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UNICEF Uganda

**Research Design for a baseline, impact and economic
evaluation of the Health Systems Strengthening
Interventions in the West Nile region of Uganda**

Annexes to Draft endline evaluation report

Submitted: 21st July 2025

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ANNEXES

1.1. Annex 1: Modification of evaluation objectives from ToR to final protocol

Purpose and objectives - Terms of Reference	Objectives - Inception report	Objectives - ethically approved research protocol
<p>This is an endline impact evaluation with a focus on the UNICEF component, whose purpose is to assess the impact of the programme interventions on the health and nutrition outcomes and health system. The evaluation will establish attribution of the implemented interventions to planned programme objectives and explain the differentials by the level of attained health system and beneficiary outcomes. The evaluation will establish cost effectiveness and efficiency of the program to inform scalability and sustainability considerations. The evaluation will also serve an accountability purpose to the stakeholders especially direct beneficiaries (in the districts), government (local and central) and funders; and will provide lessons for programming and scale up of similar programmes to development practitioners.</p>	<p>1. Effectiveness – Coverage: To determine the differences and the associated factors (i. DHSS intervention, ii. Quality of Care, iii. SBCC) of the change in coverage of maternal and child health and nutrition services from 2019 to 2024 between intervention and counterfactual districts</p>	<p>1. Effectiveness – Coverage: To estimate the effectiveness and impact of the CSSP by determining the differences and the associated factors (i. DHSS intervention, ii. QoC and iii. SBCC) of the change in coverage of maternal and child health and nutrition services from July 2019 to December 2024 between intervention and counterfactual districts.</p>
	<p>2. Effectiveness – Utilisation: To determine the differences and the associated factors (i. DHSS intervention, ii. Quality of Care, iii. SBCC) of the change in use of maternal and child health and nutrition services from 2019 to 2024 between intervention and counterfactual districts</p>	<p>2. Effectiveness – Utilisation: To assess the impact and effectiveness of the CSSP by determining the differences and the associated factors (i. DHSS intervention, ii. QoC and iii. SBCC) of the change in use of maternal and child health and nutrition services from July 2019 to December 2024 between intervention and counterfactual districts.</p>
	<p>3. Efficiency: To establish the cost and effectiveness of DHSS, quality improvement, and SBCC in the use and coverage of maternal and child health and nutrition services from 2019-2024</p>	<p>3. Efficiency: To estimate the efficiency of the CSSP by establishing the cost and effectiveness of DHSS, quality improvement, and Social behavioural change communication (SBCC) in the use and coverage of maternal and child health and nutrition services from 2019-2024.</p>
	<p>4. Relevance, Coherence, and Sustainability: To assess the coherence, relevancy, and sustainability of the programme</p>	<p>4. Relevance, Coherence, and Sustainability: To assess the coherence, relevancy, and sustainability of the CSSP programme. This objective also examined cross-cutting issues including gender, equity, inclusion, and responsiveness to the needs of vulnerable populations.</p>

1.2. Annex 2: Evaluation matrix

No.	Evaluation questions	Indicators	Data collection Method	Sources of information	Data analysis	Timelines	OECD/DAC Criteria
Objective 1&2: To determine the differences and the associated factors (i. DHSS intervention, ii. quality of care, iii. SBCC) of the change in use of maternal and child health and nutrition services from 2019 to 2024 between intervention and counterfactual districts							
1	What are the differences in the change in targeted mothers and children accessing the package of essential RMNCAH, nutrition and HIV/AIDS services in the intervention and counterfactual districts?	1. Differences in the change of the proportion of mothers and children accessing the package of essential RMNCAH, nutrition and HIV/AIDS services between intervention and counterfactual districts 2. How do the results compare with the programmatic logical framework targets?	<ul style="list-style-type: none"> Primary data collection 	Household survey KII – Implementers, community members, district officials.	<ul style="list-style-type: none"> Difference in difference 	1. Baseline 2. Endline	Effectiveness, Impact
2	Is the DHSS progression model score associated with the changes in use of RMNCAH, nutrition and HIV/AIDS services in the intervention districts?	1. DHSS progression model score. 2. Differences in the change of the proportion of mothers and children accessing the package of essential RMNCAH, nutrition and HIV/AIDS services in intervention and counterfactual districts 3. How regularly has the DHSS been conducted during 2019-2024? How was it funded? 4. What aspects of the DHSS have been integrated in the routine operations during 2019-2024? (Coherence) 5. How relevant was DHSS implementation in addressing the local nutrition and RMNCAH priorities during 2019-2024? 6. Were there differences in how priorities in refugee and host communities were attended to?	<ul style="list-style-type: none"> Secondary data extraction Primary data collection (Health Facility Survey) KIIs FGDs 	<ul style="list-style-type: none"> DHSS database Implementers Community members District Officials 	<ul style="list-style-type: none"> Chi-square for trend Linear regression T-tests Content analysis. 	1. Baseline 2. Endline	Relevance, Coherence

No.	Evaluation questions	Indicators	Data collection Method	Sources of information	Data analysis	Timelines	OECD/DAC Criteria
		7. How will the practices adopted be sustained after the end of the programmatic support.					
3	Is the HFQCAP score associated with the changes in use of essential RMNCAH, nutrition and HIV/AIDS services in intervention districts?	<ol style="list-style-type: none"> 1. HFQCAP score. 2. Differences in the proportion of mothers and children accessing the package of essential RMNCAH, nutrition and HIV/AIDS services in intervention and counterfactual districts. 3. How regularly has the HFQAP been conducted during 2019-2024? How was it funded? 4. What aspects of the HFQAP have been used to inform routine nutrition and RMNCAH operations during 2019-2024? 5. How relevant was HFQAP implementation in addressing the local nutrition and RMNCAH priorities during 2019-2024? 6. Were there differences in how priorities in refugee and host communities were attended to? 7. How will the practices adopted be sustained after the end of the programmatic support. 	<ul style="list-style-type: none"> • Primary data collection (health facility survey) • Document review • KIIs • FGDs 	<ul style="list-style-type: none"> • HFQAP database • Implementers • Community members • District Officials 	<ul style="list-style-type: none"> • Chi-square for trend • Linear regression • T-tests • Content analysis. 	<ol style="list-style-type: none"> 1. Baseline 2. Endline 	Relevance, coherence
4	Is SBCC associated with the changes in use of essential RMNCAH, nutrition and HIV/AIDS services in the intervention districts?	<ol style="list-style-type: none"> 1. Percentage of children, adolescents, caregivers and leaders who promote positive practices. 2. Number of people reached with key health/educational messages. 3. Difference in the proportion of the targeted mothers and 	<ul style="list-style-type: none"> • Primary data collection • KIIs • FGDs • Survey 	<ul style="list-style-type: none"> • Household survey • Implementers • Community members • District Officials 	<ul style="list-style-type: none"> • Chi-square for trend • Linear regression • T-tests 	<ol style="list-style-type: none"> 1. Baseline 2. Endline 	Relevance, coherence

No.	Evaluation questions	Indicators	Data collection Method	Sources of information	Data analysis	Timelines	OECD/DAC Criteria
		<p>children are accessing the package of essential RMNCAH, nutrition and HIV/AIDS services.</p> <p>4. How regularly has SBCC been conducted during 2019-2024? How was it funded?</p> <p>5. What aspects of the SBCC been used to inform routine nutrition and RMNCAH operations during 2019-2024? (Coherence)</p> <p>6. How relevant was SBCC implementation in addressing the local nutrition and RMNCAH priorities during 2019-2024?</p> <p>7. Were there differences in how priorities in refugee and host communities were attended to?</p> <p>8. How will the practices adopted be sustained after the end of the programmatic support.</p>			<ul style="list-style-type: none"> Content analysis. 		
Objective 3 To establish the cost effectiveness of DHSS, quality improvement and SBCC in the use and coverage of maternal and child health and nutrition services from 2019-2024							
1.	What is the cost of implementing the standard of care?	<p>1. Costs of provision of the current services in the intervention and control districts</p> <p>2. Costs per study arm</p>	Document review	Programmatic District budgets and reports focusing on financing, human resources, infrastructure and equipment	<p>Micro-costing / ingredients approach</p> <p>Costs subgroup analysis</p>	Baseline	
2.	What is the additional cost of implementation of i) DHSS ii) Quality of care and iii) SBCC on the government (MOH), and UNICEF as a partner?	<p>3. Cost of implementation of DHSS.</p> <p>4. Cost of implementation of quality of care interventions.</p> <p>5. Cost of implementation of SBCC interventions.</p>	Document review	Detailed programmatic financial reports	Micro-costing / ingredients approach	Endline	Efficiency

No.	Evaluation questions	Indicators	Data collection Method	Sources of information	Data analysis	Timelines	OECD/DAC Criteria
		6. Cost of proving a full package of essential RMNCAH, nutrition and HIV/AIDS services to beneficiary. 7. How has this been funded?					
3	What is the additional cost (DHSS + Quality of care + SBCC) per unit increase in coverage and utilisation of maternal and child health and nutrition services from 2019-2024?	1. Change in coverage and utilisation 2. Change in total costs 3. Cost per person served 4. Did implementation of the DHSS result in time and resources savings? 5. How has this been funded?	<ul style="list-style-type: none"> Document review. Surveys Secondary data extraction 	<ul style="list-style-type: none"> DHIS2 Survey reports Financial reports 	Costs analysis	Endline	Efficiency
4	What is the incremental cost-effectiveness ratio (ICEAR) for implementation of the (DHSS + Quality of care + SBCC)? Is the programme cost-effective?	1. Incremental cost effectiveness ratio 2. Deaths averted 3. DALYS averted	<ul style="list-style-type: none"> Document reviews Surveys, Secondary data extraction 	<ul style="list-style-type: none"> DHIS2 Programmatic Financial reports f 	Cost-effectiveness analysis		
Objective 4: Assess the coherence, relevancy, and sustainability of the programme.							
	What is the coherence of the programme?	1. What aspects of the HFQAP have been used to inform routine nutrition and RMNCAH operations during 2019-2024? (4.	<ul style="list-style-type: none"> Primary data collection (Health Facility Survey) KIIs FGDs 	<ul style="list-style-type: none"> Dist Implementer s Community members District Officials 	Content analysis.		
2.	What is the relevancy of the programme ?	1. How regularly has the HFQAP, SBCC and DHSS been conducted during 2019-2024? How were these funded? 2. How relevant were the HFQAP, SBCC, and DHSS implementation	<ul style="list-style-type: none"> Primary data collection (Health Facility Survey) KIIs FGDs 	<ul style="list-style-type: none"> D Implementer s Community members District Officials 	Content analysis		

No.	Evaluation questions	Indicators	Data collection Method	Sources of information	Data analysis	Timelines	OECD/DAC Criteria
		in addressing the local nutrition and RMNCAH priorities during 2019-2024?		•			
3	What is the sustainability of the programme?	8. How will the practices adopted be sustained after the end of the programmatic support.	<ul style="list-style-type: none"> • D Primary data collection (Health Facility Survey) KIIs • FGDs 	<ul style="list-style-type: none"> • Implementers • Community members • District Officials 	Content analysis		

1.3. Annex 3: IRB approved protocol and approval letter

Attached as a separate folder

1.4. Annex 4: IRB approved data collection tools

Attached as separate folder

1.5. Annex 5: Approved inception report

Attached as separate folder

1.6. Annex 6: Workplan

Attached as a separate document

1.7. Annex 7: Agreed terms of reference

UNICEF
TERMS OF REFERENCE FOR SERVICES – INSTITUTIONS (CONTRACT OR LTA)

SHORT TITLE OF ASSIGNMENT / LTA

Impact Evaluation of the Health Systems Strengthening on Nutrition and Health under the CSSP project

BACKGROUND & OBJECTIVES

Background:

The CSSP Programme is 5-year (2019–2024) USD 50 million programme funded by the Swedish International Development Cooperation Agency (Sida) in 13 districts of West Nile Sub region of Uganda. It is jointly implemented by UNICEF in partnership with WFP and the Government of Uganda, through the Office of the Prime Minister's (OPM), the Ministry of Gender, Labour and Social Development (MLGSD), Ministry of Health (MoH), and Ministry of Local Government. The programme's overall objective was to achieve improved health and nutrition of young children and enhanced community and household resilience among refugees and host populations in refugee-hosting districts of West Nile. To achieve these objectives, the CSSP programme was to provide direct support to targeted households and help government and its partners to support social protection and health systems to become more efficient, transparent, child- and nutrition-sensitive; and to scale up coverage of existing programmes and improve their effectiveness.

Objectives:

This is an endline impact evaluation with a focus on the UNICEF component, whose purpose is to assess the impact of the programme interventions on the health and nutrition outcomes and health system. The evaluation will establish attribution of the implemented interventions to planned programme objectives and explain the differentials by the level of attained health system and beneficiary outcomes. The evaluation will establish cost effectiveness and efficiency of the program to inform scalability and sustainability considerations. The evaluation will also serve an accountability purpose to the stakeholders especially direct beneficiaries (in the districts), government (local and central) and funders; and will provide lessons for programming and scale up of similar programmes to development practitioners.

This evaluation is being conducted in the final year of programme implementation as was initially planned and coincides with the preparation of UNICEF Uganda Country programme 2026- 2030, the preparation of the National Development Plan IV and the corresponding District Development Plans. The evaluation is timely for informing the programme implementors and funders on the effectiveness, efficiency, relevance, coherence, impact and sustainability aspects of the programme, for learning, accountability and replicability. Lessons will be used in the preparation of the next UNICEF programme, the next NDP and other planning processes in the districts and ministries and other stakeholders, especially the accelerating of the country's achievement of the SDG targets, particularly 1&3 by 2030. The users will therefore include, but not limited to, UNICEF, SIDA, WFP, GoU, District local governments, implementing partners.

SCOPE

Programmatic scope: The evaluation is summative in nature including a rigorous impact and economic evaluation that will cover all the of the UNICEF-led interventions covered by the programme, over the programme period 2019 - 2024. It will be centered on an assessment of the contribution of the health systems (supply side) and Social and Behavioral Change Communications (demand side) interventions to both maternal and child nutrition as well as maternal and child health.

Moreover, the evaluation will seek to assess contributing factors to the success or failure of the programme interventions, the adaptiveness/responsiveness of the programme, the child-centered aspect, and how the programme addressed gender, disability, and age vulnerabilities, including marginalization, and deprivation.

Geographic focus: The evaluation team will consider the 13 programme districts (Adjumani, Arua, Koboko, Maracha, Moyo, Nebbi, Pakwach, Yumbe, Zombo, Obongi, Madi Okollo, Terego and Arua City)

Institutional scope: While noting the multi-stakeholder dimensions, the evaluation will target the Government counterparts (both at national, regional and district levels), development partner (SIDA), the Implementing CSO partners (AVSI), other international non-governmental organizations and national civil society organizations supporting similar initiatives in West Nile. The Evaluation will labour to analyze the respective role the CSSP programme played in overall Health sector and the related expectations of stakeholders regarding the programme. Within CSSP – West Nile, the evaluation will assess interactions, coordination, roles and responsibilities, support from and expectations of SIDA.

Operational scope: The evaluation will assess the timeliness, and efficiency of delivery of the interventions; the quality and inclusiveness of internal collaboration and cohesion between UNICEF and WFP on operational aspects of programme planning and implementation; the relevance of financial modalities, governance and assurance procedures and measures introduced; and will reflect on operational opportunities, best practices, and challenges implementing the programme in West Nile.

METHODOLOGY

The end term/impact evaluation will aim to establish attribution of the implemented interventions to planned programme objectives, explaining the differentials by the level of attained health system and beneficiary outcomes. Attribution will be established by comparing results in the West Nile with that in the counterfactual districts. The evaluation will also establish the cost efficiency/effectiveness on health systems strengthening on the coverage, quality and utilisation of RMNCAH, nutrition and HIV/AIDS services.

A mixed methods approach will be utilized in order to generate clear and actionable evidence-based insights and learning on both the supply side and demand side of the interventions. The methodology will mirror that used during the baseline survey for comparison of the before and after and between the intervention and counterfactual districts. The baseline results will therefore form the main reference of this evaluation. The Quasi-experimental design, factored into the programme at the design stage, will be employed where the Difference in Difference (DiD) approach¹ will be used to understand the impact in the intervention and counterfactual districts as a result of the implementation of SIDA-UNICEF RMNCAH, and nutrition service interventions. Attribution will be established by comparing results in the West Nile with that in the counterfactual districts.

¹ DiD is an evaluation method used in non-experimental settings. The goal of this method is to estimate the causal effects of a program when treatment assignment is non-random; hence, there is no obvious control/counterfactual group

The counterfactual districts were selected based on their refugee status, refugee population, neighboring a refugee hosting district, health facilities registered as per DHIS2, DHSS progression score, district performance based on MOH Annual Health Sector performance that among others looked at coverage of health services (ANC, ART, Immunization), maternal and child morbidity and mortality, and HMIS reporting rates. An exact or close match of the intervention with a corresponding counterfactual district was done using at least two of the variables mentioned above with a priority given to the refugee status, health sector performance, and DHSS progression score. These variables are considered primary to this evaluation. It was possible to find closely related matches on more than three variables for 6/11 districts. The inability to find perfect matches for all districts presents a limitation, but this will potentially be addressed by including matching variables as control variables in the analysis to control for any confounding influence on the evaluation outcomes. In order to facilitate comparisons, the end-term and impact evaluations should draw from the evaluation matrix of indicator variables (see Annex 2).

The approach to assessing the differences and the associated factors of the change in maternal and child nutrition from 2019 to 2024 between the intervention and counterfactual districts will reference baseline values for maternal and child health and nutrition.

The main outcome of interest for this specific objective is change in maternal and child health and nutrition indicators as defined in the evaluation matrix (see Annex 2.) between 2019 to 2024. The change in maternal and child nutrition indicators will be computed for each district and compared initially between the matched intervention and counterfactual district. Group comparisons will be made to allow comparisons of the changes between refugee hosting and non-hosting districts in either the intervention or counterfactual arm.

The main explanatory variables under consideration are all the health systems and beneficiary outcomes i.e. coverage, Utilization, quality of care and health seeking behavior; and the level of health systems strengthening as measured by the DHSS progression model score.

Difference-in-difference (DID) approach, which will measure the differential outcomes between estimates in treatment districts and the counterfactual districts at baseline and end-term (double difference). This approach effectively factors out all pre-existing differences between the two groups so as to be able to assess the impact of the HSS interventions. A multivariable regression approach for the difference in difference analysis will be undertaken to control for other factors. Where the outcome is binary logistic regression will be applied while linear regression will be used where it is continuous quantitative data. Tests for the significance of the trends using different methods, for instance Chi-square.

To evaluate the economic benefit of the incremental critical funding for health systems on targeted maternal and child health and maternal and child nutrition outcomes, the evaluation will document itemised funding given to the West Nile sub-region districts and how it has affected the targeted RMNCAH, HIV & Nutrition outcomes.

Qualitative methods will include Key Informant Interviews and Focus group discussions across a wide range of stakeholders. More specifically, the key informant interviews will be used with policymakers, government officials, program managers, community leaders, beneficiaries with knowledge on the research topic. KIIs will be semi-structured or structured interviews that follow a predetermined set of questions while allowing flexibility for probing and exploration. They will be conducted mostly face-to-face. The use of KIIs will help provide an opportunity to delve deeply into specific issues and obtain detailed information from knowledgeable sources. Focus group discussions will be conducted with homogeneous groups of participants who share common characteristics or experiences in which shared perceptions, attitudes, beliefs, or experiences related to the research topic will be discussed. Validation and

Triangulation of insights obtained from KIIs and FGDs across various stakeholder groups will enhance the credibility and validity of the findings.

Sampling

The same sampling procedures (for both qualitative and quantitative methods) as those used at the baseline for consistence comparison over time and between the intervention and counterfactual districts. (to be outlined in the inception report).

DELIVERABLES AND TIMELINES

Activity	Deliverable	Timeline
<u>Preparatory phase</u>		
<ol style="list-style-type: none"> 1. Understanding the TOR- Review of baseline evaluation and other reports and seeking any required clarity 2. Preliminary stakeholder analysis 3. Preparation for the inception phase 		1 weeks
<u>Inception phase</u>		
<ol style="list-style-type: none"> 1. 1-week inception mission 2. Preparation of draft inception report) 3. Engagement with stakeholders on inception report 4. Finalization of inception report 	<ul style="list-style-type: none"> • Draft inception report. • Presentation of the draft inception report – in person to the Evaluation Reference Group. • Final inception report (plus completed audit trail addressing all comments) 	3 weeks
<u>Data collection phase</u>		
<ol style="list-style-type: none"> 1. Preparation for data collection 2. Mission to collect data 3. Preparation of interview reports 4. Population of evaluation matrix 5. Preparation and delivery of emerging findings 	<ul style="list-style-type: none"> • Presentation of preliminary findings at a workshop with key evaluation stakeholders, including the Evaluation Reference Group 	4 weeks
<u>Drafting, validation and completion phase</u>		
<ol style="list-style-type: none"> 1. Data analysis and drafting 2. Engagement with stakeholders on draft report 3. Finalization of report and summary 	<ul style="list-style-type: none"> • PowerPoint presentation – on emerging findings, conclusions and recommendations • A complete first draft evaluation report. • Presentation of the draft evaluation report– to the CSSP stakeholders, Evaluation Reference Group. 	3 weeks

	<ul style="list-style-type: none"> A final evaluation report (plus completed audit trail addressing all comments) should be between 40-60 pages 	
<u>Dissemination and Advocacy</u>	<ul style="list-style-type: none"> Evaluation Policy brief PPT Presentation of the findings, conclusions and recommendations at a workshop with key evaluation stakeholders 	1 weeks
TOTAL		12 weeks

PROPOSED PAYMENT SCHEDULE

Payment will be as per below schedule and upon submitting Invoices with evidence of completed works:-

Deliverables	Delivery Date	Payment
<u>Inception phase</u>		
1. Final inception report (plus completed audit trail addressing all comments)	<ul style="list-style-type: none"> 4 weeks after signature of contract 	30% of agreed amount
<u>Drafting, validation and completion phase</u>		
2. A draft evaluation report	<ul style="list-style-type: none"> 9 Weeks after signature of contract 	40% of agreed amount
3. <u>Final Evaluation Report</u>	<ul style="list-style-type: none"> 11 weeks after signature of contract 	30% of agreed amount
4. <u>Policy Brief</u>		
5. <u>PPT on key Findings & Recommendations</u>		
<u>Total amount</u>		100%

Content of technical proposals

The Evaluation is **The Child Sensitive Social Protection (CSSP) Programme in West Nile**. It is a 5-year (2019-2024), USD 50 million programme funded by the Swedish International Development Cooperation Agency (SIDA) and is jointly implemented by WFP in partnership with UNICEF and the Government of Uganda, through the Office of the Prime Minister's (OPM), the Ministry of Gender, Labour and Social Development (MLGSD), Ministry of Health (MoH), and Ministry of Local Government. The programme covers the 13 districts of West Nile namely (Adjumani, Arua, Koboko, Maracha, Moyo, Nebbi, Pakwach, Yumbe, Zombo) including the two newly carved out districts of Madi-Okollo (from Arua 2019) and Obongi (from Moyo 2019).

Key stakeholders	Roles and responsibilities
SIDA	Funding and oversight

WFP	Grant manager for the United Nations Joint Programming (UNJP) and leads in annual planning, monitoring and financial reporting. Implementer of the Social protection component of the CSSP project.
UNICEF	Implementer of the HSS component of the CSSP programme
OPM	OPM chairs the UNJP steering committee that guides the UNJP throughout implementation.
The Ministry of Gender, Labour and Social Development (MGLSD)	In charge of the national social protection framework. MGLSD is the main partner with respect to tools, systems and standards that increase social protection integration.
MoH	Responsible for overseeing and managing the health systems strengthening component of CSSP
Ministry of Local Government	Responsible to deliver health services at the district level. System strengthening activities are implemented in close collaboration with the District Local Government.

The main objective of the Child Sensitive and Social Protection programme in the West Nile region of Northern Uganda is to achieve improved community and household resilience among host and refugee populations in refugee-hosting districts of West Nile². To address the multiple deprivations in the West Nile region, the programme targets the enhanced economic inclusion of households; improved maternal and child nutrition; and improved maternal and child health.

The programme is structured into three components, each with several subcomponents:

- i. Support to social protection systems, providing household transfers, strengthening national cash-transfer mechanisms, and strengthening national beneficiary identification and assistance management systems (WFP).
- ii. A comprehensive health and nutrition package including health systems strengthening (i.e., enhancing management capacity at the district level, quality of care at the facility level, strengthening referral linkages and behavioural change communication) as well as systems support to the provision of health and nutrition services (i.e., support to supply chain management for nutrition and RMNCAH services) (UNICEF)
- iii. Finally, a component addressing cross-cutting aspects, including strong linkages with existing programmes, strengthening local retail markets, strengthening national systems for feedback and complaints, and operational research (UNICEF/WFP).

The Theory of Change (ToC) for the Child Sensitive and Social Protection programme identifies critical inputs into social protection, markets, health and community systems that will stimulate the efficiency and transparency of the social protection systems, as well as that of nutrition and health systems. Improvements in the latter areas are, in turn, anticipated to contribute to more secure incomes, improved access to markets and the dietary diversity, higher quality of health care and health seeking behaviour. The beneficiary and health system goals are anticipated to result into the improved economic inclusion of households, improved maternal and child health and nutrition, which should lead to the attainment of the overall programme objective of improved community and household resilience for both the host and refugee populations. The diagrammatic illustration of the ToC can be found in Annex 1.

The UNJP for West Nile was developed during implementation of the 2016-2020 UNICEF Uganda Country Programme. In January 2021, UNICEF started implementing the 2021-2025 Country programme. In the health sector, the country programme is operationalizing the UNICEF 2030 Health Strategy with a strong focus on strengthening health systems to deliver results for children and a strategic prioritization for the most vulnerable children. The Country Program's overall goal is to support national efforts and strategies to accelerate the realization of children's rights and progress towards achievement of the sustainable development goals for children, in line with agenda 2063 for Africa. The Country Program is aligned to NDPIII and the National Health Sector Strategic Plan. UNICEF is offering expertise and influence on the UNJP for the realization of children's rights; leveraging financing for children; supporting child rights-based policies; shaping markets and promoting equitable access to essential supplies and services; brokering

² Child-Sensitive Social Protection in Refugee-Hosting Districts of West Nile, Uganda – Programme Document – June 2019.

partnerships for children and influencing social behaviours and norms. UNICEF outcomes relate to health, nutrition, WASH, and social protection, in terms of increasing access and utilization.

To achieve objectives linked to component 2 of the program, UNICEF employs the following Key strategies and interventions.

District Level: Enhance management capacity.

- Train DHT members in bottleneck analysis for planning and budgeting
- Strengthen HMIS (data collection, analysis and use)
- Performance reviews and district and regional levels
- Supportive supervision, mentorship and coaching to health facilities.
- Functionalization of the human resource information system (iHRIS)
- Support stakeholder coordination
- support annual DHSS assessments using the progression model.

Facility level: Improve quality of care.

- Functionalization of health unit management committees
- Training of health care workers in various aspects of RMNCAH, data management and use
- Provision of basic equipment, essential medicines, and supplies
- Repair of selected health facilities, set up of neonatal intensive care units (NICUs) and maternal high dependency units (HDUs)
- Functionalization of Health Center IVs in some districts to provide CEmNOC care service.
- Water, sanitation, and hygiene (WASH) improvements (installation of piped water systems, construction of sanitation facilities, bathrooms) at selected health facilities
- Monthly and quarterly health facility reviews and learning meetings.
- Conducting periodic data and service quality assessments and improvement (DQAIs) for RMNCAH services
- Conducting annual client satisfaction/exit interviews to determine quality of care gaps and plan for quality improvement measures.
- Implementation of annual health facility quality assurance program (HFQAP) assessments

Community level: Strengthen referral linkages and support behavioral change communication.

- Training of village health teams (VHTs) in various aspects of RMNCAH and supporting them to deliver on their mandate.
- Supporting integrated community outreaches for hard-to-reach populations
- Implementation of Family Connect, a digital health solution for increasing uptake of maternal and child health services.
- Supporting the community boda boda (motorcycle taxis) referral system of pregnant mothers and children in hard-to-reach communities in some districts
- Conducting quarterly community dialogue meetings on various aspects of RMNCAH services
- Supporting quarterly meetings between health facility staff and community health workers
- Facilitation of the VHT peer supervisors for monthly data compilation to support reporting at community level.

MANAGEMENT & OVERSIGHT
A designated focal point within UNICEF Uganda will provide technical advice as and when required

CONDITIONS OF WORK
This contract will be for a period of six months with key tasks delivered within a 3-month period. The consulting team can work remotely with a field missions that can be agreed upon with all parties.

CRITERIA FOR EVALUATION – INSTITUTIONS

TECHNICAL CRITERIA	POINTS TO CONSIDER	MAX POINTS
Overall Response	<ul style="list-style-type: none"> ✓ Completeness of response ✓ Overall concord between TOR/needs and proposal 	5
Company profile	<ul style="list-style-type: none"> ✓ Profile of company and experience on similar projects ✓ Client references ✓ Previous UNICEF contracts and duration ✓ Number of customers, size of projects, number of staff per project 	15
Key Personnel	<ul style="list-style-type: none"> ✓ Range and depth of organizational experience with similar projects ✓ Samples of previous work ✓ Number of customers, size of projects, number of staff per project ✓ Client references ✓ Key personnel: relevant experience and qualifications of the proposed team for the assignment ✓ Company policy on Child labor, Safeguarding and Prevention of Sexual Exploitation and Abuse (articulate policies for the protection & safeguarding of children and prevention of PSEA) – mandatory. 	25
Proposed Methodology and Approach	<p>Proposed Methodology and Approach</p> <ul style="list-style-type: none"> ✓ Work plan showing detail sampling methods, project implementation plan in line with the project ✓ Project management, monitoring and quality assurance process. ✓ Innovation approaches (With less impact to the Environment) ✓ Gender and disability considerations ✓ Organization commitment to Sustainability (Please provide details (including and targets and achievements) of your organization's sustainability management policy, management system to control sustainability issues. e.g., Environmental Management System, Social Accountability e.g., your 	25

	contribution to local community etc.) that covers the service required.	
TOTAL SCORE		70
Minimum score for technical evaluation		50

EVALUATION COMPONENT	WEIGHT
TECHNICAL	70
FINANCIAL	30

1.8. Annex 8: List of interviews conducted

The below table is a list of interviews conducted during the endline data collection.

No.	Category	Method	Actual			Gender	
			Intervention (West Nile)	Counter-factual	Total	Male	Female
1	DHT Members	KII	05	03	08	4	4
2	Hospital Staff	KII	01	02	03	1	2
3	Hospital Board Members	KII	04	00	04	3	1
4	HC IV Staff	KII	01	03	04	2	2
5	HC III Staff	KII	03	01	04	2	2
6	HC II Staff	KII	03	02	05	4	1
7	HUMC	KII	02	01	03	2	1
8	PLHIV Networks Peer Mentors - Adolescents	KII	01	00	01	0	1
9	Boda boda riders	KII	01	00	01	1	0
	Sub total		21	12	33	19	14
1	VHT	FGDs	05	01	06	16	20
2	Mothers	FGD	05	01	06	0	36
3	Fathers	FGD	01	01	02	16	0
4	Adolescents	FGD	04	02	06	13	19
	Sub total		15	05	20		
1	UNICEF		03		00	2	1
2	Implementing Partners		06		00	2	4
	Subtotal		00		00	49	80
	Grand Total		36	17	53	68	94

1.9. Annex 9: Sample of Health Facilities across the West Nile Region

District	Health facility	Level
Adjumani	Adjumani HOSPITAL	Hospital
Adjumani	Mungula HC IV	IV
Adjumani	Alere HC III	III
Adjumani	Ayiri HC III	III
Adjumani	Openzinzi HC III	III
Adjumani	Pakele HC III	III
Adjumani	Robidire HC III	III
Adjumani	Ukusijoni HC III	III
Adjumani	Adjugopi HC II	II
Adjumani	Adjumani Arra HC II	II
Adjumani	Adjumani Police HC II	II
Adjumani	Ajeri HC II	II
Adjumani	Bira HC II	II
Adjumani	Elema HC II	II
Adjumani	Maaji B HC II	II
Adjumani	Olia HC II	II

Adjumani	Opejo HC II	II
Adjumani	Zoka HC II	II
Arua	Arua REGIONAL REF HOSPITAL	Referral Hospital
Arua	Kuluva HOSPITAL	Hospital
Arua	Oriajini HOSPITAL	Hospital
Arua	Pioneer Hospital	Hospital
Arua	Rhema Hospital	Hospital
Arua	Adumi HC IV	IV
Arua	Omugo HC IV	IV
Arua	River Oli HC IV	IV
Arua	Ajia HC III	III
Arua	Arua Prison HC III	III
Arua	Ayivuni HC III	III
Arua	Bileafe HC III	III
Arua	Bondo HC III	III
Arua	Logiri HC III	III
Arua	Ofua HC III	III
Arua	Oluko Solidale HC III	III
Arua	Pajulu HC III	III
Arua	Riki HC III	III
Arua	Siripi HC III	III
Arua	Vurra HC III	III
Arua	AIC Arua Main Branch CLINIC	II
Arua	Arua Marie Stopes HC II	II
Arua	Arua Reproductive Health HC II	II
Arua	Ayayia HC II	II
Arua	Masjid Noor HC II	II
Arua	Ndaapi HC II	II
Arua	Obofia HC II	II
Arua	Oreku HC II	II
Arua	Tuku HC II	II
Arua	Uganda Military HC II	II
Koboko	Koboko Hospital	Hospital
Koboko	Dricile HC III	III
Koboko	Koboko Mission HC III	III
Koboko	Lobule HC III	III
Koboko	Bamure HC II	II
Koboko	Koboko Police Barracks HC II	II
Koboko	Kuluba HC II	II
Koboko	Pamodo HC II	II
Madi-Okollo	Rhino Camp HC IV	IV
Madi-Okollo	Inde HC III	III
Madi-Okollo	Offaka HC III	III
Madi-Okollo	Olujobo HC III	III
Madi-Okollo	Pawor HC III	III
Madi-Okollo	Akino HC II	II

Madi-Okollo	Odraka HC II	II
Madi-Okollo	Ogoko HC II	II
Maracha	Maracha HOSPITAL	Hospital
Maracha	Maracha HC IV	IV
Maracha	Kijomoro HC III	III
Maracha	Ovujjo HC III	III
Maracha	Tara HC III	III
Maracha	Wadra HC III	III
Maracha	Curube HC II	II
Maracha	Liko HC II	II
Maracha	Odupiri HC II	II
Moyo	Moyo HOSPITAL	Hospital
Moyo	Dufile HC III	III
Moyo	Eria HC III	III
Moyo	Lefori HC III	III
Moyo	Moyo Mission HC III	III
Moyo	Afoji HC II	II
Moyo	Cokwe HC II	II
Moyo	Gbalala HC II	II
Moyo	Gbari HC II	II
Moyo	Lama HC II	II
Moyo	Munu HC II	II
Moyo	Panyanga HC II	II
Nebbi	Angal St. Luke HOSPITAL	Hospital
Nebbi	Nebbi Hospital	Hospital
Nebbi	Akworo HC III	III
Nebbi	Jupanziri HC III	III
Nebbi	Kalowang HC III	III
Nebbi	Kucwiny HC III	III
Nebbi	Padwot Midyere HC III	III
Nebbi	Jupangira HC II	II
Nebbi	Kituna HC II	II
Nebbi	Ossi HC II	II
Nebbi	Pagwata HC II	II
Obongi	Obongi HC IV	IV
Obongi	Itula HC III	III
Obongi	Luru HC III	III
Obongi	Palorinya HC III	III
Obongi	Iboa HC II	II
Obongi	Lomunga HC II	II
Obongi	Malanga HC II	II
Obongi	Palorinya Health Post HC II	II
Pakwach	Pakwach HC IV	IV
Pakwach	Alwi HC III	III
Pakwach	Pakwach Mission HC III	III
Pakwach	Wadelai HC III	III

Pakwach	Dei HC II	II
Pakwach	Noah'S Medical Clinic	II
Pakwach	Nyariegi HC II	II
Pakwach	Paroketo HC II	II
Pakwach	Ragem HC II	II
Yumbe	Yumbe Hospital	Hospital
Yumbe	Midigo HC IV	IV
Yumbe	Yumbe HC IV	IV
Yumbe	Bangatuti Health Centre HC III	III
Yumbe	Bidibidi Health Centre HC III	III
Yumbe	Igamara Health Centre HC III	III
Yumbe	Kochi HC III	III
Yumbe	Kulikulinga HC III	III
Yumbe	Lodonga HC III	III
Yumbe	Luzira Health Centre HC III	III
Yumbe	Matuma HC III	III
Yumbe	Swinga Health Centre HC III	III
Yumbe	Yayari Health Centre HC III	III
Yumbe	Yoyo HC III	III
Yumbe	Abiriamajo HC II	II
Yumbe	Goboro HC II	II
Yumbe	Kerwa HC II	II
Yumbe	Lokpe HC II	II
Yumbe	Okubani Health Centre HC III	II
Yumbe	Okuyo HC II	II
Yumbe	Pajama HC II	II
Zombo	Nyapea HOSPITAL	Hospital
Zombo	Alangi HC III	III
Zombo	Jangokoro HC III	III
Zombo	Pakadha HC III	III
Zombo	Warr HC III	III
Zombo	Amwonyo HC II	II
Zombo	Atyak HC II	II
Zombo	Padea HC II	II
Zombo	Paidha Medical Clinic	II
Zombo	Papoga HC II	II

1.10. Annex 10: Sample of health facilities across the counterfactual districts

District	Health facility	Level
Amuru	Bira	HC II
Amuru	Labongogali	HC II
Amuru	Odokonyero	HC II
Amuru	Okunggedi	HC II
Amuru	Otici	HC II

Amuru	Parabongo	HC II
Amuru	Lamogi	HC III
Amuru	Olwal	HC III
Amuru	Otwee	HC III
Amuru	Pabbo	HC III
Amuru	Atiak	HC IV
Isingiro	Eyeitu Medical Centre Clinic	Clinic
Isingiro	Birunduma	HC II
Isingiro	Buhungiro	HC II
Isingiro	Burungamo	HC II
Isingiro	Busheka	HC II
Isingiro	Jon	HC II
Isingiro	Kagaaga	HC II
Isingiro	Katembe	HC II
Isingiro	Migyera	HC II
Isingiro	Murema	HC II
Isingiro	Rurongo	HC II
Isingiro	Rwetango	HC II
Isingiro	St. Luke Kisyoro	HC II
Isingiro	Kanywamaizi	HC III
Isingiro	Kasana	HC III
Isingiro	Kikagate	HC III
Isingiro	Kyabirukwa	HC III
Isingiro	Mabona	HC III
Isingiro	Nyakitunda	HC III
Isingiro	Nyarubungo	HC III
Isingiro	Ruhiira	HC III
Isingiro	Rushasha	HC III
Isingiro	Kabuyanda	HC IV
Isingiro	Nyamuyanja	HC IV
Isingiro	Rugaaga	HC IV
Isingiro	Rwekubo	HC IV
Kamwenge	Bamwe	Clinic
Kamwenge	Medical Centre	HC II
Kamwenge	D.M Medical Centre	HC II
Kamwenge	Kabambiro	HC II
Kamwenge	Kimulikidongo	HC II
Kamwenge	Mugume Arinaitwe	HC II
Kamwenge	Reka Clinic	HC II
Kamwenge	Rwamwanja Medical Centre	HC II
Kamwenge	Bigodi	HC III
Kamwenge	Kamwenge	HC III
Kamwenge	Kyempango	HC III
Kamwenge	Maranatha NGO	HC III
Kamwenge	Rwamwanja	HC III
Kamwenge	Rukunyu	HC IV

Kikuube	Kisiiha	HC II
Kikuube	Kyehoro	HC II
Kikuube	Ngurwe	HC II
Kikuube	Bugambe	HC III
Kikuube	Buhuka	HC III
Kikuube	Bujugu	HC III
Kikuube	Kabwoya	HC III
Kikuube	Lucy Bisereko	HC III
Kikuube	Maratatu	HC III
Kikuube	Kikuube	HC IV
Kikuube	Kyangwali	HC IV
Kiryandongo	Diika	HC II
Kiryandongo	Kaduku	HC II
Kiryandongo	Panyadoli Hill	HC II
Kiryandongo	Yabwenge	HC II
Kiryandongo	Katulikire	HC III
Kiryandongo	Kigumba	HC III
Kiryandongo	Masindi Port	HC III
Kiryandongo	Mutunda	HC III
Kiryandongo	St. Mary's Kigumba	HC III
Kiryandongo	Kiryandongo	HOSPITAL
Kiryandongo	Restoration Gateway	Hospital
Kyegegwa	Casa Clinic	HC II
Kyegegwa	Community care clinic	HC II
Kyegegwa	Kyaka Domicilliary	HC II
Kyegegwa	Mpara Nursing Home	HC II
Kyegegwa	Pearl Medical Centre	HC II
Kyegegwa	Source of Life	HC II
Kyegegwa	St. Thomas medical Centre	HC II
Kyegegwa	Hapuuyo	HC III
Kyegegwa	Kazinga	HC III
Kyegegwa	Mpara	HC III
Kyegegwa	Wekomiire/ St. Thereza	HC III
Kyegegwa	Kyegegwa	HC IV
Kyenjonjo	Emmanuel Health Care	Clinic
Kyenjonjo	Katooke Health	Clinic
Kyenjonjo	Royal Doctors & Research	Clinic
Kyenjonjo	Kyankaramata	HC II
Kyenjonjo	Kyenjonjo Police Clinic	HC II
Kyenjonjo	Rwaitengya	HC II
Kyenjonjo	Villa Maria Kaihura	HC II
Kyenjonjo	Kataraza	HC III
Kyenjonjo	Kyakatara	HC III
Kyenjonjo	Kyembogo Holy Cross	HC III
Kyenjonjo	Nyamabuga	HC III
Kyenjonjo	Nyankwanzi	HC III

Kyenjonjo	St. Klaus	HC III
Kyenjonjo	St. Martins Mabira	HC III
Kyenjonjo	Kyarusozi	HC IV
Kyenjonjo	Midas Torch	HC IV
Kyenjonjo	Kyenjojo	Hospital
Lamwo	Katum	HC II
Lamwo	Lamwo	HC II
Lamwo	Ngomoroma	HC II
Lamwo	Okol	HC II
Lamwo	Lamwo Agaro	HC III
Lamwo	Lokung	HC III
Lamwo	Padibe West	HC III
Lamwo	Palabek-Kal	HC III
Lamwo	Madi-Opei	HC IV
Lamwo	Padibe	HC IV
Masindi	Biizi	HC II
Masindi	Katasenywa	HC II
Masindi	Kirasa	HC II
Masindi	Masindi St. Gude Clinic	HC II
Masindi	Ntooma	HC II
Masindi	Nyamigisa	HC II
Masindi	Police Training School	HC II
Masindi	Kibwona	HC III
Masindi	Kimengo	HC III
Masindi	Kyatiri Mary Mother of The Church	HC III
Masindi	Ngomokwe Nursing Home	HC III
Masindi	Nyakitiibwa	HC III
Masindi	Pakanyi	HC III
Masindi	Supreme Medical Centre	HC III
Masindi	Bwijanga	HC IV
Masindi	Masindi Military/Army Barracks	HC IV
Masindi	Masindi	HOSPITAL
Ntungamo	Family Doctors	clinic
Ntungamo	Allied Health medical centre	Clinic
Ntungamo	Happy Health Insurance Scheme	HC II
Ntungamo	Kafunjo	HC II
Ntungamo	Kibeho	HC II
Ntungamo	Kihanga Medical Centre	HC II
Ntungamo	Kyamwasha	HC II
Ntungamo	McNeil Medical Centre	HC II
Ntungamo	Ntungamo Nyabushenyi	HC II
Ntungamo	Ntungamo Police	HC II
Ntungamo	Rwanda	HC II
Ntungamo	Bwongyera	HC III
Ntungamo	Kayonza Ntungamo	HC III
Ntungamo	Nyakeera	HC III

Ntungamo	Ruhaama	HC III
Ntungamo	Rwabakunya Domiciliary Clinic	HC III
Ntungamo	Kitwe	HC IV
Ntungamo	Ntungamo	HC IV
Ntungamo	Rubaare	HC IV
Ntungamo	Rwashamaire	HC IV
Ntungamo	Itojo	HOSPITAL
Ntungamo	Doctors Referral	Referral Hospital
Nwoya	Coo-Rom	HC II
Nwoya	Kinene	HC II
Nwoya	Langol	HC II
Nwoya	Panokrac	HC II
Nwoya	Alero	HC III
Nwoya	Anaka	HOSPITAL

1.11. Annex 11: Ethical guidelines

Montrose employed appropriate research ethics in the implementation of this study by adhering to both 'UNEG ethical Guidelines for evaluations' and the 'UNICEF procedure for ethical standards in research, evaluation, data collection and analysis. Montrose endeavour to follow the guidelines of utility, independence, impartiality, credibility, honesty and integrity as outlined in the inception report and below.

1.11.1. Pre-data collection

- Montrose shall aim to promote social inclusion, particularly in the sampling and data collection phases of the assignment by ensuring that all categories of people e.g. women, adolescents, boda boda riders are included in the evaluation.

Montrose shall ensure that appropriate methodologies are tailored to the varying needs of the programme's stakeholders.

Following UNICEF approval of the evaluation approach and methodology, Montrose will submit the study protocol (methodology) and appropriate documentation to the IRB Committee to be considered for an expedited review, prior to data collection taking place in West Nile and counterfactual districts. If accepted, it is expected that approval will be granted by the Uganda National Council for Science and Technology (UNCST) within three to four weeks of the application being received.
- To ensure appropriate ethical considerations in administrative, technical and physical safeguards to protect the confidentiality of those participating in research and comply with codes protecting vulnerable groups and avoid harm, close to 80% of the data collection shall be done using electronic tablets. Data will be uploaded to a digital repository and will not be accessed without a password and username only known to the Statistical Technical Lead and the Montrose programme manager. Therefore, all identifiable data will be stored securely using encrypted, password-protected files, and anonymised data (removing participant names) prior to analysis. Enumerators shall be equipped with proper identification in the form of an identity card and a letter of introduction from UNICEF. All hard copy documents with participant confidential information shall be kept in a locked cabinet at the Montrose office with restricted access.

Furthermore, with respect to the 'Do No Harm Guideline', Montrose will incorporate a consent protocol before each FGD or Key Informant interview requiring each participant to consent to taking part in the research before any interview or discussion can take place. This information will be made available to UNICEF to put into practice the guidelines of justice and aid in redress.

- To ensure child safety, all enumerators shall undergo child protection training and sign a statement of commitment to Montrose’s safeguarding policy as confirmation that they will abide to while in the field. This policy, which underpins all methodological approaches implemented during data collection aligns with the Global and UN specific minimum standards for child protection. Montrose’s whistleblowing policy will also be adhered to and included in the statement of commitment that will be signed by the enumerators.

The training will cover but will not be limited to topics such as the categorisation of child abuse, child safeguarding/protection and procedures; recruitment, selection and engagement of personnel code of conduct; communication about children; standard whistleblowing/reporting procedures including reporting steps, and the information required when a report is being made and with whom the report should be filed; steps in conducting activities involving children; ramifications of misconduct; and assessment and management of child protection risk.

1.11.2. During data collection

Physical safeguards for those conducting research will be implemented. In keeping with other UNICEF regulations, Montrose shall ensure that due diligence checks are performed on all its service providers, and, the vehicle hire company, to reduce the risk of vehicle accidents. Additional risk reduction measures can be found in the risk matrix in Annex 5 of this report. Enumerators shall also be reminded to protect their property while in the field, including protection related to the COVID-19 pandemic.

- As previously mentioned, a consent protocol will be established prior to data collection. The intention of the research study, including the procedure of data cleaning and analysis, will be explained to participants prior to any interview or discussion. Participants will all sign a consent form to participate in the study. For children taking part in the study, consent will be obtained from the children’s parents or guardian to allow them to participate. Additional assent/affirmative agreement shall be obtained from the child prior to beginning the interview or assessment. If the child declines to participate, the interview is automatically stopped and saved. Enumerators shall be instructed to collect data in open, well-lit spaces under the supervision of a responsible adult, where possible.

The consent form will be written in English and verbally translated into local languages as appropriate. Participants who are illiterate will have the form read and explained to them. Completed consent forms will be scanned and stored by the senior Montrose team member responsible for data security and the hard copies disposed of. Any participant that no longer wants to be part of the study is free to withdraw at any point without fear. This will be clearly explained to all participants prior to any interview or discussion.

1.11.3. Post data collection

Data protection and secure maintenance procedures for personal information will be stringent. Montrose shall ensure that a master copy of all digital files (i.e., research data files, documentation, and other related files) is stored with the Montrose Statistical Technical Lead and the Programme Manager. All data collected shall be kept with the utmost confidentiality and will only be used by the data analyst and designated members of the evaluation team.

The research will remove any direct identifiers in the data and assign a unique project ID to each study participant which will also facilitate the linking of data sets. Once deposited, the data will undergo procedures to protect the confidentiality of individuals whose personal information may be part of archived data. These include: (1) rigorous review to assess disclosure risk, (2) modifying data if necessary, to protect confidentiality, (3) limiting access to datasets in which risk of disclosure remains high, and (4) conducting consultation to manage disclosure risk.

- The Statistical Technical Lead, who is experienced in disclosure risk management, will act as the steward for the data while it is being processed and analysed. The data will be processed and managed in a secure non-networked environment using virtual desktop technology.

1.11.4. Ethical Compliance

Ethical Approval: The development of the study protocol has included an internal review by UNICEF and ESARO. Subsequently, the protocol will be submitted for peer review to the Makerere University School of Public Health's Institutional Review Board (MakSPH IRB) and the Uganda National Council for Science and Technology (UNCST). The Principal Investigator has a current certificate on the protection of human subjects, which is a requirement of the MakSPH IRB.

Montrose adheres to both the 'UNEG ethical guidelines for evaluations' and the 'UNICEF procedure for ethical standards in research, evaluation, data collection and analysis' and, as a result, endeavours to ensure the following:

- **Utility:** Montrose has been contracted to design and implement a rigorous impact and economic evaluation and conduct a baseline of UNICEF's health system strengthening interventions summarised above, share findings and feedback, and prepare discussion papers on key issues identified.
- **Independence:** This research will be free of bias. Montrose consultants have been recruited and background checks completed to ensure total impartiality and ability to exercise independent judgement. Where such pressures may endanger the completion or integrity of the evaluation, the issue will be referred to the Montrose contact person at UNICEF.
- **Impartiality:** This research aims to give a comprehensive and balanced presentation of strengths and weaknesses of the programme, taking into consideration the views of a diverse cross-section of stakeholders. Montrose shall endeavour to operate in an impartial and unbiased manner at all stages of the evaluation, collect diverse perspectives and guard against distortion in reporting as a result of researcher personal views and feelings.
- **Credibility:** This research shall be credible as demonstrated through its evidence-base of reliable data and observations presented in the final report. The report shall show evidence of consistency and dependability in data, findings, judgements and lessons learned. Montrose shall endeavour to ensure that this research is accurate (to the level possible), relevant and provides a clear, concise and balanced presentation of the evidence, findings, issues, conclusions and recommendations. This, however, will take into consideration the safety and security of Montrose personnel while in the field as they collect the data required.
- **Conflicts of interest:** Conflicts of interest shall be avoided as far as possible so that the credibility of the research process and product shall not be undermined. Any conflicts of interest arising shall be disclosed to UNICEF and dealt with openly and honestly.
- **Honesty and integrity:** Montrose will employ honesty and integrity throughout the entire research process. This will also include but is not limited to the recruitment of Montrose staff and adherence to in-country laws and regulations.
- **Respect:** This research will ensure to respect participants' rights to provide information in confidence and ensure all participants are made aware of the scope and limits of confidentiality.
- **Dignity and diversity:** Montrose researchers and team will ensure to respect differences in culture, local customs, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity, and will be mindful of the potential implications of these differences when planning, carrying out and reporting on the programme.
- **Rights:** Montrose will ensure everyone participating in this review has the right to self-determination, where every participant will be treated with respect and given the time and information to decide whether or not they wish to participate and be able to make an independent decision without any pressure or fear of penalty for not participating.

- **Compliance with codes for vulnerable groups:** Montrose will ensure members of vulnerable groups such as children, refugees or ethnic minorities participating in this research will be protected through compliance with child protection policies and any laws governing interviewing children, young people and other vulnerable groups.
- **Redress:** Montrose will ensure that all stakeholders and participants in this research receive sufficient information to know how to seek redress for any perceived disadvantage suffered as a result of the research or the programme, and how to register a complaint concerning the conduct of the Montrose team.
- **Confidentiality:** Montrose shall respect people's right to provide information in confidence and make participants aware of the scope and limits of confidentiality. Montrose will ensure that sensitive information cannot be traced to its source so that individuals are protected from reprisals. Montrose shall employ the use of unique identification numbers for each participant to ensure discretion in the data collected.
- **Avoidance of harm:** Montrose shall seek to minimise risks to, and burdens on, those participating in the review and will seek to maximise the benefits and reduce any unnecessary harms that might occur without compromising the integrity of the evaluation.
- **Accuracy, completeness and reliability:** Montrose will ensure that all reports and presentations are accurate, complete and reliable.
- **Transparency:** Montrose shall clearly communicate to stakeholders the purpose of the study, the criteria applied and the intended use of findings.
- **Omissions and wrong-doing:** Where Montrose finds evidence of wrong-doing or unethical conduct, this shall be reported to UNICEF immediately and all evidence and actions taken to rectify the wrong-doing will be documented.
- **Beneficence:** Montrose shall ensure that actions done within evidence generating activities promote the well-being of individuals, communities or society as a whole. Any evidence generated will be conveyed back to the participants so that they may triangulate findings, contextualise their participation and potentially gain from the knowledge disseminated.
- **Non-maleficence:** Montrose shall ensure to do no harm, avoiding harm or injury to participants, both through acts of commission or omission.
- **Justice:** Montrose will ensure that due reflection is given to determining the appropriateness of proposed methods of selecting participants and selection shall not result in unjust distributions of the burdens and benefits of evidence generation on certain participant groups over others.

1.11.5. Quality assurance process

Quality assurance within Montrose

Montrose has an overarching Quality Management Policy covering beneficiary and client focus, leadership, engagement, process approach, improvement, evidence-based decision making and relationship management. Our corporate commitment to quality is evidenced through our progress towards full ISO 9000/9001 compliance.

Quality assurance within this assignment

Within this assignment, data collection tools will be developed using a participatory approach, with involvement of UNICEF and project staff to ensure they are quality and fit for purpose. Further, data collection tools will be pre-tested and reviewed during inception. The research team will be trained at the beginning of the baseline survey with follow up/refresher training as required. The data collection team will be comprised of Supervisors who will be supported to monitor and supervise the entire field data collection exercise. The Lead consultant will also closely supervise the other researchers and research assistants during data collection. The ODK data forms and stata V14 forms will be fitted with consistency and reliability checks to ensure high quality data collection and analysis. Filled data

collection tools will be reviewed, and errors and discrepancies addressed while still in the field. Quality assurance strategies will include keeping field diaries for recording any event deemed important in the interpretation of findings and recording most interviews and discussions to allow capture of all simultaneous responses verbatim. There will also be daily de-briefing among the research team in the field to share experiences and lay strategies for the way forward, check saturation and identify new issues for follow up.

Quality assurance and evaluation standards

The assignment will be conducted in line with the OECD DAC evaluation standards of relevance, efficiency, impact and sustainability. Our delivery will be aligned to core Montrose standards of sound financial management, quality assurance, and inclusion. We have rigorous policies in place and strict internal quality standards that ensure our evaluation approaches are aligned with United Nations Evaluations Group (UNEG) norms and standards, the UNICEF revised Evaluation Policy and UNICEF evaluation standards. In designing our evaluation approach, we have recognised the vulnerability of refugee populations and other marginalised groups and have incorporated a gender equity and human rights-based approach across our design.

Results framework for Child-sensitive social protection programme, Uganda

Programme element	Indicator	Means of verification	Key assumptions
Overall objective: Improved community and household resilience among refugees and host populations	Coping strategy index (livelihoods)	Household surveys	<ul style="list-style-type: none"> No major disruption during programme period such as major drought, massive new influx of refugees, serious and widespread conflicts, etc.
Specific objective 1: Improved economic inclusion of households	Average income for the poorest quintile of the population	Poverty surveys	<ul style="list-style-type: none"> No major disruption during programme period such as major drought, massive new influx of refugees, serious and widespread conflicts, etc. Other programmes such as NUSAF 3 and DRDIP are implemented as planned National budgets for health and social protection do not deteriorate No major epidemic
	Percentage of beneficiary households ¹ that have become economically independent from external support	Household surveys	
Specific objective 2: Improved nutrition	Prevalence of wasting in children 6-59 months of age ²	Localized DHS; reports from CHEW;	
	Prevalence of stunting in children 6-59 months of age		
	Prevalence of beneficiaries participating in nutrition counselling and training sessions No/Percentage of mothers practicing exclusive breastfeeding. No/Percentage of caregivers with increased knowledge on complementary feeding No/Percentage of beneficiaries who are advocating for appropriate infant and young child feeding. anaemia among children 6-59 months	Localized household survey	
Specific objective 3: Improved health	Rate of Maternal Mortality	UDHS	
	Teenage pregnancy rates	UDHS	

¹ All household-based indicators to be disaggregated by male / female // elderly head of household; as well as by sources of support (this programme, NUSAF 3, SAGE, DRDIP, other)

² All person-based indicators to be disaggregated by gender and age

	Rate of under-five mortality	UDHS	
Beneficiary level outcome 1: Increased or more secure incomes	Household income, alternatively as a proxy: Share of household income spent on food	Household expenditure surveys	<ul style="list-style-type: none"> ▪ No major disruption during programme period such as major drought, massive new influx of refugees, serious and widespread conflicts, etc. ▪ Other programmes such as NUSAF 3 and DRDIP are implemented as planned
	Coping strategy index (food)	Household surveys	
Beneficiary level outcome 2: Improved access to markets	Availability and price of food items for basic household needs	Market surveys (ideally being transformed into a standing market observatory)	<ul style="list-style-type: none"> ▪ No major price hikes for fuel and food ▪ No major drought or other harvest failure ▪ Road and storage infrastructure is improved as planned
	Proportion of beneficiary households with increased knowledge and where to access food items		
Beneficiary level outcome 3: Improved dietary habits of households	Percentage of beneficiary households with acceptable nutrition food consumption scores (FCS-Nutrition)	Household surveys	<ul style="list-style-type: none"> ▪ Other programmes become more nutrition sensitive ▪ No major price hikes for fuel and food ▪ No major drought / harvest failure
	and minimum dietary diversity scores	Household surveys	
Beneficiary level outcome 4: Improved access to quality health services	Number of pregnant women and children who utilised a transport voucher	Voucher data base	<ul style="list-style-type: none"> ▪ National budgets for health do not deteriorate
	Availability and implementation of the RMNCAH Quality of Care Standards for RMNCAH in UNICEF supported health facilities.	Facility Records	
	Institutional delivery rates	HMIS / UDHS	
	Number of children aged 6-59 months affected by SAM who are admitted into treatment	HMIS	
	Number of children aged 6-59 months who received (a) Vitamin A supplements in semester 1, (b) Vitamin A supplement in semester 2	HMIS	

	Number of primary caregivers of children aged 0-23 months who received counselling on IYCF	HMIS	
	Availability and implementation status of national guidelines and job aids for health workers on managing adolescent health/pregnancies.	Health Facility Records	▪
Beneficiary level outcome 5: Improved health seeking behaviour	Share of persons that attend a health facility when advised so by VCT	Community health management system?	▪ Other programmes become more nutrition and health sensitive
	Share of households that apply minimum sanitation and hygiene practices Share of beneficiaries attending counselling sessions with the VHTS and health workers in the health facilities Share of beneficiaries who visit the health facilities for routine services	Household surveys	
Systems level outcome 1: Better integrated, more efficient, transparent and nutrition-sensitive social protection systems and programmes	Share of beneficiary households that have been referred successfully to another programme	Analysis if BIAM / single registry data	▪ Other programmes are implemented as planned ▪ Other programmes become more nutrition sensitive
	Share of beneficiaries of all on-going programmes that are covered by a harmonised BIAM system that reduces gaps and overlaps	Analysis if BIAM / single registry data	
	Share of beneficiaries of all on-going programmes that are aware of their entitlements	Beneficiary surveys	
	Share of beneficiaries of all on-going programmes that report having received their entitlements as planned	Beneficiary surveys	
	Share of beneficiaries of all on-going programmes that report having increased their dietary diversity and habits.	Beneficiary surveys	
Systems level outcome 2: Better and more efficient health services	Percentage of weekly DHIS2 reports submitted on time and complete by all districts	Health facility records, HMIS, UDHS	▪ National budgets for health do not deteriorate ▪ No major epidemic

	# of districts with a one district annual operational plan		
	HSS: Number of districts in which barriers and bottlenecks related to child survival are monitored		
	O/IPTF specific data	HMIS	
	Outpatient New attendances	Health facility records, HMIS	
	Number of health facilities that provide SAM treatment services to children 6-59 months	HMIS	
	Reporting rate for HMIS facility level reports that include nutrition indicators	HMIS	
	Proportion of health facilities that experience stock outs of SAM treatment supplies (RUTF)	HMIS	

1.13. Annex 13: Risk matrix

Attached as a separate document

1.14. Annex 14: Child Sensitive Social Protection Uganda - Programme document

Attached as a separate document