | 7 |
| Others | - | 6 | 2 | - | 13 | 21 |
| **N** | **-** | **82** | **67** | **-** | **16** | **14** |
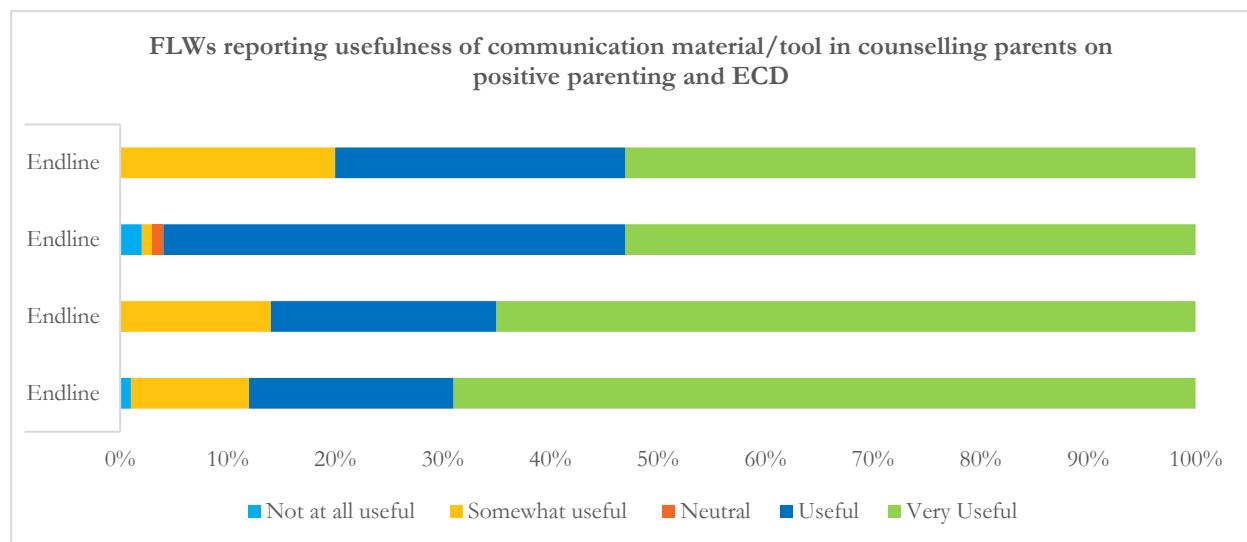
*Figure 122: FLWs reporting usefulness of communication material/tool in counselling parents on positive parenting and ECD*

*Table 89: FLWs reporting usefulness of communication material/tool in counselling parents on positive parenting and ECD in Maharashtra*

| Maharashtra | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q506c1 In your view, how useful do you find the communication material/tool in communicating messages to parents/caregivers on positive parenting and early childhood development** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Not at all useful | 0 | 1 | 1 | - | 0 | 0 |
| Somewhat useful | 11 | 9 | 14 | - | 11 | 18 |
| Neutral | 0 | 0 | 0 | - | 0 | 0 |
| Useful | 16 | 11 | 31 | - | 13 | 30 |
| Very Useful | 73 | 79 | 54 | - | 76 | 52 |
| **N** | **103** | **123** | **99** | **-** | **47** | **44** |

*Table 90: FLWs reporting usefulness of communication material/tool in counselling parents on positive parenting and ECD in Rajasthan*

| Rajasthan | AWW | | | ASHA | | |
|---|---|---|---|---|---|---|
| **Q506c1 In your view, how useful do you find the communication material/tool in communicating messages to parents/caregivers on positive parenting and early childhood development** | **Endline Only** | | | | | |
| | **Urban** | **Rural** | **Tribal** | **Urban** | **Rural** | **Tribal** |
| Not at all useful | - | 4 | 0 | - | 0 | 0 |
| Somewhat useful | - | 1 | 0 | - | 13 | 29 |
| Neutral | - | 1 | 2 | - | 0 | 0 |
| Useful | - | 45 | 40 | - | 37 | 14 |
| Very Useful | - | 49 | 58 | - | 50 | 57 |
| **N** | **-** | **82** | **67** | **-** | **16** | **14** |