REPORT

Process Evaluation
Positive Parenting Program
Plan International in Laos

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ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CLTS</td>
<td>Community-Led Total Sanitation</td>
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<td>DESB</td>
<td>District Education &amp; Sports Bureau</td>
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<td>ECCD</td>
<td>Early Childhood Care &amp; Development</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HC</td>
<td>Health Centre</td>
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<td>IDI</td>
<td>In-dept Interview</td>
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<td>INGO</td>
<td>International Non-governmental Organisation</td>
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<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<td>LANN</td>
<td>Linking Agriculture, Natural Resource Management, and Nutrition</td>
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<td>LWU</td>
<td>Lao Women’s Union</td>
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<tr>
<td>MNCH+N</td>
<td>Maternal, Neonatal &amp; Child Health + Nutrition</td>
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<td>ORS</td>
<td>Oral Rehydration Solution</td>
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<td>PDR</td>
<td>People’s Democratic Republic</td>
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<td>PPP</td>
<td>Positive Parenting Program</td>
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<td>Village Health Volunteer</td>
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<td>WASH</td>
<td>Water Sanitation &amp; Hygiene</td>
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EXECUTIVE SUMMARY

INTRODUCTION

This report describes a process evaluation undertaken in March 2015 for Plan International in Laos, of a Positive Parenting program (PPP) piloted in Bokeo Province, as part of an ongoing Early Childhood Care and Development (ECCD) implementation plan.

The purpose of the evaluation was to document the process, early outcomes and the lessons learned from the PPP initiative, and to formulate recommendations for improvement and expansion, particularly as it relates to improving nutritional status of children under the age of 5 years.

The PPP is aligned with the first of four ‘Cornerstones’ described in Plan Laos’ 5 year ECCD plan and evolved from a government-led Parenting Orientation program aimed at addressing the gap of early childhood care and development for children aged 0-3.

The Positive Parenting approach includes a focus on both early learning, stimulation and play, as well as on early childhood health, sanitation and nutrition. The program was launched in January 2013, alongside Plan’s Maternal, Neonatal & Child Health and Nutrition (MNCH+N) program in Bokeo province, drawing on the skills and technical advice of both the ECCD and MNCH+N teams.

To support the Positive Parenting program, a new curriculum was developed in the form of a Facilitation Guide with modules for each session, along with supplemental IEC materials. Modules are delivered to parent groups by trained village volunteers (VVs), selected by and within the communities, who are supervised by multi-disciplinary teams comprising Plan and local government staff.

This evaluation took place 11 months after the start of the PPP implementation, after 6 of the 11 Facilitation Guide modules had been delivered in the program’s target villages.

The current Positive Parenting program supports the first objective outlined in the Plan Laos ECCD program plan (2012-2017):

**Objective 1:**

*All parents and caregivers in targeted villages have improved skills, knowledge and practice to provide a healthy, stimulating and safe environment for children aged 0-3 years.*

- **Outcome 1.1:** Parents accessing and using quality information to support improved child rearing at home
- **Outcome 1.2:** Quality home and community based care provided by village members to all children aged 0-3 years

This 0-3 age group is considered to be the primary target as these children are too young to attend any formal or informal schooling. However given the remote locations of the project villages, the PPP also includes children aged 4-5, most of whom do not have access to any form of pre-schooling.
METHODOLOGY

The two districts of Pha Oudom and Phaktha were selected as the study sites for the evaluation. Eleven villages from these districts were included in the study, all of which were among the original 32 project villages.

The evaluation employed mixed methods, primarily qualitative in nature. These methods included in-depth interviews (IDI), focus group discussions (FGDs), a rapid ‘mini survey,’ observation and a review of secondary data.

A total of 58 parents were interviewed for the mini survey, and 75 for the FGDs, for a total of 133 parents. Of the 11 villages visited, 6 were predominantly of the Khmu ethnic group, 3 Hmong and 2 Lue. In total 6 FGDs were conducted among mothers, and 2 comprised of fathers.

KEY FINDINGS

Findings on Program Design

On the whole the Positive Parenting Group (PPG) curriculum has been well designed to address the ECCD program objective of improving the skills, knowledge and practice of parents to provide a healthy, stimulating and safe environment for children aged 0-5 years.

Some gaps need to be filled in order to comprehensively address underlying determinants to nutrition in the target communities. For example, there is no explicit discussion mentioned in the session guide on the benefits of breastfeeding, encouragement for early onset and exclusive breastfeeding in the first 6 months.

Little evidence was found that parents were involved in the design and planning of the PPGs, though parents were consulted in a participatory manner during development of the accompanying IEC materials.

While there are numerous monitoring mechanisms built into the PPP, it was not clear how each set of data was to be used to the benefit of program planners, highlighting the need for Theory of Change model and a clear monitoring framework for the PPP, including numerical targets.

Findings on Implementation

This evaluation concluded that parents in target communities value the health and well-being of their children and appreciate Plan’s Positive Parenting Program.

Recruitment and maintenance of PPG participants has been challenging. Barriers to attendance have included inconvenient timing of the groups; limited eligibility criteria (for example, not explicitly inviting fathers); and loss of interest due to fatigue at the length and frequency of sessions and cited inability to put recommendations into practice.

The evaluation highlights some issues with PPG facilitation and supervision. Program managers and the village volunteers themselves felt that the VVs ability to effectively
facilitate the PPGs was affected by their lack of facilitation skills and knowledge to go “off-script.” It was also noted that while most of the targeted parents are women, the majority of selected facilitators are men.

Another issue that was identified during interviews was the varying commitment of the District Facilitators who are trained to supervise the VVs and assist with monitoring. There is high turnover in district staff that Plan trains, affecting continuity.

The PPG sessions were designed to solicit significant participation from the parents but PPG facilitators have mixed reports on the level of parental participation during sessions, with a number of variables coming into play, such as the skill of the facilitator; ethnic and demographic characteristics of the community and size of the group. Cited barriers include: language barrier; newness of participatory methods and concepts; too much talking, not enough doing; insufficient visual aids; length of sessions; dominance of men in mixed groups; distraction from children and perceived irrelevance.

Findings on Outcomes

Knowledge
It was found that the program has succeeded in increasing some knowledge of direct nutritional interventions such as infant and young child feeding and growth monitoring, as well as indirect determinants for health improvement, such as illness management and hygiene. Parents were able to remember basic concepts learned in the PPGs including the 3 kinds of care children need and provide some examples. Most parents knew of the importance of breastfeeding children under 6 months, though half of them surveyed also felt other foods should be fed along with breastmilk.

Behaviour change
Respondents have reported a degree of behaviour change related to areas covered by the PPP. For example, the majority (53%) of mini survey respondents whose children showed danger signs reported having taken their children to either a health centre or hospital. 83% of women surveyed reported their husbands’ having made changes in child-caring practices as a result of the PPP. VVs and focus group participants anecdotally mentioned various changes they’d observed in their communities since implementation of the PPGs. These include improvement in hygiene practices, appearance of home gardens, increased attendance at health centres and an increase in children attending school.

However the majority (72%) of mini survey respondents reported facing some difficulty in adopting recommendations, with the majority of reasons cited pointing to a lack of means - particularly in the form of resources and capacity - rather than to a lack of will.

RECOMMENDATIONS

Recommendations for Program Design

- Develop a Theory of Change (ToC) model and logical framework specific to the Positive Parenting Program that represents the needs that the PPP is trying to
address, the changes it aims to achieve, how it hopes to achieve these changes and how these changes will be measured.

- Increase parental involvement in the design of the PPP. Enlist parents in identifying their ECCD learning priorities; adapting the content flexibly to the context of each distinct community; improving motivation and enabling factors for change; and developing activities to increase their direct involvement during and in-between the sessions.

- Improve learning materials by developing more visual aids and reducing text; making context flexible for adaptation to each community’s context and pretesting materials.

- Gain a more in-depth understanding of target communities to allow messages and methods to be better targeted and to understand barriers and enabling factors for behaviour change. Do this by reviewing and utilizing existing anthropological studies and conducting a community assets mapping exercise to outline availability of resources that could enable communities to adopt optimal child caring practices.

- Support village groups to create the means to enable positive behaviour change in their communities via linking with parallel complementary programs; learning from program success stories; and community-mobilisation to take ownership of village improvement initiatives.

- Fortify human resources by
  - Providing village volunteers with strengthened training that includes facilitation skills and additional knowledge, and intensified supervision and feedback; and
  - Securing commitment and continuity of district facilitators

**Recommendations for Implementation**

- To increase relevance and address complaints about the length and frequency of sessions, be selective and flexible with the learning curriculum.

- Take advantage of positive deviance by learning from parents who report positive behaviour change and regular PPG attendance.

- During the sessions, involve parents in more “doing” activities and encourage parents to continue these activities in between sessions, and to reflect on their successes and motivating factors.

- Incorporate children into the learning process rather than treating them as distractions.

- Explicitly invite fathers to attend PPGs and consider having separate sessions for men only, focusing specifically on gender sensitivity and male involvement in child-rearing and family protection and welfare.
Recommendations for Nutrition Expansion

Acknowledging the direct relationship between children’s wellbeing, healthy growth and development, with nutrition, early stimulation and sanitation, Plan hopes to create a more comprehensive nutritional component for the next phase of the PPP.

- A strengthened nutrition curriculum should use the 1000 days approach, covering the period from conception until the child reaches 24 months of age.

- Expand Infant and Young Child Feeding (IYCF) components to include messages on the importance of breastfeeding and appropriate complementary feeding on a child’s nutrition and future learning potential. Strengthen breastfeeding messages to include the importance of colostrum, early initiation, frequency and duration. Add a component on barriers to breastfeeding and working with parents to overcome them.

- Strengthen links between the PPP and the local health workers (skilled birth attendants, village health workers etc.) so that parents have continuous semi-professional support when adopting new feeding practices.

- Improve complementary feeding recommendations by formatively exploring which kinds of food are highly valued by communities, and reinforcing the value of locally available nutritious food. Expand messages to ensure they cover frequency, texture and amount appropriate to child age groups, as well as variety, responsive feeding and hygiene.

- Coordinate with Plan’s MNCH+N an WASH programs on seeking solutions to enable behaviour change; curriculum development; strengthening VV training on health-related components; supervision and support of VVs; and linking shared goals of improved nutrition to the community-led Total Sanitation (CLTS) program.
1. **INTRODUCTION**

This report describes a process evaluation undertaken in March 2015 for Plan International in Laos, of a Positive Parenting program (PPP) piloted in Bokeo Province, as part of an ongoing Early Childhood Care and Development (ECCD) implementation plan.

2. **BACKGROUND**

2.1 **Current Situation**

In Laos the past 10 – 15 years has seen significant gains for children aged up to eight years, both in terms of health as well as education. However despite considerable progress made in economic development over the past decade, chronic malnutrition remains high, with 27% of children under five being underweight and 44 % being stunted\(^1\)

Contributing factors include pregnant women’s poor nutrition; high rates of adolescent pregnancy\(^2\); poor protein and fat intake; high disease prevalence; poor infant and child feeding practices; widespread practice of food taboos; poor sanitation and common practice of open defecation; and high levels of vulnerability to resettlement, natural hazards and shocks.\(^3\) Chronic under nutrition has a direct impact on children’s growth and their learning outcomes, with a direct impact on brain development. A 2007 multi-country study found that for every 10% increase in stunting prevalence in school-age children, the proportion that reached the final year of primary school dropped by 8%.\(^4\)

The Convention of the Right of the Child calls for a holistic approach that guarantees both child survival and development. However child development programs have traditionally focused on child nutrition for growth and survival in the first 3 years of life, with stimulation and play emphasized for children over 3 years\(^5\). In Laos, government ECCD programs target children only starting from the age of 3 years, with a strong focus on school readiness among 5 year olds. In remote areas, there are currently no government ECCD programs for children who fall in the 0-5 age group.

There is now strong evidence that programs that combine early childhood stimulation and protection with health and nutrition are the most effective at ensuring good child growth and development. Through its Positive Parenting Program Plan Laos has aimed to address the early development gap via this integrated approach.

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\(^1\) Lao Social Indicator Survey 2011/12  
\(^3\) REACH, 2009  
\(^5\) UNICEF and WHO. *Integrating early childhood development (ECD) activities into nutrition programs in emergencies: why, what and how*
2.2 Program Background

Plan International has been working in Laos since 2007 and has been implementing an ECCD Program in remote and ethnic villages in Bokeo Province since 2008. This program initially focused on preparing children for entry into primary school through the provision of pre-school infrastructure and teacher training and support.

In July 2012 a next phase 5 year ECCD plan was developed, using the ‘Four Cornerstones’ developed by the Consultative Group on Early Childhood Care and Development as an overall organizing principle and in defining the goals, objectives, outcomes and activities. These four cornerstones cover three developmental stages i.e., 0-3 years; 3 – 6 years; and 6 – 8 years, as well as aspects related to ECCD policy and policy implementation.

The Positive Parenting Program is aligned with the first Cornerstone and evolved from a government-led program aimed at addressing the gap of early childhood care and development for children aged 0-3. Within Bokeo Province, a situation assessment in 2011 by Plan staff in the three target districts of their program found that parents’ knowledge of child development and parenting skills were limited. Parents lacked knowledge about the importance of early stimulation (physical and cognitive) for children’s early development. Parents reportedly fed their smaller children the same food as they ate, which suggests inadequate nutrition, with longer term negative implications for child development.

In 2011-12, using materials produced by the Ministry of Education & Sports (MoES), Plan expanded support to children aged 0-5 by initiating Parenting Orientation sessions in 24 villages across three districts of Bokeo (Pha Oudom, Pak Tha and Meung), delivering ECCD information, including basic health and nutrition messages, to parents and caregivers, in close collaboration with District Education and Sports Bureau staff.

An evaluation of the first phase of Plan’s ECCD program indicated that the Parenting Orientation sessions showed some encouraging initial results, in that parents were interested in discussing the welfare of their young children, and started to demonstrate some basic understanding of the importance of the early years in children’s development. Parents also reported some new knowledge and skills related to sanitation and nutrition. According to the ECCD Program Plan for 2012-2017, however, these gains were limited and the overall conclusion was that the sessions were not achieving the intended outcomes of providing knowledge to parents on the importance of ECCD.

Program limitations were attributed in part to the “stand-and-teach” style methods used, language barriers across ethnic groups and that there were some fundamental areas of ECCD missing from the sessions.

2.3 Positive Parenting Program (PPP)

In an effort to improve program implementation, and to provide a more holistic approach to working with parents and caregivers of children aged 0-5, Plan embarked on a new Positive Parenting approach that includes a focus on both early learning, stimulation and play, as well as on early childhood health, sanitation and nutrition. The program was launched in January 2013, alongside Plan’s Maternal, Neonatal & Child Health and Nutrition (MNCH+N) program.

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4For more information, refer to Section 3.1 below, as well as to the website of the Consultative Group on ECCD – [www.ecdgroup.com](http://www.ecdgroup.com)
in Bokeo province, drawing on the skills and technical advice of both the ECCD and MNCH+N teams.

To support the Positive Parenting program, a new curriculum was developed in the form of a Facilitation Guide with modules for each session, along with supplemental IEC materials.

This evaluation took place 11 months after the start of the PPP implementation, after 6 of the 11 Facilitation Guide modules had been delivered in the program’s target villages.

2.4 Implementation Methodology

As described in a concept paper prepared on the Positive Parenting Program, modules are delivered to parent groups by village volunteers (VV), selected by and within the communities, usually including the village chief, village health volunteer, or village Lao Women’s Union representatives. At least one of the VVs is required to be literate. Each village selected four VVs for a total of 208 (86 women / 122 men). 7

These VVs are supported by multi-disciplinary teams, consisting of provincial and district trainers teams including staff from among the provincial and district Health Offices, Education and Sports Bureaus, Rural Development Offices, Provincial Committee for the Advancement of Women, Lao Women’s Union, Lao Youth Union as well as village cluster leaders and local Health Centre staff (approximately 8 people per team). These teams deliver regular training, monitoring and support to VVs, who implement sessions once a month in their villages with the target parents.

For this pilot program, training of district trainers was divided into two parts, the first taking place in December 2013, covering sessions 1-5 of the Facilitation Guide, the second in October 2014, covering sessions 6-11. Each training took 3 days.

In turn, the district facilitators deliver a one-day training per each of the 11 PPP modules, to the village volunteers at the cluster level. The day following their training, the VVs return to their villages to immediately implement each module in the form of parenting groups comprising 15-30 parents, and lasting approximately 2-3 hours. The frequency of VV training/implementation varies according to the season, taking place once a month during the dry season, and once every 2 months during the rainy season, when access to villages can be limited due to impassable roads.

Each VV is given a bag and a shirt, and are provided with perdiem and travel costs when they attend training sessions. They are not provided any other material incentives or remuneration.

The PPP was initiated in 32 villages and has now been expanded to include 52 villages. To date the program has reached 1,392 parents (736 women. 656 men) and 1,861 children (896 girls/ 965 boys), aged 0-5 years.

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7 The PLAN ECCD June 2014 Quarterly Report, however, stated that 117 (26 female) VVs were trained on sessions 2-5
2.5 Project Objective

The current Positive Parenting program supports the first objective outlined in the Plan Laos ECCD program plan (2012-2017):

**Objective 1:**

*All parents and caregivers in targeted villages have improved skills, knowledge and practice to provide a healthy, stimulating and safe environment for children aged 0-3 years.*

- **Outcome 1.1:** Parents accessing and using quality information to support improved child rearing at home
- **Outcome 1.2:** Quality home and community based care provided by village members to all children aged 0-3 years

This 0-3 age group is considered to be the primary target as these children are too young to attend any formal or informal schooling. Given the remote locations of the project villages, however, the PPP also includes children aged 4-5, most of whom do not have access to any form of pre-schooling.

While a project logframe specific to the PPP has not been formally developed, the PPP concept paper states that the objective is:

“To empower communities, particularly parents and other guardians, to better support the development of their children through increased understanding of the young child’s needs and concrete care and stimulation methods gained through participatory discussions, demonstrations and practice.”

3. PURPOSE OF THE EVALUATION

The purpose of the evaluation as stipulated in the Terms of Reference (ToR) was:

1. To document the process, early outcomes and the lessons learned from the initiative of facilitating parents groups using the positive parenting modules, particularly as it relates to improving nutritional status of children under the age of 5 years, and

2. To provide recommendations for further improvements in the program that can be used in implementation of the same approach in other villages and districts in Laos, particularly as it relates to improving nutritional status of children under the age of 5 years

The evaluation was commissioned midway through the five-year ECCD Lao program plan (21012-2017), and about halfway through the pilot implementation of the Positive Parent Group (PPG) curriculum, rather than at the project’s completion. As such the evaluation was not so much summative in nature as it was part of a reflective process of action research, aimed at taking stock and verifying the Positive Parenting Program approach.
4.  **RESEARCH QUESTIONS**

The key research questions that the evaluation aimed to examine were those outlined in the ToR:

**Project Design**

1. To what extent is it evident that the project design is:
   - Informed by critical underlying determinants of children’s nutrition in the communities where it was implemented
   - Coherent with achieving child nutrition-related outcomes
   - Empowering, inclusive of ethnic diversity and gender aware

2. To what extent do learning tools allow customization according to the local context of each community?

**Implementation Process**

3. To what extent were the parents and other caregivers involved in the design, implementation and monitoring of the project?
4. To what extent were the guiding principles stated in the project documents adhered to in the implementation?
5. To what extent has this project contributed to engagement of communities with development work that Plan facilitates?

**Outcomes**

6. To what extent were the changes in key determinants of nutrition achieved or likely to be achieved?
7. Have there been any reported unintended outcomes?
8. What were the major factors influencing the achievement or non-achievement of the outcomes?

5. **METHODOLOGY**

5.1 **Approach**

This evaluation employed mixed methods in order to gather information from several sources – both primary and secondary – to allow for a degree of triangulation. These methods, described in more detail below, included a review of secondary data, along with the collection of primary data from in-depth interviews, focus group discussions, and a short survey, henceforth referred to as the “mini survey.”

The primary data was qualitative in nature, aimed at drawing out information on perceptions regarding the successes and challenges of implementing the program, as well as self-reported outcomes and their influencing factors. Once coded, the mini survey also allowed for some quantification, for the purpose of rapid assessment.
Due to the absence of a project logical framework, the study did not formally evaluate the program’s progress against pre-defined baseline indicators, nor seek to obtain statistical measures of change or impact.

5.2 Data collection methods

The study methods used in the evaluation are described below. The data collection tools (questionnaire and question guides) are included as Appendices 1-3.

Review of secondary data
In order to supplement the primary field data collected during this study, relevant secondary data and background documents were reviewed. These included, but were not limited to:

- Articles describing the status of children in Lao PDR
- ECCD and MNCH+N project documents
- Program monitoring and evaluation reports and raw data
- PPG IEC materials and session guide
- Progress and donor reports
- Documents detailing the nutritional status among under 5 children in Laos
- Documents detailing the status of early childhood learning and development in Laos

Background and planning documents served to put the ECCD parenting program in context, while field monitoring reports were reviewed in order to draw inferences with respect to progress made towards achieving expected outcomes.

In-depth Interviews (IDI)
Qualitative, face-to-face interviews were conducted with individuals who have first-hand or specific knowledge of the Positive Parenting Program and, through their insight, could assist in identifying successes of, and barriers to the design, implementation, and outcomes of the program. Opinions were also solicited from interviewees on their recommendations for program improvement and scale-up. Semi-structured, open-ended question guides were developed in advance, with elaboration and further questions emerging on the spot.

Interviewees included:

- Plan ECCD managers/coordinators at the central and district levels
- Plan MNCH+N coordinators
- Technical advisors/consultants involved in the design of the positive parenting program
- Government implementing partners from the District Education & Sports Bureau (DESB) and district health departments
- Program Managers of related programs from other implementing agencies

(See Appendix 4 for a list of the key informants interviewed)

Group discussions
In addition to the individual interviews, the evaluation team aimed to collectively interview district trainers/facilitators who trained village volunteers to lead the positive parenting
sessions, to gain their insights into the training process and curriculum, and the perceived capabilities and effectiveness of the village volunteers/trainees. Due to short notice, Plan district staff were only able to contact 4 district facilitators, of whom two were available to come for the interview.

Additionally village volunteers/facilitators who led the positive parenting sessions were called for group interview sessions. One interview comprising 3 VVs each were held in each of the two study districts. Semi-structured open-ended questions guided a discussion on their experiences – both positive and negative – with facilitating the PPG sessions; learning outcomes among the participants; factors of success; and areas for improvement.

**Focus Group Discussions (FGD)**
Each focus group comprised of maximum 15 participants from the same village, all of who have participated in at least one parenting group session. The group dynamic encouraged participants to open up and share common concerns, opinions and ideas that could help to identify cultural or motivational factors influencing the success of, and sticking points to, adopting the child-caring behaviours targeted through the parenting sessions.

**Mini Surveys**
Mini surveys targeted participants who have attended at least one parenting session.

The mini survey was designed to assess the knowledge gained from the parenting group sessions and as such the key messages from the curriculum formed the basis of the questionnaire. In addition to collecting data on knowledge, questions were also designed to solicit information on attitudes, practices and beliefs related to the modules they have been taught. Only questions related to sessions 1-6 were covered, as at the time the evaluation was conducted, sessions 7-11 had not yet been carried out.

In order to allow parents to give unprompted responses, the majority of questions were open-ended and qualitative in nature. However common responses were later coded to allow for a certain degree of quantification during analysis.

**Observation**
The timing of the field visits did not allow the evaluation team to observe any PPGs in progress. However some inferences could be drawn with respect to group demographics, dynamics, level of participation and parent-child interaction via observation of the focus groups, which were held onsite in the communities. Additionally evaluation team members did walk-throughs in the villages taking note of variables such as environmental hygiene; presence of home gardening and animal husbandry; general economic indicators; presence of water sources and schools; and proximity to health centres.

The team had also originally planned to make informal observations on indicators, such as household hygiene and family foods available, during home visits while carrying out the mini-surveys. Once onsite however, the data collection team found it more feasible to conduct the surveys in public gathering places outside, rather than visiting parents in their homes.
5.3 Sampling
The two districts of Pha Oudom and Phaktha were selected as the study sites for the evaluation. In order to adhere to the tight time frame allotted to fieldwork, Meung, the third district in which the PPP operates, was not selected due to the increased time needed to access its more remote location.

Eleven villages were selected for inclusion in the study, all of which were among the original 32 project villages, where implementation began in December 2013. It should be noted that all the villages had exposure to Plan’s MNCH+N program, which collaborated with the ECCD program on the PPP. Some of these villages have also participated in the WASH program’s Community-Led Total Sanitation (CLTS) project.

Table 1 below outlines the sampling per village from the FGDs and mini surveys. A total of 58 parents were interviewed for the mini survey, and 75 for the FGDs, for a total of 133 parents. Of the 11 villages visited, 6 were predominantly of the Khmu ethnic group, 3 Hmong and 2 Lue. In total 6 FGDs were conducted among mothers, and 2 comprised of fathers.

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>VILLAGE</th>
<th>ETHNICITY</th>
<th>FGD (n)</th>
<th>MINI SURVEY</th>
<th>NO. PARENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pha Oudom</td>
<td>Pouvienxay</td>
<td>Khmu</td>
<td>1 women (11)</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Mokakhang</td>
<td>Khmu</td>
<td>1 woman (9)</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 men (7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pheanghat</td>
<td>Khmu</td>
<td>1 men (6)</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Pheangteung</td>
<td>Khmu</td>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Phaktha</td>
<td>Phousathan</td>
<td>Hmong</td>
<td>1 woman (9)</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Mokajok</td>
<td>Hmong</td>
<td>1 woman (12)</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Houaymong</td>
<td>Khmu</td>
<td></td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Phasok</td>
<td>Lue</td>
<td>1 woman (11)</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Pangsa</td>
<td>Lue</td>
<td>1 woman (10)</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Houaykod</td>
<td>Hmong</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Houayja</td>
<td>Khmu</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11 villages</td>
<td></td>
<td>6 women FGD</td>
<td>58</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 men FGD (n=75)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.4 Research Team
The evaluation team consisted of one international consultant and three Lao consultants, with qualifications in public health and experience conducting qualitative and quantitative research. The team trained a group of 20 data collectors, to carry out the mini survey and
act as translators and note-takers for the FGDs. The trainees were a mixed group including Plan interns, district facilitators and local translators.

The focus group discussions were facilitated by the three Lao consultants, all of who had prior experience in doing so, and were accompanied each by a note-taker, and a translator to provide simultaneous translation to the local ethnic languages.

6. **KEY FINDINGS**

6.1 **Findings on Program Design**

6.1.2 **Adherence to proposal**

The Positive Parenting Program was a follow-on to the Parenting Orientation Program that took place in the prior phase of Plan’s ECCD program. As proposed in the wider ECCD five-year (2012-2017) plan document, the delivery mechanisms for the Parenting Orientation sessions were to be reviewed with the aim of developing more interactive methodologies, using community based trainers working alongside DESB co-facilitators.

The curriculum for the PPGs – in the form of a Facilitation Guide – were found to hold true to this new model. Session guides call for facilitators to engage parents in discussions (as opposed to lectures) on positive early childhood care. The accompanying IEC materials aim to stimulate further interaction, and include built-in monitoring activities calling for parents to reflect on what they have learned and what behaviours they’ve trialled as a result. Parents interviewed also reported participating in cooking demonstrations and games.

As per the revised design, village volunteers have been trained to facilitate the PPGs, and been generally supported by DESB co-facilitators.

6.1.3 **Curriculum and materials: format and content**

The English-language version of the Facilitation Guide and some supplementary IEC materials that were made available for the evaluation were reviewed. The Facilitation Guide was in the form of separate sessions, each containing key positive parenting messages, corresponding activities designed to convey the messages, and materials needed. Each session was clearly and uniformly laid out in a format that, assuming adequate training was provided, appeared to be very user-friendly.

Progress reports describe the process of developing the Guide as being very participatory in allowing the district trainers and Plan staff to provide input. However, it is not explicitly stated that the materials were pre-tested among the main target ethnic groups. Nevertheless the IEC materials contain many pictures, which seem generic enough to be customised to a good degree, to varying ethnic groups, and can aid in overcoming language barriers.
The content of the curriculum was comprehensive in addressing the first ECCD “Cornerstone” that calls for children aged 0-3 to have access to responsive parenting, stimulating physical and social environment, primary health care, a nutritious diet and a safe clean environment. The illustrations were clear and simple, and appeared to be appropriate for the target audiences but were provided in isolation without explanation as to their usage.

The curriculum addresses a number of underlying determinants for nutrition in its target communities, including the importance of keeping children healthy through growth monitoring, vaccinations and treatment of illness; and maintaining good personal, food and environmental hygiene. The module on “Healthy food for your child” advises to continue breastfeeding until the age of two, and explains that breast milk needs to be supplemented with complementary foods starting at 6 months. However there is no explicit discussion mentioned in the session guide on the benefits of breastfeeding to begin with, nor encouragement for early onset, and exclusive breastfeeding in the first 6 months.

There were several additional gaps identified in determinants of child nutrition. These include addressing the health of the mother and improving poor fat and protein intake via food security.

With respect to gender inclusivity, Session 2 on “Our traditions and child rearing practices,” contains a subsection on gender aspects of early childhood care. This section comprehensively covers the importance of fathers and mothers equally sharing childcare and protection responsibilities and the importance of equal care for boys and girls.

6.1.4 Parental participation in design

The evaluation team found very little evidence that parents were involved in the design and planning of the PPGs, as was confirmed by ECCD staff and parents when questioned anecdotally. Parents in one focus group said that they've never told Plan what they’d like to learn, but had never been asked either. One coordinator suggested that “Plan needs to be more ‘bottom up’ in its approach.”

However ECCD coordinators reported that some attempt had been made to apply feedback from parents to make small changes during implementation. Additionally, a consultant who was heavily involved in the early stages of the program design explained that parents were consulted in a participatory manner when it came to developing IEC materials that supplemented the sessions.

6.1.5 Monitoring and evaluation

Secondary documents detailed a number of built-in mechanisms for monitoring the PPP. These methods include baseline information on knowledge and practices taken during the first session (baseline posters); participant and training registration forms; pocket votes that allow parents to indicate which of the 12 key child development supporting activities they

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8 The “Four Cornerstones” is a rights based conceptual framework for ECCD programming and advocacy. See [http://www.ecdgroup.com/](http://www.ecdgroup.com/)
have done in the past 3 days; session quality monitoring by district and Plan supervisors and an end-of-session evaluation game. In addition to the data collected during the sessions, the program design allows for 3 rounds of 10 monitoring home visits per cluster, to collect qualitative information on changes in parenting practices. IDIs with Plan program managers and progress reports confirmed that much of this rich data has indeed been collected and, to some degree, reported. However the evaluation team faced difficulties in accessing the information and received only partial data in the form of lengthy spreadsheets and un-translated raw questionnaires.

Furthermore, it was not clear how each set of data was to be used to the benefit of program planners, highlighting the need for a clear monitoring plan/framework for the PPP, including numerical targets.

The lead evaluator was able to collect 3 separate sets of draft/proposed indicators/targets during the review of secondary data that relate entirely, or partially, to the PPP. One set was proposed in the PPP concept paper and includes proposed nutrition targets, health and hygiene targets, baseline targets, and indicators to be measured routinely during implementation. A detailed list of “parent change indicators” has been developed that relates specifically to topics discussed in each session of the PPG Facilitation Guide. Finally, an outline of indicators entitled “Early Childhood Care and Development from conception to 5-8 years in the context of Positive Parenting” has been prepared by Plan/Vientiane.

An attempt has also been made to relate the wider ECCD logframe to the PPP with suggested means for verifying key indicators set out in the ECCD 5 year plan, against the first objective (see section 2.5).

Linking data collection mechanisms to a clear PPP-specific framework will allow monitoring and evaluation to be more focused, systematic and useful in improving the quality of the program.

6.2 Findings on Implementation Process and Participation

6.2.1 Perceived Value

The general impression conveyed during the field visit is that parents value learning and want to help their children. This was the reason most cited during the FGDs for why they attend the PPGs. Most parents interviewed only expressed what they liked about the groups, not what they didn’t like. Many described positive changes not seen prior to the implementation, such as more people washing clothes and taking their children to health centres for treatment.

I like the sessions, and I want to have them come to this village very often. Since Plan staff carried out the sessions and provided support to the school in this village, my kids always go to school and do not like to skip class. Other reasons may be the kids now have more books, learning materials and they love games; these did not happen before the project came.

- Father, Mokakhang village
During an FGD in Mokakhang (Khmu) village, a few mothers indicated that they liked all the sessions, particularly because Plan provides toys, gifts and school materials for the children, compared to the other organisations that only hold discussions.

Fathers interviewed in FGDs also expressed great interest in participating in the PPGs, but sporadic data from interviews and mini surveys would indicate that select fathers place less value on the groups, believing the sessions to pertain only to mothers and babies.

One of the Plan coordinators explained that as the villagers are poor, the value they place on the groups would lessen during the rice-planting season, as work takes priority.

6.2.2 Attendance

Recruitment and maintenance of PPG participants has been challenging. Failure to attend the groups is attributed more to conflicting interests and barriers rather than to a lack of value placed on them. The ECCD program managers and village volunteers who facilitate the groups mentioned a number of challenges faced in trying to get enough numbers (15-30 parents) to comprise a group. These have included:

**Timing**: Plan and government support staff have tended to come to villages in the mornings – sometimes spending the prior night in the village – in an attempt to catch parents before they head off to work in the rice fields and forests. However, this timing has resulted in inconsistent attendance, with some parents alternating between husband and wife, others simply unable or unwilling to skip work. On the other hand, one FGD mother said that they prefer daytime sessions, as they feel too sleepy in the evenings.

**Limitations set on attendance**: Some villages recruited parents from a specified list, based on pre-defined criteria. While this approach was employed to target the most relevant parents, i.e. those with children under 5 and those most at risk due to poverty and other factors, it’s resulted in some parents being excluded. For example, some men interviewed during FGDs said that they would like to attend the groups, but were not invited.

* I want to attend the session too but when the project staff announces it, they just target the women who have kids under 5. I am a man so I cannot join the session.
  - Father, Mokakang village

On the other hand, Pha Oudom PPG coordinators noted that they invite fathers and mothers, but only the women tend to show up.

**Loss of interest**: Several key informants noted that, while attendance is generally high for the first few sessions, numbers eventually tend to dwindle. Some reasons cited for the dropout include:

- The length of each session and frequency of visits has led to fatigue. According to the ECCD provincial manager, each session takes 2-3 hours to complete. One of the IDIs indicated that some sessions – particularly where there are large numbers in attendance – last a long time. It was noted that the length could also be related to the limited facilitation skills of the VVs.
Another interviewee cited the frequency as an issue: in order to keep sessions shorter, it was decided to only address one session per meeting, but this has resulted in parents having to attend 11 times. Some parents complain that this takes too much of their time and makes the PPGs no longer a priority.

- The inability of parents to put recommendations into practice due to lack of the means to do so has led to a loss of interest.

- One interviewee suggested that some parents are more interested in “hardware not software;” i.e., concrete material inputs rather than messages.

Program managers noted that these issues of participant recruitment and maintenance have made it difficult for each session to build upon the previous one. By design, the curriculum assumes continuity, calling upon participants to review the last session and discuss practices trialled.

Nevertheless, a group interview in Pha Oudom with the Plan ECCD and MNCH coordinators and a district education partner revealed that in many villages there tends to be a core group of parents – namely stay-home mothers with very young children – who attend regularly.

6.2.3 PPG Facilitation and Supervision

Facilitation
A number of key informants, including the Village Volunteers themselves highlighted the limited capacity of the VVs to facilitate the PPGs. It was felt that the VVs, generally coming from backgrounds of little or no training or education, have struggled to lead sessions as effectively as called for in the program design. The VVs run the PPGs immediately after receiving their one-day training per session, and are able to deliver key messages and engage the participants on a basic level. However, this often takes the form of reading directly from text, not all of which is understood by the parents. The VVs also struggle when asked for further factual information, or when required by group participation to go “off-script.” Thus it was felt that their facilitation skills needed strengthening (see ‘Inexperience of VVs in facilitation techniques’ in section 6.2.4).

It was also noted in an interview that the majority of VV facilitators are men, and that men sometimes struggle to feel comfortable leading groups of primarily women. According to the latest Plan ECCD quarterly report (March 2015), of the VVs trained in session 2-5, only 22% were women. The reasons cited were that it’s difficult for women to travel out of their villages for training, and lower literacy rates among women made it difficult for them to read the program materials. The Plan provincial ECCD manager suggested that Plan better define the gender balance required among the VVs. The report also detailed the recommendation to recruit one more woman per village, who would not be required to travel but would rather be supported by the district trainer at the village level.

Supervision
Another issue that was identified during interviews was the varying commitment of the District Facilitators who are trained to supervise the VVs and assist with monitoring. Two ECCD managers explained that there is high turnover in district staff that Plan trains, affecting continuity. ECCD managers felt that there needs to be commitment on the part of
the district team, so that even if they are re-assigned to a different department, they can continue to serve the parenting groups.

A Plan consultant involved with the program felt that the district staff needed to take a greater role in supervising the VVs, rather than focusing primarily on monitoring, and that Plan ECCD staff in turn needed to demand more of them, and supervise them more in their role.

Both the Plan ECCD consultant and ECCD manager felt that the program would benefit from having a consistent supervision and monitoring team comprising members from Plan, Plan interns and committed district staff; that it would be the same team to supervise each time.

6.2.4 Level of Participation During Sessions

As described in section 6.1.2, the PPG sessions were designed to solicit significant participation from the parents.

In practice, however, Parenting Group facilitators have mixed reports on the level of parental participation during sessions, with a number of variables coming into play, such as the skill of the facilitator; ethnic and demographic characteristics of the community; size of the group; and other influencing factors. IDIs identified some perceived barriers affecting the degree of participation:

Language barrier. The PPP has been commendable in efforts to reduce the language barrier faced by some of the target ethnic groups. Planners have tried to ensure that at least one of the PPG facilitators is able to speak the local language.

*It was easy for us to understand the sessions. In addition, the village volunteers can speak our language so we can ask question when we don’t understand the messages.*

- Father, Pheangteung village

However, language was still mentioned as a challenge. One of the VVs interviewed said that when there are parents who don’t say anything during the groups, he’s not sure whether they don’t understand the concepts, or whether they don’t understand/speak the language. In this case, it’s possible that language barriers may also pertain to the use of technical jargon or formal terms, rather than plain and more familiar terms. Language is reported to be more of a barrier for women than men, who are more likely to have some proficiency in Lao.

Concepts and participatory methods are too new. Program managers and village volunteers felt that while they were ready to embrace the PPG curriculum, they emphasized that it would take time for everyone to adapt to the concepts and methods, which were new to them. Some felt that the concepts were too theoretical for the participants and emphasis should be placed more on simplifying messages and increasing practical knowledge. While no specific examples were provided by interviewees on how concepts were too theoretical, one example provided on improving practice was to demonstrate ways to play with children. There was also a feeling that participatory methods were too new for both parents and
facilitators, leading to a lack of confidence. A couple of mothers, for example, explained that they were too shy or intimidated to ask questions.

There’s never been an organisation coming in like this to give this kind of education. The challenge though is that we’ve never done anything like this before so it’s difficult for us to lead the groups. We need more training.
- VV, Pha Oudom

Too much talking, not enough doing. IDIs advised that sessions are too long, with too much talking and not enough “doing.” They reported that participation was highest when session involved hand-on activities, with less emphasis on reading and discussion. Some focus group participants confirmed that they most enjoyed sessions where they partook in activities such as cooking, measuring their children, singing and playing games. Several also mentioned enjoying the “pocket votes” that take place at the beginning of each session, whereby they place gold cards in pockets indicating which child care practices they’ve trialled since the last meeting.

To me I don’t like to listen to the session but I understand more if they demonstrate the activities.
-Father, Pheangteung village

Not enough pictures. Parents, facilitators and managers all agreed that the PPG sessions would benefit from more illustrations, so that participants can better visualize target practices. In addition to more pictures there were numerous requests for videos that show people demonstrating the recommended behaviours.

Length of sessions. Though parents did not specifically say that sessions were too long, some of the village volunteers and program coordinators felt that, according to their observations, participants tend to lose focus because the sessions take too much time. One facilitator explained that this was particularly the case in large groups, when trying to ensure everyone’s participation.

Dominance of men in mixed groups. Program coordinators also felt that when men and women are both present at a PPG, the men tend to dominate, causing the women to lose confidence and not participate equally. More men from non-Lao speaking ethnic groups are able to understand some Lao, differentiating themselves from the women. A progress report supported this claim and described great success in levels of participation when a separate PPG was held only for fathers.

Distraction from children. Most parents attending the group bring their children. According to group facilitators, this causes disruption and makes it difficult for parents to maintain concentration, though they report that snacks distributed to the kids have helped. (Observation found these snacks to be processed sugary snacks without nutritional value. It is recommended that Plan reconsider its choice of snacks in line with the messages on nutrition at sessions).
Inexperience of VVs in facilitation techniques. All ECCD program managers interviewed cited limitations of the VVs to effectively run the PPGs. They explained that the VVs only have the capacity to run the session according to their limited education and training and tend to read directly from the materials. They are not trained in facilitation techniques. The few interviews conducted with VVs themselves confirmed that they lacked some confidence in conducting the groups. One female VV said that facilitating the groups was difficult for her because she’s a shy person by nature (though she had volunteered for the program), while another male VV said that he only has the capacity to say what he knows or reads from the materials provided, but when people ask questions, he can’t answer them.

Perceived irrelevance. A few of the men felt that they did not need or want to attend the PPGs because caring for children is the work of women and therefore did not pertain to them. While the PPP curriculum includes a session on gender roles in child care, there is a need to reach out to a wider audience beyond group participants with the message, so as to encourage men’s participation in PPGs.

6.3 Findings on Outcomes

6.3.1 Knowledge gained

In order to assess the knowledge that participants gained from attending the PPGs, mini survey questions were based directly on the key messages developed for each parenting group session, from session 1 until session 6, the most recent session completed by the time the evaluation took place. The topics of these sessions are as follows:

Session 1: Baseline on 3 child caring areas
Session 2: Our traditions & child rearing practices
Session 3: Health and growth monitoring
Session 4: Healthy food for your child
Session 5: Good hygiene practices
Session 6: Protection of children

The first session discusses the three kinds of care that a young child needs in order to positively influence their development, described in the Facilitation Guide as follows:

1: **Health and Growth:** good food, a clean environment, vaccinations against illness and health care should children become sick.

2: **Protection:** a safe environment and protection from any danger that could hurt a young child e.g. falling, burning, drowning, cutting, swallowing small objects, poisonous things.

3: **Learning:** time to play and interaction with parents that stimulate the child’s learning.

Mini survey respondents were asked, via open-ended questions, to provide (un-prompted) examples of each kind of care. The tables below list the responses received, along with the percentage of respondents that spontaneously mentioned each response. Some parents named more than one example per question.
Table 2 Examples provided by parents of Health and Growth

<table>
<thead>
<tr>
<th>Practice Named</th>
<th>% from Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good feeding</td>
<td>62 %</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>5 %</td>
</tr>
<tr>
<td>Good hygiene</td>
<td>21 %</td>
</tr>
<tr>
<td>Growth monitoring</td>
<td>7 %</td>
</tr>
<tr>
<td>Health-seeking care (vaccinations, Health Centre when ill)</td>
<td>12 %</td>
</tr>
<tr>
<td>Social &amp; mental development</td>
<td>5 %</td>
</tr>
</tbody>
</table>

Table 3 Examples provided by parents of Child Protection

<table>
<thead>
<tr>
<th>Practice named</th>
<th>% from Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protect from risky behaviours &amp; objects (e.g. Sharp objects, fire, dangerous areas)</td>
<td>90 %</td>
</tr>
<tr>
<td>Feeding</td>
<td>4 %</td>
</tr>
<tr>
<td>School</td>
<td>3 %</td>
</tr>
<tr>
<td>Health Centre</td>
<td>3 %</td>
</tr>
<tr>
<td>Non-violence</td>
<td>7 %</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>10 %</td>
</tr>
</tbody>
</table>

Table 4 Examples provided by parents of Child Learning

<table>
<thead>
<tr>
<th>Practice Named</th>
<th>% from Total Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>31 %</td>
</tr>
<tr>
<td>Teach to learn</td>
<td>28 %</td>
</tr>
<tr>
<td>Teach Lao</td>
<td>7 %</td>
</tr>
<tr>
<td>Teach ethnic language</td>
<td>5 %</td>
</tr>
<tr>
<td>Teach housework</td>
<td>7 %</td>
</tr>
<tr>
<td>Play with parents</td>
<td>3 %</td>
</tr>
<tr>
<td>Do counting etc. together</td>
<td>10 %</td>
</tr>
<tr>
<td>Don’t know</td>
<td>10 %</td>
</tr>
</tbody>
</table>

The tables presented above serve merely to demonstrate rough awareness gained by parents of the three types of care that children need, along with examples that parents spontaneously associate with each section, when not prompted with suggestions. It’s noted, for example that the majority (62%) of respondents knew/remembered that good feeding is relevant to children’s health and growth, with 5% separately mentioning breastfeeding. Most parents (90%) associated child protection with keeping children away from risky behaviours and dangerous objects. Only 7% mentioned some form of non-violence. For examples of child learning, 31% cited schooling, 28% mentioned general learning, while the remaining responses pertained to teaching of specific knowledge or skills: language, housework and counting. It’s notable that only 3% (2 parents) mentioned play as an example of child learning.

To test knowledge learned from Session 4 on healthy foods for children, the mini survey asked parents what kinds of foods should be fed to children under and over 6 months of age.
The findings demonstrated that most mothers understand the importance of breastfeeding, with 91% of mothers surveyed mentioning breast milk as a food that should be fed to children under 6 months of age. When mothers were questioned about what age rice and food should be introduced to a child, 43% of them responded that complementary foods should start at 6 months, thus indicating their knowledge of exclusive breastfeeding for a child’s first 6 months. Half of the mothers, however (including some of the same mothers who’d indicated that foods should be introduced at 6 months) also felt that for a child under 6 months, breast milk should be supplemented with other foods such as rice, meat, vegetables and sweetened condensed milk. Four mothers said that a child under 6 should only be fed rice.

Feeding of sticky rice to newborns was also said to be a common practice among the Khmu, as discussed during one of the focus groups with fathers in Pheanghat village. They emphasized that this was a traditional practice that had been done for generations and that it not only did no harm, but was considered to be good for the newborns, to help them grow well. Though it’s unknown how widespread this belief is, this information should be linked back to Session 2 of the Parenting Manual, which is specifically on exploring traditional practices, identifying harmful ones and encouraging participants to think of what should be done.

For children older than 6 months, all parents surveyed understood that foods other than breast milk needed to be introduced, with 86% describing a varied diet combining more than one food group: rice plus meat; or rice plus meat and vegetables (see also below on feeding-related behaviour change). Only 6 parents spontaneously mentioned that breast milk could/should continue to be given, along with foods.

While this information on knowledge gained could be useful to program designers to understand what knowledge has made an impression and been retained, and what knowledge should be emphasized more in the future, it is difficult to directly link it to the PPG curriculum. Apart from the list of examples per category provided in the Facilitation Guide (see above), learning has taken the form of discussions. Without being present to observe them, we cannot know how much emphasis was placed on each example. This information is thus provided for descriptive purposes only.

6.3.2 Behaviour change

Health-seeking

Several of the mini survey questions were designed to find out whether parents report that they have been able to put some of the child-caring knowledge they’ve learned into practice. In Session 3, for example, parents learned about danger signs for which children should be taken to the Health Centre. Respondents were questioned whether their children had suffered from any of these three dangers signs – fever, vomiting and diarrhoea – in the past month, and if so, what they did about it. Among the respondents, 27% reported their children having had a fever, 14% reported vomiting, and 28% reported bouts of diarrhoea. Figure 1 below lists the types of care sought for these illnesses. As recommended during the session, the majority (53%) of respondents whose children showed danger signs reported
having taken their children to either a health centre or hospital (Note: these actions were not stratified per ailment).

The responses received were all unprompted and thus the findings imply that parents are absorbing and retaining a degree of knowledge gained from the PPGs.

**Figure 1**

![Graph showing what parents did when their child was ill.](image1)

**Child Feeding**

On feeding recommendations covered in Session 4, surveyed parents were asked which kinds of food a child over 6 months needs. Of the 58 respondents, 14 said rice and meat; 36: listed rice, meat and vegetables; 6 said the child also needs breast milk in addition to food; 2 gave other responses. When they were then questioned as to whether they were able to feed that food to their children every day, 32% of respondents said that they were, 7% said they were not, and the majority - 61% - said only sometimes. The most common reasons given for not being able to feed the named/recommended food daily included not having enough money, not having enough food and living far from the market.

**Hygiene**

Parents were also asked to identify good hygiene practices, as covered in Session 5. Figure 2 lists the hygiene practices that were spontaneously mentioned and the percentage of respondents that mentioned them.

**Figure 2**

![Bar chart showing percentages of good hygiene practices.](image2)
When asked in a follow up question whether they had difficulty in practicing good hygiene, 57% replied that they did. The most common reasons given for this were not having soap, not having enough water and/or not having enough money. These responses were consistent with the limited household monitoring data that was reviewed.

**Self-reported behaviour change**

Parents who participated in both FGDs and mini surveys were asked whether they or other caretakers of their children were inspired to change their child caring behaviours as a result of having attending the PPGs. They were also questioned on what specific behaviours they were – or were not – able to change and the reasons why.

When asked whether the parenting sessions had influenced them to change any of their behaviours, most mini survey respondents (88%) reported that they had. When probed as to what these behaviours were, the most common responses, listed in order of frequency, were:

1. Good hygiene
2. Wash hands
3. Wash kids/wash clothes
4. Good health
5. Don’t hit children
6. Boil water
7. Clean house
8. Play with children
9. Bring child to the Health Centre

FGD parents were also asked whether the sessions they participated in led them or others who take care of their children to change their child care practices.

A common behaviour change that was cited in all groups related to sending children to school. A couple of men who partook in a focus group said that now they understood the importance of school, implying a change in attitude, with one father adding that now that he sends his kids to school, he has more time to work.

*Before we would say why do we need to send kids to school? There’s no need for education, we already have managers and bosses, and so the program teaches us not to think like that. So now we’ve changed....if the child doesn’t want to go to school we find ways to make them go like give them snacks or some money for them to go to school.*

-mother, Mokakhang village

Some additional practices that were mentioned by FGD participants included engaging in home gardening; exclusive breastfeeding; giving birth to their children at a hospital; teaching children to use a latrine; boiling water and no longer hitting their children.

*Before the program started we hit our children but now we don’t anymore, we’ve changed.*

-mother, Mokakhang village
Observed behaviour change
During interviews and focus groups, villagers were asked whether they had observed people changing the way they raise their children, since the implementation of the parenting groups.

In response, one village volunteer, who was also the village leader, noted that now children in his village are attending school, whereas before they were not. Another VV said he observed people washing hands more frequently and demanding latrines. FGD participants also mentioned observing an increase in better hygiene practices, along with the presence of more home gardens and poultry raising. One father said that he saw his wife working harder in the fields and planting more vegetables in order to provide better food to their children, and that this motivated him to help and support her.

Focus group participants also noted that more people are taking their children to the health centre. One FGD father said that now one could see people giving advice to mothers to take children with fevers to the health centre, which did not happen before. Though not explicitly addressed in any of the sessions, one of the village leaders, as well as some focus group men, commented that now more people know about, and are seeking family planning services from the health centre. (See 6.3.3 on Unintended Outcomes).

You can see there are no kids playing during this time because they are at school. Before children did not attend school they just ran around and played in the village.
- Father, Pheangteung village

Husbands’ behaviour change
Each woman interviewed for the mini survey was asked whether her husband had changed any of his child-caring practices as a result of the positive parenting programs. The majority - 83 % - responded positively. The most frequently-mentioned changed practices were that their husbands now:

- Keep kids clean
- Share in childcare (although some men still feel this is primarily a woman’s job)
- Help with feeding
- Don’t hit their children; and
- Send children to school

Other responses mentioned included: teaches, shares housework, shares external labour (feeding pigs, gathering vegetables etc.), washes clothes and cares about health. Only one respondent said that her husband didn’t change his behaviour, because he “doesn’t care.”

Men interviewed directly via FGDs also reported having changed some of their behaviours. For example one man said that he helps take care of the children while his wife is cooking, and also helps to feed them and take them to school. Several fathers indicated that they learned to boil drinking water from the PPGs and most fathers mentioned better hygiene practices when questioned on behaviour change.
Challenges to behaviour change
Out of the 58 mini survey respondents, 42 (72%) reported having some difficulty in adopting recommendations. Unprompted reasons given are listed in Table 5 below, along with the numbers of parents that mentioned each response:

<table>
<thead>
<tr>
<th>Why are PPG recommendations difficult?</th>
<th>Frequency of response</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Money</td>
<td>19</td>
</tr>
<tr>
<td>Can’t afford school supplies</td>
<td>4</td>
</tr>
<tr>
<td>Can’t afford clothes</td>
<td>3</td>
</tr>
<tr>
<td>No soap</td>
<td>4</td>
</tr>
<tr>
<td>No toilet</td>
<td>1</td>
</tr>
<tr>
<td>No fruit/veg/meat/ingredients</td>
<td>10</td>
</tr>
<tr>
<td>No time / too busy</td>
<td>6</td>
</tr>
<tr>
<td>No babysitting</td>
<td>1</td>
</tr>
<tr>
<td>Illiterate</td>
<td>1</td>
</tr>
<tr>
<td>Cannot speak Lao</td>
<td>2</td>
</tr>
<tr>
<td>Singing to children(^9)</td>
<td>6</td>
</tr>
</tbody>
</table>

Most responses point to a lack of means - particularly in the form of resources and capacity – rather than to a lack of will.

Similar findings emerged during FGDs, as well as a review of secondary information, particularly data taken from a sampling of household visit surveys conducted by Plan staff in Pha Oudom. When questioned as to what barriers they faced when trying to implement the recommendations they’d learned from the PPGs, parents repeatedly cited lack of means such as “no soap,” “no money,” and “no meat or fish.”

We have learned from many sessions about feeding, preparing good food for kids and hand washing, bathing and using latrines. However, we have limitation to practice those things. For example, Plan staff asked us to use soap for washing hands but we didn’t have soap. They support us to use latrines but we don’t have water and they don’t provide support for that. I think Plan should provide a water-tank here in our village.

- Father, Mokakhang village

6.3.3 Unintended Outcomes

One of the evaluation research questions asked whether there were any unintended outcomes that resulted from the Positive Parenting Program. A couple of results emerged during this brief study:

**Interest in family planning.** A number of parents, in both the men’s and women’s FGDs, mentioned having learned about family planning during the parenting sessions. While the

\(^9\) The evaluation team were intrigued to note that 6 respondents indicated that singing to children was a difficult behaviour to adopt. Anecdotal probing revealed that this may be due to cultural norms that reserve singing for certain situations such as rituals and holidays.
Facilitation Guide (PPG curriculum) does not explicitly include any modules on family planning, it’s inferred that the subject emerged in context during sessions. Additionally, when probed, fathers participating in one of the focus groups said that they got information about family planning from the health centre staff, as well as from village health workers who came for vaccinations. Thus increased interest in, and access to, family planning could be considered a secondary outcome partially resulting from the increase in HC visits, as encouraged in PPG Session 3 on Health and Growth Monitoring. The participants expressed a great interest in gaining better access to, and information on, family planning and have suggested that future sessions include this addition.

**Information dissemination.** The evaluation team learned from FGD participants that non-participants also benefited indirectly from the parenting groups by way of information sharing from those who did attend the sessions. An FGD mother in Phousathan village, as well as a father from Pheangteung village, for example, explained that they share information among family members and neighbours, who are curious to know what they had learned at the sessions.

This was corroborated unexpectedly by data from four mini survey questionnaires that were originally discounted during analysis due to the interviewees not having attended any parenting group sessions. Upon examination, these questionnaires revealed results that were not unlike those gathered from PPG attendees: the non-attending parents were by-and-large able to correctly describe knowledge and recommended practices included in the PPG curriculum. While encouraging, without questioning these four respondents on the source of their information, caution must be taken, however, in attributing this knowledge solely to the PPP.

### 6.4 Findings from Observations

The evaluation team members – all outsiders with no prior experience working for Plan – made informal observations during field data collection.

The variation in economic levels and resource availability among the villages sampled was noted by the team. In the first village visited (Mokakhang, a Khmu village), for example, villagers were poorly dressed, children appeared unwashed, and open defecation by children was observed. Additionally there was little interactive play observed amongst children gathered in the vicinity. A walk-through and ad-hoc discussions with community members, confirmed via FGDs, revealed that availability of water was a big problem.

A subsequent village visited (Mokajok, a Hmong village), appeared to be more prosperous. There was a school, with solid latrines and a gravity-fed water pump, which was in constant use during the visit. Children were engaged in lively games with one another and were generally clean and clothed.

A third village visited (Phasok, a Lao-speaking Lue village) was more prosperous still. There were a number of solidly constructed houses and buildings. Both parents and children were very well dressed and lively interaction was observed among children and between children and parents throughout the visit. In a second Lue village (Phangsa village) visited, every
household had latrines, a lot of households had televisions, and gravity-fed water systems at three separate points.

Based on these observations, a number of inferences could be made about the link between ethnic/language groups, and poverty levels supporting observations conveyed during the in-depth interviews. Key informants, for example, report that from their experiences, Hmong villages tend to be better off than Khmu ones, and those who speak Lao have more opportunities available to them. 10

One can also observe the direct affects that availability of resources has on a community’s ability to improve its well-being. For example, without water, villages face difficulty in bathing and washing clothes, nurturing home gardens and flushing latrines.

7. LESSONS AND CONCLUSIONS

7.1 Lessons Learned on Design

On the whole the Positive Parenting Group curriculum has been well designed to address the ECCD program objective of improving the skills, knowledge and practice of parents to provide a healthy, stimulating and safe environment for children aged 0-5 years. Some gaps need to be filled in order to comprehensively address underlying determinants to nutrition in the target communities, beyond imparting messages.

There’s a need for a more nuanced understanding of what it takes to facilitate behaviour change. It’s difficult to determine the degree to which gains in knowledge and behaviour change can be directly attributed to the PPG and its curriculum. As the name suggests, the Facilitation Guide is designed to be an outline with key messages and guiding points for leading parents in group discussions and activities aimed at conveying these messages. Though some program managers have alluded to VVs leading groups by “reading” directly from materials, to the observation of the evaluators, the Guide does not detail specific information to be verbally delivered. On the contrary, it was designed as an antidote to the “stand and teach” method previously employed by the Parenting Orientation groups from the previous phase. One can thus assume that degree of success is linked not just to the design of the curriculum – which is generally good – but also to the skill of the facilitator in effectively leading the discussion in a way that encourages participation and dynamic learning process involving questioning and sharing of local knowledge, ideas and experiences.

It’s universally accepted that behaviour change is more challenging and takes more time than changing/acquiring knowledge. It can be assumed to a certain degree that as knowledge on the benefits of ECCD to families is gained and maintained, that more value will be placed on increasing and improving ECCD practices. However program success will depend on gaining a deeper understanding of enabling factors for, as well as barriers to change.

10 While it’s a logical assumption that having Lao language skills would create more options for poverty alleviation, the numbers of villages visited was too small to give any scientific weight to the impressions regarding ethnic group variations.
For scale-up to be effective, a Theory of Change (ToC) model and logframe need to be developed to provide clear purpose and strategic direction. A good monitoring framework, which will link directly to the ToC, will also lay the groundwork for program evaluation. Most of the ToC elements already exist in program documentation but further exploring and defining of enabling factors for change will need to be carried out. This is discussed further in recommendations section 8.1, no. 1.

To facilitate the ToC development a deeper understanding of community norms is needed to understand influencing factors such as culture, gender roles, language and literacy, daily and seasonal routines, dietary habits & taboos. Potential for behaviour change also needs to be set in the context of environmental (including economic, social and political) determinants, and resource availability. This understanding will allow the messages and methods to be adapted locally.

Enlisting parents’ participation on a more significant level will not only allow Plan to help gain this richer understanding of influencing factors that will facilitate change, but also empower communities to identify and solve their own problems. While some participating parents seem to have shared the knowledge they gained with non-participants, there is no organized process or social support mechanism in the community in between sessions, to help them adopt the healthier practices. Such a mechanism for the parents to support each other in smaller neighbourhood groups, and undertake specific actions collectively agreed upon at the end of each session, would be expected to facilitate behaviour change among families. These actions should be those that can be embedded in their daily routines and actionable in the local context. The PPGs could function as self-organized groups to sustain parental participation in future planning and improve relevance of the contents and effectiveness of methods and materials.

Plan Laos senior program managers and consultants are re-thinking ways to make the PPG less prescriptive and more empowering to the communities it aims to help. One option presented, for example, would be to focus on transforming the PPGs into a core support group of committed, model parents that have ownership of the group and are empowered to come up with their own priorities and solutions to better their families and communities. Meanwhile the PPG curriculum messages could be re-directed towards public awareness campaigns.

Along these lines, any evaluation conducted after this pilot has been completed should examine the effectiveness of the PPG model in achieving the goals set out in the ECCD plan. This will be challenging in the absence of clear pre-set targets and indicators against which to measure if the program has achieved it’s goals, but at a minimum lessons from this process evaluation can be used to create an options paper comparing the current model to a modified model (as described above), or other models entirely. For example the LANN model is already being examined by Plan for either areas of synergy with the PPP or as a new approach to trial in the next phase. Appendix 5 presents a brief comparative analysis of the PPG and the LANN approach.
7.2 Lessons Learned on Implementation

This study concludes that parents in the target communities value the health and wellbeing of their children and appreciate Plan’s Positive Parenting Program. Thus any shortcomings observed or reported do not relate to lack of interest or will. Rather it was felt that to more effectively capitalize on their interests improve effectiveness of the program, Plan should work on adapting the program implementation to the parents rather than struggling to find way to get them to adapt to the ECCD program’s plan for them. For example, the PPP program planners should be prepared to:

- Catch parents at convenient times/places
- Expand inclusion criteria
- Re-think volume of messages
- Supplement verbal teaching with more practical learning activities, i.e. “learning by doing.”
- Develop/utilize new modalities for delivering messages, such as video
- Tailor learning to their priorities, interests and contexts
- Provide incentives of value to them, to get them on board
- Allow time for new participatory methods to be adopted
- Think outside the pre-planned groups by promoting an on-going process of follow-up actions in between sessions among families in the community.

This study also identified a number of other ways effectiveness of the groups could be improved so that parents participate actively in the learning process. These include engaging parents in more activities where they are trying out the recommended practices rather than just hearing about them or seeing pictures of them, and tailoring messages and materials to each specific culture.

Finally, to improve implementation, it emerged that human resources need to be strengthened. In particular issues of availability, commitment and role need to be addressed among district facilitators, and knowledge and facilitation skills of the village volunteers needs to be strengthened. Additionally there needs to be a better gender balance among the selected volunteers.

7.3 Lessons Learned on Outcomes

At the time this study took place, the Positive Parenting Program had not yet completed all 11 sessions contained in the Facilitation Guide. The remaining 5 sessions (7-11) will cover the areas of: Social and emotional development; Motor development; Language development; Cognitive development; and a final review session entitled “What did we learn and what do we do next?”

Hence it’s too early to assess the achievements of the full PPG curriculum, or impact gained over time. Several lessons can be drawn, however, on process and early outcomes related to knowledge gained and behaviours changed in the short term:

- A more sustained awareness and appreciation has been achieved on the importance of early childhood education. Where schools are present parents are sending their children there, expressing appreciation for support that Plan has provided toward
building, furnishing and promoting the schools, and also demonstrating an awareness of the importance of early childhood education. This achievement can be attributed to the sustained life of the early education program, allowing time to take effect.

- It was found that the program has succeeded in increasing knowledge of direct nutritional interventions such as infant and young child feeding and growth monitoring, as well as indirect determinants for health improvement, such as illness management and hygiene. Some parents were able to mention good practices related to child learning, but specific knowledge related to early childhood stimulation and social and emotional development was not recorded. We assume that this is due to the fact that the sessions covering these areas had not yet been implemented at the time this evaluation took place.

Caution needs to be taken in assuming that all gains in knowledge are directly attributable to the PPP. For example, while most mothers surveyed in this assessment knew of the importance of breastfeeding, it was noted earlier that key messages on the importance of breastfeeding are not explicitly detailed anywhere in the Facilitation Guide. Further discussions with facilitators and supervisors may shed light on to what extent breastfeeding topics in actual practice, are covered through group discussion.

- While knowledge and recommendations are starting to get through and appreciated, and some parents are already reporting a certain degree of behaviour change, parents reported that the means for putting knowledge into practice are lacking, in varying degrees. Among data collected from the participants via all methods, lack of means, versus lack of will was nearly universally cited as the main barrier to behaviour changes related to child feeding and hygiene. Specifically, this refers to the respondents who cited lack of commodities such as money, water, food and soap.

However, without data on socio economic indicators, we are not in a position to verify whether community members actually lack the means to purchase such items, or whether the program has been unable to convince them to place enough relative value on them to create the means to obtain these items. For example, communities trying to adopt practices as prescribed rather than customizing the practices to their context with the understanding of how important they are to their children’s well-being, may make them realize that they are not realistic and abandon the effort.

We understand the lessons but we live in the mountains and don’t have a lot of things so doing some of the practices is difficult, like some of the sanitation messages are hard to do.

- mother, Mokajok village

7.4 Lessons Learned on Gender

This study has concluded that the PPP has been gender sensitive to a moderate extent. On the one hand, the Facilitation Guide covers the topic of gender in a very comprehensive
manner, explaining the difference between sex (biology) and gender (role), the importance of both parents sharing equally in childcare, and the importance of giving equal care to boys and girls. Men are interested in the welfare of their children and in attending the PPGs, and women have generally reported alternating attendance with their husbands and some positive changes in their husbands' child-caring behaviour as a result of the PPGs.

On the other hand this study flagged some issues related to gender inclusion during program implementation. PPGs in the villages visited by the evaluation team have primarily targeted women/mothers, and men have not been systematically targeted to attend the PPGs. Nonetheless, there are more male facilitators than female (91 men vs. 26 women trained in sessions 2-5). A few men have reported participating directly in the groups and demonstrate knowledge of what has been learned in the groups, while others express an interest in being explicitly invited to attend the groups. However, men still assume a secondary role in childcare and there is little evidence that women’s domestic work load has not been reduced. Indeed, a few men feel that childcare is women’s work.

A more gender transformative approach would have empowered women to challenge traditional gender norms and obtain better support from their husbands for child care. Moreover, gender inclusion does not necessarily mean combining men and women in the same group. Findings suggest that men tend to dominate groups discussions and a trial of separating men and women into different groups was reported to be very successful.

8. RECOMMENDATIONS

Recommendations for improving the ongoing program and future expansion were derived from the key findings. These include recommendations made directly by ECCD program managers, implementing partners and parents in the communities during interviews.

8.1 Recommendations for Program Design

1. Hold an internal workshop to retroactively develop:
   a. A theory of change (ToC) model that clearly represents the needs that the PPP is trying to address, the changes it aims to achieve, how it hopes to achieve these changes, and how these changes will be measured (see below). Enabling factors particularly need to be defined. For example, some factors that have emerged from this study include:
      • Alignment of key messages with a given community’s interest
      • Economic means and know-how to provide adequate foods
      • Ongoing social support mechanisms to address gender and cultural constraints to behaviour change
      • Time to attend groups and implement good IYCF
      • Existence of complementary services and infrastructure: schools, HCs, water supply and sanitation and hygiene facilities
      • Quality of facilitation and interaction in group sessions
      • Adequate training of group facilitators
      • Government support: aligning with government policy and plans and securing commitment
b. Use the ToC to develop a *logical framework* specific to the Positive Parenting Program that will form the basis for coherent monitoring and evaluation. A draft logframe has already been retroactively developed by a Plan consultant, adapting the wider M&E framework from the ECCD five year plan. This framework should be reviewed during the workshop and adjusted, where appropriate, to align with the ToC and to reflect expanded nutrition indicators (see section 8.3). For evaluation purposes, specific targets should be set for each indicator.

c. Once the logframe has been finalized, the ECCD team should review all the M&E mechanisms that have been built in to the PPP, as well as other draft indicators (see section 6.1.5) to decide which are most useful in supporting the new framework. New tools may be developed such as those allowing for external monitoring, such as PPG observation checklists or exit interviews. A user-friendly database system should be designed so that field staff can easily enter and generate data on a routine basis.

d. In the short term, existing built-in monitoring mechanisms should be used to evaluate this pilot phase once the first round of sessions has been completed. Program managers should concentrate on consolidating and analysing the data collected (as described in 6.1.5) in order to measure changes over time. Specific examples include:

- Examine registration data to analyse trends in attendance
- Summarize data from Session 1 baseline posters and report against parents’ review in Session 11 of what they have learned during the program and how they have overcome difficulties in behaviour change
- Examine Pocket Votes to measure if numbers of each of the recommended behaviours have changed over time and how
- Consolidate and report on household monitoring data for triangulation
- Summarize end of session evaluation game data to describe parents’ satisfaction with the sessions.

2. In planning the next round of PPG sessions, transition to a more “bottom-up” approach by *increasing parents’ involvement in the design*. Use participatory appraisal methods to enlist parents in identifying their priorities with respect to ECCD learning; adapting the content flexibly to priorities and the given context of each distinct community; brainstorming on how to improve enabling factors for change (income generation, community infrastructure, food security etc.); problem solving aimed at improving motivation and participation in the PPGs; and developing activities to increase their direct involvement during and in-between the sessions.

Each session could end by agreeing on simple actions that parents can do either collectively or individually with their children. Doing this in small neighbourhood groups can increase social support for change within households. Parents could be sensitized to be motivated by their children’s response to the new actions, for example observing children’s joy at receiving a simple toy that parents have made for them. These experiences could then be reported back to the group during the next session.

3. *Improve learning materials* by:
• Developing more illustrations and practical activities, and considering creating videos in local ethnic languages
• Reducing the amount of text/reading
• Pretesting all materials locally.
• Housing all materials in one kit, including a “concept note” for facilitators explaining the purpose and usage of the contents

It is critical that new materials not be developed in isolation. A consultant who worked on developing the materials currently used by the PPG has stressed that it’s not enough to develop new materials, without ensuring that the facilitators are adequately trained on how to use them effectively.

4. It is recommended that Plan gain a more in-depth understanding of its target communities to allow messages and methods to be better targeted and to understand barriers and enabling factors for behaviour change. Specifically, Plan is recommended to:

• Review in-depth studies of an anthropological nature that have already been conducted among the varying ethnic groups in Laos that provide a deeper understanding of existing child-caring practices, gender roles, and other factors that could facilitate or impede child-caring behaviour change. This should include a study of food traditions and taboos that could affect optimal nutrition for pregnant women and children. Examples that were cited during this study include not feeding newborns colostrum; feeding sticky rice to newborns; and self-starving during pregnancy to prevent having a large baby.

Some of this information may already exist in studies commissioned by Plan in Bokeo Province.\textsuperscript{11} Utilize this information to tailor methods and inputs to each culture.

• Conduct a community assets mapping exercise to outline availability – or lack of - resources that could enable each community to adopt optimal child caring practices. Such resources would include variables such as access to health care, schools, water sources, electricity income-generating opportunities, and household coverage of home/commercial gardening initiatives and animal husbandry. A study of food consumption patterns (sources, diversity, seasonal availability, frequency of consumption) could be included in this exercise. These efforts can help program staff, facilitators and trainers to focus more on areas that are lacking and provide structural support if possible, or intensify behaviour change strategies to encourage participants to view the PPG recommendations as a priority. It will also allow program implementers to link the PPG with existing programs implemented by Plan or other organisations, that could address the gaps (see also recommendation no.5 below).

5. Support village groups to create the means to enable positive behaviour change. Ideas include:

- Linking with the Plan MNCH+N proposal for village “solution funds”
- Learning from program success stories, for example CARE Laos’ WINGS project that empowered women’s groups to seek solutions to their own problems; in this case finding ways to generate income and free up their time.
- Brainstorm with village leaders and active community members on how to mobilize their communities to contribute time, labour or money towards communally beneficial projects, such as:
  - water supply systems
  - latrines
  - income generation
  - food gardens
  - rotating health care funds
  - child play groups and day care
- Models such as LANN (employed by the WINGS project) can be adapted to guide PPGs and other community groups through a process of linking knowledge and the desire to change, with “actioning” change, particularly towards improved nutritional outcomes. For example the LANN process could assist communities to diversify food crops and initiate or increase the production of livestock and aquaculture for home consumption.

6. Fortify human resources:

- Build the capacity of the village volunteers who facilitate the PPGs by providing them with intensive training on audience engagement skills, role-play, and health knowledge. During the entire duration of the pilot phase, ensure the intensive supervision of support staff from Plan and/or district health offices at every session, followed by debriefing /feedback from supervisors. The latter can be a simple self-administered survey that can be addressed immediately after sessions. This facilitator monitoring would allow program staff to address facilitation gaps, ensure proper support and build confidence.

- Revisit the criteria for selecting village volunteers, and ensure they will not be biased against women. Evaluate the gender balance among the VVs and determine if and how many more women should be recruited to the program, in order to address this discrepancy.

- Secure the commitment from local government of assigning staff to serve as district facilitators for the duration of the PPP; ensure that district facilitators who receive training continue in their PPP role to ensure continuity.

- Consider broadening the scope of Plan interns to capitalize on their enthusiasm and skills. The interns tend to be educated, multi-lingual and receive continuous “on-the-job” training from Plan. Create partnership teams comprising interns and the most competent and committed district facilitators. Enlist them during parenting groups to foster a spirit of enthusiasm, participation and inclusion among participants and
role model facilitation skills for VVs, while providing each other with mutual peer-to-peer support and sharing.

8.2 Recommendations for Implementation

1. To increase relevance and address complaints about the length and frequency of sessions, be selective and flexible with the learning curriculum; avoid a “cookie-cutter” model of delivering all sessions to all groups. Emphasize ensuring parents’ understanding and motivation to adopt child-caring behaviours, rather than on completing the sessions in a pre-set time frame. Work with participants to decide what they need and want to learn, and involve them in identifying their problems and priorities.

2. Take advantage of positive deviance. From those parents who report positive behaviour change, learn about the facilitating factors and enlist them as teachers/role models, to share their experiences during the parenting groups. This approach could also be applied in process evaluation, by consulting with those parents who succeed in regularly attending parenting groups, to understand factors that could motivate and enable others to do the same.

3. During the sessions, involve parents in more “doing” activities, such as cooking with locally available ingredients, making toys with inexpensive locally available materials, playing games with children, home-gardening and role-playing targeted behaviours. Encourage parents to continue these activities in between sessions, and to reflect on their successes and motivating factors. Start sessions with icebreakers to create a lively, participatory environment.

4. Incorporate children into the learning process rather than treating them as distractions. During the sessions, involve them in demonstrating games and other early stimulation activities, washing hands, feeding, making and playing with toys, gardening, singing songs etc. Avoid providing children with sugary snacks that have no nutritional value and contradict the health-seeking behaviours being promoted. Rather feed them food that has either been prepared together during the session, or are healthier, preferably locally accessible, alternatives.

5. Explicitly invite fathers to attend PPGs. Following on the success reported from the field on this strategy, consider having separate sessions for men only, focusing specifically on gender sensitivity and male involvement in child-rearing including topics such as increasing women’s household decision-making, sharing in child care, prevention of domestic violence, fathers’ involvement in early stimulation and importance of obtaining nutritious food for children and the family.

8.3 Recommendations for Nutrition Expansion

Acknowledging the direct relationship between children’s wellbeing, healthy growth and development, with nutrition, early stimulation and sanitation, Plan hopes to create a more comprehensive nutritional component for the next phase of the PPP.
Already findings demonstrate that the PPP has been designed to cover nutrition-sensitive education with such components as teaching parents to prepare ORS for diarrhoea management, discussing the importance of vaccinations, taking children to HCs when they exhibit danger signs, and hygiene and sanitation. Sessions 3 & 4 also covered direct nutritional messages on growth monitoring and child feeding, with some limited, but promising early results on knowledge gained and desire for change.

More than half of parents surveyed – all of who were mothers - work outside of their villages, leaving their young children in the care of their grandparents, older siblings or father. Thus we can deduce that exclusive breastfeeding on demand would be challenging for these women. There is also evidence that many parents feel that babies of this age also need to receive supplemental foods.

For children over 6 months of age, parents universally mentioned that complementary foods need to be introduced. However only 6 parents spontaneously mentioned that breast milk can/should still be given. While the session on good feeding covered the consistency of weaning foods, the materials provided to the evaluation team do not indicate that feeding frequency has been covered.

**Recommendations:**

1. A strengthened nutrition curriculum should use the *1000 days approach*, covering the period from conception until the child reaches 24 months of age. This window is now considered the crucial period during which nutritional interventions have optimal impact on child growth and development.\(^\text{12}\) In addition to targeting children directly, this approach would address the continuum of care including the prenatal and postnatal periods. Improving the nutritional status of mothers, particularly in communities where women are having children at a young age, is vital to preventing malnutrition in newborn babies. Consider incorporating family planning as an optional topic to the PPG curriculum, where there is a demand.

2. Infant and Young Child Feeding components should to be expanded as follows:
   - Importance of breastfeeding and IYCF on child’s nutrition and future learning potential as well as productivity as adults need to be strongly emphasised. This has to be done in very simple terms and using local examples and motivators for change (for example some communities may get motivated to make their children tall while some may want to see their children learning well)
   - Breastfeeding messages need to be strengthened to encourage early initiation of breastfeeding, the importance of feeding colostrum to the newborn, breastfeeding on demand, frequent breastfeeding to increase milk supply, exclusive breastfeeding for the first 6 months and continued breastfeeding until 2 years of age and during child illness. It’s recommended that exclusive breastfeeding be promoted as preventing the introduction of foods and water before 6 months. Emphasise motivators such as cost (it’s free), safety (no added water), convenience (no need for

\(^{12}\) Lancet 2008 series on Maternal and Child Nutrition
bottles and preparation), and health (breast fed babies are, smarter and taller, with less illness).

- Breastfeeding messages should be coupled with an open discussion on barriers, providing opportunities for parents to come up with new/effective solutions that are realistic for them. Also the facilitators could introduce (not impose) new techniques to overcome barriers. For example mothers could be taught to express breast milk to maintain supply and for caretakers to feed to their babies in their absence.

- Links between the PPP and the local health workers (skilled birth attendants/community midwives, village health workers and village health volunteers) need to be strengthened so that there will be continuous semi-professional support for the mothers who try these new techniques or their own solutions.

- To improve complementary feeding recommendations, Plan should formatively explore which food are highly valued by the target communities, and reinforce the value of locally available nutritious foods. Complementary feeding messages need to be expanded to ensure they cover frequency, texture and amount appropriate to child age groups, as well as variety, responsive feeding and hygiene.

- Add messages on feeding of a sick child, including the need for increased breastfeeding and administration of ORS to avoid dehydration and increased feeding frequency for added strength to fight the illness.

3. Study food traditions and taboos as described in section 8.1, no. 4

4. Link with Plan’s parallel MNCH+N + WASH programs by coordinating on:
   - Forming enabling/solution task forces with VEDCs, to seek solutions and generate means to enable behaviour change. For example develop “solutions funds” as proposed in the MNCH+N program document.
   - Curriculum development for health and nutrition components
   - Health training for VVs and district facilitators
   - Supervision + support during health-related sessions
   - Linking nutrition with sanitation (CLTS) and making nutritional improvement another goal of striving for open defecation free villages

9. LIMITATIONS OF THE EVALUATION

A mini survey aimed to provide some quantifiable data to the evaluation. However the sampling methods were purposive and results were too small (n=58) to claim to be statistically representative of Plan’s total Positive Parenting Program. This was primarily a qualitative study and thus similarly, FGD and interview data provided some anecdotal information that, while interesting, may not necessarily speak for community views as a whole. Such data, however, can nevertheless prove to be insightful, innovative and useful.
Additionally, findings on the effects that the PPGs had on parents’ knowledge and behaviour change cannot be solely attributed to the program. Some parents, for example, may not be able to distinguish the Positive Parenting Groups from the Parenting Orientation sessions that took place in the previous phase of Plan’s ECCD program. Indeed gains achieved in the value parents put on child education and sending young children to school most likely resulted from Plan’s first phase of support to early childhood education in Bokeo. Additionally Plan’s MNCH + N and WASH programs have operated in parallel to the ECCD program, incorporating some public health promotion messages that overlap with those learned at the PPGs. Parents also reported receiving vaccinations from visiting teams and gaining some child health knowledge at Heath Centres.

The time allotted for the evaluation was very tight, which led to some compromises with respect to planning, field travel, comprehensiveness of data collection training and development of data collection tools. The Contracting of 3 Lao consultants with strong backgrounds in field research greatly compensated for these constraints and allowed the evaluation team to “hit the ground running” to some degree.

Data collection tools needed to be translated from English to Lao, and, in the case of the mini survey, back to English for verification after incorporating changes suggested during training. FGDs were spontaneously translated verbally from Lao to the pertinent local languages for the benefit of the facilitators (the Lao consultants). Findings extracted from the FGD recordings, as well as the mini survey questionnaire results, needed to be translated to English to allow the international consultant to work on analysis. These multiple layers of interpretation, coupled with the time pressures, inevitably meant that some of the richness of data would have fallen through the cracks. As written translations were all done by the Lao consultants, this detracted greatly from the time needed for the evaluation team to work together, while the international consultant was still in-country.
REFERENCES


Drysdale, S F (June 2013) *Plan Laos Maternal Newborn & Child Health Project Concept Note*.


UNICEF; University of Washington: Global Centre for Integrated Health for Women, Adolescents, and Children (draft, 3 March 2015). *Baseline Survey for the Maternal and Young Child Nutrition Security Initiative in Lao PDR, 2011*


UNICEF *Multi-sectoral Approaches to Nutrition: The case for investment by education programs*
UNICEF and WHO. *Integrating early childhood development (ECD) activities into nutrition programs in emergencies: why, what and how.*

APPENDIX 1

In-depth Interview (IDI)

Individual and Group Question Guides

**Parenting Group Facilitators (Village Volunteers)**

Do you feel there is a need for the parenting groups? Why / why not?

How often do you run parenting groups?

How do you advertise them and encourage attendance?

Describe the people who usually come to the groups (gender, child age group, only parents or other community members?). Do fathers ever attend? Are they invited to?

Describe what is taught at these groups

Do parents seem like they want to go (are they self-motivated?) Why/not

Do you feel that participants are satisfied with the sessions? Why/why not

What feedback do you get from participants? Do they report any barriers to:
  - attending the parenting groups
  - implementing the recommended behaviors?

What is working well about the parenting groups? Why?

What is not working well? Why?

What suggestions do you have for improvement?

Do you feel that you have received enough training to lead the groups effectively?

Describe what kind of support and supervision you have received? How regularly did you receive this support? Has it been adequate?

What specific needs do you have, that would improve your role?

**District Facilitators/Supervisors (Group)**

Tell me about your role.

Describe the people who usually come to the groups (gender, child age group, only parents or other community members?). Do fathers ever attend? Are they invited to?

Describe what is taught at these groups
Do parents seem like they want to go (are they self-motivated?) Why/not

Do you feel that participants are satisfied with the sessions? Why/why not

What feedback do you get from participants? Do they report any barriers to:
- attending the parenting groups
- implementing the recommended behaviors?

How is the capacity of the Village volunteers?

What is working well about the parenting groups? Why?

Have you seen any positive changes among the parents and how they care for their kids?

What is not working well? Why?

What suggestions do you have for improvement?

Do you feel that you have received enough training to support the village volunteers?

Describe what kind of support and supervision you have received? How regularly did you receive this support? Has it been adequate?

What specific needs do you have, that would improve your role?

Other comments

**ECCD Staff**

What is your role in the program?

What challenges have you faced in implementing the program?

How have you worked with government programs?

What barriers and challenges have been reported to you from implementing field staff?

How has progress been monitored?

How do you think the program could be improved?

What would you like to see added or changed in the next phase

What factors need to be in place to facilitate scale-up
APPENDIX 2
Focus Group Discussions (FGD) Guides

Mothers’ Question Guide

Introduction:

We are here to learn from you about the parent groups that you have attended. We are not working for the program or the government. We are coming to find out how we can make the parent groups better.

We are going to ask some questions. There are no right or wrong answers. Please speak openly and freely so we learn about your honest opinions and feelings.

Sources of Child Care Info

From where or from whom do you get most of your information about how to care for your child and keep your family healthy and active? Of those sources, which one do you trust the most? Why?

Aside from the parenting groups, what other events or activities have you attended that relate to caring for your child? Tell me about it.

How did you come to know about the parenting groups?

Parent Group Attendance

Why did you decide to first attend the groups? Were your husbands involved in your decision to attend?

Are you able to attend regularly? Why/why not?

What would allow or motivate you to attend more regularly?

When you are not able to attend, do your husbands attend instead? Why/Why not?

Participation

What do you do at the groups?

What do you learn?

Do you understand what is being taught?

Do you talk and share your own ideas on how to care for children?

Do you ask questions during the sessions? If not, why not?

Did you help decide what to learn in the groups? → Did anyone ask for your ideas, or did you offer your ideas?
Does your group meet outside the sessions organized by the facilitator? How often do you do so? Who organizes the meeting? What do you do when you meet amongst yourselves?

**Perceived Value**

What do you think about the way the sessions are run and the methods used to teach?

Do you find the groups useful? Why/why not?

What do you like best about the groups?

What do you not like about the groups?

How could the sessions be improved?

**Behavior Change**

Have the sessions you participated in led you and others who take care of your children (husband, grandmother) to change the way you take care of your children?

What have you changed? Why?

What barriers have you faced in making changes?

Do you share the information/learning from the groups with your family members and neighbours? If so, whom do you share with? What kind of topics do you share?

What are your husband’s attitudes to information you have learned or changes you have made as a result of what you’ve learned from the sessions?

Are they supportive or not?

Have they changed their own attitudes or behaviors as a result of things you learned at the parenting groups?

Is there anything else that you would like to do in the groups or learn from the groups?

Any other comments?
Fathers’ Question Guide

Introduction:

We are here to learn from you about the parent groups that you have attended. We are not working for the program or the government. We are coming to find out how we can make the parent groups better.

We are going to ask some questions. There are no right or wrong answers. Please speak openly and freely so we learn about your honest opinions and feelings.

Sources of Child Care Info

From where or from whom do you get most of your information about how to care for your child and keep your family healthy and active?

Of those sources, which one do you trust the most? Why?

Aside from the parenting groups, what other events or activities have you attended that relate to caring for your child? Tell me about it.

How did you come to know about the parenting groups?

Parent Group Attendance

Have any of you attended the groups?

Why did you decide to first attend the groups?

Are you able to attend regularly? Why/why not?

What would allow or motivate you to attend more regularly?

Does your wife attend regularly? Why/why not?

Participation

What do you or your wives do at the groups?

What do you learn?

Do you or your wives understand what is being taught?

Do you or your wives talk and share your own ideas on how to care for children?

Do you or your wives ask questions during the sessions? If not, why not?

Did you help decide what to learn in the groups? → Did anyone ask for your ideas, or did you offer your ideas?
**Perceived Value**

What do you think about the way the sessions are run and methods used to teach?

Do you think the groups are useful? Why/why not?

What do you think is good about the groups?

What do you think is not so good about the groups?

How could the sessions be improved?

**Behavior Change**

Have the sessions you participated in led you and others who take care of your children to change the way you take care of your child?

- What have you changed? Why?
- What has your wife changed?
- What barriers have you and your wife faced in making changes?

Do you share the information/learning from the groups with your family members and neighbors? If so, who do you share with? What kind of topics do you share?

Do you support your wife to make the changes recommended in the groups? Why or why not?

Have you changed your own beliefs and behaviors as a result of what you or your wife learned at the parenting groups?

Is there anything else that you would like to do in the groups or learn from the groups?

Any other comments?
Appendix 3
Mini Survey Questionnaire

22. Demographics
1. Village/district:............................... 
2. Age...............years 
3. Ethnic group....................... 
4. Number of children ................... Number children < 5.............
5. What is your job?....................... 
   a. Do you work: Inside the village / outside the village? 
   b. If outside, who takes care of your kids when you work?.....................
6. Who do you talk to about how to give good child care? .......................

II. Participation
1. How many times have you attended the parenting group? .......... times. 
2. When was the last time you attended? .................. 
3. What was the last session about?.........................................................

III. Knowledge, Behavior and Practice
From now on we are going to ask you about how to give good care. There is no right or wrong answers, we just want to know how you feel.

22. How many types of child care are there? ............... Types
   Please give an example about health and development of a child

..........................................................................................................................

Please give an example of protecting a child

..........................................................................................................................

Please give an example about child learning

..........................................................................................................................

2. From your experience, which practices are good, and not good for children?
   Good:..............................................................................................................
   Not good: ........................................................................................................

22. In what ways can your husband help you in taking care of your children?
..........................................................................................................................
22. Have you taken your kids for vaccinations?
   Why/Why not?............................................................................................................
   Why does a child need vaccinations?........................................................................

6. Have you ever measured your child’s weight? Yes / No
   If yes, how many times? ............times

7. During the past month, did your child have: Fever Vomiting Diarrhea
   If yes, what did you do about it?................................................................................

8. What kind of food should we give to a child < 6 months? ...........................................
   Any other type of food?.............................................................................................

9. At what age should we provide rice and food to a child? ..............months

10. At how many months of age should you provide breastfeeding to your child?
    ............. Months
   Why did you start to provide foods to your child?..................................................
   ....................................................................................................................................

11. What kind of food does a child > 6 months of age need everyday?
    Are you able to provide those foods to your child everyday? Yes/ No
    Why /Why not?...........................................................................................................

12. Can you explain what is good hygiene practice?
    Do you have any difficulty in practicing those behaviors? Yes / No
    Why /Why not?............................................................................................................

13. When should we wash our hands?
    Are you able to wash your hands as you mentioned? Yes / Sometimes / No
    Why /Why not?............................................................................................................

14. Can you describe how to make ORS?

15. Have you ever de-wormed your kid? Yes / No

16. In your opinion, how can you protect your kid and whose responsibility is it?

17. What do you do to protect your kid?

18. Do you think play is important for your child? Yes / No / Don’t know
19. Have you changed your behaviour after attending parenting sessions? Yes / No
   If yes, what practice? ...........................................................................................................

20. Has your husband changed his behavior after attending parenting sessions?
   Yes / No
   If yes, what practice? ...........................................................................................................

21. Has anyone else who helps take care of your child changed their behavior after
    attending parenting sessions? Yes / No
   If yes, what practice? ...........................................................................................................

22. Have you found it difficult to follow any of the practices recommended to you
    during the parenting sessions? Yes / No
   Why/Why not? ..............................................................................................................
## APPENDIX 4

In-depth Interviews (IDI) : Key Informants List

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mette Boatman</td>
<td>Consultant</td>
<td>Plan International</td>
</tr>
<tr>
<td>Mona Girgis</td>
<td>Country Director</td>
<td>Plan International</td>
</tr>
<tr>
<td>Adam Folkard</td>
<td>Consultant/business devt</td>
<td>Plan International</td>
</tr>
<tr>
<td>Allison Rusinow</td>
<td>Asst Country Director for Programs</td>
<td>CARE International Laos</td>
</tr>
<tr>
<td>Sharon Kane</td>
<td>Program Quality Director</td>
<td>World Vision Laos</td>
</tr>
<tr>
<td>Somxay Inthasone</td>
<td>ECCD Program Manager, Vientiane</td>
<td>Plan International</td>
</tr>
<tr>
<td>Somsak Yang</td>
<td>ECCD Provincial Manager, Bokeo</td>
<td>Plan International</td>
</tr>
<tr>
<td>Phuangmalay Bountome</td>
<td>Pha Oudom District ECCD Coordinator</td>
<td>Plan International</td>
</tr>
<tr>
<td>Souksakhone</td>
<td>Pha Oudom District MNCH Coordinator</td>
<td>Plan International</td>
</tr>
<tr>
<td>Bouatong</td>
<td>Technical staff for preschool education</td>
<td>Government of Laos</td>
</tr>
<tr>
<td>Boualaphanh Inthaxay</td>
<td>MNCHN Program Manager</td>
<td>Plan International</td>
</tr>
<tr>
<td>Amphone Keooudom</td>
<td>MNCHN Provincial Manager</td>
<td>Plan International</td>
</tr>
<tr>
<td>Yee Song</td>
<td>Phaktha District ECCD Coordinator</td>
<td>Plan International</td>
</tr>
<tr>
<td>Kalana Peiris</td>
<td>MNCH+N Program Manager, Vientiane</td>
<td>Plan International</td>
</tr>
</tbody>
</table>
APPENDIX 5
Comparative Analysis: LANN and PPP
(Prepared by Banthida Komphasouk)

The Positive Parenting Program (PPP) is a structured curriculum targeting mothers and caregivers of children aged 0-5 delivered in a participatory approach by the community members. Participants of the PPP are women and caregivers of children under 5 years old. Positive Parenting Group (PPG) sessions are carried out every 1-2 weeks for a 6-9 month period and are designed as support groups that allow mothers to discuss and learn from each other on issues of parenting and topics of nutrition, including infant and young child feeding (IYCF), exclusive breastfeeding and complimentary feeding and hand-washing with soap, with Plan staff providing the technical training for government district counterparts and community volunteers (village chiefs, village health volunteers, Women’s Union representatives).

Benefits:
• The handbook has structured curriculum with essential topics not only on nutrition but also incorporates early childhood development topics such as encouraging social and emotional development, protection and early stimulation
• The handbook includes many pictures and activities, which allows it to overcome language barriers between different ethnic groups
• The parenting group design allows for the space to practice positive deviance (page 11) and “provide training and engage all key caregivers on nutrition, hygiene and sanitation” (page 7)

Limitations:
• PPP is still quite new and the whole 11 sessions have not yet been completed thus, has only been evaluated at mid-point.
• At the moment the PPP only targets women and women caregivers with children under 5 years, with husbands occasionally attending though it has not yet expanded to have male parenting groups
• PPP is based on a handbook which, although it is community based, is not community led/driven since the sessions are designed to cover a certain topic each session, thus delivering standardized behaviour change communication messages.
<table>
<thead>
<tr>
<th>PPG lessons:</th>
<th>LANN lessons:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1: 3 kinds of care</td>
<td>TOT 1:</td>
</tr>
<tr>
<td>Session 2: Our traditions &amp; child-rearing practices</td>
<td>Session A: What is nutrition and malnutrition</td>
</tr>
<tr>
<td>Session 3: Health &amp; growth monitoring</td>
<td>Session B: What are causes of malnutrition</td>
</tr>
<tr>
<td>Session 4: Healthy food for your child</td>
<td>Session C: Impacts of malnutrition and good nutrition on life</td>
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<tr>
<td>Session 5: Good hygiene practices</td>
<td>Session D: How to move out of malnutrition</td>
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<td>Session 6: Protection of children</td>
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<tr>
<td>Session 7: Social and emotional development</td>
<td>TOT 2:</td>
</tr>
<tr>
<td>Session 8: Motor development</td>
<td>Session A: Body functions of food/nutrients</td>
</tr>
<tr>
<td>Session 9: Language development</td>
<td>Session B: Principles of healthy diets</td>
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<td>Session 10: Cognitive development</td>
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<tr>
<td>Session 11: What did we learn and what do we do next?</td>
<td>TOT3:</td>
</tr>
<tr>
<td></td>
<td>Session A: Food taboos</td>
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<td></td>
<td>Session B: Future food sources</td>
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</table>

The **LANN approach** is suitable for those organizations and/or projects that aim to exploit actionable linkages between agriculture, natural resource management, income growth and nutrition. It was initially developed for 7 INGOs in Lao PDR in 2009, though it has since been expanded to Cambodia in 2010 and Sri Lanka and Burma in 2012. LANN has two outcomes: (1) improved knowledge and (2) behaviour change. LANN has a 2 step approach:

- First is cultivating awareness on the causes of malnutrition in communities. More specifically, villagers benefiting from LANN village trainings will understand their family nutritional problems in practical terms (knowledge)
- In the second step, with increased knowledge, they would be able to identify appropriate action to address them (behaviour change), facilitated by program staff, government counterparts and community leaders. Thus, the process of mobilises the community to take action and change behaviour by linking causes to action such as:
  - Actionable linkages between agriculture and nutrition
  - Linkages between natural resource management and nutrition
  - Linkages between income growth/food expenditures and nutrition
  - Potentials to increase family food and nutrition intake
The purpose of the LANN guidelines is to guide managing staff of projects using LANN to supervise their field staff in properly implementing village trainings, facilitating evening classes and conducting M&E activities. It is not a training handbook for the facilitators to implement at the village, but to provide knowledge.
to the program managing staff so they can ‘pick and choose’ out of the 22 modules what would be appropriate for their field staff and target village. Nevertheless, some of the benefits and limitations of the LANN include:

**Benefits:**
- LANN has a variety of IEC materials and tool kits, which can be adapted to suit various ethnic groups, overcome language barriers (since many IEC are picture based) and tailored to suit various focuses
- LANN has been successfully implemented by 7 INGOs, thus the approach can be adaptable to suit different contexts, ethnic groups and organizations
- The design of the program allows the community to identify the main causes of malnutrition in mothers and children in their own community and to assist them in developing their own solutions, thus being community led rather than “delivering standardized behaviour change communication messages”

**Limitations:**
- Experiences with LANN during the last three years have not been systematically evaluated and only some qualitative evaluations exist.
- Implementation of LANN requires strong facilitation skills, health, nutrition and program design background as well as local knowledge to identify which IEC materials to use that would be culturally appropriate, and tailor the IEC materials to meet the needs and address the issues of malnutrition identified by the community, while also maintaining some level of standardization for monitoring and evaluation purposes.
- The LANN approach’s activities are driven by the community’s needs and identified gaps to address malnutrition in their context, thus, the activities vary in each district making it difficult to anticipate costs and directly support some activities since the RFA only supports some activities such as positive deviance groups; while linkages and not actual implementation in others, such as creating home gardens or income generation activities.

As a result the WINGS program by CARE was developed and designed to tackle the 2 most important gaps for addressing malnutrition in their community, Dak Cheung district, Sekong Province, which is freeing up time by providing wheelbarrows to assist women in gathering wood in the forest and rice mills to save time on husking rice and income generation activities such as coffee planting, pig raising, etc. It is important to point out that the LANN approach does not commit to improve nutritional outcomes such as better child growth. It does commit only to increase knowledge and improved food and nutrient intake. Also, it relies on linking with existing programs to address the needs of the community as mentioned earlier. The LANN model will not work on its own without actionable activities.

In summary, I would propose using the LANN approach as an initial tool to understand the community-identified causes for malnutrition from women and children in their community, similar to a needs assessment, and allow them to find their own solutions that would work in their situation and context. This process will not only allow the community members to find their own solutions to address their
nutrition problems, but also hopefully generate community mobilisation and generate sustainable actions. By putting nutrition as the centre of the issue/discussion, the PPG sessions can be used as resources to add in WASH behaviours, early situation, etc., which are all needed for a holistic development for a child. The PPG sessions will still be carried out in 11 session per year, the change would be starting with nutrition as the problem and working with the community to address it, though guiding it with nutrition, WASH, early stimulation and child protection sessions along the way. However, this model would only work if the program has enough flexibility for change, creativity and strong knowledge of PPG and LANN modules and also some support for activities that communities prioritise to address nutrition, such as income generation skills. Additionally, the recommendations would also depend on the ultimate goal of PPG, since the LANN approach is nutrition focused. Additionally, it is important to point out for LANN to be achievable:

- Only start LANN if there is a time frame of a minimum of 2 years as it is unlikely that behaviour change can be triggered after one year only.
- After the completion of TOT 1 develop a clear timeline for TOTs 2, 3, and 4, village kickoff trainings, evening classes and their follow-up. Ensure that there are no large gaps between trainings and evening classes in order not to lose momentum, to avoid knowledge dilution and the decreasing enthusiasm by villagers.
- Link workplans for LANN and other project activities in a sensible manner and be accountable (e.g. stimulate interest in crops and follow-up with support from the agricultural team). Unmet demands by villagers will reduce enthusiasm and prevent future behaviour change.