# Inception Report

## Impact Evaluation of a UNICEF Cash Plus Intervention ("Stawisha Maisha - Nourishing Life" Programme)

**16 Jun 2023**

Submitted to UNICEF by Policy Research Solutions, EDI Global, and Empathea Consulting

## Contents

# 1. Introduction

This inception report summarizes activities conducted to date and plans for an evaluation (2023-2025) of Stawisha Maisha (Nourishing Life), formally an intervention which has graduated into a national program, delivered by the Tanzania Social Action Fund (TASAF) hand-in-hand with a government-implemented cash plus (or integrated social protection) program called the Productive Social Safety Net (PPSN). Stawisha Maisha aims to improve infant and child feeding practices with the ultimate goal of reducing child malnutrition in Tanzania. This intervention is an example of a gender-sensitive social protection program because it recognizes the barriers that women face, particularly as they relate to food and resource allocation during pregnancy (a vulnerable period in the life course), as well as women's barriers to acting in accordance to their preferences when it comes to antenatal care, feeding practices, and securing resources within the household for themselves and their children. Stawisha Maisha aims to address some of these barriers and empower pregnant women and caregivers through improving their social capital, self-efficacy, and related outcomes. The experimental, longitudinal, mixed method evaluation aims to examine to what extent and through what pathways Stawisha Maisha achieves these goals. The purpose of the inception report is to share the evaluation plans with UNICEF for their approval prior to commencement of additional phases of the evaluation.

The evaluation will be led by EDI Global, Empathea, and Policy Research Solutions, in collaboration with UNICEF Tanzania and the TASAF. The evaluation has been commissioned by UNICEF Tanzania.

The evaluation design is a cluster randomized controlled trial (cluster RCT), whereby 150 villages will be randomized into either control or treatment arms, and both arms will be interviewed using quantitative surveys at two rounds (baseline and endline). Endline surveys will be conducted approximately 13-14 months after baseline (and approximately 12 months after the intervention is rolled out). In addition to quantitative surveys, a sub-set of the study participants will be interviewed qualitatively using either in-depth interviews or focus groups. Contextual information will be collected via health facility and community questionnaires. Baseline surveys will allow the study team to test for statistical equivalence between study arms to determine whether the randomization was successful and whether the study has internal validity. Then, the endline surveys will allow us to compare changes in the control group to changes in the treatment group over time, which will allow us to make conclusions about impacts of Stawisha Maisha. To summarize, this evaluation is an experimental design comprised of baseline and endline surveys

and corresponding reports. In-depth study details being submitted to study registration entities and ethical review boards are provided in the Study Protocol Annex.

### 1.1. EVALUATION STAKEHOLDERS

The evaluation will provide Government and UNICEF, and PSSN beneficiaries with rigorous evidence on the ability of Stawisha Maisha to achieve its objectives. The evaluation stakeholders include TASAF, who implements the PSSN and Stawisha Maisha programs, as well as UNICEF, who provides technical assistance around these social protection programs. Findings from the evaluation can be used to assist TASAF in further adapting Stawisha Maisha and/or other cash plus programming in the future. Moreover, findings around radio messaging receipt can be used by TASAF to inform their modes of communication with TASAF participants.

### *1.2.* EVALUATION ACTIVITIES TO DATE *AND EMERGING ISSUES*

The Request for Proposal (RFP) was put out in October 2022 and the evaluation team submitted the proposal in November 2022. A contract between EDI Global and UNICEF was signed on 24th March 2023. Our proposal indicated that the team would need 18 weeks from signing of the contract and start of fieldwork training to conduct all inception and planning activities. However, we have had to condense that timeline, given that Stawisha Maisha implementation activities will commence in September. The evaluation team has thus condensed the timeline, taking into consideration the following parameters:

- Intervention activities will commence in September.
- Data collection will take 8 weeks and thus needs to start in early July to end by September (before program rollout)
- Ethical review takes approximately 8 weeks to secure and must be secured prior to data collection.
- Development of key indicators, study protocol, and quantitative and qualitative questionnaires need to be reviewed by TASAF and UNICEF and then revised according to feedback prior to finalization.
- The evaluation design needed to be designed according to implementation plans, which were as yet underdetermined at the start of the contract.

To date (March-May 2023), the evaluation team has conducted the following activities spanning Phase 1 and part of Phase 2 of the evaluation (described in more detail below):

- Held multiple meetings with UNICEF and TASAF to understand the components of the Stawisha Maisha intervention, program rollout options, and activities to inform evaluation design decisions.

- Developed the conceptual framework (theory of change)
- Revised the conceptual framework (theory of change) based on UNICEF and TASAF feedback.
- Agreed upon a randomized implementation approach to enable a cluster randomized controlled trial evaluation design.
- Discussed with UNICEF and TASAF to select target regions and districts for the evaluation.
- Analysed secondary data to determine prevalence of key outcomes to inform power analyses.
- Conducted power analyses to determine sample size needed to detect impacts through this evaluation.
- Worked with UNICEF and TASAF to develop a list of key indicators for the evaluation to measure.
- Developed quantitative questionnaires (household, community, health facility) and qualitative guides (interviews and focus groups) and submitted these to UNICEF and TASAF for review.
- Revised quantitative questionnaires and qualitative guides according to UNICEF and TASAF feedback.
- Developed corresponding consent forms.
- Translated all questionnaires, guides and consent forms from English to Swahili
- Developed a study protocol.
- Developed materials for ethical review submission.
- Submitted the protocol and materials for ethical review.

The following challenges/issues are being managed by the evaluation team:

Based on the condensed timeline for the aforementioned activities, available time for both 1) development of questionnaires and guides and 2) review/feedback of these items was limited. This increases the risk of omitting relevant questions/indicators from the baseline surveys and interviews.

Moreover, adherence to the above-referenced timeline for data collection is dependent upon securing ethical clearance and research permits by July 3, 2023. Ethical clearance can take approximately 6-8 weeks to secure. Any unforeseen delays in securing ethical approval would delay fieldwork and may run the risk of overlapping fieldwork activities with intervention activities. This is not ideal, as we aim to collect baseline data prior to intervention rollout. To mitigate this risk, we will apply for the expedited National Institute for Medical Research (NIMR) process, which may be obtained in less than a month. Additionally, we will apply for COSTECH approval. The approval process for COSTECH typically takes six weeks.

## 1.3. Background and Context of the Evaluation

Despite significant progress in human development and poverty reduction between 2018 and 2021 in Tanzania, poverty reduction has slowed in recent years. Rapid population growth and fall out from the COVID-19 pandemic have contributed to more than one million Tanzanians falling

below the national poverty level, with three in 10 children experiencing basic needs poverty, and one in 10 suffering from extreme poverty.

While stunting has significantly decreased nationally from 42% in 2010 to 34% in 2016 to 30% in 2022 (Ministry of Health et al., 2023), Tanzania still suffers from high levels of child malnutrition, with roughly 3 million children under the age of five experiencing stunting. Poverty, food insecurity, lack of access to water and good hygiene practices all contribute to malnutrition, which can lead to child mortality, disability, cognitive impairment, chronic disease, and reduced productivity across the life course. In this way, malnutrition perpetuates the persistence of poverty and poor health not only through an individual's lifespan, but across generations.

## 1.4. Social Protection in Tanzania

Nutrition and social protection policies are incorporated into the Tanzanian Government's five-year Development Plan III (2021-2025), including social protection programmes that are multi-sectoral and implemented by several ministries, departments, and agencies.

As part of the government of Tanzania's social protection strategy under the President's Office, the Tanzania Social Action Fund (TASAF) was established in 2010 and implements the Productive Social Safety Net (PSSN). PSSN is a large-scale social assistance programme (cash transfers and public works) in its second four-year phase (PSSN II, 2020-2023). PSSN II reaches 1.2 million beneficiaries in chronically poor households in 187 project authority areas (PAAs). UNICEF has supported complementary programming within PSSN I and PSSN II to improve nutritional outcomes.

## 1.5. Cash Transfers and Child Nutrition

There is strong evidence that cash transfers can improve many mediators of nutrition, including economic security, food security, healthcare visits, and productive activities (Bastagli et al., 2019; Davis et al., 2016; de Groot et al., 2017; Hidrobo et al., 2018; Owusu-Addo et al., 2018). However, the evidence on cash transfers and child nutrition status is mixed (Manley et al., 2022; Manley et al., 2020; Manley et al., 2013; Manley & Slavchevska, 2019).

In light of this mixed evidence, a cash plus approach, whereby cash is combined with complementary programming [for example, behaviour change communication (BCC) or linkages to existing services (Roelen et al., 2017), is often advocated. Social and behaviour change communication (SBCC), previously referred to as BCC in most studies, uses behavioural science-

based communication strategies to improve social norms, knowledge and attitudes of individuals, organizations and communities. The evidence on cash plus programmes, particularly in Africa, is still growing, and many initiatives have not been rigorously evaluated. A recent review and meta-analysis of this emerging body of work found that compared to cash transfers only, cash plus food transfers improved height-for-age, but cash plus BCC was not found to improve anthropometrics (Little et al., 2021). Nevertheless, only seven cash plus BCC studies were reviewed, and only three of these studies took place in Africa (one each in Niger, Kenya and Ethiopia). Thus, more evidence on the topic is urgently needed. The Stawisha Maisha pilot and evaluation aim to build on that body of evidence.

In Tanzania, between 2018 and 2019, UNICEF and TASAF piloted *Stawisha Maisha* Cash Plus programme, a cash plus intervention where the additional plus component layered on top of the government cash transfer program (Productive Social Safety Net, PSSN) – administered by the Tanzania Social Action Fund (TASAF)—was targeted to children 0-5 and aimed at enhancing their nutrition outcomes. The Stawisha Maisha I intervention was comprised of an in-person drama delivered at TASAF payment sites, small peer-led groups which met at the TASAF payment site that met in person on cash transfer days (six times per year). Groups of ten or more members operated both independently, led by a peer-chosen leader, and in clusters of three groups that jointly receive learning support from volunteers of the local TASAF Community Management Committee (CMC). A qualitative evaluation of the Stawisha Maisha I pilot found that the pilot was well received by participants, and that activities were successfully integrated into the social protection workforce. Moreover, the intervention increased Maternal, Infant and Young Child Feeding (MIYCF) knowledge among participants (Kajula, 2021). However, some challenges were identified, including an overbroad targeting approach which included many households without young children, low frequency of sessions, limited quality control of facilitation, and use of materials not appropriate for a largely illiterate population. Thus, Stawisha Maisha has been further adapted to address these challenges. However, the in-person drama component is costly to scale-up and the quality of implementation is difficult to ensure and monitor. Thus, for Stawisha Maisha, a radio broadcast was developed.

# 2. Intervention: Stawisha Maisha

The Stawisha Maisha intervention will **target mothers/primary caregivers from rural TASAF PSSN participating households that include under-five children**, with the primary aim of reducing nutritional stunting through improved maternal, infant, and young children feeding practices. Pathways to reach the desired change include operationalized knowledge, increased self-efficacy, peer support, and openness to learning and change; increased aspiration for self and child(ren); improved skills for planning and goal setting, problem-solving, and increased resilience in the face of challenges and setbacks. Changes to the intervention in its second phase include a plan for geographical expansion, the new eligibility criteria, and the modality of the new programme (i.e., via radios).

## 2.1. ELIGIBILITY CRITERIA FOR THE INTERVENTION

In the first stage of selection into the intervention, **villages** must fulfill the following eligibility criteria:

1) Be located in a rural area.
2) Have at least 9 PSSN households with a child aged under 5 years.

Next, at the **household level**, eligibility criteria are:

1) Participation in the PSSN II program
2) Has a child aged under 5 years?

Finally, at the **individual level**, eligibility criteria are:

1) Status as mothers or primary caregivers of child aged 5 years or under (including expecting mothers). Stawisha Maisha will also target, as a secondary group, adolescent girls to increase their knowledge in future parenting but also grandmothers/active senior women and fathers / grandfathers who have a role in young childrearing.

More than one eligible individual from a PSSN household can participate in Stawisha Maisha activities. Participation of more than one person per household will be promoted in small villages (that is, those with fewer than 22 eligible households per village). In larger villages, households will be encouraged to designate a group member and an alternate who can participate in activities when the designated group member is not available.

# 3. Overview of the Assignment and Objectives of the Evaluation

UNICEF has commissioned the research team (EDI Global, Empathea, and Policy Research Solutions) to conduct a rigorous impact evaluation of the recently redesigned *Stawisha Maisha* and in learning about the impacts of this initiative. **The purpose of the longitudinal mixed-methods impact evaluation of *Stawisha Maisha* is to:**

1. Improve the learning on synergies between social protection and maternal and child nutrition, in particular on integrating cash transfers and Social Behaviour Change (SBC) to improve MIYCF practices and access to nutritious food This will be accomplished through dissemination (nationally and internationally) of impact evaluation findings related to these outcomes.
2. Generate lessons learned to inform current and future programming. This will be accomplished through national dissemination of findings related to all outcomes.
3. Feed into the broader academic and policy debate at global level about the effectiveness of cash plus interventions aimed at reducing stunting and wasting among children 0-5 years. This will be accomplished through dissemination of impact evaluation findings related to stunting and wasting.

## 3.1. OBJECTIVES

**The overarching objectives of the impact evaluation of *Stawisha Maisha* are to understand:**

1. Understand whether an SBC component targeted to primary caregivers of 0-5 children and layered on top of a cash transfer program can improve MIYCF practices and in turn reduce stunting in the long term (*impact*)
2. Understand whether radios and/or the use of the Radio+ approach were effective means of communication[1] with PSSN beneficiary households to improve nutrition knowledge and outcomes and to further understand whether radio can be used for rollout of social and behavioural change on issues in addition to nutrition (*effectiveness*). This will be achieved through examining outcomes related to messaging and via key informant interviews with intervention implementers (TASAF staff) at endline.

[1] Disseminating reminders and new programme information.

The evaluation will be performed with an inclusive lens along the following criteria:

- **Human rights:** Article 1 of the Universal Declaration of Human Rights refers to equal dignity and rights. This evaluation will be comprised of a sample of participants of a government social protection program, which aims to reduce poverty and food security. Thus, the targeting of the intervention and evaluation are based on criteria related to improving equity among marginalized populations. Moreover, as detailed in the ethical considerations section of our study protocol (Appendix 3), we will adhere to Ethical Principles and Guidelines for the Protection of Human Subjects of Research as outlined in the Belmont Report. These include respect for dignity and diversity, right to self-determination, fair representation, and compliance with codes for vulnerable groups (i.e., adherence to ethical principles and procedure, do no harm, confidentiality and data collection).
- **Gender:** The intervention and evaluation activities and stakeholders recognize that, due to gender and social norms, women are often subject to structural constraints that impede their equal access to health, nutrition, and education (Holmes & Jones, 2013). In this way, the intervention is designed with the gender dynamics of the context in mind. To partially address economic and social risks and vulnerabilities created by these gender norms and existing structures, the intervention aims to empower women through increased self-efficacy and a sense of group belonging/participation. Both of these will be measured in the evaluation.
- **Disability:** We will measure disability of individuals (adults and children) in sample households using the validated Washington Group Measure. We will descriptively analyse these data; however, the sample will not have statistical power to detect differences by disability status (this would require a large sample size outside of the budget parameters).

## 3.2. RESEARCH QUESTIONS

The overarching research question to be answered by the accompanying impact evaluation **addresses how and to what extent *Stawisha Maisha* – a 'plus component' integrated in government structures within a cash transfer programme – affects nutrition outcomes of mothers and young children and their intermediate and underlying determinants**[2]. Impacts will not only be measured on nutrition outcomes but also across the results chain/nutrition impact pathway, and across different sectors including health, women's empowerment and so forth, based on the programme's ToC. This evaluation will also further investigate the effectiveness of radios as the main communication channel with PSSN beneficiaries and as an approach to rollout

[2] The 6–12-month follow-up may focus (depending on the time elapsed since the start of the SM II) mostly on output level impacts and effects on intermediate and underlying determinants of child nutrition and caretaker behaviour and knowledge rather than impacts on outcomes which may take longer to substantiate.

social and behavioural change on issues in addition to/other than nutrition. While these questions will only be responded at follow-up/s, the baseline will gather all necessary information to later estimate impacts of the intervention**. Key research/evaluation questions** are listed below, and how they map to indicators and evaluation domains are provided in the **Evaluation Matrix** (Appendix 2).

*Key Research/Evaluation Questions for Impact (what and how):*

1.1 Does Stawisha Maisha reduce stunting and wasting?
1.2 Does *Stawisha Maisha* improve MIYCF practices and diets, including exclusive breastfeeding, complementary feeding, and maternal diets during pregnancy?
1.3 Does *Stawisha Maisha* improve ECD outcomes?
1.4 Does *Stawisha Maisha* improve the knowledge of programme beneficiaries on MIYCF, including that related to exclusive breastfeeding, complementary feeding, dietary diversity, minimum meal frequency, vitamin A and iron rich foods, and recommended dietary practices during pregnancy?
1.5 Does *Stawisha Maisha* improve preconditions to achieving *Stawisha Maisha*'s nutrition-specific aims (or intermediate outcomes), including understanding of growth monitoring, peer support and group belonging, self-efficacy, social support, ability to plan and set goals, and openness to learning and change;
1.6 Does *Stawisha Maisha* improve household dietary diversity?
1.7 Does *Stawisha Maisha* improve women's empowerment?
1.8 What are the pathways through which *Stawisha Maisha* improves MIYCF knowledge and practices?

*Key Research/Evaluation Questions for Impact Effectiveness:*

2.1 What was the uptake and operational performance of the *Stawisha Maisha* cash plus programme?
2.2 Is the radio an effective way to communicate with PSSN beneficiaries? Do PSSN participants receive messages, notices or reminders from TASAF via radio?
2.3 Can the (Radio+) approach be used to rollout social and behavioural change on issues in addition to/ other than nutrition? Can the Radio+ approach be used to enhance community sessions?

The evaluation will also collect data on enabling factors and barriers to improving child nutrition beyond the SBC sessions (i.e., service availability and readiness for health services, care seeking practices, access to affordable foods, household sanitation and hygiene, etc.).

The intervention and evaluation objectives are related to the **following Sustainable Development Goals (SDGs)** and targets:

- SDG 2 Zero Hunger
    - **Target 2.2 End all forms of malnutrition**, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.
- SDG 5: Gender equality and women's empowerment
    - Target 5.4 Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and **social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate.**

In addition to relevance to the SDGs, this intervention and evaluation are aligned with the intent of the **Convention on the Rights of the Child (CRC),** specifically as it aims to support families and provide them with assistance to fully assume their roles within the community. In particular, Stawisha Maisha promotes full and harmonious development of children. The rollout of Stawisha Maisha is within the context of the PSSN, which addresses language in Article 4 of the CRC, namely related to economic rights, through its goals to reduce poverty and food insecurity. The intervention further respects the rights and duties of parents (Article 5), by supporting their learning and self-efficacy around providing nutrition foods to their children. Importantly, nutrition relates Article 6, which recognizes that every child has the "inherent right to life." The intervention in its entirety supports Article 24, which recognizes the "right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health." Finally, as the intervention is implemented within the PSSN, it supports Article 26, which states children have "the right to benefit from social security, including social insurance." The evaluation supports the rights outlined in the CRC by measuring the extent to which the intervention is successful in achieving its aims, aligned with the above-referenced rights.

The list of **key indicators** to be evaluated and what SDGs they map to are found in the Evaluation Matrix in Appendix 2. We hypothesize that Stawisha Maisha will improve outcomes listed on the indicator list. For example, that stunting and wasting will decrease, and that knowledge of feeding practices and nutrition will increase. Moreover, we hypothesize that the intervention will increase enabling factors such as caregivers' social support and self-efficacy.

# 4. Methodology

**4.**

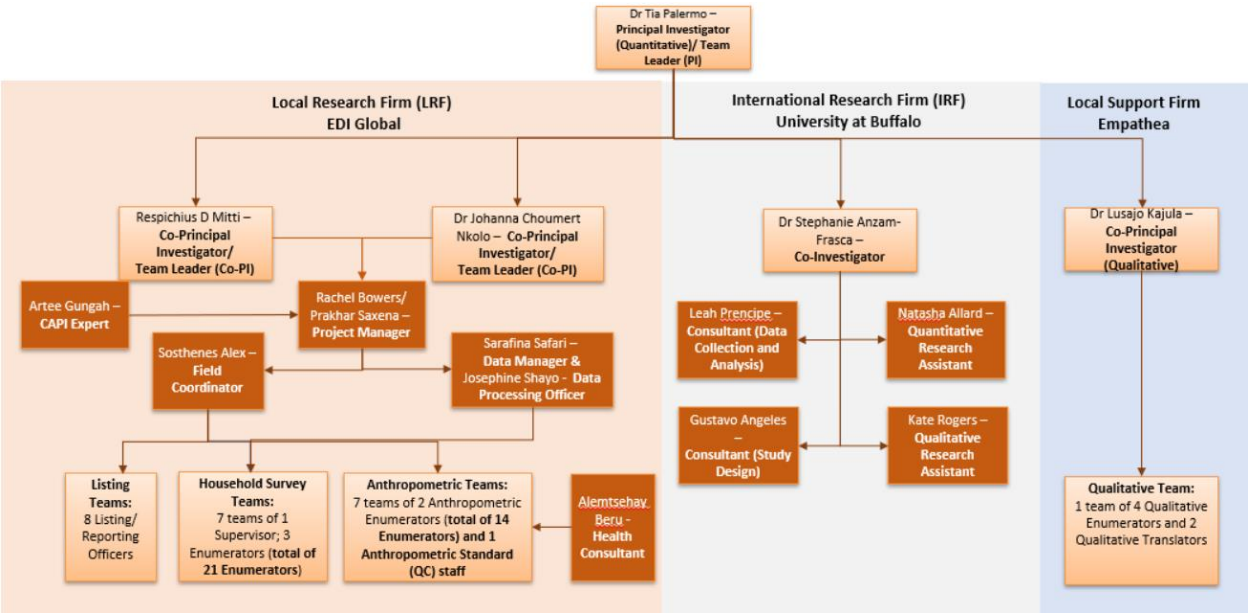
This impact evaluation follows an experimental design. We use the terms impact evaluation and research study interchangeably, as impact evaluation is one type of research study. The impact evaluation is comprised of two components: 1) baseline surveys and report and 2) endline surveys and report. Together, these comprise the impact evaluation and will allow us to determine impacts of the intervention.

## 4.1. TEAM

Overall responsibility for quality assurance and the timely delivery of all deliverables will be with the Team Leader (Principal Investigator), Dr. Tia Palermo (Policy Research Solutions). She will coordinate the communication between Policy Research Solutions team, EDI Global, Empathea and UNICEF. UNICEF, in turn, will be the main liaison with TASAF. Dr. Palermo will lead the development of study design, plans for data analysis, and oversee writing of the report and research brief. She will also support data collection training and observation of fieldwork (both to be led by EDI Global), along with her research assistants. EDI Global will lead all planning, logistics, and implementation of quantitative enumerator training and data collection. Empathea, under sub-contract to EDI Global, will lead all planning, logistics, and implementation of qualitative enumerator training and data collection. EDI Global will clean and prepare data for analysis and support Policy Research Solutions in analysis of data and drafting of the report and brief. Empathea will provide translated transcripts of qualitative interviews, lead coding and analysis of qualitative data, and support drafting of the report and brief.

Study team members at Policy Research Solutions, EDI Global, and Empathea will work closely together to ensure that the research questions, analysis, and findings reflect the collective knowledge to be obtained from both quantitative and qualitative methods. The organisations will work closely in the following activities: design and implementation of key phases of the evaluation, refinement of the theory of change, evaluation and sampling design, data collection protocols and instruments, securing ethical clearance, field procedures and quality control, data processing, estimation strategy, analysis, report writing, and dissemination. The research team structure is detailed in **Figure 1.**

**Figure 1: Team Structure**




The research team makes up a portion of the **Stawisha Maisha Evaluation Team**. The Evaluation team will be comprised of the research team together with representatives of UNICEF and TASAF and will be consulted on study design, will meet to review all draft reports (baseline and endline), and will participate in dissemination activities. In addition, the Evaluation Team will be acknowledged in all presentations and publications (including in peer-reviewed journals) utilizing data from the evaluation. The evaluation team is comprised of the following individuals:

**Policy Research Solutions:** Tia Palermo (co-Principal Investigator), Natasha Allard, Gustavo Angeles, Stephanie Anzman-Frasca, Leah Prencipe, Kate Rogers

**EDI Global:** Johanna Choumert Nkolo (co-Principal Investigator), Respichius Mitti (co-Principal Investigator), Rachel Bowers, Marie Mallet, Prakhar Saxena, Sosthenes Alex, Sarafina Safari, Josephine Donasian Shay

**Muhimbili University of Health and Allied Sciences (MUHAS) and Empathea:** Lusajo Kajula (co-Principal Investigator), Graca Marwarwe, Agatha Kiama, Agness Ignass, Anitha Mapunda

**Tanzania Social Action Fund:** Paul Luchemba, Tumpe Lukongo, Zuhura Mdungi

**UNICEF Tanzania:** Diego Angemi, Patrick Codjia, Tuzie Edwin Ndeki, Jennifer Matufu, Luisa Natali, Patricia Ruddy

The study team recognizes our obligations as evaluators, including independence, impartiality, credibility, the need to stay alert for conflicts of interest, and accountability in accordance with UNEG ethical standards. The research team will analyze data through an independent and impartial lens. Members of the evaluation team from UNICEF and TASAF will be consulted for interpretation and dissemination purposes. However, they will not determine whether negative or null findings are reported.

Moreover, we will follow **the norms and standards for Evaluation of the United Nations Evaluation Group (UNEG)**.

We will follow the **norms** as follows:

1. **Internationally agreed principles, goals and targets:** Indicators to be measured have been mapped to Sustainable Development Goals (SDGs)
2. **Utility:** findings from the intervention are intended to help adapt and improve future cash plus programming
3. **Credibility:** the study team is independent and impartial and will employ a rigorous methodology
4. Independence: the research team will employ behavioural independence and we have organizational independence from UNICEF and TASAF
5. **Impartiality:** The evaluation will be conducted in an impartial manner
6. **Ethics:** Belmont principles will be followed, and the study will be reviewed by ethics boards
7. **Transparency:** Evaluation products will be made publicly available, including reports, briefs and manuscripts.
8. **Human rights and gender equality**: these values will be respected, addressed and promoted as described in more detail below.
9. **National evaluation capacities:** two of the institutions which make up the research team (EDI and Empathea) are Tanzanian-based firms comprised of Tanzanian nationals.
10. **Professionalism:** the evaluation will be conducted with professionalism and integrity.
11. **Enabling environment:** this applies to UNICEF as the commissioning agency.
12. **Evaluation policy:** this applies to UNICEF as the commissioning agency.
13. **Responsibility for the evaluation function:** this applies to UNICEF as the commissioning agency.
14. **Evaluation use and follow-up:** Findings will be disseminated widely and UNICEF and TASAF will promote their uptake in future programming.

In addition, we will follow the standards for evaluation as follows:

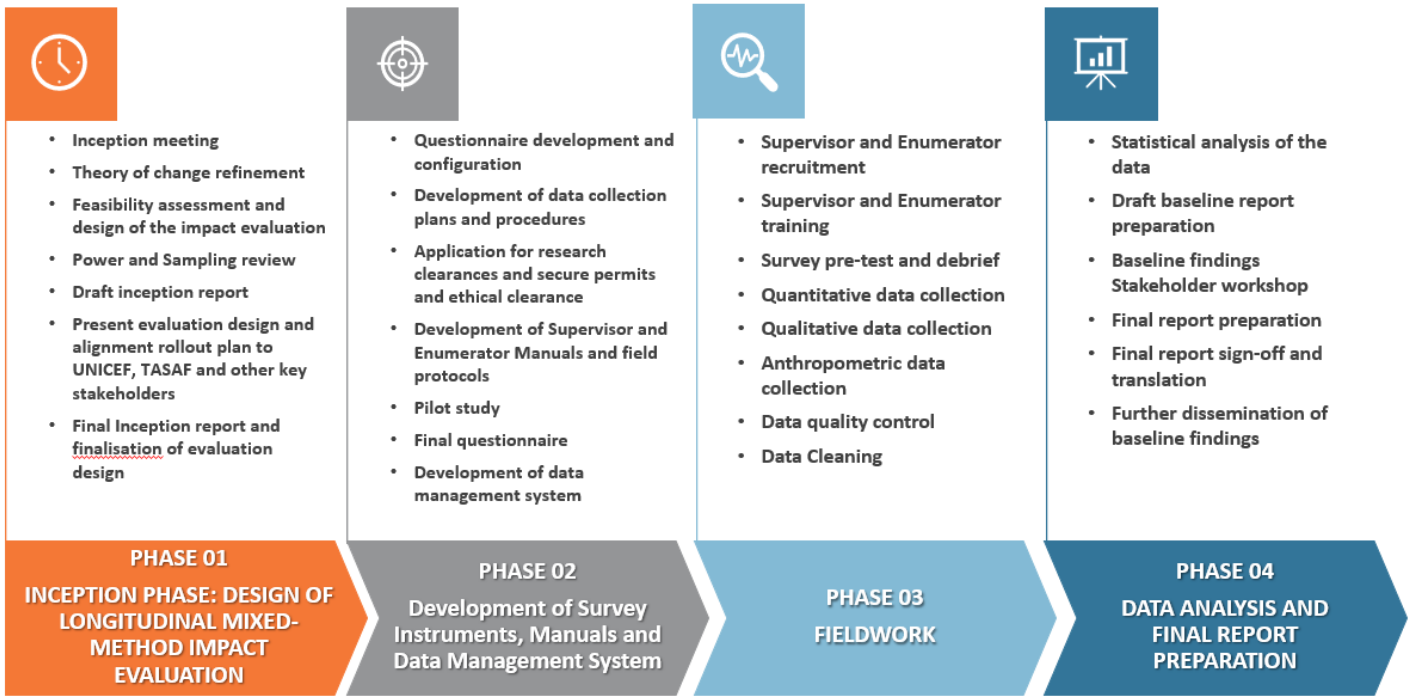
1. **Institutional framework:** this applies to UNICEF as the commissioning agency.
2. **Management of the evaluation function:** this evaluation is independent, follows evaluation guidelines, and contributes to national capacity.

3. **Evaluation competencies:** we will conduct high-quality work guided by professional standards and ethical and moral principles.
4. **Conduct of evaluations:** there is a clear rationale for the evaluation, and it will be conducted in a timely and cost-effective manner. The team has been selected in an open and transparent process, and reports and related materials will be used to widely disseminate findings.
5. **Quality:** quality of the outputs is supported by the team's experience and expertise and the rigorous evaluation design.

## 4.2. ACTIVITIES

The project will be carried out in four key phases outlined in Figure 2 with key activities. The activities are explained in detail in the subsequent sections.

**Figure 2: Key Activities**




## 4.3. PHASE 1: INCEPTION PHASE

### 4.3.1. THEORY OF CHANGE

The inception phase consisted of two main activities: 1) Refinement of the Theory of Change (ToC) for Stawisha Maisha; and 2) design of the mixed method longitudinal impact evaluation. This work was carried out by the research team through a series of meetings in March and April 2023 with UNICEF Tanzania and TASAF to gather information about Stawisha Maisha. Additionally, we

incorporated desk-based research on evaluations of cash plus programmes targeting nutrition. This was all done to finalize the impact evaluation design, which included sampling strategy, power calculations, design of procedures for sample selection (the actual sample selection will be conducted in July 2023 during fieldwork), and development of quantitative questionnaires and qualitative guides. Further details on the evaluation are provided in the Study Protocol (Appendix 3). UNICEF Tanzania, TASAF, and UNICEF's Evaluation Reference Group (ERG) will review this inception report and Study Protocol, and subsequently, the research team will make any additional changes required in accordance with feedback from these groups.

Research permits and ethical clearance are currently being sought from the Tanzania Commission for Science and Technology (COSTECH), the National Institute for Medical Research (NIMR), respectively. Ethical clearance is also being sought from the Institutional Review Board (IRB) at Policy Research Solutions. This is a secondary IRB review, and the IRB of record will be NIMR. Fieldwork for data collection can only commence once these clearances and permits are obtained.

The Theory of Change (ToC) in Figure 3 is a revision of the original ToC provided by UNICEF from Stawisha Maisha I. The Research team, TASAF, and the UNICEF team met, discussed, and extensively reviewed existing ToCs from the Transfer Project, LEAP 1000, and other evaluations of cash plus for nutrition (e.g., (Ahmed et al., 2019; de Groot et al., 2017) and related literature to inform revision of the ToC. Given the focus of Stawisha Maisha on SBCC, our revised ToC, along with intermediate outcomes to be measured quantitatively and qualitatively in the evaluation, are informed by SBCC theory. Measuring the effectiveness of communication components will allow us to elucidate the specific communication mechanisms that are necessary and sufficient to increase knowledge and spur behaviour change. By analysing message recall (of both the educational elements and the entertainment drama storyline) and attitudes about edutainment content, message delivery (including the elements of singing and group discussion), and message channel, we can better understand how to ensure that tailored educational content resonates and encourages maximum engagement and action. Many of these indicators related to communication and message recall will be collected at endline (after rollout of the intervention), and thus all intended questions are not applicable for baseline instruments.

Additionally, through our quantitative questionnaires, we will measure several proximate or pathway indicators (for example, knowledge, diet diversity, food security, etc.), given that distal outcomes such as stunting may take longer than the period of the evaluation to demonstrate changes. Key evaluation questions presented in the Terms of Reference (ToR) helped to refine

questions in the evaluation that are relevant for UNICEF's understanding of the impact of Stawisha Maisha on child and health nutrition. These key evaluation/research questions included the following:

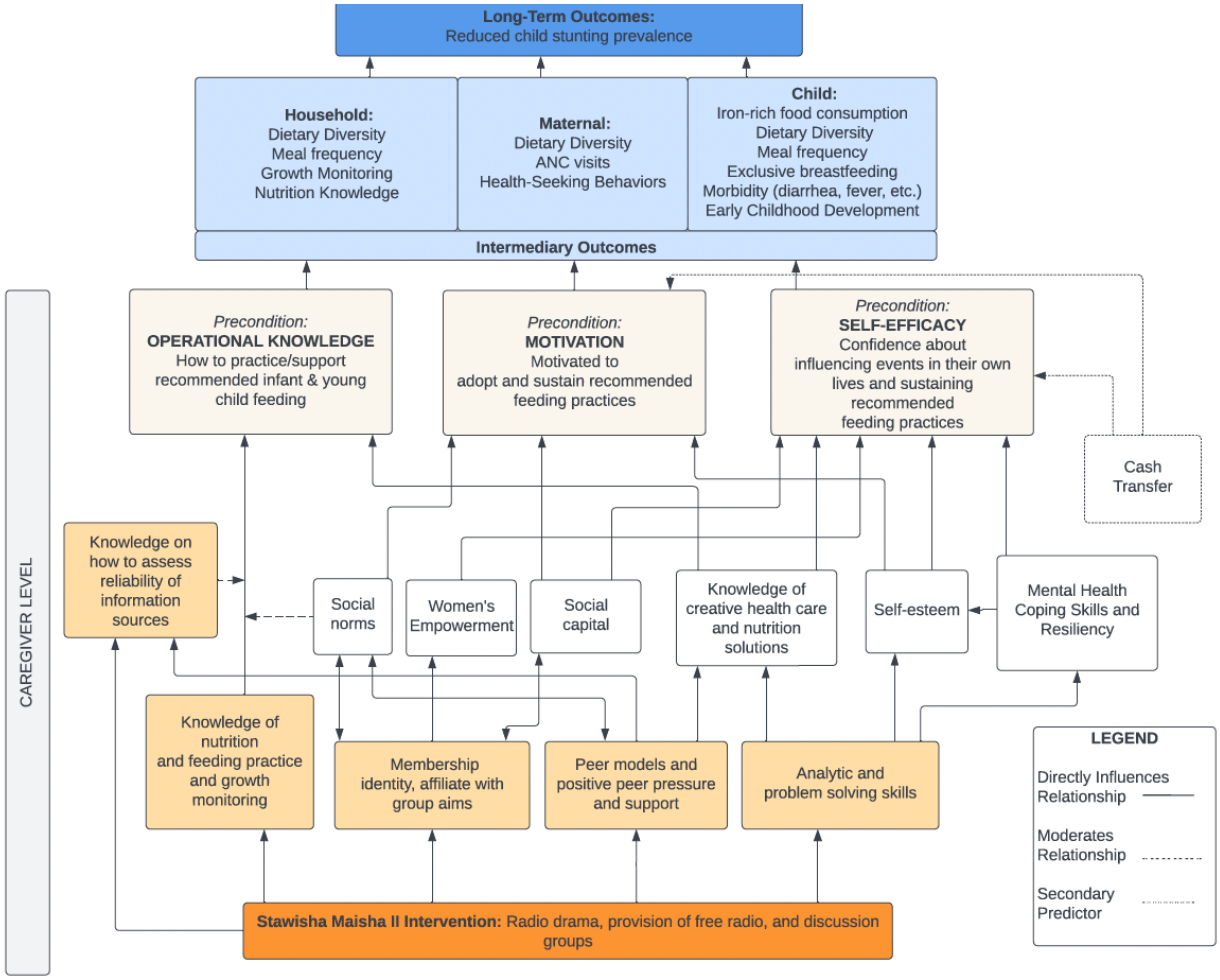
- Research questions related to the impact of the Stawisha Maisha, that is what and how:
    - How has Stawisha Maisha impacted stunting and other anthropometric indicators at follow-up/s?
    - How has Stawisha Maisha impacted MIYCF practices / diets at follow-up/s?
    - How has Stawisha Maisha impacted ECD outcomes after a six-month cycle (established follow-ups)?
    - How has Stawisha Maisha impacted the knowledge of programme beneficiaries on MIYCF at follow-up/s?
    - At follow-up/s, how has Stawisha Maisha impacted preconditions to achieving Stawisha Maisha's nutrition-specific aims (or intermediate outcomes)? Preconditions may include peer support, participants' sense of self-efficacy, aspirations for self and children, ability to plan and set goals, skills for analysing and solving problems, resilience, openness to learning and change;
    - How has Stawisha Maisha impacted household food security at follow-up/s?
    - How has Stawisha Maisha impacted women's empowerment at follow-up/s?
    - What are the pathways through which Stawisha Maisha has an impact on individual and household level outcomes?

- Research questions related to the effectiveness of the Stawisha Maisha:
    - What was the uptake and operational performance of the Stawisha Maisha cash plus programme?
    - Is the radio an effective way to communicate with PSSN beneficiaries? Has the radio been effective at delivering messages, notices or reminders to programme beneficiaries?
    - Can the (Radio+) approach be used to rollout social and behavioural change on issues in addition to/ other than nutrition? Can the Radio+ approach be used to enhance community sessions?

To hone in on outcomes to be measured in quantitative and qualitative questionnaires, we drew on the finalized TOC, the Transfer Project's conceptual framework for assessing cash transfer and cash plus programme impacts, and Grossman's theory (Grossman, 1972) of household demand for health and human capital. Community-, household-, caregiver-, and child-level outcomes were

developed using the finalized ToC, the Transfer Project's conceptual framework for assessing cash transfer and cash plus programme impacts, and Grossman's theory (Grossman, 1972) of household demand for health and human capital. Measures were discussed between EDI, Empathea, Policy Research Solutions, TASAF and UNICEF team members, and the final questionnaires include distal background factors, intermediate outcomes, and final outcomes.

**Figure 3. Theory of Change for *Stawisha Maisha***




As indicated in Figure 3, we theorize that the Stawisha Maisha intervention, by providing free radios, discussion groups, and edutainment broadcast programming, will directly impact beneficiaries': 1) Knowledge of maternal and child nutrition and feeding practices and knowledge of child growth monitoring, 2) Membership identity, group connectivity and affiliation with

group's aims, 3) Access to peer models and positive peer pressure/support and 4) Analytic and problem solving skills. These areas subsequently lead to pathways of change via:

1. Social and gender norms
2. Women's empowerment
3. Social capital
4. Attitudes on sources of information
5. Intrahousehold bargaining and allocation of time/resources.
6. Knowledge of creative healthcare and nutrition solutions
7. Self-esteem
8. Mental health coping skills and resiliency

Through these seven pathways, Stawisha Maisha aims to influence three pre-conditions: operational knowledge (of nutritional practices), motivation (to adopt and sustain these practices) and self-efficacy (confidence in one's abilities). These pre-conditions then affect intermediary outcomes at the household level (e.g., household knowledge about child growth monitoring), maternal level (e.g., antenatal care visits) and child level (e.g., dietary diversity). These intermediary outcomes are the driving forces for changing long-term (12+ months) child stunting prevalence.

The Theory of Change presented in Figure 3 maps out various possible pathways through which the Stawisha Maisha intervention can have a positive impact on maternal, infant and young child feeding knowledge practices. Additionally, the Theory of Change includes pathways that are related to each of the key research questions for impact. Research question 1.1 is presented in the Theory of Change as the long-term outcome of stunting prevalence. Research questions 1.2, 1.3 and 1.6 are all intermediary outcomes that stem from the intervention and also are theorized to impact the long-term outcome of stunting prevalence. Research questions 1.4, 1.5 and 1.7 are related to pre-conditions and intermediary steps in the Theory of Change. Finally, research question 1.8 addresses the overall connections and pathways between intermediary steps, pre-conditions, and outcomes in the Theory of Change.

### 4.3.2. Evaluation Design

Detailed information on the study design and instruments is provided in the Study Protocol. Key information from the protocol is summarized here.

This study uses a cluster randomized controlled trial (cRCT) design to estimate causal impacts of the Stawisha Maisha intervention. It is important to note that the study will only estimate impacts of the Stawisha Maisha (i.e., the 'plus' component) and not the combined PSSN + Stawisha Maisha impacts. This is because both treatment and control groups receive the PSSN, and the randomized component is Stawisha Maisha.

Three regions out of seven priority regions have been selected for the evaluation (Rukwa, Ruvuma, Geita). While Stawisha Maisha will be rolled out in all regions of Tanzania starting in September 2023, our budget for evaluation provided constraints on the number of regions we could cover in the evaluation. Thus, the research team consulted with TASAF and UNICEF to select regions on which the evaluation will focus. Selection criteria included high stunting prevalence and burden [regionally as measured in the 2015/16 and 2022 Demographic and Health Surveys (DHS), as well as calculated among the poorest wealth quintile from each region using data from the 2015/16 DHS[3]] and low rates of early antenatal care and dietary diversity among children 6-23 months of age. This resulted in a priority list of the following seven regions: Arusha, Geita, Kagera, Kigoma, Mwanza, Rukwa, and Ruvuma. From this list, the final three regions were selected by UNICEF, TASAF, and the research team based on stunting burden and prevalence, as well as logistical concerns related to intervention implementation and data collection. The final three regions selected were Rukwa, Geita, and Ruvuma.

The number of TASAF PAAs (corresponding to districts) in each of these regions ranges from 3 to 6. The total number of total villages eligible for the intervention (those in rural areas with at least 9 PSSN households with a child aged under 5 years) per region ranged from 238 in Rukwa to 407 in Geita. Next, 1-2 PAAs per region will be selected for the evaluation. As TASAF was conducting recertification activities in 2023 to evaluate PSSN households' continuing eligibility for the program, we will prioritize districts for the evaluation which would complete their recertification process prior to our baseline data collection activities (in July 2023). This is intended to avoid sampling households for the evaluation which would no longer be eligible to receive the PSSN II or Stawisha Maisha after recertification (expected to conclude in September 2023). By the end of May 2023, among our potential list of 7 regions, only Kigoma, Rukwa and Ruvuma will have fully undergone recertification in all districts. Based on preferences expressed by TASAF and the UNICEF Nutrition team, Rukwa, Ruvuma and Geita were selected as the final three regions for the evaluation. Next, the research team will randomly select one district per region for inclusion in the study, after excluding any districts that are either 1) very unique and would not be a good

[3] We used 2015/16 data for these calculations as data from the 2022 DHS were not yet publicly available at the time our sampling strategy was designed.

representation of the larger region or 2) already participating in an evaluation of the PSSN II program (which is separately being led by the World Bank and National Bureau of Statistics).

We will proportionally select clusters (villages) by region based on general population of TASAF households, for a total of 150 selected clusters. The distribution is as follows:

- Geita, 54 villages
- Rukwa, 40 villages
- Ruvuma, 56 villages

Among the selected PAAs, a list of villages from rural areas with at least 9 PSSN households with a child aged 5 years or younger will be provided by TASAF. Next, evaluation team institutional member EDI Global will randomly select the above-referenced number of villages from each region, and then randomize half into the treatment arm and half into the control arm, resulting in 75 total treatment villages and 75 total control villages. After a 12-month period, Stawisha Maisha will be rolled out to the control group (delayed entry).

After a 12-month period, Stawisha Maisha will be rolled out to the control group (delayed entry).

Due to the randomized nature of selection into treatment arms[4], treatment and control groups are assumed to be statistically equivalent in terms of background characteristics and outcomes of interest. Because of this statistical equivalence (which will be tested) at baseline, which will be conducted prior to rollout of intervention activities, any differences in nutrition and pathway outcomes between the groups at endline can be attributed to causal impacts of the treatment intervention. Thus, we will aim to interview all selected, eligible households and estimate "intent-to-treat" (ITT) impacts of the intervention. ITT effects are estimated among the full sample, as opposed to average treatment on the treated effects, which are estimated only on those who participate in the intervention. ITT impacts reflect effectiveness of the programme at the population level, since in a fully scaled up programme, not all households offered the programme would choose to participate (i.e., listen to the radio broadcasts and participate in facilitation activities). In addition, we will assess participation in intervention activities in our endline surveys to understand programme take-up and then estimate "average treatment on the treated" (ATT) effects as a robustness check.

[4] Treatment arms refer to which group of the study a village/individual is assigned. In this study there are two groups: treatment and control. Treatment arms get the intervention and control arms do not.

### 4.3.3. Power and Sampling

To determine the required sample size, power calculations were conducted based on the following key indicators (selected by the research team with input from UNICEF and TASAF): stunting among children 0-5 years, dietary diversity among child 6-23 months, early antenatal care rates among women 15-49 years, and consumption of iron-rich foods among children 6-23 months. Prevalence of these indicators among the poorest 20% of the population in the three selected regions was calculated by the research team using data from DHS 2015/16. In order to detect impacts of 5 percentage point differences in the prevalence of these indicators between the study arms with 80% power, it was determined that 420 households per study arm would need to be sampled using a simple random sampling (SRS) design. However, since we are using a cluster sampling design (households are selected within villages), we calculated intracluster correlation coefficients (ICC) among the four above-referenced indicators (using data from households in the lowest wealth quintile in rural areas of the selected regions in the 2015/16 DHS) to determine the design effect. We used an average ICC across the indicators of 0.12. Combined with an expected average of 15 households per cluster (village), we calculated a design effect of 2.68. As a result, it was determined that 75 villages with a minimum sample of 1,126 households per study arm would be needed to detect impacts of 5 percentage points. This results in a total sample size of 150 villages and a minimum requirement of 2,252 households.

### 4.3.4. Limitations

The strengths of this evaluation include the following:

- Cluster RCT design is the gold standard for estimating causal impacts.
- Strong, diverse study team with national and international partners
- Study team has experience conducting large-scale data collection among PSSN populations in Tanzania.
- Data collection will include several dimensions of outcomes to understand broad impacts of the program, as well as contextual factors (e.g., norms and health facility services availability readiness, among others).
- Multiple levels of data collection
- Longitudinal, mixed method study

Nevertheless, some limitations do exist. These include the fact that our questionnaires rely on self-reported data (with the exception of anthropometric measurements and data from health cards). Thus, data are subject to recall bias or social desirability bias. Further, our study is powered to detect impacts of 5 percentage point differences between study arms. It is unlikely that

stunting will decrease a full 5 percentage points in the treatment arm over a 12-month period. A 1 percentage point decrease in stunting is more likely; however, our sample size is not large enough to detect a statistically significant difference of this size (that would require >10,000 households). Another limitation relates to generalizability. Our evaluation will take place in three regions and thus findings might not be generalizable to other regions. Finally, our evaluation is powered to detect average effects across the entire sample. It is not powered to detect heterogeneous impacts by characteristics such as disability status, child's gender, etc.

### 4.3.5. Ethical Considerations

We will adhere to Ethical Principles and Guidelines for the Protection of Human Subjects of Research as outlined in the Belmont Report. All study personnel, including principal investigators, co-investigators, data managers, research assistants, and data collection enumerators have received (or will receive prior to commencement of study activities) training in the ethical conduct of research from either Collaborative Institutional Training Initiative (CITI) or FHI360 (https://www.fhi360.org/expertise/ethical-standards-and-training).

Enumerators will receive further instruction at data collection trainings in areas such as ethical data collection (e.g., sensitivity toward study subjects, the importance of securing and maintaining privacy, and talking about sensitive topics), informed consent, referral services and procedures and vicarious trauma and self-care. All study members will act in accordance with recommendations and guidance around adherence to ethical principles and procedures, principles of do no harm, and confidentiality with respect to data collection.

Informed consent will be obtained from all study participants aged 18 years and above being interviewed. If a Stawisha Maisha eligible caregiver is a pregnant woman, mother or caregiver under the age of 18 years and married, then she is understood to be acting in an adult capacity, and we will obtain informed consent from her. However, if a Stawisha Maisha eligible caregiver is a pregnant woman, mother or caregiver under the age of 18 years and not married, then we will obtain informed consent to interview her from the household head and informed assent from the individual female (see Parental Consent and Household Assent forms in Study Protocol Appendices). This is relevant to the household surveys, where the main respondent may be an unmarried female under the age of 18 years (if she is eligible for Stawisha Maisha and the only eligible female in the household). However, for community, health facility, in-depth qualitative interviews, and qualitative focus group discussions, all respondents will be adults aged 18 years or older. Informed consent includes the ethical components regarding: 1) objectives and content

of the study, 2) privacy and data security, 3) voluntary participation, 4) the right to refuse or skip any questions without consequences, and 5) source to follow-up regarding complaints or further information on the study. Consent forms will be read aloud in Swahili to the participant and then consent will be obtained orally and recorded via electronic tablets. The reason for reading consent forms and obtaining oral consent is that the educational attainment and literacy levels in our study population are very low, and thus many respondents will not be able to read and write.

***Questionnaires***

The following questionnaires (target sample size) will be implemented for this study:

1. Quantitative Household surveys with mothers/caregivers who are PSSN recipients and Stawisha Maisha participants (N=2,252)
2. Quantitative Community Surveys (N=150) with community leaders
3. Quantitative Health facility surveys (N=150)
4. Qualitative in-depth interviews with mothers/caregivers who are PSSN recipients and Stawisha Maisha participants (N=18)
5. Qualitative Focus group discussions with mothers/caregivers who are PSSN recipients and Stawisha Maisha participants (N=8)
6. Anthropometric measurements will be collected for children 0-59 months (N=3,000)

More details on these are provided in the Study Protocol, and draft questionnaires are provided in Appendices 5-9.

***Selection of respondents***

For the intervention and evaluation, target households are the PSSN rural households with children under five years. The primary target group of the programme are mothers and primary caregivers (including expecting mothers). The programme will also target as secondary target group, adolescent girls and grandmothers or active senior women, and fathers or grandfathers who have a role in young childrearing.

Eligibility criteria for the intervention and evaluation are as follows:

In the first stage of selection into the intervention, **villages** must fulfill the following eligibility criteria:

3) Be located in a rural area.
4) Have at least 9 PSSN households with a child aged under 5 years.

Second, at the **household level**, eligibility criteria are:

3) Participation in the PSSN II program
4) Has a child aged under 5 years?

Third, at the **individual level**, eligibility criteria are:

2) Status as mothers or primary caregivers of children aged 5 years or under (including expecting mothers). Stawisha Maisha will also target, as a secondary group, adolescent girls to increase their knowledge in future parenting but also grandmothers/active senior women and fathers / grandfathers who have a role in young childrearing.

More than one eligible individual from a PSSN household can participate in Stawisha Maisha activities. Participation of more than one person per household will be promoted in small villages (that is, those with fewer than 22 eligible households per village). In larger villages, households will be encouraged to designate a group member and an alternate who can participate in activities when the designated group member is not available. However, for the evaluation surveys, only one participant per household will be selected for interviews.

In the second stage of sampling, we will sample households from the listing data and cross check information with the TASAF lists. During the listing, EDI Global will collect information on household composition (gender and age of household members), as well as confirmation of the PSSN status for the household. Using a Stata do-file, allowing for transparency and replicability, EDI Global will select a random sample of respondents in each cluster, including replacements. For households where there is more than one targeted child under five years, a random selection of the targeted child will be performed in Stata, allowing us to identify the targeted main caregiver of the selected child for the household survey.

The evaluation will further be restricted to only three regions as described in the evaluation design section above.

***Selection of respondents for the Anthropometric survey***

In each household sampled for the household survey, all children under five years old will be measured.

***Selection of respondents for the FGDs and IDIs***

Qualitative research in the form of in-depth interviews (IDIs) and focus group discussions (FGDs) will be conducted in two of the three study regions (Ruvuma and Rukwa). Given similarities between Geita and Mwanza, only Mwanza will be selected for qualitative fieldwork out of the two. A total of 18 in-depth interviews and 8 focus groups will be conducted (split evenly between each district/PAA). These will be conducted with the target Stawisha Maisha participants (i.e., female caregivers of young children). Qualitative interviews and focus groups aim to understand mechanisms of impact (the "how") and help contextualize information in a way that is not possible in quantitative surveys.

### 4.4. Phase 2: Development of Survey Instruments and Manuals

Given requirements and timelines for ethical review, some activities for Phase 2 have already been conducted. Quantitative questionnaires have been developed for households, communities, and health facilities, and qualitative surveys have been developed for focus group discussions and in-depth interviews (see Figure 4).

**Figure 4. Research Tools**

| Questionnaire | Respondent Type | Type (Quantitative or Qualitative) | Sample size[5] | Survey length in minutes[5] |
|---|---|---|---|---|
| Household survey | Main caregiver / intended Stawisha Maisha recipients[6] | Quantitative | 2,252 | 60 |
| Child Anthropometrics | One child aged 0-5 years randomly selected from each surveyed household[7] | Quantitative | 3,000 | 45 |
| Community survey | Group of community leaders (e.g., Village Chairman, Village Executive Officer) | Quantitative | 150 | 30 |
| Health facility survey | Facility in-charge | Quantitative | 150 | 30 |
| Focus Group Discussions (FGDs) | Main caregiver / intended Stawisha Maisha recipient | Qualitative | 8 groups (96 individual participants) | 90 |

[5] The specific sample and duration of surveys will be confirmed at the end of the inception phase when the evaluation design is finalized. As mentioned in the TOR page 17, the sample and durations are indicative estimates and the final budget for the data collection would be finalized after the inception period.
[6] The Household survey will be administered to the household head and one woman in each household (priority will be given to child caregivers who are the intended Stawisha Maisha II recipients and may also be administered to a man if there are no women available).
[7] The child anthropometrics will not be conducted in eligible households with pregnant women who are not mother of eligible children 0-5 years old at the time of the baseline survey.

| | | | | |
|---|---|---|---|---|
| In-Depth-Interviews (IDIs) | Main caregiver / intended recipient | Stawisha Maisha | Qualitative | 18 | 60 |

### 4.4.1. Household Survey

The household survey questionnaire was developed based on the programme's reconstructed ToC and measures key outcome and impact indicators as well as intermediate outcomes that lie along the causal pathway. Topics include time use, nutrition knowledge, specific health education message recall, attitudes about message sender, attitudes about message delivery, breastfeeding practices and knowledge, economic activities, food security, dietary diversity, child feeding practices, child's dietary diversity (types of foods eaten and frequency), child development, health and nutrition status, knowledge of and access to health services, school attendance, women's empowerment, health insurance enrolment, shocks and participation in Stawisha Maisha activities, and social support measures.

For the baseline survey, we focus on questions related to radio access and use before the start of the programme. To further understand SBCC effectiveness at follow-up rounds of data collection, we will include a radio+ module with items assessing edutainment message recall, understanding of message content, attitudes about drama storyline, attitudes about message delivery/sender, health literacy as it relates to terminology used in the broadcast, ability to draw causal links between healthy actions and expected outcomes, and subjective norms. Additionally, we will directly measure children's anthropometrics in the target age range in each household in both baseline and follow-up surveys.

The household survey questionnaire will also collect data on basic household composition and children characteristics to allow us to disaggregate the data in terms of sex, age, disability, education level and so on during the descriptive analysis phase. However, it is important to note that logistical and budget constraints will not allow estimation of disaggregated impacts by these characteristics (that would require very large sample sizes). With our extensive experience of undertaking household surveys in Tanzania and experience with the PSSN in Tanzania, we will further ensure that the questionnaire and the tools are well suited to the local context. The household survey is expected to last 60 minutes. The full survey can be found in Appendix 5.

### 4.4.2. Child Anthropometric Measurements

A tool has been developed to record child anthropometric measurements for one child under five years in each selected household, using the standard measurements of height, weight and mid-upper arm circumference (MUAC) using accredited equipment (SECA or SALTER brands). The child anthropometric measurements and the data entry in the tool is expected to take 45 minutes per household.

### 4.4.3. Community Survey

The community survey questionnaire was developed to capture information on prices, access to markets, accessibility of roads, electricity, health facilities, schools and so on in each community. The information from this survey will be used in the analysis to capture differences between the communities across the sample. The community survey will be conducted with a group of a maximum of four respondents acting as community leaders (e.g., Village Chairman and Village Executive Officer). The community survey is expected to last 30 minutes. The full survey can be found in Appendix 6.

### 4.4.4. Health facility survey

The health facility questionnaire was developed to collect information on service availability and readiness and is informed by WHO Service Availability and Readiness indicators. The health facility survey will be conducted in each community with the acting facility in charge and is expected to last 30 minutes. We will also measure GPS coordinates for each health facility. The full survey can be found in Appendix 7.

The three quantitative tools (household, community, and facility) will be programmed by EDI Global using our use in-house programming expertise to configure the survey in SurveyCTO, a Computer-Assisted Personal Interviewing (CAPI) software for data collection. GPS coordinates will be captured for each sampled household, community and health facility. EDI Global will use its experience in programming surveys to desk-test the survey instruments, and add further validation conditions, skipping patterns, and other features.

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

Empathea developed a semi-structured IDIs guide to be used to interview household heads/intended Stawisha Maisha recipients. In-depth interviews with caregivers will explore mechanisms of programme impact (message recall, attitudes about channel delivery, attitudes about message sender) and follow a sub-set of topics from the quantitative questionnaire, with a focus on participation in Stawisha Maisha activities, feeding practices and knowledge, and household food security, and opinions about broadcast message delivery and content. This baseline interview guide includes key research questions pertaining to the status of concepts that are difficult to be measured in the quantitative tools such as:

- Feeling of affiliation
- Perceived self-efficacy for MIYCF practices.
- Openness to change.
- Potential barriers to change including personal and relational.
- Aspirations for self and child
- Improved skills
- Other personal concerns that may hamper the adoption of MIYCF practices.

Each IDI is expected to take 60 minutes. The full guide can be found in Appendix 8.

***Focus Group Discussions (FGDs)***

Empathea developed a FGD guide to conduct the discussions with household heads/intended Stawisha Maisha recipients to explore similarities and shared sentimentalities among a group around concepts that are difficult to capture in the in-depth interviews. The FGD guide includes key research questions, and will be complemented by probe areas to gather in-depth information from the participants on the following topics:

- Perceived self-efficacy for MIYCF practices, differences and similarities.
- Openness to change - group differences and similarities.
- Potential barriers to change including relational, cultural and any other barriers.
- Aspirations for self and child - similarities and differences
- Improved skills and how head of households influenced these.
- Other group concerns that may hamper the adoption of MIYCF practices.

Each FGD will consist of approximately 12 participants and is expected to take 90 minutes. The full guide can be found in Appendix 9.

#### 4.4.6. Development of Interview Manuals and Instructions for Field Staff

Protocols will be established, and the following manuals will be incorporated to include fieldwork management, general interviewing skills, qualitative interviews, and CAPI manuals.

Listing Manual: In order to identify the households to be surveyed as part of the treatment and control groups, EDI Global will develop a Listing Manual for the Listing Team. This manual will be used for training of Listing Team and as a guide throughout the listing exercise. The manual will provide a background to the project, protocol for identification and recruitment of village guides, criteria for listing a household in line with the programme targeting criteria and sample selection criteria. It will also provide orientation on informed consent and protocols for verifying the listed households.

Quantitative Manual: To support the implementation of the survey, an Enumerator Manual will be developed for the survey teams by EDI Global. This manual will be used as both a learning aid for the training phases as well as a reference guide for the survey team throughout the implementation of the project. As all Enumerators will be competent in English, the manual will be provided in English. The manual will provide a background to the project, explain key concepts and their interpretation, describe field protocols for respondent selection and provide guidelines to conducting CAPI interviews using electronic devices.

Qualitative Manual: Empathea will also develop a qualitative manual to aid Qualitative Enumerators with FGDs and IDIs. This manual will provide a background to the project, explain research objectives and probe areas along with the respondent/participant role in context of the programme where relevant. The Qualitative Manual will also emphasize on probing techniques and guidelines to support the facilitator in moderating and ensuring uniform engagement during FGDs interviews.

### 4.5. Phase 3: Field Work

#### 4.5.1. Enumerator Recruitment

*Quantitative and Anthropometric Interviews*

EDI Global will select Supervisors with experience overseeing the implementation of large household surveys, preferably, on health projects. The Quantitative Enumerators will be selected based on their experience in conducting surveys and with preference for those with a background in health, social science, social work or counselling. All Quantitative Supervisors and Enumerators will have completed at least secondary education and be experienced in data collection using

electronic tablets. All field staff will also be fluent in both English and Kiswahili. Enumerators will be observed throughout the training period and their overall performance will be assessed.

*Qualitative Interviews*

Empathea will select Qualitative Enumerators and Qualitative Translators who will handle interviewing and transcription tasks. The Qualitative Enumerators will only transcribe the interviews into Kiswahili (the interview language), while the Qualitative Translator is based off-field will carry out only translation. Empathea will select experienced and professional Qualitative Enumerators who can establish a supportive interview environment, have a positive attitude, maintain confidentiality and are fully committed to maintaining the survey protocol and ethical procedures.

### 4.5.2. ENUMERATOR TRAINING

*Quantitative Enumerators*

Ahead of the main quantitative training, the Field Coordinator and Data Manager will lead a two-day training with six prospective Supervisors to ensure understanding of administrative responsibilities. General Enumerator training will be conducted by EDI Global over a period of six days in Bukoba, with support from EDI and Policy Research Solutions team members. The training will incorporate project overview, ethical research practice, data collection techniques and concepts, field protocol, electronic data entry, and questionnaire training.

Once the six-day training is complete, all trainees will administer mock interviews, both to each other and plausible respondents from outside the team. Mock interviews will be supervised by the Field Coordinator, Data Manager, and Supervisors, and trainees will be asked for and provided with feedback on an ongoing basis. All problem areas expressed by trainees will be fed back to the entire training group. Finally, EDI Global will conduct a comprehensive full-scale one-day outdoor practice with all trainees near the end of the training. The practice will take place in out-of-sample villages near the training venue. During the outdoor survey practice, EDI Global will ensure that all Enumerators perform at least two household interviews each[8]. At the end of the day, the Field Coordinator and Data Manager will lead a review and feedback session to obtain feedback about the interviews conducted during the day and provide an opportunity for trainees

[8] Two Enumerators will also conduct health and communities interviews and have less households to be completed and they share feedback during the debrief session to the whole team.

to ask questions. At the end of the training phase, the survey instruments and manuals will be revised to incorporate any issues and changes based on the outdoor practice and comments from the trainees.

*Anthropometric Enumerators*

Anthropometric Enumerators will follow a five-day specialized training course, in Bukoba, delivered by a Health Consultant. The Anthropometric Enumerators will also undergo ethics training. To ensure that the Anthropometric Enumerators understand the context of the study, they will also take part in various sections of the quantitative household survey training relating to survey background and sample. The Anthropometric Enumerators will conduct anthropometric surveys during a one-day outdoor practice in the same out-of-sample villages used by the household teams near the training venue in Bukoba. EDI Global will ensure that all Anthropometric Enumerators perform at least two interviews each. On the next day, the Health Consultant will lead a review and feedback session to obtain feedback about the interviews conducted during the day and provide an opportunity for trainees to ask questions.

*Qualitative Enumerators*

The Qualitative Enumerators will follow a five-day specialized training course, in Dar es Salaam, with the Qualitative co-PI, Dr. Lusajo Kajula. This will cover concepts of performing a qualitative interview, such as probing, verbal and non-verbal cues and include how to prepare accurate transcriptions of the discussions. The qualitative Enumerators will also undergo ethics training. The Qualitative Enumerators will conduct a one-day outdoor practice, in suburban areas near Dar es Salaam. After the outdoor practice, the Qualitative Enumerators will listen to the interviews in class and receive feedback from the Qualitative co-PI on their performance.

### 4.5.3. Data Collection and Reports

Regular quality checks will be completed to ensure accuracy of both qualitative and quantitative data collection. Upon completion of data collection in the field, EDI, Empathea, and Policy Research Solutions team members will jointly review, clean, and analyze the data, including translation to English. Following this, a fieldwork report will be drafted to provide a description of the survey and data architecture for data users. This document supplements the data collected as part of the survey and is designed to provide information to enable its proper and effective

use. It summarizes the preparation and data collection phases, describes the data consistency checks and data architecture. The report will be 40-60 pages long and will contain:

- A summary of the project, including the design, methodology and sampling approach.
- A description of the data collection method including the data collection mode and field staff training.
- An overview of survey preparation, team structure and a fieldwork summary.
- An overview of quality control protocols in the collection, checking, and cleaning of the data.
- A detailed description of the data file structure, including information on the tables' content and relation to the questionnaires, and information about specific variables.
- An overview of the challenges faced in the field and actions taken to minimise them.
- A list of other deliverables/documents, such as:
    - The clean and translated datasets in Stata format.
    - Stata checking do-files used to identify inconsistencies and errors in the data.
    - The clean and translated transcripts.
    - Programmed questionnaires in Excel format.
    - Consent forms in English and Kiswahili
    - Paper questionnaires in English and Kiswahili in PDF format
    - Survey manuals and protocols in PDF format

## 4.6. Phase 4: Data Analysis and Report Preparation and Dissemination

### 4.6.1. Quantitative Data Analysis

The baseline report will summarize quantitative and qualitative findings from the baseline surveys and interviews. The baseline quantitative data analysis will serve two purposes:

- The first goal will be to offer baseline values of key outcomes to describe the research sample's characteristics.
- The second goal will aim to evaluate if the evaluation design proposed during the inception phase produced statistically equivalent treatment and control groups, that would allow us to conclude that differences between treatment arms observed at follow-up rounds would be attributable to the Stawisha Maisha programme, and not to systematic differences pre-existing prior to the programme rollout.

To test balance of indicators between study arms, we will perform simple ordinary least squares (OLS) regressions with each outcome of interest separately, controlling for sampling (stratification) variables (e.g., district/PAA), and indicator for treatment status, and adjusting standard errors for clustering due to the nested nature of the data (that is, households are nested within villages). We will test for differences at an alpha level of 0.05, and if fewer than 5% of outcomes (the percentage expected to be statistically significant due to chance) show statistically significant differences between treatment groups, we will conclude that the study design is internally valid. In addition to the statistical tests, we will provide graphs of key indicators by treatment arm.

Our quantitative analysis will therefore provide an overview on the comparability of treatment and control/comparison groups, thereby setting context for the impact evaluation going ahead. The majority of the data analysis will rely on the primary data we collected, however, when relevant, we will complement the analysis with secondary data sources identified during the inception phase (e.g., stunting rates and study outcomes as measured in DHS) in an effort to demonstrate how similar our sample is to regional and national samples.

In the baseline report, we will also provide estimates of key indicators from the most recent Demographic and Health Surveys (as of drafting most recent data publicly available are from 2015/2016; however, a 2022 DHS was conducted), estimated among the lowest wealth quintile (that is, to be comparable to PSSN households). This will help us understand how our study sample compares to national and regional comparisons.

Follow-up analysis will be performed longitudinally using ANCOVA models (see Study Protocol in Appendix 3 for additional details) and reported in an "endline report". This report will document intervention impacts.

The Evaluation Team members at EDI Global and Policy Research Solutions will undertake quantitative analysis using the Stata statistical software to manage, analyse and visualise the data. The team members will divide sections of the report according to topics and split analyses. Prior to conducting the analysis, the team will create an '.ado' file which will allow the team to systematically perform analyses across indicators, to minimize potential for errors, but also to format outputs consistently. The 'do.' and '.ado' files used for analysis will further ensure that all the steps taken from cleaning to analysis and production of graphs are clear and can be used by any external user in the future to reproduce the analysis. These files will be included as deliverables to UNICEF.

Findings from these analyses will be written up in the baseline report in a manner that is easily understood by non-specialist readers, accompanied by easy-to-interpret graphics.

### 4.6.2. Qualitative Data Analysis

Qualitative data analysis will follow a multi-step approach. First, we will hold an in-person coding workshop to perform steps 1-2 below, where qualitative co-PI, Dr. Lusajo Kajula, will lead three additional coders (two from Empathea and the Qualitative Research Assistant from Policy Research Solutions) in review and coding of transcripts as follows:

1. *Reading and summarizing*: in the first step, we will read transcripts multiple times and develop themes individually and then discuss as a group.
2. *Coding:* based on emerging themes in Step 1, we will create a list of codes, and subsequently, a codebook together as a team. In addition, we will use memo writing throughout the coding process to summarise observations about the data.
3. *Data reduction and display:* after coding, we will summarize key patterns in the data and then visually display these with matrices, tables, and other figures to facilitate analysis.
4. *Interpretation and recontextualizing:* lastly, we will summarize the thematic findings and review transcripts as needed in the final analysis phases.

*Qualitative analysis will be conducted in two phases:*

1. ***Rapid initial analysis to document observations during fieldwork*** - each interviewer will take a 1-2 page note of observations immediately after the interview and
2. ***In-depth analysis to be conducted after the end of the interviews by a team of four*** - transcripts will be analyzed using MAXQDA software program (*MAXQDA 11—Software for Qualitative Data Analysis 1989–2016*. Berlin, Germany: VERBI.). A codebook will be created using *a priori* themes from the interview guides and will be supplemented with themes that emerge during data analysis. Initial coding structures will be developed by the Qualitative co-PI (Kajula). The coding structures will be shared with two other coders for recoding. This will ensure that the final coding structure is validated, therefore maintaining consistency in the application of codes.

### 4.6.3. Combined Quantitative and Qualitative Reports

The Evaluation Team will prepare a baseline report (combining qualitative and quantitative analysis), written in English. This report will present the findings from the baseline data collection and analysis, and will include:

- Cover Page, Acknowledgments and Abbreviations
- Executive Summary
- Introduction and Background
    - Overall background, presentation of TASAF and Tanzania's PSSN
    - Programme background and the 'Plus' Intervention '*Stawisha Maisha - Nourishing Life' programme'*
    - Review of cash plus programmes to improve young children nutritional outcome.
- Conceptual Framework and Programme Theory of Change
- Impact Evaluation Framework and Sample
    - Research questions
    - Study design
    - Questionnaires, data collection training and activities
    - Ethical guidelines
    - Guidance and recommendations for future data collection rounds
    - Data analysis (quantitative and qualitative)
- Sample Response Rates
- Communities Characteristics
- Health Facilities Characteristics
- Qualitative Sample Characteristics
- Sample Description: Households Demographics and Economic Characteristics
- Sample Description: Mothers, Primary Caregivers, Expecting Mothers Characteristics
- Findings by Outcome of Interests (divided into chapters including food security, knowledge, etc.); at follow-up waves it is proposed to include a section on programme activities' uptake.
- Conclusion
- References
- Annexes

When preparing the draft reports (baseline and endline), the Evaluation Team will adhere to several quality standards, including the Revised Evaluation Policy of UNICEF, UNEG Ethical Guidelines for Evaluation, UNEG Code of Conduct for Evaluation, UNICEF Reporting Standards and UNICEF's Global Evaluation Reports Oversight System (GEROS) quality standards. The draft report

will be submitted to UNICEF Evaluation Management Team, the ERG and Regional Evaluation Adviser within UNICEF ESARO Evaluation and Social Policy Sections to obtain their technical inputs and quality assurance. We understand that receiving at least a satisfactory review from ESARO Evaluation Section will be a precondition for moving to the next phase. The Evaluation Team will also prepare a PowerPoint presentation that will facilitate a stakeholder dialogue process.

Additionally, the Evaluation Team will lead a one-day in-person workshop with UNICEF and TASAF to review findings from the baseline report before finalization. The Evaluation Team will prepare the final evaluation report incorporating any comments and feedback received from the workshop as well as the peer review process at Policy Research Solutions. This process will be replicated after follow-up data collection.

The Evaluation Team will disseminate the findings of the study through additional means, such as policy briefs, blog posts, as well as presentations at academic and policy conferences. We will produce policy briefs, both in English and Swahili. They will be shared with parliamentarians, high-level political leaders, the Ministry of Finance, President's Office – Finance and Planning (Zanzibar) and line ministries, and civil society organizations. We will also develop peer-reviewed publications reporting on the findings. A list of proposed papers will be submitted to TASAF and UNICEF for approval prior to analysis and drafting. No presentations or journal article submissions will be conducted until after the Government has approved the report (separately for baseline and endline). That is to say, baseline findings can be presented before approval of the endline report.

### 4.6.4. TIMELINE & DELIVERABLES

The proposed timeline for on-going and future study activities is as follows:

| |
|---|
| 17-28 April: Development of paper tools (e.g., surveys and guides) |
| 28 April-5 May: Translation/backtranslation of tools |
| 10 May: Inception report submitted to UNICEF |
| 8 May: Submission to NIMR |
| 1-3 June: Pilot |
| 28 May: Draft Field Plan based on **final village selection** |
| 28 June: Listing Training (1 day, enumerators travel on 29 June) |
| 26 June-19 July Listing and Reporting Exercise |

| |
|---|
| 30 June-1 July: Supervisor Training (2 days) |
| 3-8 July: Quantitative Training (6 days) |
| 9 July: Quantitative Enumerators travel |
| 10 July-7 August: **Quantitative** Fieldwork |
| 5-10 July: Anthropometric Training (5 days) |
| 10-14 July: Qualitative Training (5 days) |
| 12 July-23 August: **Anthropometric** Fieldwork |
| 19 July-9 August: **Qualitative** Fieldwork |
| 23 August: All fieldwork completed |
| 24 August-8 September: Qualitative coding |
| 24 August-30 September: Data cleaning for quantitative analysis |
| 1 September 1-30 October: Qualitative analysis |
| 1 September-30 October: Quantitative analysis |
| 30 October: Draft of fieldwork report submitted |
| 1 December: Draft Qualitative and Quantitative Baseline Report submitted |
| January 2024: Baseline Findings Workshop |

February 2024: Final Qualitative and Quantitative Report Submitted

### 4.6.5. LEVEL OF EFFORT OF EVALUATION TEAM

| Name | Role | No. of Posts | Days | Total Staff Days |
|---|---|---|---|---|
| Dr. Tia Palermo | Principal Investigator (Quantitative)/Team Leader | 1 | 33 | 33 |
| Dr. Johanna Choumert Nkolo | Co-Principal Investigator/Team Leader | 1 | 21.5 | 21.5 |
| Respichius D. Mitti | Co-Principal Investigator/Team Leader | 1 | 15.5 | 15.5 |
| Dr. Stephanie Anzman Frasca | Co-Investigator | 1 | 11 | 11 |
| Kate Rogers | Qualitative Research Assistant | 1 | 70 | 70 |
| Natasha Allard | Quantitative Research Assistant | 1 | 70 | 70 |
| Leah Prencipe | Consultant Data collection and Analysis | 1 | 7 | 7 |
| Dr. Gustavo Angeles | Consultant Study Design | 1 | 6 | 6 |
| Dr Lusajo Kajula | Co-Principal Investigator (Qualitative) | 1 | 48.5 | 48.5 |
| Rachel Bowers | Project Manager | 1 | 99.5 | 94.5 |
| Sarafina Safari | Data Manager | 1 | 62.43 | 52.43 |
| Sosthenes Alex | Field Coordinator | 1 | 58.43 | 53.43 |
| Artee Gungah | CAPI Expert | 1 | 9 | 9 |
| Multiple | Supervisors | 7 | 21.43 | 150 |
| Multiple | Enumerators | 21 | 21.43 | 450 |
| Dr Alem Beru | Health Consultant | 1 | 3 | 3 |
| Multiple | Qualitative Enumerators | 4 | 21.5 | 86 |
| TBC | Translator | 1 | 13 | 13 |
| TBA | Qualitative Translators | 2 | 21 | 42 |
| TBA | Listing Officers | 8 | 13 | 104 |
| TBA | Pilot Enumerators | 2 | 3 | 6 |
| TBA | Enumerator Trainees | 24 | 6 | 144 |
| TBA | Supervisors Trainees | 8 | 8 | 64 |
| TBA | Qualitative Enumerators Trainees | 4 | 4 | 16 |
| TBA | Listing Officers Trainees | 8 | 9 | 72 |
| TBA | Anthropometric Enumerators | 15 | 31 | 465 |
| TBA | Anthropomeric Trainees | 18 | 5 | 90 |
| TBA | Anthropometric Standard (QC) staff | 1 | 31 | 31 |

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# 5. List of Appendices

Appendix 1: List of Abbreviations

Appendix 2: Evaluation Matrix

Appendix 3: Study Protocol

Appendix 4: Terms of Reference

Appendix 5: Household Survey

Appendix 6: Community Survey

Appendix 7: Health Facility Survey

Appendix 8: In-depth Interview Guide

Appendix 9: Focus Group Discussion Guide

Appendix 10. Power calculations