



Submitted by:  
**AAN Associates, Pakistan**

Submitted to:  
**UNICEF Country Office Rwanda**

# Endline Evaluation of the **Developing Human Capital in Rwanda (DHCR)**



**Final Evaluation Report**

**May 30, 2022**

Evaluation Timeframe: **2017 - 2021**

Evaluation Execution:  
**September 2021 – May 2022**



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Draft Evaluation Report:  
April 30, 2022

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## LIST OF ACRONYMS

Abbreviation	Full-Form
ADEPE	Anglican Church of Rwanda
AVSI	Association of Volunteers in International Service
CAPI	Computer-assisted personal interviewing
CFSVA	Comprehensive Food and Vulnerability Assessment
CHW	Community Health Worker
CRC	Convention on the Rights of the Child
CR	Child rights
CSO	Civil Society Organisation
C4D	Communication for Development
DHCR	Developing Human Capital in Rwanda
DHS	Demographic Health Survey
DPEM	District Plans for Elimination of Malnutrition
ECD	Early Childhood Development
EFA	Education for All
EKN	Embassy of the Kingdom of Netherlands
ERG	Evaluation Reference Group
ESA	Eastern and Southern Africa
FAO	Food and Agriculture Organization
FDA	Food and Drug Agency
FGD	Focus Group Discussions
FFRP	Rwandan Women Parliamentary Forum
GEROS	Global Evaluation Reports Oversight System
GDP	Gross Domestic Product
GEEW	Gender Equality and the Empowerment of Women
GoR	Government of Rwanda
HH	Household
Hmis	Health Management Information System
HRBA	Human Rights-Based Approach
IEE	International Education Exchange
IP	Implementing Partner
JADF	Joint Action Development Forum
LODA	Local Administrative Entities Development Agency
KII	Key Informant Interview
MDGs	Millennium Development Goals
MIGEPROF	Ministry of Gender and Family Promotion
MINAGARI	Ministry of Agriculture
MINALOC	Ministry of Local Government
MINECOFIN	Ministry of Finance and Economic Planning
MINEDUC	Ministry of Education
MINICOM	Ministry of Trade and Industry
MINISANTE/MoH	Ministry of Health
MYICN	Maternal, Infant and Young Child Nutrition
MNP	Micronutrient powder
NAEB	National Agriculture Development Board
NAP	Nutrition Action Plan
NCC	National Commission for Children
NCDA	National Child Development Agency
NECDP	National ECD Programme
NFNP	National Food and Nutrition Policy
NFNSP	National Food and Nutrition Strategic Plan
NTWG	Nutrition Technical Working Group
PANEL	Participation, Accountability, Non-Discrimination and Equality, Empowerment, and Legality
PLW	Pregnant and Lactating Women
PM&E	Project Monitoring and Evaluation
PPP	Public-Private Partnership
RBM	Results-based Management
RCB	Rwanda Biomedical Centre
RCO	Rwanda Country Office
RDHS	Rwanda Demographic and Health Survey
RHCC	Rwanda Health Communication Centre
RICH	Rwanda Interfaith Council on Health
RMI	Rwanda Management Institute
RMC	Rwanda Medical Centre
RNEC	Rwanda National Ethics Committee
RUFT	Ready-to-use Therapeutic Food
RURA	Rwanda Utilities Regulatory Authority
SAM	Severe Acute Malnutrition

Abbreviation	Full-Form
SDG	Sustainable Development Goals
SFH	Society of Family Health
SILC	Savings and Internal Lending Communities
SP	Strategic Plan
SUN	Scaling Up Nutrition
ToC	Theory of Change
U5	Under 5
UNEG	United Nations Evaluation Group
UN-SWAP	United Nations System-wide Action Plan
USAID	United States Agency for International Development
VUP	Vision 2020 Umurenge Program
WASAC	Water and Sanitation Corporation
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

# GLOSSARY

Key Terms of Evaluation	
<b>Before-after</b>	Involves measuring the dependent variable both before and after the participants have been exposed to the independent variable. <sup>1</sup>
<b>Child Protection</b>	UNICEF uses the term 'child protection' to refer to preventing and responding to violence, exploitation and abuse against children—including commercial sexual exploitation, trafficking, child labour and harmful traditional practices, such as female genital mutilation/cutting and child marriage. <sup>2</sup>
<b>Contribution analysis</b>	Contribution analysis explores attribution through assessing the contribution a programme is making to observed results. <sup>3</sup>
<b>Early Childhood Development</b>	ECD is defined as the period from conception up to school entry. It is a unique window of opportunity for children's cognitive, social, emotional and physical development, which occurs as the result of the interaction between the environment and the child. <sup>4</sup>
<b>Endline</b>	Quantitative (descriptive statistics) and qualitative (inferential statistics) information about the situation or condition after the intervention/programme / project is completed. It must ideally be done using the same set of tools and with the same group of beneficiaries.
<b>Global Evaluation Reports Oversight System (GEROS)</b>	The GEROS system consists of systematic and independent quality assessment of evaluation reports that have been uploaded to the corporate Evidence Information Systems Integration database (EISI) by UNICEF Country Offices, Regional Offices, HQ divisions and Evaluation Office. The purpose of the Global Evaluation Reports Oversight System (GEROS) is to support and strengthen the evaluation function to meet and exceed United Nations Evaluation Group (UNEG) standards, UN System Wide Action Plan on gender equality (UN-SWAP) and other UNICEF commitments (including equity and human-rights based approaches). <sup>5</sup>
<b>Human Rights based Approach</b>	A human rights-based approach is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights. <sup>6</sup>
<b>Mixed Method</b>	A procedure for collecting, analysing, and 'mixing' both quantitative and qualitative research and methods in a single study to understand a research problem. <sup>7</sup>
<b>OECD DAC Criteria</b>	The OECD DAC Network on Development Evaluation (EvalNet) has defined six evaluation criteria—relevance, coherence, effectiveness, efficiency, impact and sustainability—and two principles for their use. These criteria are intended to guide evaluations. <sup>8</sup>
<b>Participatory Evaluation</b>	Participatory evaluation is an approach that involves the stakeholders of a programme or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis, and the reporting of the study. <sup>9</sup>
<b>Stunting</b>	Stunting refers to low height of a child compared to age. It is an indicator of chronic undernutrition and is caused by inadequate intake of nutritious food, frequent illnesses such as diarrhoea and intestinal worms, poor care practices, and lack of access to health and other essential services, especially in the first 1,000 days of a child's life but with potential effects lasting a lifetime. <sup>10</sup>
<b>Summative Evaluations</b>	Summative evaluations are usually conducted at the end of an intervention and should produce objectively verifiable information on project / programme effectiveness. Such an evaluation involves the use of quantitative methods and looks at the realisation of committed outcomes or the likelihood of those materialising. Any unintended consequences of the intervention and lessons learnt are identified and highlighted. <sup>11</sup>
<b>WASH</b>	WASH is the collective term for Water, Sanitation and Hygiene. Due to their interdependent nature, these three core issues are grouped together to represent a growing sector. While each is a separate field of work, they are dependent on the presence of the others. For example, without toilets, water sources become contaminated; without clean water, basic hygiene practices are not possible. <sup>12</sup> All three areas in WASH support and strengthen one another. If one is missing, the others cannot progress.

1 <http://www.fao.org/3/W3241E/w3241e07.htm>

2 Child Protection Information Sheet: What is Child Protection; [https://www.unicef.org/protection/files/What\\_is\\_Child\\_Protection.pdf](https://www.unicef.org/protection/files/What_is_Child_Protection.pdf)

3 [https://www.betterevaluation.org/en/plan/approach/participatory\\_evaluation](https://www.betterevaluation.org/en/plan/approach/participatory_evaluation)

4 ECD in the UNICEF Strategic Plan 2018–2021; <https://www.unicef.org/sites/default/files/2019-05/Early%20Childhood%20Development%20in%20the%20UNICEF%20Strategic%20Plan%202018-2021.pdf>

5 <https://www.unicef.org/evaluation/documents/global-evaluation-reports-oversight-system-geros-handbook-and-summary>

6 HRBA Portal - What is a human rights-based approach; <https://hrbaportal.org/faq/what-is-a-human-rights-based-approach>

7 [https://education.nova.edu/Resources/uploads/app/35/files/arc\\_doc/mixed\\_methods.pdf](https://education.nova.edu/Resources/uploads/app/35/files/arc_doc/mixed_methods.pdf)

8 <https://www.oecd.org/dac/evaluation/evaluation-criteria-flyer-2020.pdf>

9 [https://www.betterevaluation.org/en/plan/approach/participatory\\_evaluation](https://www.betterevaluation.org/en/plan/approach/participatory_evaluation)

10 <https://www.unicef.org/esa/reduce-stunting>

11 Mefalopulos, P. and Kamlongera, C., 2004. Participatory communication strategy design: A handbook. Food & Agriculture Org.

12 Water, Sanitation and Hygiene; [https://www.unicef.org/wash/3942\\_3952.html](https://www.unicef.org/wash/3942_3952.html)

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Nutrition and early childhood development remain crucial for enabling children to realize their full potential. We wish the Government of Rwanda and UNICEF Rwanda well for their future work and continued partnership for the improved nutrition and ECD services for the children of Rwanda. We are confident that this evaluation shall inform future UNICEF efforts for the children and women of Rwanda.

On behalf of the Evaluation Team

**Nadeem Haider**  
**Managing Director**  
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## Executive Summary

This is the final evaluation report of the **Developing Human Capital in Rwanda** programme (henceforth referred to as DHCR or the Programme), supported by the United Nations Children's Fund (UNICEF), Rwanda Country Office (RCO). The DHCR Programme aimed to: *increase human capital development in 14 districts of Rwanda by establishing optimal conditions for children (aged 0-6 years) to achieve their full potential and build a strong foundation to develop into adolescents with key problem-solving and socio-emotional competencies.* The Programme's implementation was led by the Government of Rwanda (GoR) represented by: Ministry of Health (MINISANTE); Ministry of Gender and Family Promotion (MIGEPROF); Ministry of Local Government (MINALOC); and Ministry of Agriculture and Animal Resources (MINAGRI). AAN Associates, (a Pakistan-based research and evaluation consulting firm) implemented the evaluation between September 2021 and May 2022.

**Intervention Context:** Rwanda is a country with a population of 12.9 million people (2020). Rwanda has made important economic and structural reforms and recorded strong economic growth over the past two decades. The impact of COVID-19 (with subsequent lockdown and social distancing measures) sharply curtailed economic activities in 2020, causing the country's gross domestic product (GDP) to drop by 0.2 percent in 2020 compared to a projected expansion of 8 percent before the COVID-19 outbreak.<sup>13</sup> The country has a high stunting rate of **33 percent** according to Demographic Health Survey (DHS 2019-2020), which is higher than the average for the Africa region (30.7 percent).<sup>14</sup> The bottlenecks that prevent children from reaching their full developmental potential include inadequate dietary intake (as only one in six children enjoys all recommended feeding practices); repeated infection; inadequate psychosocial stimulation (parents engaged in activities that stimulate a child's development and early learning); and lack of opportunities for optimal child development.<sup>15</sup>

**Object of Evaluation:** UNICEF RCO has supported the GoR to model and scale up integrated approaches to delivery of programmes addressing the needs and rights of young children in Rwanda. DHCR is driven by the intent to identify and address the cross-sectoral issues that affect children's holistic development in Rwanda. The design features a multi-sectoral and integrated approach, to address both immediate and underlying causes affecting the attainment of optimal child growth and development. The focus is on systems strengthening through multiple strategies i.e., capacity-building; behaviour-change communication; and coordination for integrated services at central, decentralized and community levels. Programme implementation followed a hybrid approach featuring collaboration between multiple stakeholders including public agencies, private sector, and civil society organizations (CSOs). DHCR was implemented between 2017 and 2022 (initially planned until 2020) in 14 districts. The total budget was US\$27 million funded by the Embassy of Kingdom of the Netherlands (EKN).

**Purpose and Scope of Evaluation:** This is a **Summative Evaluation**, with an expressed purpose to better understand how and under what conditions the interventions and activities were implemented under DHCR; and to assess the extent to which the initiative has met its objectives and achieved the desired results. The results from this evaluation will inform decisions by the GoR to scale up and continue implementation of similar approaches, including adjustments needed. The evaluation scope includes all EKN-funded Programme activities implemented from 2017 to 2021 in 14 targeted districts, i.e., Nyamagabe, Ngororero, Rutsiro, Gakenke, Burera, Rubavu, Nyaruguru, Karongi, Gicumbi, Nyamasheke, Gatsibo, Rusizi, Nyagatare and Musanze.

**Evaluation Design, Methodology and Limitations:** The overarching design include Mixed Methods<sup>16</sup> and Participatory<sup>17</sup> approaches. Keeping in view the intervention design and evaluation expectations, the evaluation team applied a Hybrid Evaluation Design, featuring **Contribution Analysis**<sup>18</sup> and **Comparative Analysis**<sup>19</sup> (with 'Before-After'<sup>20</sup> sub-design). The evaluation had to drop the quasi-experimental design (or data collection from control districts) for contamination risks due to similar interventions (by other actors) in control districts. Evaluation methodology included a household (HH) survey (sample size of **1,352 households** with a mother or female caregiver as respondent)

<sup>13</sup><https://www.worldbank.org/en/news/press-release/2021/02/08/covid-19-pandemic-pushes-rwanda-into-recession-severely-impacts-human-capital>

<sup>14</sup> Global Nutrition Report: <https://globalnutritionreport.org/resources/nutrition-profiles/africa/eastern-africa/rwanda/>

<sup>15</sup> Rwanda Demographic Health Survey 2019/2020.

<sup>16</sup> **Mixed Methods** research design is a procedure for collecting, analysing, and 'mixing' both quantitative and qualitative research and methods in a single study to understand a research problem.

<sup>17</sup> **Participatory evaluation** is an approach that involves the stakeholders of a programme or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis and the reporting of the study.

<sup>18</sup> **Contribution analysis** explores attribution by assessing the contribution a programme makes to observed results.

([https://www.betterevaluation.org/en/plan/approach/participatory\\_evaluation](https://www.betterevaluation.org/en/plan/approach/participatory_evaluation)).

<sup>19</sup> **Comparative analysis** is the process of comparing items to one another and distinguishing their similarities and differences.

<sup>20</sup> Before-after design involves measuring the dependent variable before and after the participants have been exposed to the independent variables (taken from FAO Marketing Research and Information Systems – Chapter 6).

implemented in seven districts (Nyaruguru, Karongi, Rutsiro, Ngororero, Burera, Gicumbi and Gatsibo). The endline survey followed the same methodology and design as the programme baseline (carried out in 2019) for comparison purposes. Qualitative data was gathered through **30 focus group discussions** (FGDs) (including 139 male and 154 female participants) with mothers, fathers, community health workers, farmers and community influencers. The evaluation team conducted **39 key informant interviews** (KIs) with stakeholders including UNICEF RCO, relevant public ministries, implementing partners (IPs) and donors. Desk review of 77 internal and external documents was undertaken to inform and corroborate the primary data. Evaluation design methods and implementation placed a considered focus on the integration of human rights-based programming, gender equality and equity by developing separate evaluation questions, tools, analysis and findings section for three cross-cutting programming priorities (treated as non-DAC criteria). Limitations of the evaluation include: data constraints that prevented comprehensive efficiency and effectiveness analysis (missing information on targets and programme progress from April – December 2021); majority of HHs that participated in the baseline study were ineligible to participate in the endline study which were replaced with other households within the same communities; and safety risks posed by COVID-19 leading to hybrid data collection modality (remote and in-person).

**Evaluation Findings & Conclusions:** Key findings against DAC and non-DAC criteria are given below:

**Relevance:** The findings indicate alignment between DHCR outcomes and strategies with those of national and development partners policies and plans (for the nutrition and early childhood development (ECD) sectors), which validates the Programme's relevance. Ample evidence is available to suggest an inclusive process featuring extensive consultations, joint reviews, validation meetings and bilateral meetings with key stakeholders was followed to involve them in design. There is evidence of changes in the context and beneficiary needs due to several factors (including government restructuring, changes in policy mandates and COVID-19), but limited evidence is available to show if or how the Programme made design level adjustments in terms of changes in the results framework and budget.

Relevance is evident as the Programme used both primary and secondary data (including the 2019 baseline, capacity gap analysis, ethnographic study) to deepen understanding of needs, barriers, drivers, and local dynamics, and used this data to inform the programme design. The selection of programme districts is driven by a multi-factor vulnerability assessment, which adds further to DHCR's relevance in terms of targeting the most impoverished and under-developed districts and communities. Programme design (strategies/interventions) are appropriate for addressing both the demand and supply-side barriers to malnourishment and development delays such as: capacity-building (of both duty-bearers and rights-holders); dialogue and advocacy (for uptake of promoted behaviour and practices); public-private partnership (for linkages with businesses and ECD centres); and evidence generation (for effective decision-making).

**Coherence:** The findings indicate that during programme design, UNICEF RCO managed to leverage internal coherence by engaging multiple UNICEF's sections. This enabled designing an intervention that aimed to address the causative elements behind stunting in children under 5 (U5) and holistic child development. The evaluation did not find significant evidence around how internal integration (resources and strengths across sections) was leveraged through implementation, and merits better documentation.

The Programme took a systematic approach to map and leverage external complementarities across stakeholders. This was achieved through multiple processes e.g., i) conducting studies to map stakeholders and interventions to have holistic view of actors and interventions; ii) collaborative consultations during the proposal stage to ensure there is no duplication of efforts; iii) partnering with relevant government and private entities to design and implement DHCR interventions; iv) use of existing platforms (the National Child Development Agency (NCDA), Scaling Up Nutrition (SUN) network, national ECD sub-cluster, child development technical working group) to coordinate, collaborate, plan and reflect with other development partners and relevant government agencies to implement DHCR activities, whilst avoiding duplication and overlap. This contributed to engaging with and utilising sector/cross sectoral forums.

**Effectiveness:** The effectiveness measurement remains incomplete, hence inconclusive for the fact that out of seven outcomes, only three could be rated for relative effectiveness (for having sufficient information to rate outcomes on the scale). For four outcomes i.e., 1 (nutrition), 3 (water, sanitation and hygiene (WASH)), 6 (integrated multisectoral interventions), and 7 (private sector linkages), either data or targets are unavailable to compare performance data. Out of the remaining three outcomes, two outcomes on social protection (outcome 4) and education (outcome 5) are assessed as 'Fully Achieved'

and one outcome (i.e., ECD – outcome 2) is rated as ‘Mostly Achieved’.<sup>21</sup> From the achievement data on programme components i.e., nutrition, health, ECD, WASH, and social protection, where the evaluation team has compared the baseline (2019) with endline data (2022) for 46 indicators (across seven districts), the evaluation concludes that the Programme was ‘**Partially Effective**’. Out of 46 indicators, the evaluation found incremental change in **28 indicators (61 percent)** covering mostly the WASH and health components. There are 18 indicators (39 percent of total) where the evaluation noted declining trends. The plausible explanation is COVID-19 and its impact on incomes, poverty and restricted mobility, however, merits further exploration. The key enablers for the Programme are: alignment with GoR priorities resulting in ownership and commitment of public sector partners; use of community-based models (community-driven) resulting in community engagement and ownership; adaptive measures taken during COVID-19. The disabling factors that hindered achievements include institutional changes (NECDP becoming NCDA); frequent public sector staff turnover (in districts); and COVID-19 disruptions and restrictions.

The Programme is largely a success in strengthening public sector nutrition and ECD systems, and packaging as integrated services. As part of system strengthening efforts, DHCR appears to be relatively more successful (or effective) with respect to two elements (out of five) of Enabling Environment<sup>22</sup> i.e., policy and strategy (supported GoR to develop multiple policies and strategies) and monitoring and evaluation (supported GoR to conduct national surveys and improve nutritional governance). The Programme remained partially successful for others i.e., capacity-building (undermined by high staff turnover reported at the district level); financing and budgeting (for limited focus and visible results around this component) and institutional arrangements and coordination (stakeholders reported gaps in district level coordination).

The community capacity development is assessed with respect to community mobilization and linkages development; skills and knowledge development; materials assistance; and monitoring and social accountability. The Programme successes are evident in organizing communities (for collective actions); wider community participation and engagement; leveraging influence of local influencers, i.e., religious leaders, theatres, faith-based organizations; and provision of skills and supplies. All these factors contributed to cultivating ownership and mobilizing community for collective benefit.

**Efficiency:** The evaluation team is unable to draw conclusions on the Programme’s efficiency due to unavailability of performance data from March to December 2021. The Programme reached to 8.5 million beneficiaries against a target of 0.5 million (the number hints to double counting of beneficiaries reached out by different interventions). In addition, the number was reached while using only 79 percent of allocated funds. As a result, it seems that the Programme set lower targets in comparison to the resources available. Given the Programme’s focus on nutrition and ECD, the allocation of over 55 percent of resources to these two components justifies the allocation of resources. The average per beneficiary cost comes at **\$2.05** for the Programme which is lesser than the planned cost/beneficiary (\$2.65). The cost comparison between EKN I<sup>23</sup> (\$2.15) and EKN II (\$2.05) underlines EKN II was as cost efficient as EKN I (in terms of cost/beneficiary).

**Impact:** The Programme has two impact indicators (reduction in stunting and improvement in child holistic development). The national stunting numbers indicate reduction from **38 percent to 33 percent** (from 2015-2020) which equals the Programme’s intended target of achieving 5 percent reduction in stunting nationally. This measurement is for national level whereas the Programme was implemented in 14 of the 30 districts and it may have contributed to the observed change. For Programme districts however, the numbers show a reduction of **1.6 percent** (in 7 out of 14 Programme districts – for 6-23 months children) between 2019-2022. The lower results for Programme districts (in comparison to national numbers) beg further enquiry. For holistic development, the national numbers have increased from **63 percent** (DHS 2014-2015, among children 36-59 months) to **76 percent** (DHS 2019-2020, among 24-59 months). However, comparison between these two values is not possible due to variation in age groups between the two surveys. For programme districts, the comparison remains incomplete (for all indicators that make up the holistic development) between the baseline (2019) and endline (2022), however for most of these indicators there is an upward trend in uptake of early stimulation activities. The unintended impact is evident in terms of improvement in fathers’ involvement in child development activities including shift in behaviour to save money rather than using money for personal expenses.

<sup>21</sup> The evaluation team applied a rating scale where ‘Mostly Achieved’ means 61-90% of intended targets achieved whereas ‘Fully Achieved’ means 91-100% of intended targets achieved.

<sup>22</sup><https://agora.unicef.org/pluginfile.php/69724/course/summary/WASH%20Guidance%20Note%20Draft%20Updated%20LR.pdf>

<sup>23</sup> The DHCR Programme (known as EKN II) is a second phase of an earlier project funded by the EKN Kigali, known as the ‘EKN Phase I. Phase 1 was implemented from 2014-2017 in 10 districts and focused on nutrition-specific interventions.

**Sustainability:** The Programme operated without a documented Sustainability/Exit Plan; and as a result, the evaluation team is unable to comment on success around its implementation. From the data, it appears that programme strategies of evidence generation (with availability of requisite data for future interventions) and public-private partnerships (PPP) (commitment by private companies to continue supporting ECD centres) show higher prospects of sustainability. Whereas strategies such as capacity-building, dialogue and advocacy, and cross-sectoral linkages are relatively less likely to be sustainable due to continued need for implementation. There is evident interest and willingness in the GoR agencies to continue and replicate the Programme which have translated into securing additional public sector financial contribution for components including nutrition, ECD and social protection. Initiatives by UN agencies and World Bank also highlight the development partners commitment to continue supporting GoR in reducing stunting and improving child holistic development in Rwanda.

#### **Non-DAC**

**HRBA:** Programme design and implementation is found largely consistent with HRBA principles. The consistency with the principle of participation is evident at varied levels such as engagement of right-holders, duty-bearers and influencers. The Programme is consistent with local laws and international rights conventions and has empowered rights-holders by enabling access to knowledge leading to perceived sense of empowerment in community members for better food, health and child nurturing choices. The Programme is found to be largely non-discriminatory with the exception of some families who were excluded from programme services for not meeting the desired Ubudehe criteria/rating. The Programme missed out on developing/supporting a feedback and grievance management system for accountability.

**Gender Equality:** The Programme is found to be partially compliant to gender equality principles. The Programme design offers limited gender disaggregation, as no indicators call for collection of gender disaggregated data (stunting and child development of girls and boys). Moreover, Programme design was not informed by formal gender assessment but utilised secondary evidence to inform its design. Programme implementation is assessed as gender responsive, as both male and female community members were sensitised on promoted behaviour; gender-segregated toilets were built in schools to address the needs of women and girls; female participation in committees and capacity-building initiatives; ECD centres set up by tea companies to promote work-life balance (women could work without having to worry about children). Results from the evaluation endline survey underscore that the prevalence of stunting in children aged 6-23 months though decreased, still continues to be higher for boys than girls in seven targeted districts (21.6 percent (boys) and 19.4 percent (girls) in 2022).

**Equity:** The Programme is found to be mostly compliant with equity principles. The Programme's geographical targeting was based on equity parameters including prevalence of stunting, poverty rates, household food insecurity and access to improved drinking water and improved sanitation and leveraged existing data to understand equity related needs and barriers and design interventions accordingly. Mostly, the interventions remained non-discriminatory; however, beneficiary prioritisation was done on the basis of Ubudehe (categorisation), but community discussions indicate the targeting was sometimes incorrect and in some cases deserving HHs did not receive benefits. More interventions are needed for people with disabilities and teenage mothers and their children also were not prioritized for the interventions.

### **Conclusions, Lessons Learnt and Recommendations**

#### **Conclusions on the Way Forward**

The Programme has been largely successful in creating momentum as is evident from contributions to intended impact. There is evident public sector willingness to continue implementation which has translated into increased public sector financial contribution to DHCR components. Still, the situation merits continued engagement of UNICEF RCO with GoR, possibly in a different role. For UNICEF the focus must shift to policy advocacy and development of a medium to long term road map, documentation of good practices, successes and business cases. The GoR must continue to allocate public financial allocations to DHCR interventions. The private sector holds the key and GoR must find ways to stimulate corporate social responsibility (CSR) and incentivise businesses (through tax breaks and other incentives) to become partners in delivery social goods. The GoR must continue working with external stakeholders to leverage their presence and resources and strengthen community engagement mechanisms including local coordination to sustain interest and ownership of other actors including communities. These ideas have been crystallised into actions in the recommendations.

#### **Lessons Learnt**

The Programme contributed to useful lessons and good practices as outlined below.

1. The wider consultative process evolved and applied for programme design and rollout (with active engagement of public and non-public stakeholders) was identified as a good practice that enabled cultivating broader ownership and merits continuation.
2. The use of a systematic approach to map stakeholders (through multiple exercises) and leverage information for improved external coherence has proven useful and effective and merits continuation.
3. The Programme has been effective in private sector/businesses engagement for creating social impact/public good and business continuity. The engagement with tea companies and cooperatives proved to be a win-win relationship, which should continue and be expanded to other sectors.

### **Recommendations**

Find below evaluation recommendations framed whilst keeping in view that the Programme has come to a close. Key recommendations have been included here, for more details, refer to Chapter 5:

#### **GoR:**

1. Seek technical assistance to undertake a broader review of national nutrition and ECD policies and to translate policy frameworks in a Child Development Road Map (for the next 5-10 years), which should leverage the structures and systems.
2. Undertake an extensive stock-taking exercise whilst using the enabling environment framework to map the systemic strengths and gaps and use the assessment to inform both the roadmap formulation and put measures in place for continuity of interventions.
3. Seek technical assistance to document the interventions, forums, and successes to make a case for additional public financial allocations whilst demonstrating results.
4. The Programme has proven the benefits of community engagement approaches for demand creation and cultivating local ownership and traction. The future must leverage pledges by local community leaders/warriors.
5. Work with businesses and cooperatives where mostly mothers are engaged in implementing workable public-private partnership models, offering a win-win equation for everyone involved.
6. The GoR may undertake assessment of systems/services with the lens of equity, human rights, and GE, with the view to integrate them into future nutrition and ECD services.

#### **UNICEF:**

1. Remain engaged with GoR and extend technical assistance with above mentioned actions (for GoR) such as policy reviews and revisions, sector stocktaking exercise/s, formulation of stunting reduction and child holistic development roadmaps, documentation of business cases and successes of DHCR, and facilitating donor and GoR engagement for continuity.
2. Assess the current level of documentation around processes, systems, standards, sector coordination, monitoring and evaluation (to guide GoR-led implementation) and identify need for additional documentation to enable GoR to be able to deliver quality services.
3. Continue to use the documentation—business cases, successes and others, for policy advocacy with GoR to prioritise nutrition and ECD interventions and increase public allocations for relevant public sector entities.
4. For future similar interventions, at the design stage, set realistic impact targets and use district-based targets rather than overall targets, whilst keeping in view the contextual variations in terms of baseline, risk exposure, and overall level of development. In addition, commission exploratory studies to understand the district-specific context which may explain the increase in stunting in some of the target districts.
5. The budgeting process for similar future interventions must link costs to results/outcomes. Moreover, planning should include development of a realistic budget as DHCR planned versus utilised costs were lower for all outcomes
6. Document the best practices around creating win-win partnerships between private and public sector. Use the documentation for wider advocacy around greater engagement of the private sector in public services delivery.
7. Advocate for and support greater integration of equity, human rights and GE into future nutrition and ECD services.

# 1

## Introduction and Object of the Evaluation



Picture: UNICEF Rwanda

# Chapter 1: Introduction and Object of the Evaluation

This is the final report of the **Summative Evaluation** of the United Nations Children's Fund (UNICEF), Rwanda Country Office (RCO) supported flagship intervention named: **Developing Human Capital in Rwanda** (henceforth referred to as DHCR or the Programme). The Programme aimed to increase human capital development in Rwanda by establishing optimal conditions for children (aged 0-6 years) to achieve their full potential and build a strong foundation to develop into adolescents with key problem-solving and socio-emotional competencies. The DHCR was implemented from 2017 to 2021 in 14 districts<sup>24</sup> and with funding from one primary donor—the Embassy of the Kingdom of Netherlands (EKN). The Programme's implementation was led by the Government of Rwanda (GoR) represented by: Ministry of Health (MINISANTE); Ministry of Gender and Family Promotion (MIGEPROF); Ministry of Local Government (MINALOC); and Ministry of Agriculture and Animal Resources (MINAGRI).

AAN Associates (a Pakistan-based evaluation firm) was commissioned to design and implement the evaluation from September 2021 to May 2022. The evaluation followed the objectives and scope as listed in the evaluation Terms of Reference (ToR, attached as Appendix 1). However, the evaluation methodology was slightly modified in view of the partial lockdown imposed by the GoR due to the COVID-19 pandemic. Consequently, a hybrid data collection model (remote and in-person) was implemented for key informant interviews (KII) and focus group discussions (FGD) to comply with local administrative regulations. All changes related to evaluation methodology and timeline were discussed and agreed with UNICEF Rwanda in advance.

The report follows UNICEF's Global Evaluation Reports Oversight System (GEROS)<sup>25</sup> guidelines for an evaluation report. The structure of the report is outlined below:

- **Chapter 1:** Presents the intervention context and the intervention itself, i.e., programme or object of the evaluation.
- **Chapter 2:** Offers an overview of the evaluation's purpose, objectives, scope, roles (of stakeholders), uses and significance.
- **Chapter 3:** Explains evaluation design, methodology, quality assurance, ethical considerations, evaluation management and implementation arrangements.
- **Chapter 4:** Outlines the evaluation's findings, analysis and preliminary conclusions.
- **Chapter 5:** Presents evaluation conclusions, outlines lessons learnt and gives recommendations.
- **Appendices:** Includes all relevant supporting material for this evaluation report.

## 1.1 Intervention Context

This section provides a brief overview of the country and the context of the intervention (early childhood development (ECD) and stunting) at global, regional and country levels. Refer to Appendix 2 for a more detailed analysis.

**Global Context:** ECD refers to the process of a young child acquiring essential motor, cognitive, social, emotional and language skills.<sup>26</sup> Children who do not receive adequate health, nutrition, early stimulation, learning opportunities, and care and protection tend to have lowered cognitive, language and psychosocial outcomes which translate to lowered academic achievement. Around **40 percent** (350 million) of children below primary school entry age need childcare, but do not have access to it.<sup>27</sup> Stunting (low height-for-age) is an indicator of chronic undernutrition. Globally, undernutrition remains a key factor in 35% of child deaths and irreversibly impairs the physical and mental development of children leading to a 10% reduction in lifetime earnings and up to 8% reduction in gross domestic product (GDP) in high burden countries. The underlying reasons for stunting and low child development are similar across regions and countries including **poverty, conflict and displacement, inadequate infant and young child feeding practices and disabilities, among others.**<sup>28</sup>

**Regional Context:** In the Eastern and Southern Africa (ESA) region, ECD and nutrition are an integral part of countries' sectoral policies and strategic frameworks. Despite this progress, there are evident gaps in implementing these policies and frameworks, including lack of i) detailed financing strategies; ii) multi-sectoral coordination mechanisms; and iii) accountability structures for services delivered.<sup>29</sup> Approximately **three-quarters of children** between 0-6 years do not have access to early childhood

<sup>24</sup> Nyamagabe, Ngororero, Rutsiro, Gakenke, Burera, Rubavu, Nyaruguru, Karongi, Gicumbi, Nyamasheke, Gatsibo, Rusizi, Nyagatare, Musanze.

<sup>25</sup> <https://www.unicef.org/evaluation/global-evaluation-reports-oversight-system-geros>

<sup>26</sup> UNICEF's Programme Guidance for Early Childhood Development, 2017.

<sup>27</sup> <https://www.worldbank.org/en/topic/earlychildhooddevelopment#1>

<sup>28</sup> [https://www.who.int/nutrition/topics/globaltargets\\_stunting\\_policybrief.pdf](https://www.who.int/nutrition/topics/globaltargets_stunting_policybrief.pdf)

<sup>29</sup> Ibid.

education. Stunting (a proxy for the incidence of developmental delays) has declined from **46 percent in 2000 to 32 percent in 2020**.<sup>30</sup> There are still considerable challenges such as **lack of funding, proper budget allocation, and lack of technical expertise and robust monitoring systems from the GoR.**

**Country Context:** Rwanda is a country of 12.9 million people (2020), with a population that is 49.1 percent male and 50.8 percent female.<sup>31</sup> The country's surface area covers 26,340 sq. km<sup>32</sup> divided into five provinces (Northern, Southern, Eastern, Western and the Municipality of Kigali), 30 districts, 416 sectors, 2,148 cells, and 14,837 villages.<sup>33</sup> The official languages are Kinyarwanda (spoken by most Rwandans), English, French and Swahili.<sup>34</sup> A strong focus on homegrown policies and initiatives contributed to significant improvement in access to services and human development indicators. Growth averaged 7.2 percent in the decade before 2019.<sup>35</sup> According to the national poverty line, poverty declined from 77 percent in 2001 to 38 percent in 2016. Moreover, life expectancy at birth improved from 33 years (1990s) to 69 (2019).<sup>36</sup> The impact of COVID-19 (with subsequent lockdown and social distancing measures critical to controlling the pandemic) sharply curtailed economic activities in 2020, resulting in the country's gross domestic product contracting by 0.2 percent, i.e., 10.3 billion<sup>37</sup> in 2020 compared to a projected expansion of 8 percent before the COVID-19 outbreak.<sup>38</sup>

Despite improvement in development and economic growth, Rwanda continues to face some significant challenges, particularly pertaining to the first critical years of children's lives. In 2015, 38 percent of children (under five) were stunted, which has fallen to 33 percent by 2019-2020. The high prevalence of stunting and children not reaching their full developmental potential is due to the combined effects of **inadequate dietary intake (as only one in six children enjoys all recommended feeding practices), insufficient nutrition intake of pregnant and lactating women, repeated infection, inadequate psychosocial stimulation, and a lack of opportunities for optimal child development** (Rwanda Demographic and Health Survey (RDHS) 2019-2020).<sup>39</sup>

**Policy Framework around ECD:** As a signatory to the global and regional frameworks such as the United Nations Convention on the Rights of the Child (UN CRC),<sup>40</sup> Education for All (EFA),<sup>41</sup> Sustainable Development Goals (SDG) and standards on the child's rights, Rwanda is committed to improving ECD services for children aged 0-6. In this regard, the country has put in place several policies and strategies to tackle challenges related to ECD, for instance, the National ECD Policy<sup>42</sup> sets the conditions to develop community led integrated ECD programmes and strengthen and coordinate essential inter-sectoral and sectoral services for children and parents. The National Child Development Agency (NCDA) oversees all nutrition promotion-related activities, standard-setting, curricula and implementation approaches to provide national guidance to programme implementers.

**Policy Framework around Nutrition (Stunting):** Several policies and frameworks govern Rwanda's nutrition sector. The National Food and Nutrition Policy (NFPN, 2014)<sup>43</sup> articulates actions needed to drive and sustain economic growth and poverty reduction; this agenda necessitates an innovative multi-sector approach with sector-specific strategies, explicitly addressing the prevalence of stunting among children under two years of age.

<sup>30</sup> <https://data.unicef.org/resources/jme-report-2021/>

<sup>31</sup> Retrieved from: World Bank Statistics.

<sup>32</sup> National Institute of Statistics Rwanda: <https://www.statistics.gov.rw/>

<sup>33</sup> <https://www.gov.rw/government/administrative-structure#:~:text=Rwanda%20is%20composed%20of%20two,%2C%20Sectors%2C%20cells%20and%20villages>.

<sup>34</sup> <http://uis.unesco.org/en/country/rw/>; accessed on 28/02/2022

<sup>35</sup> <https://www.worldbank.org/en/country/rwanda/overview>

<sup>36</sup> National Institute of Statistics Rwanda: <https://www.statistics.gov.rw> accessed on 28/02/2022

<sup>37</sup> The World Bank Data: <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=RW>

<sup>38</sup> <https://www.worldbank.org/en/news/press-release/2021/02/08/covid-19-pandemic-pushes-rwanda-into-recession-severely-impacts-human-capital>

<sup>39</sup> <https://thedocs.worldbank.org/en/doc/554941595276442131-0090022020/original/TF0A4965ASARwandaNutritionSituationAnalysisNovember212018FINALwithlogo.pdf>

<sup>40</sup> Article 27: Right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

<sup>41</sup> It aims to strengthen the capacities of member states to design, develop, and implement curricula that ensure the equity, quality, development-relevance and resource efficiency of education and learning systems.

<sup>42</sup> The policy aims to ensure all Rwandan children achieve their potential, are healthy, well-nourished and safe, and their mothers, fathers and communities become nurturing caregivers through receiving integrated early childhood development services.

<sup>43</sup> The National Food and Nutrition Policy, sourced at <https://www.moh.gov.rw/news-detail/national-food-and-nutrition-policy>.

UNICEF RCO has supported the GoR to model and scale up integrated approaches<sup>44</sup> to delivery of programmes addressing the needs and rights of young children in Rwanda. The support includes the **DHCR**, which is the focus of this evaluation.

## 1.2 Programme Introduction (Object of Evaluation)

This section describes the intervention that is being evaluated (also referred to as object of the evaluation). The description includes an overview, goals and expected results, geographic scope and implementation status, stakeholders and their roles, resources, participants (beneficiaries), and the Programme's significance and Theory of Change (ToC).

### 1.2.1 Programme Overview

The DHCR Programme (or EKN II) is a follow-up to UNICEF Rwanda's Nutrition programme (referred to as EKN I) implemented in 10 districts from October 2013 to December 2016,<sup>45</sup> with an aim to reduce stunting in children under two years of age. Alternatively, DHCR broadened its thematic focus with interventions targeting the ECD, nutrition, water, sanitation and hygiene (WASH), education and social protection sectors. The Programme's design was driven by identifying the cross-sectoral issues that affect children's holistic development in Rwanda. It featured a multi-sectoral and integrated approach to address immediate and underlying causes affecting optimal child growth and development. The implementation was led by multiple stakeholders including public agencies, the private sector and civil society organizations (CSO).<sup>46</sup>

#### Programme's Goal

The Programme's overall goal was “to improve human capital development in Rwanda by establishing optimal conditions for children to achieve their full potential and build a solid foundation to develop into adolescents with key problem-solving and socio-emotional competencies”.<sup>47</sup> The Programme's two impact level indicators are mentioned below:

- Reduced stunting amongst children under five years (U5).
- Improved holistic development amongst young children.

#### Programme Strategies

The Programme used the following strategies across these components to achieve intended results:<sup>48</sup>

- Capacity development
- Dialogue and advocacy
- Evidence generation
- Public-private partnerships (PPP)
- Innovation and cross-sectoral linkages

#### Programme's Timeline and Implementation Status

The DHCR was implemented between 2017 and 2022 (initially planned until 2020).<sup>49</sup> The Programme was extended by almost a year and six months due slow start of implementation in the beginning and delays caused by COVID-19. The Programme was implemented in **14 districts** (as mapped in Figure

**Figure 1: Programme's Components**



<sup>44</sup> Integrated ECD services include, but are not limited to, the following activities: (a) early learning and stimulation, (b) medical check-ups, (c) child growth monitoring (d) birth registration control, protecting children from any abuse and neglect (e) provision of meals, (f) parent education program, (g) sensitization on water, hygiene and sanitation (h) sustainability strategy, (l) early disability and special needs detection and referral.

<sup>45</sup> Nutrition monitoring mission, 2019; Human Capital Development project UNICEF Rwanda.

<sup>46</sup> DHCR - Baseline Evaluation Report (2019).

<sup>47</sup> Phase II donor proposal to the Embassy of the Kingdom of the Netherlands.

<sup>48</sup> Programme document 07. DHCR - Donor proposal to the Embassy of the Kingdom of the Netherlands – 3rd Version - 16 August 2016

<sup>49</sup> Due to COVID-19, the EKN programme was extended to June 2022 reported in: EKN- IV annual progress report for 2020\_as of 26 March 2021

2). The following criteria was used to select target districts (see Appendix 3 for the weightages applied against each criterion):<sup>50</sup>

- High poverty levels;
- High stunting levels;
- Household food insecurity;
- Access to improved drinking water and improved sanitation.

### Programme Stakeholders and their Roles

Several key stakeholders were involved in the Programme. Table 1 outlines key stakeholders with their specific roles in design and implementation (refer to Appendix 4 for more details on the role of key stakeholders):

Table 1: Key Programme Stakeholders and their Roles

Stakeholder	Role in Programme
<b>Primary Duty-Bearers - Government</b>	
GoR (MINISANTE, MIGEPROF, MINALOC, MINEDUC, MINAGRI, Rwanda Management Institute)	These ministries were responsible for leading the implementation and coordination of Programme activities.
<b>Technical and Financial Partners - Donors</b>	
UNICEF Rwanda	Responsible to provide technical, managerial and coordination support to the implementation of DHCR activities. Additionally, UNICEF was responsible for tracking and reporting to GoR and EKN (the donor) on progress, challenges, and results of the Programme.
EKN	<ul style="list-style-type: none"> <li>- Provided financial support to the implementation of DHCR activities.</li> <li>- Ensured accountability of UNICEF and GoR against target results.</li> </ul>
<b>Civil Society Partners (Implementing Partners)</b>	
<ul style="list-style-type: none"> <li>- ECD – Association of Volunteers in International Service (AVSI), Imbuto Foundation, Anglican Church of Rwanda (ADEPE), Rwanda Interfaith Council on Health (RICH)</li> <li>- Nutrition - World Relief, Civil Society Alliance for Nutrition (SUN)</li> <li>- Education - International Education Exchange (IEE)</li> <li>- WASH - World Vision and Society of Family Health (SFH)</li> <li>- Social Protection - World Relief</li> </ul>	Trained, deployed, and managed community health workers (CHW), teachers, religious leaders, farmer promoters and ECD caregivers. These implementing partners (IP) remained involved in: <ul style="list-style-type: none"> <li>- Establishing a system for local production of the play and learning materials for young children</li> <li>- Capacity-building of services providers and health systems to effectively manage and prevent severe acute malnutrition (SAM).</li> <li>- Constructing improved sanitation services in ECD centres and schools.</li> <li>- Providing childcare and nutrition support to Vision 2020 Umurenge Program (VUP) families with young children.</li> </ul>
<b>Rights-Holders</b>	
Parents/caregivers of children aged 0-6 years.	Decision-makers of target beneficiaries (children aged 0-6 years).

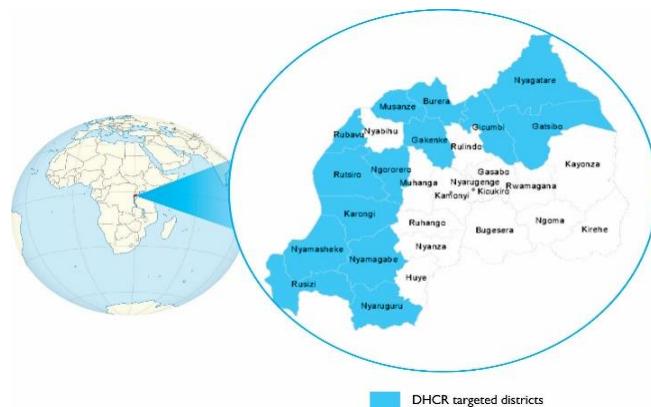
### Programme Participants (Beneficiaries)

The DHCR's principal beneficiaries included children aged 0-6 years, their parents and families, and communities of 14 targeted districts. Other beneficiaries included a series of public sector entities and CSOs that were involved in programme implementation and benefitted from capacity-building initiatives. The Programme had set an intended target to reach **500,000** beneficiaries (children aged 0-6 and families) but does not specify targets for capacity-building initiatives. Approximately **8.5 million beneficiaries** were reached through various interventions.<sup>51</sup> However, there is a possibility of multiple counting as one beneficiary might have received more than one intervention and was therefore counted more than once. Refer to Appendix 5 which provides disaggregated data with respect to different categories of programme beneficiaries.

### Programme Resources and Donor

The Programme's total budget was **US\$27 million** primarily funded by the EKN.<sup>52</sup> Table 2 provides the comparative analysis of planned and utilised budget over the course of four years (until March 2021). The evaluation team did not receive expenditures pertaining to April to December 2021. Furthermore,

Figure 2: DHCR's Geographic Spread



<sup>50</sup> Phase II donor proposal to the Embassy of the Kingdom of the Netherlands.

<sup>51</sup> Data shared by UNICEF RCO on May 25, 2022.

<sup>52</sup> EKN- IV annual progress report for 2020\_ as of 26 March 2021

the evaluation team did not receive information on financial and/or in-kind contribution made to DHCR by the relevant GoR ministries.

**Table 2: Programme Budget - Allocated vs. Utilised**

	Planned budget (\$)	Expenditure (\$)	Utilisation Rate (%)
Total direct program cost	24,719,619	19,566,855	79%
Operations costs	689,546	537,086	78%
Harmonised cost recovery	2,032,733	1,608,315	79%
<b>Grand total</b>	<b>27,441,898</b>	<b>21,712,256</b>	<b>79%</b>

### 1.2.2 Significance of the Programme

Find below key aspects of the Programme that contribute to its significance.

- **The Programme holds significance for GoR** as its priorities align with the GoR's nutrition and ECD policies such as National Food and Nutrition Policy (2014), Nutrition Action Plan (2013-2018), National Food and Nutrition Strategic Plan (2013-2018) and National ECD Policy (2016). The Programme also supports the GoR to achieve the SDGs (specifically 2, 3, 4 and 16) in reducing stunting and improving the childhood development status of the most vulnerable communities at the national level (14 target districts out of total 30 districts). The successful approaches and interventions could also potentially guide scale-up to other districts of Rwanda.
- **The Programme holds significance for UNICEF** for the above-mentioned reasons. In addition, the Programme also offered an opportunity to develop and implement innovative models for integrated service packages and engage stakeholders to coordinate efforts to reduce stunting and provide ECD services to target communities.
- **The Programme holds significance for the Kingdom of the Netherlands** as it aligned with its development priorities in Rwanda, including enhanced food and nutrition security and early childhood development.
- **The Programme significantly contributed to improving ECD and the nutrition status of target communities** (including reducing stunting numbers). Furthermore, improved community awareness on critical maternal and child nutrition may improve health and nutrition in infants and pregnant and lactating women.

### 1.2.3 Programme ToC

The overall goal of the multi-sectoral Programme was to establish optimal conditions for children to achieve their full potential. It aimed to help them build critical problem-solving and socio-emotional competencies, thereby increasing human capital development in Rwanda. The EKN-funded programme interventions focused on young children, pre-natal to six years of age, including their parents and families, thereby ensuring a continuum of care that enhances and sustains optimal child growth and development. Refer to Appendix 6 for the Programme's ToC which outlines the desired state of change (or goal) i.e., improved human capital development in Rwanda. The ToC further stipulates impact, outcome and output level results with identification of strategies that may lead to the desired change. There are some elements omitted from the visual including assumptions and risks for the desired change to take place.

# 2

## Evaluation Purpose, Objectives, Scope        and Criteria



Picture: UNICEF Rwanda

## Chapter 2: Evaluation Purpose, Objectives, Scope and Criteria

This chapter describes the evaluation purpose, objectives, criteria, scope (chronological, thematic and geographic), key evaluation questions, stakeholders' interests, and possible use of the evaluation results.

### 2.1 Evaluation Purpose and Objectives

This is an endline evaluation commissioned towards the end of the intervention. The purpose of the evaluation is to generate evidence of the Programme's achievements vis-à-vis intended results. This evaluation is a **Summative Evaluation** with a demonstrated accountability focus. With that there is a considered focus on reflection and learning to enable both the GoR and UNICEF RCO to make an evidence-based decision around continuity, improvements to and future scale-up of the intervention.

The **evaluation objectives** as outlined in the ToR were reviewed and rephrased, and these changes were approved by the evaluation oversight forum i.e., Evaluation Reference Group (ERG) upon approval of the inception report. The rephrased objectives are presented below:

1. To objectively assess programme achievements by drawing a comparison between baseline and endline data (for indicators that feed into the Programme's logframe) and any gaps and challenges (in achieving intended results);
2. To assess and offer a considered opinion around the Programme's achievements as per OECD-DAC criteria, i.e., relevance, coherence, efficiency, effectiveness, impact, sustainability;
3. To assess the integration of gender equality and equity principles/approaches and results achieved across DHCR components and interventions;
4. To assess the contributions of UNICEF and other partners for the successful implementation of DHCR, and;
5. To identify the lessons learned (by the stakeholders) and list recommendations for continuity, integration and scale-up of DHCR interventions by the GoR.

### 2.2 Evaluation Stakeholders' Role and Uses of Evaluation

Several key stakeholders remained involved in the evaluation with varied interests. Table 3 below outlines the key stakeholders' roles and possible uses of the evaluation.

Table 3: Stakeholders' Role and Uses of the Evaluation

Stakeholder	Role and Uses of the Evaluation
UNICEF Rwanda Office	<b>Role:</b> Initiated this evaluation and was responsible for contract management, coordination with evaluation team, ERG, stakeholders, facilitating the primary data collection, and responsible for overall quality assurance (review and finalization of deliverables). <b>Uses:</b> To guide future programming, especially for the effectiveness and relevance of the organisation's ToC on vital health services.
The GoR (MIGEPROF, MINEDUC, MINISANTE, MINALOC and NCDA)	<b>Role:</b> These relevant ministries were not directly involved in planning of the evaluation, however, participated as key respondents. Additionally, the stakeholders also provided access to relevant documents/data, identified stakeholders to consult, and facilitated meetings with the staff at national, provincial and district levels. <b>Uses:</b> To provide feedback for the future development of policies and strategies for improving nutrition and ECD through integrated and multisectoral interventions.
Donor (EKN)	<b>Role:</b> Participated as key respondents without being directly involved in the planning and management of the evaluation. <b>Uses:</b> To provide evidence of accomplishments of programme achievements and objectives to inform future support to the country.
Communities in the 14 targeted districts	<b>Role:</b> The primary beneficiaries who shared their thoughts and experiences regarding programme activities, results and benefits for children aged 0-6 years. <b>Uses:</b> To provide evidence on progress, lessons and best practices on child growth and development.

### 2.3 Evaluation Scope, Criteria and Key Questions

This subsection outlines the evaluation scope, criteria and key questions separately.

#### 2.3.1 Evaluation Scope

The evaluation scope with respect to thematic, chronological and geographic aspects is mentioned below. The scope did not change as defined in the evaluation ToR.

- **Chronological scope:** All programme activities implemented from 2017 to 2021.
- **Thematic focus:** All EKN-funded programme activities focusing on gender, equity and child rights dimensions.

- **Geographic focus:** All 14 districts where DHCR was implemented (including Nyamagabe, Ngororero, Rutsiro, Gakenke, Burera, Rubavu, Nyaruguru, Karongi, Gicumbi, Nyamasheke, Gatsibo, Rusizi, Nyagatare and Musanze). It is important to note that the nutrition-sensitive activities implemented in the other 16 districts do not fall within the evaluation scope of this study.

### 2.3.2 Evaluation Criteria and Key Evaluation Questions

The evaluation followed the standard OECD-DAC<sup>53</sup> criteria comprising **relevance, coherence, effectiveness, efficiency, impact and sustainability**.

The ToR also included coordination (non-DAC criterion) to assess the coordination structures developed by DHCR. For consistency, the evaluation team has merged this element with the effectiveness criterion; this change was approved by UNICEF during the inception phase. There is also considered focus on UNICEF's cross-cutting programming priorities including **gender equality, equity and human rights-based programming** (particularly concerning child rights) which have been treated as non-DAC criteria.

The **evaluation questions** (as listed in the ToR) were critically reviewed, discussed and rephrased (listed in Table 4) to fit into the Evaluation Matrix (see Appendix 7). These changes were approved in advance by the ERG upon approval of the inception report. Find below the final list of key evaluation questions for DAC and non-DAC criteria.

Figure 3: Evaluation Criteria

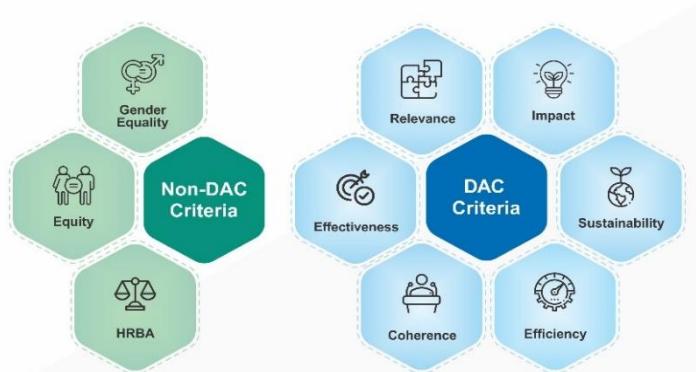


Table 4: Key Evaluation Questions

Evaluation Criteria Key Questions– Against each DAC/Non-DAC Criteria	
Relevance	EQ1 – To what extent was DHCR design (objectives and strategies) informed by national/local nutrition and ECD needs (children 0-6 including the most disadvantaged), included the relevant stakeholders, and evolved to accommodate the changing context?
Coherence	EQ2 – To what extent did DHCR utilise internal (in terms of synergies, interlinkages) and external (in terms of complementarities, harmonization) coherence?
Efficiency	EQ3 – To what extent did DHCR allocate and deploy resources (time, funds, capacity-building through nutrition and ECD materials, management arrangements) to achieve intended results?
Effectiveness	EQ4 – To what extent did DHCR achieve the intended results (outcomes and outputs) including public sector capacity development (including communities), and factors that influenced achievement (or non-achievement of results)? EQ5 – To what extent has DHCR been planned and implemented in a coordinated manner, challenges faced and to what extent is it replicable?
Impact	EQ6 – To what extent did the Programme contribute to achieve desired impact?
Sustainability	EQ7 – To what extent did DHCR enable the GoR's ownership, capacity development and institutionalisation of nutrition and ECD interventions, and what factors either influenced or are likely to influence sustainability?
HRBA, Gender Equality, and Equity	EQ8 – To what extent did DHCR incorporate human rights-based/child rights approaches (HRBA/CR), gender equality, and equity principles and approaches, and results created thereof?

<sup>53</sup> <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

# 3

## Methodology, Quality Assurance and Ethics



Picture: UNICEF Rwanda

## Chapter 3: Evaluation Methodology, Quality Assurance and Ethics

This chapter describes the evaluation design, methodology and data sources, sampling strategy, data analysis approach, compliance to United Nations Evaluation Group (UNEG) norms and standards, limitations and mitigation measures, and evaluation implementation and management.

### 3.1 Evaluation Design

The evaluation was guided by two overarching approaches including **mixed-method<sup>54</sup>** and **participatory**.<sup>55</sup> The mixed-method approach (featuring desk review, household (HH) survey, KIIs with key stakeholders and FGDs with communities) helped collect information from varied sources to overcome any method-related deficiencies and gather rich and complementary information for cross validation and triangulation. Similarly, the participatory approach facilitated engaging all relevant stakeholders (e.g., the ERG) to inform the evaluation as well as provide oversight. The evaluation was informed by the opinions, experiences and suggestions of key stakeholders, including service providers (at national, provincial, district and community levels); rights-holders (farmers, mothers, fathers and community influencers); technical and financial partners (UNICEF RCO and EKN) and key IPs.

Keeping in view the Programme's design and evaluation expectations, the evaluation team applied a **Hybrid Evaluation Design**, featuring two sub-designs i.e., **contribution analysis**<sup>56</sup> and **comparative analysis**.<sup>57</sup> Contribution analysis was applied for measurement of outcome achievements and to assess whether the Programme interventions contributed to the observed changes. As a form of comparative analysis, the evaluation team has used **Before-After Design**.<sup>58</sup> This implies that the evaluation team has drawn a baseline and endline comparison for intervention districts (where a baseline was conducted). The endline values have been compared against the baseline to measure the 'net impact' for indicators that feed into the Programme's logframe. It is important to note that Quasi-Experimental Design was initially proposed for this endline study but was replaced with Before-After design during the inception phase. Refer to Appendix 8 for the rationale behind the departure from the proposed design.

### 3.2 Evaluation Methods

The evaluation employed a **Mixed-Methods** approach (refer to Figure 5), whereby both quantitative and qualitative methods were applied to generate usable evidence to inform evaluation analysis, conclusions and recommendations. Methodology was slightly adapted in view of the partial lockdown imposed in Rwanda due to COVID-19.

Find below an overview of the evaluation methodology.

#### 3.2.1 Desk Review

The evaluation team reviewed **82** documents (such as the programme proposal, progress and financial reports, baseline, midline and ECD and nutrition-related law and policies). The desk review remained an ongoing process throughout the evaluation as it enabled a better understanding of the context, the interventions, results, challenges and learning. A systematic approach was applied during desk

Figure 4: Evaluation Design

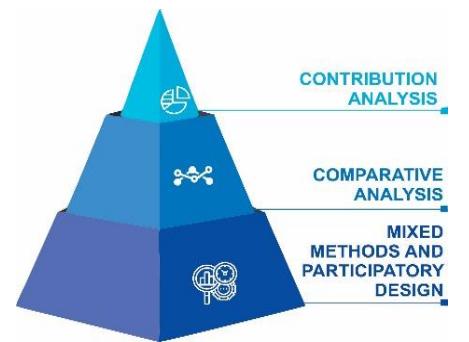


Figure 5: Evaluation Methods



<sup>54</sup> Mixed Methods research design is a procedure for collecting, analysing, and 'mixing' both quantitative and qualitative research and methods in a single study to understand a research problem.

<sup>55</sup> Participatory evaluation is an approach that involves the stakeholders of a programme or policy in the evaluation process. This involvement can occur at any stage of the evaluation process, from the evaluation design to the data collection and analysis and the reporting of the study.

<sup>56</sup> Contribution analysis explores attribution through assessing the contribution a programme is making to observed results. ([https://www.betterevaluation.org/en/plan/approach/participatory\\_evaluation](https://www.betterevaluation.org/en/plan/approach/participatory_evaluation)).

<sup>57</sup> Comparative analysis is the process of comparing items to one another and distinguishing their similarities and differences.

<sup>58</sup> Before-after design involves measuring the dependent variable both before and after the participants have been exposed to the independent variables (taken from FAO Marketing Research and Information Systems – Chapter 6).

research. This entailed initial screening and classification (whereby documents were organized and catalogued according to the type of documents), broader themes were identified (keeping in view the evaluation matrix) and relevant information was extracted using word search and general reading. The information thus gathered was used to appropriately respond to evaluation questions either on its own or with the primary data collected through field research. Refer to Appendix 9 that provides a complete list of documents reviewed during evaluation.

### 3.2.2 Quantitative Data Collection

For quantitative data collection, a HH survey was administered in **1352** households in seven districts (refer to Figure 6 for sampling distribution per district) with a mother or female caregiver of children aged 6-23 months. The endline followed the same methodology and approach as applied during the baseline study. For the baseline, a comprehensive assessment tool was designed to measure several internationally recognized indicators covering household characteristics, child development, nutrition, health, caregiving practices and access to services. The evaluation team refined the baseline tool during the inception phase to focus on those indicators that directly feed into the Programme's logframe (refer to Appendix 10 for HH survey endline tool).

Following the sampling plan laid out in the baseline, the endline used the Cochran's sample size formula<sup>59</sup> with the assumption that about 9.4 percent of all the households had children between 6–23 months, as well as two-sided alpha significance level of 0.05, plus a margin of error of  $\pm 4$  percent. Prior to the HH survey, a household listing exercise was conducted where all those households (1637)<sup>60</sup> that participated in the baseline study were visited. From the planned 1637 HHs, only 411 eligible households (who still had a child aged 6-23 months) were identified. After consultation with UNICEF RCO, the evaluation team replaced these households with other households in the same villages to reach a sample size of 1352.

More details on sampling frame, rationale, the anthropometric measurements, and strategies used for selection of HHs, and respondents are given in the Appendix 11.

### 3.2.3 Qualitative Data Collection

KIIs with stakeholders and FGDs with communities were used to collect qualitative data. Keeping in view the local restrictions (in the shape of partial lockdown) due to COVID-19, some of the KIIs were remotely conducted. Before providing details on each individual method, the following descriptions highlight the sampling approach that was applied to select districts and respondents for qualitative data collection methods.

**Sampling for Qualitative Data Collection:** In terms of geographic sampling, the evaluation team randomly selected three treatment districts namely **Burera, Nyaruguru and Rutsiro** (one from each province) for district level KIIs and FGDs. The evaluation team employed a purposive sampling approach<sup>61</sup> to identify the respondents of KIIs and FGDs. The selection of KII respondents was driven by the purpose of involving all those stakeholders who have been involved directly or indirectly in programme design and implementation. This ensured gathering of a diverse range of opinions to inform the evaluation findings. For FGDs, those groups were selected which directly or indirectly benefitted or have been involved in the Programme's activities at the community level. The descriptions below outline the key aspects of each data collection method.

Figure 6: Sampling Distribution per District



<sup>59</sup> Cochran formula allows you to calculate an ideal sample size given a desired level of precision, desired confidence level, and the estimated proportion of the attribute present in the population.

<sup>60</sup> UNICEF provided the evaluation team with the list of households that participated in the baseline study.

<sup>61</sup> Purposive sampling, also known as judgmental, selective or subjective sampling, is a form of non-probability sampling in which researchers rely on their own judgment when choosing members of the population to participate in their study. Better Evaluation, 'Purposive Sampling', <https://www.betterevaluation.org/en/resources/overview/purposive-sampling>.

**Key Informant Interviews (KIs):** The evaluation team conducted all planned **39** KIs with key stakeholders including UNICEF, relevant public ministries, IPs and the donor (refer to Figure 7 for the distribution). The KIs were used to draw in-depth understanding of the views of participants on DHCR design, implementation, achievements, challenges, lesson learnt and scalability. The evaluation team employed semi-structured guidelines (refer to Appendix 12), which were approved by UNICEF Rwanda to interview key informants at various levels (refer to Appendix 13 for complete list of people met during KIs).

**Focus Group Discussions (FGD):** The evaluation team conducted **30** FGDs with respondents from various categories including mothers, fathers, farmers, community influencers, CHWs and ECD teachers. A total of **293 participants** (139 male and 154 female) participated in FGDs and shared their opinions and perceptions as rights-holders in three districts. Structured guides were used (see Appendix 14 for FGD guides) to steer the discussions. Figure 8 shows the number of participants who participated from each group category (refer to Appendix 15 for more details on participants of the FGDs).

**Validation Workshop:** The evaluation team held a virtual validation workshop on May 24, 2022, with national and subnational stakeholders after the submission of the draft evaluation report to finalise the findings and recommendations with the participation of key stakeholders (UNICEF, MoH, MIGEPROF, MINAGRI, and others).

**Field Photographs:** The evaluation team took photographs (with permission) to support the field findings (data triangulation) and presentation. Appendix 16 includes samples of the field photographs.

### 3.3 Quality Assurance of the Data Collection

The evaluation team applied the following approaches and processes for quality assurance purposes of the data collection process.

**Training and Pre-testing:** The core evaluation team provided comprehensive remote training for KIs in December 2021 while the master training for FGDs and HH surveys was conducted from January 10-13, 2022. Following the master training, the national partner organized the enumerator trainings from January 17-21, 2022 (refer to Appendix 17 for the training agenda). Post-training, the HH survey questionnaire was pre-tested in 20 HHs in a nearby community within a conveniently approachable location. The collected data was processed and analysed with minor revisions made in the HH survey questionnaire based on the enumerators' feedback.

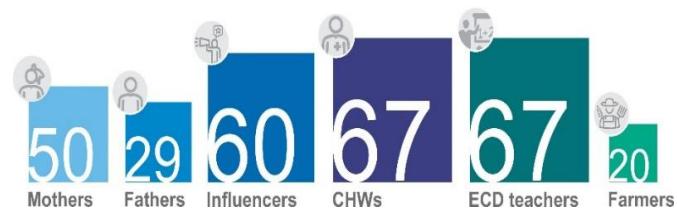
**General Quality Assurance:** The evaluation team established and maintained strict quality assurance field protocols. Key measures implemented included deployment of field supervisors (accompanying interviews, on-spot checking), validation checks on the HH survey tool, dedicated quality assurance staff (random spot-checks, 10 percent back-checks), gender balanced teams, ensuring voice recordings of KIs/FGDs, and maintaining close coordination and communication among all field staff (Appendix 18 offers more details on actions implemented for quality assurance). Furthermore, three field monitors were hired to monitor HH surveys and FGDs in each district. These monitors were provided with checklists (refer to Appendix 19 for the spot check tool) to monitor the field team and ensure adherence to the guidelines for conducting HH surveys and FGDs.

**Safety and Protective Protocols implemented under COVID-19:** In addition to general quality control measures, the evaluation team ensured implementation of various safety and protective protocols to ensure that all research participants/respondents and the evaluation team were not exposed to any possible risks related to the COVID-19 pandemic. Key measures included a) maintaining safe distance; b) avoiding physical contact; c) covering face with masks at all times; d) carrying and using sanitizer

Figure 7: Distribution of KIs



Figure 8: Distribution of FGD Participants



during field work, and others (refer to Appendix 20 for more details on the measures undertaken by the evaluation team).

**Ethical Approval:** The field work was initiated after obtaining the requisite ethical approval from the Rwanda National Ethics Committee (RNEC) on 29 November 2021. For details relating to the process of ethical approval and letter, refer to Appendix 21. All interviews from the respondents were initiated after obtaining consent from respondents (refer to Appendix 12 and 13 for the consent forms).

### 3.4 Data Processing and Analysis

A parallel mixed method data analysis approach was employed whereby data from each strand (qualitative and quantitative) was collected, processed and analysed to draw findings, conclusions and recommendations.

**Quantitative Data Analysis:** The household listing and survey data was collected using computer-assisted personal interviewing (CAPI) devices whereby data was uploaded on the local partner's server. The quantitative data analysis utilised cross tabulation and frequency tables using SPSS (see Appendix 22 for HH survey tabulations). Findings from the analysis of HH survey results were corroborated and triangulated with qualitative data and secondary information to formulate valid arguments against the evaluation questions and sub-questions. The evaluation team also utilised and analysed data from secondary sources (progress reports, budget/expense sheets) to validate and triangulate evaluation findings.

**Qualitative Data Analysis:** The qualitative data analysis utilised a content and thematic analysis approach<sup>62</sup> using MaxQDA.<sup>63</sup> The process involved: 1) transcribing the qualitative data collected through KIIs and FGDs; 2) compiling and consolidating field notes; 3) coding qualitative data; 4) collating and summarising data into categories and themes, as deemed necessary to answer evaluation questions and sub-questions.

### 3.5 Integration of HRBA, Gender Equality and Equity in the Evaluation

This evaluation benefitted from and adhered to all applicable principles as prescribed by the United Nations System-wide Action Plan (UN-SWAP 2.0, 2018) on Gender Equality and the Empowerment of Women (GEEW).<sup>64</sup> Refer to Table 5 below for the measures taken by the evaluation team to ensure compliance with UNICEF's cross-cutting priorities during each stage of the evaluation:

Table 5: Integration of HRBA, GE and Equity in the Evaluation

Evaluation Phase	Measures Taken for Compliance
Design	<ul style="list-style-type: none"> <li>The evaluation matrix included a separate section to include specific questions, sub-questions and indicators on gender equality, HRBA and equity.</li> <li>The selection of evaluation methods ensured inclusion or participation of duty-bearers and rights-holders (male/female, rural/urban, literate/illiterate, etc.)</li> <li>Specific guides were applied for each stakeholder (duty-bearers, rights-holders, donors) under each evaluation method (KII or FGD).</li> <li>Appropriate capacity-building of all evaluation team members was ensured.</li> </ul>
Implementation	<ul style="list-style-type: none"> <li>Gender balanced teams were deployed for data collection. For HH surveys, only female staff was deployed to demonstrate respect to cultural norms.</li> <li>To ensure perspectives of all relevant stakeholders are included in evaluation findings, the evaluation team reached <b>1688 participants (91 percent female)</b> through HHs, KIIs and FGDs.</li> <li>For HH survey, <b>1352 mothers/caregivers</b> were interviewed to assess their knowledge, awareness and practices against several components.</li> <li>In FGDs, significant participation of both genders was attained. Out of 293 participants, <b>139 were male (47 percent) and 154 were female (53 percent)</b>.</li> <li>For FGDs, separate discussions were conducted with mothers and fathers.</li> </ul>
Analysis and Reporting	<ul style="list-style-type: none"> <li>Analysis of all data was disaggregated by parameters of gender equality, HRBA and equity.</li> <li>Distinct coding for gender equality, HRBA and equity was implemented to extract themes.</li> <li>The synthesis of evaluation findings, conclusion and recommendations were informed with the above key considerations.</li> </ul>

<sup>62</sup> Vaismoradi, M., Turunen, H. and Bondas, T. (2013), Qualitative descriptive study. Nurs Health Sci, 15: 398-405. doi:10.1111/nhs.12048

<sup>63</sup> MAXQDA is a software for qualitative and mixed methods data analysis. MAXQDA can help with systematic analysis and interpretation of the data. It allows the user to develop a system of categories and mark important information in the data with different codes using MAXQDA flexible and powerful coding features.

<sup>64</sup> <https://www.shareweb.ch/site/Multilateral-Institutions/Documents/UN%20SWAP%20Gender%20Equality%20Brochure.pdf>

### 3.6 Compliance to UNEG/UNICEF Adopted Norms and Standards

A brief overview of the measures planned and implemented to ensure compliance to UNEG<sup>65</sup> and UNICEF's adapted norms and ethical standards is outlined below (for more details, refer to Appendix 23 and 24).

- **Independence and impartiality:** The evaluation team members had no conflict of interest and no role in the implementation of programme activities, and the staff was able to evaluate the DHCR without the influence of any outside party.
- **Credibility:** The evaluation team applied a participatory data collection methodology (involving a range of relevant stakeholders for feedback) and triangulation of reported findings by using an analysis of evidence from both primary and secondary data sources.
- **Utility:** UNICEF is committed to publish and disseminate duly quality-assured evaluation reports in the public domain without undue influence by any party.
- **Professionalism:** The evaluation team is comprised of professionals with extensive knowledge, training and experience working with multiple clients on local and international projects.
- **Avoidance of Harm:** The evaluation team took requisite measures in light of COVID-19 (details in section 3.3). Some of the in-person interviews were replaced with remote interviews to avoid COVID-19 related contraction risks.
- **Privacy of Participants:** The participants were informed about protocols for protection of their private data and that the data was password protected. The feedback and opinions of the respondents included in the final report are anonymous to maintain the confidentiality of the respondents.

### 3.7 Limitations and Mitigation Measures

Table 6 outlines the limitations and the mitigation measures taken to address constraints.

Table 6: Limitations and Mitigation Measures

Risks and Limitations	Mitigation Measures
The COVID-19 situation posed safety risks for all evaluation participants and the team itself.	Wherever the national team's movement was restricted, the evaluation team used technology for data collection whereby the field team conducted interviews through Zoom or telephonically. The evaluation team remained in touch with UNICEF Rwanda and local partners/consultants to stay abreast of COVID-19-related restrictions and find ways to implement fieldwork.
Data constraints to undertake comprehensive analysis of the Programme's effectiveness and efficiency.	The Programme's achievements for April – December 2021 were not shared with the evaluation team; therefore, findings from the effectiveness and efficiency sections are shared for the duration of 2016 - March 2021. For outcome level indicators, four outcomes were not assessed due to missing data (either in the form of unavailability of targets or achievements).
Majority of HHs that participated in the baseline study were no longer eligible to participate in the endline study.	The evaluation team addressed this by replacing missing HHs with other eligible HHs (within the same village) with a child of 6-23 months of age. The replaced HHs are from the same village, and therefore, offer similar socio-economic characteristics as those who participated in the baseline.
Identification of district level stakeholders was not entirely accurate.	As a standard practice, the evaluation team took UNICEF's support to identify respondents for KIs. However, at the district level, most of the respondents who were interviewed were either new or were not involved in implementation. This has resulted in limited primary information obtained at the subnational level.

### 3.8 Evaluation Management and Implementation

This section covers the evaluation management arrangements, evaluation team and functions, implementation phases and deliverables under each evaluation phase.

#### 3.8.1 Evaluation Management – Evaluation Reference Group (ERG) Role

UNICEF Rwanda commissioned the evaluation. The evaluation team worked under the direct supervision of Monitoring and Evaluation Specialist. The oversight function was performed by the ERG comprising primarily of UNICEF and NCDA. The key functions of ERG are listed below.

- Provide feedback and technical inputs by reviewing key deliverables at all stages of the evaluation for quality assurance purposes as per UNEG Norms and Standards.
- Support the participation of (and access to) relevant stakeholders and data during the evaluation, dissemination of the information and future use of the evaluation.
- Advise on the development of the management response to the evaluation and monitor implementation of the evaluation management response.

<sup>65</sup> UNEG Ethical Guidelines for Evaluation

### 3.8.2 Evaluation Partner, Team and Roles

AAN Associates<sup>66</sup> a Pakistan based consulting firm, led the evaluation design and implementation. Local data collection was supported by Rwanda-based partner Research Hub. A team of international and national experts with complementary training and skills was deployed to design and implement the evaluation. The team had adequate representation of female team members. Refer to Appendix 25 which provides complete team organogram, brief profile, and role of each team member.

### 3.8.3 Evaluations Implementation Phases and Deliverables

The evaluation was implemented from September 2021 to May 2022. The evaluation followed a phased approach with five key phases, i.e., pre-inception, inception, field data collection, data processing, consolidation and analysis, and reporting and dissemination. Each phase had a series of activities/tasks (implemented both concurrently and sequentially) and associated deliverables (more details in Figure 9). The evaluation followed an evolving work plan appended as Appendix 26.

Figure 9: Evaluation Phases and Deliverables

PHASES	ACTIVITIES	DELIVERABLES
 <b>Pre-Inception Phase</b>	<ul style="list-style-type: none"> <li>Document Request</li> <li>Detailed literature review (Continuous process)</li> <li>Draft Evaluation Matrix</li> <li>Kick-off meeting</li> </ul>	Final Evaluation Matrix
 <b>Inception Phase</b>	<ul style="list-style-type: none"> <li>Draft Inception Report shared with UNICEF for feedback</li> <li>Inception Report finalized based on feedback and shared with UNICEF</li> <li>Draft field plan shared with UNICEF before starting the field mission</li> </ul>	Final Inception Report
 <b>Field Data Collection Phase</b>	<ul style="list-style-type: none"> <li>Preparations and planning for the field mission finalised.</li> <li>Comprehensive training to the field team.</li> <li>A more detailed fieldwork plan shared with UNICEF at this stage.</li> <li>All planned number of KIIs and FGDs completed.</li> <li>Household Survey conducted</li> </ul>	N/A
 <b>Data Management and Analysis Phase</b>	<ul style="list-style-type: none"> <li>Consolidation of the primary data (qualitative &amp; quantitative) collected</li> <li>Transcription of the KIIs and FGDs recordings</li> <li>Data cleaning, entry, coding, and editing</li> <li>Literature review of the relevant documents continued</li> <li>Data analysis completed</li> <li>Draft report preparation initiated</li> </ul>	<ul style="list-style-type: none"> <li>Final Evaluation Report</li> <li>Validation workshop / Final PowerPoint Presentation</li> <li>Raw data</li> </ul>
 <b>Reporting and Dissemination Phase</b>	<ul style="list-style-type: none"> <li>Draft Evaluation Report was produced, prepared and shared with UNICEF</li> <li>The report was finalized based on the feedback received.</li> <li>Final PowerPoint presentation submitted with key evaluation findings.</li> </ul>	

<sup>66</sup> <https://aanassociates.com/>

# 4

## Evaluation Findings, Analysis and Preliminary Conclusions



Picture: UNICEF Rwanda

## **Chapter 4: Evaluation Findings, Analysis and Preliminary Conclusions**

This chapter presents the evaluation findings, analysis and preliminary conclusions. The description includes key findings for each question (and sub-questions) under each criterion. The findings are drawn from both primary and secondary data sources. Preliminary conclusions for each question are placed at the end of each sub-section.

### **4.1 Relevance**

**EQ1 – To what extent was DHCR design (objectives and strategies) informed by national/local nutrition and ECD needs (children 0-6, including the most disadvantaged), and to what extent did design include the relevant stakeholders, and evolve to accommodate the changing context?**

The relevance criterion has one key question and two sub-questions.

**EQ1.1 – How relevant is DHCR design—objectives, components and strategies—to GoR and partners' nutrition and ECD policies/plans, and does it remain consistent with them?**

The findings are grouped into three sub-sections, whereby the first section outlines alignment (in terms of outcomes) between DHCR and GoR policies and plans (including development partners). The second section presents findings around the level of engagement of national stakeholders in the design of DHCR. The third and the last describes the contextual evolution and corresponding adaptations made in the Programme's design and delivery. The findings are primarily drawn from the desk review and analysis leverages comparative techniques.

#### **DHCR Outcomes Alignment with GoR Policies and Plans (including Development Partners)**

To keep findings focused around ECD and nutrition, the following matrix (Table 7) presents findings and analysis around overlaps between DHCR outcomes (objectives) and those of GoR sectoral policies i.e., National ECD Policy 2016 and National Nutrition and Food Policy 2014. For overlaps between DHCR strategies and those of GoR's broader development policies and plans, refer to Appendix 27.

**Table 7: Alignment Between DHCR Outcomes & GoR Sectoral Policies**

Programme's Outcomes	National Policies Specific Objectives (SO)	Development Partners' Priorities	Analysis
<b>OUTCOMES (O)</b> <b>O1:</b> Children U5 utilize effective nutrition / health interventions <b>O2:</b> Young children and families utilize quality ECD services <b>O3:</b> Families with young children in the targeted districts use improved WASH services <b>O4:</b> Poorest households with children U5 in 10 districts/sectors have benefitted from child-sensitive public works <b>O5:</b> Improved and equitable participation in quality pre-primary education <b>O6:</b> The integrated multi-sectoral programme interventions are effectively planned, managed and coordinated at the national and sub-national level; and key family practices across sectors are promoted <b>O7:</b> Private sector investment and support to the multi-sectoral nutrition programme increased	<p><b>National ECD Policy (2016)</b></p> <p><b>SO2:</b> To improve parents' and legal guardians' knowledge, skills, and resources to support the development of their children (<b>O2, O1, O6</b>)</p> <p><b>SO3:</b> To ensure infants and toddlers receive nurturing care and developmental services, and are prepared for success in school and life (<b>O2, O5</b>)</p> <p><b>SO4:</b> To prevent and reduce stunted growth and improve child development outcomes for the most vulnerable children and children with special needs (<b>O2, PC1</b>)</p> <p><b>SO5:</b> To reduce malnutrition and child (U5) mortality and morbidity through preventive measures and child health care and nutrition services (<b>O1</b>)</p> <p><b>SO6:</b> To reduce the incidence of childhood illnesses and diseases due to WASH issues (<b>O3</b>)</p> <p><b>SO8:</b> To provide comprehensive ECD services of high quality (<b>O2, O6</b>)</p> <p><b>SO9:</b> To ensure that all children begin school at the correct age (<b>O5</b>)</p> <p><b>SO10:</b> To support the coordination, monitoring and evaluation of all processes, programmes and services related to ECD (<b>O2, O6</b>)</p> <p><b>SO11:</b> To sensitise local authorities, opinion leaders, parents, communities, and journalists about the importance of children's early development, ECD policy provisions, and their roles in assisting with planning, implementing and overseeing essential children's services (<b>O2, O6</b>)</p> <p><b>National Nutrition and Food Policy Objectives (2014)</b></p> <p><b>SO1:</b> Sustain the position of food and nutrition as central priorities of the GoR (<b>O1, O7</b>)</p> <p><b>SO2:</b> Prevent stunting in children under two years of age (<b>O1, O2, O3</b>)</p> <p><b>SO3:</b> Strengthen, expand and promote services and practices of food security year-round (<b>O1, O4, O6</b>)</p> <p><b>SO4:</b> Prevent and manage all forms of malnutrition (<b>O1, O3</b>)</p> <p><b>SO5:</b> Strengthen nutrition education in schools and higher learning institutions (<b>O5</b>)</p> <p><b>SO6:</b> Strengthen emergency preparedness and response (<b>O1, O6</b>)</p> <p><b>SO7:</b> Improve governance systems and accountability for nutrition and food security (<b>O6, O7</b>)</p>	<p><b>Donor Priorities - Alignment with EKN:</b> The Kingdom of Netherlands policy on food and nutrition security addresses nutrition improvement (including stunting reduction) within the context of food security and agro-economic development. Nutrition sensitive, agriculture and nutrition-sensitive value chain development are seen as valuable mechanisms.</p> <p><b>WHO ECD Guidelines (2020)<sup>67</sup></b> provides global, evidence-informed recommendations on improving ECD. The objective is to identify ECD-specific interventions and feasible approaches that are effective in improving developmental outcomes in children.</p> <p>The nutrition objectives in the World Food Programme (<b>WFP</b>) <b>Strategic Plan (2017-2021)</b> aimed to treat and prevent MAM, stunting and micronutrient deficiencies.<sup>68</sup></p> <p><b>Food and Agriculture Organization (FAO) Nutrition Strategy</b> is part of the organization's strategic framework and aims to achieve the corporate goal of reducing malnutrition through efficient, inclusive, resilient and sustainable agri-food systems.</p>	<ul style="list-style-type: none"> <li>The DHCR design fully corresponds with GoR ECD and Nutrition Policy. The outcomes of the DHCR are in line with <b>ECD policy</b> in terms of provision of WASH services, pre-primary education, ECD services, integrated multi-sectoral interventions, reduction in stunting and holistic development. Likewise, the outcomes of the DHCR are in accordance with nutrition policy that includes preventing stunting, providing public works, improving WASH services, preventing malnutrition, providing ECD services to children and caregivers, ensuring active participation of private sector and government officials, improving quality of education and improving household food security</li> <li>Alignment with the priorities of EKN is also evident. Institutional priorities of key DHCR partners (UNICEF, WHO, WFP and FAO) overlapped with the DHCR programme outcomes.</li> <li>Majority of the KII respondents were of the view that the Programme is fully aligned with government priorities; particularly the Programme's outcomes/objectives are aligned with the GoR's WASH and health policies including poverty reduction programmes. Specifically, the KII stakeholders referred to the ECD interventions being aligned with the GoRs National ECD Policy. Kitchen gardening and village kitchen-related interventions were aligned with the national food and nutrition policy of Rwanda. Moreover, Vision 2050 of Rwanda was also considered while implementing the intervention. The interventions that led to the reduction of stunting and malnutrition are also aligned with government policy to fight stunting and hunger in the country.</li> </ul>

<sup>67</sup> <https://www.who.int/publications/item/97892400020986>

<sup>68</sup> <https://docs.wfp.org/api/documents/WFP-0000037871/download/>

## **Stakeholders Participation in the Programme's Design**

1. Literature review and consultations with key stakeholders suggest an extensive review and broader consultative process spread over several months that contributed to the design of DHCR. These included: proposal development workshop (March 2016), joint reviews, validation meeting (May 2016) and bilateral meetings (UNICEF and EKN) involving internal and external reviews.
2. Below are details on the steps taken to include key stakeholders in the design phase. Discussions with key stakeholders indicate that the process was extensive and participatory.
  - **Proposal development workshop (March 2016):** In which 48 representatives participated from GoR, development partners, civil society, private sector and academia.<sup>69</sup> The workshop aimed to: (i) build a common understanding of the proposal objectives and proposed intervention areas; (ii) plan key interventions for each sector; and (iii) identify opportunities for programme integration and joint interventions between sectors, as well as potential linkages and synergies for collaboration with the private sector. The workshop resulted in participants agreeing on their roles and responsibilities, including a proposal completion procedure and schedule.
  - **Joint Reviews:** After incorporating different stakeholders' input into a draft proposal, UNICEF organized follow-up meetings with line ministries and technical partners for joint review.
  - **Validation Meeting (May 2016):** The agreed key interventions were presented to technical personnel from all relevant line ministries for validation.
  - **Bilateral UNICEF-EKN Meetings:** Following the validation meeting, UNICEF held a *bilateral meeting with EKN* technical personnel to examine and finalise the proposal paper, which was externally reviewed by EKN specialists.

## **Evolving Needs and Programmatic Adaptations**

3. Desk review indicates evolving needs and subsequent programmatic adaptions during the course of programme implementation, the details of which are as follows:<sup>70</sup>
  - Due to institutional changes in GoR's coordination and implementation structures for nutrition, the coverage of some of the programmes—including growth monitoring and promotion—went down in 2018. UNICEF worked with the NECP (now NCDA) and MoH to ensure increase in coverage.<sup>71</sup> Health Management Information System (HMIS) routine data on nutrition indicators noted that the coverage of growth monitoring services grew from 82 percent to 87 percent among children aged 6-23 months. While there are many other factors at play and these figures should be read with caution given the challenges of data collection during COVID, these findings point to some degree to the success of the growth monitoring and promotion efforts as community members clearly continued to utilise nutrition services during the pandemic.<sup>72</sup>
  - The drop in multiple micronutrient powder (MNP) coverage from 86 percent (2019) to 42 percent (2020) was caused by changes in GoR's medicine and nutrition supply chain management systems, including new institutional homes governing these functions namely the newly established Rwanda Medical Centre (RMC) and the Food and Drug Agency (FDA). These changes caused delays in clearance of nutrition commodities and, consequently, periodic stock outs.<sup>73</sup>
  - Desk review indicates that programme implementation was adjusted in light of new sectoral policies and plans. These policies included the Social Protection Strategy (2018-2024), National Social and Behaviour Change Communication Strategy for Integrated Early Childhood Development, Nutrition and WASH (2018-2024).

### **Excerpts from KIIs on evolving needs and programmatic adaptations**

"The stunting statistics reported in the DHS report 2015 (nationally, 38 percent of children U5 are stunted, and 14 percent are severely stunted) served as a wake-up call to address the issue of stunting urgently. As a result, GoR prioritized the stunting issue and involved relevant departments to tackle the issue on a priority basis." – **National Level Stakeholders**

"Integration of nutrition interventions into other social sectors, The Local Administrative Entities Development Agency (LODA) and the Ministry of Agriculture (MINAGRI) was constrained in 2018, mainly due to the frequent changes in relevant government bodies that required additional time to buy in and agree on the model to be applied." – **National Level Stakeholders**

<sup>69</sup> UNICEF-EKN Phase II approved proposal.

<sup>70</sup> EKN Mid-Term Review (MTR) Report, Compressed 2019.

<sup>71</sup> Progress Report – 2018.

<sup>72</sup> <https://www.ennonline.net/fex/65/covid19rwanda>.

<sup>73</sup> Progress Report - 2020-2021.

- The desk review points to the scale-up of the National School Feeding Programme in view of the arrival of some 65,000 Burundian refugees<sup>74</sup> in Rwanda in 2020. This affected approximately 35,286 refugee children and host community children attending the same schools as refugee children.<sup>75</sup>
- COVID-19 posed several challenges to DHCR implementation, such as: closure of ECD centres, delayed supplies (to the ECD centres), cancellation of farmer promoters training, impeded community mobilisation and campaigns (such as for Vitamin A campaigns), and discontinuation of field monitoring. Desk review and discussions with stakeholders indicate that the Programme adopted online and electronic modes of communication with community members to mitigate mobility challenges.

#### **EQ1.2 – Was programme design adequately informed and appropriate to address needs of children aged 0-6 (including the most disadvantaged)?**

The findings are structured into two parts. The first part outlines the number/types of assessments used or undertaken to identify the nutrition and ECD (the two most important sectors/themes) needs for children 0-6. The second part matches programme interventions that address the drivers for 0-6 malnutrition and limited enrolment in ECD centres.

#### **Assessments to Identify Local Nutrition and ECD Needs (0-6 Children)**

4. Desk review indicates that prior to designing DHCR, a series of consultative sessions were conducted with beneficiary communities, local leaders and service providers to identify needs and priorities. In addition, UNICEF and GoR undertook a situation analysis to ensure the interventions were aligned with national priorities, plans and policies.
5. The Programme took a hybrid approach to identify local nutrition and ECD needs, whereby it used the existing national data (from RDHS 2014-2015) and did multiple studies to collect usable data to design DHCR interventions. Data from primary and secondary sources enabled mapping of the extent and drivers of the problem.
  - Desk review further indicates that a capacity gap analysis of key stakeholders was conducted in 2018; the aim of this exercise was to formulate an integrated capacity development plan for relevant stakeholders.
  - The Programme mainly used RDHS data to identify the most impoverished districts. The Programme selected 14 districts (out of 30 total districts), by using multiple deprivation criteria including poverty and prevalence of stunting (refer to Appendix 3 for the rationale behind district selection).
  - In 2018, a mapping study of the private sector was concluded. Consequently, linkages were developed with 20 companies and corporations across strategic industries.
  - Desk review and discussions with UNICEF indicate that UNICEF and NCDA undertook the first ethnographic study to explore nutrition and WASH practices to understand the bottlenecks around these problems.

#### **Excerpts from KIs on assessments undertaken to identify local nutrition and ECD needs (for children aged 0-6 years)**

“A mapping study on a public-private partnership was conducted to inform integration with other relevant sectors from a strategic point on tiers one, two and three. The mapping study also helped in the development of a public-private strategy that functions as a guiding tool to direct the engagement with other private sectors even when the funding ends. For the private sector engagement, tea companies, telecom, rice and mining companies are engaged. Moreover, various informal assessments were undertaken; and the tea sector was identified with the most programmatic need. Tea is grown in twelve districts of Rwanda; however, a comprehensive food vulnerability study showed higher malnutrition rates in the tea belt. To identify the factors contributing to malnutrition various stakeholders including managers of tea companies were engaged by National Agriculture Development Board (NAEB) and it was revealed that there were large numbers of children in the tea plantation sector. Therefore, the Programme extended its interventions in tea plantations to better address the needs.” – **Government**

“In 2019-2020, UNICEF together with NECDP conducted the first ethnographic study on nutrition in the communities to explore nutrition and WASH practices. The study explored the barriers preventing healthier nutrition and WASH practices amongst communities in the country. The study identified that the communities had awareness around healthier nutrition practices, for instance people understand what they need to do to give their child a healthy diet; however, they were not practising health nutrition practices even when they were aware of them. Therefore, the UNICEF team invested more in social behaviour change communication, sensitization campaigns and generation of income sources, etc.” – **UNICEF**

“We undertook a baseline survey for this programme which helped us to identify needs but simultaneously when we started the implementation of the programme, there were consultations with line ministries and communities.” – **UNICEF**

<sup>74</sup> The latest Burundi refugee crisis began in 2015, as refugees fleeing violence in Burundi sought shelter in several neighbouring countries, including Rwanda.

<sup>75</sup> <https://docs.wfp.org/api/documents/WFP-0000125428/download/>.

## Bottlenecks Leading to Stunting and Developmental Delays and Corresponding Programme Strategies

Find below the matrix that identifies the bottlenecks that lead to stunting and development delays (local needs) and identifies programme interventions/strategies that address those needs.

**Table 8: Bottlenecks and DHCR Strategies Addressing those Bottlenecks**

Drivers of Stunting and Development Delays	Programme Strategies Addressing Bottlenecks
Extensive poverty and limited access to social protection mechanisms, result in food insecurity and lack of fiscal space to focus on child early education/development.	<p><b>Capacity-Building</b></p> <ul style="list-style-type: none"> <li>• HHs provided financial literacy/savings and loans training</li> </ul> <p><b>Dialogue and advocacy</b></p> <ul style="list-style-type: none"> <li>• Community saving-lending groups receiving supportive supervision visits</li> </ul> <p><b>Innovation and cross-sectoral linkages</b></p> <ul style="list-style-type: none"> <li>• Multi-sectoral ECD coordination mechanisms at national and district levels</li> <li>• Vulnerable and poor households with children U5 are included in the child-sensitive expanded public works social protection model</li> <li>• UNICEF in partnership with World Relief implemented the integrated social protection and nutrition programme to ensure that the needs of the population</li> </ul>
Limited education and awareness of parents around feeding practices, childcare and importance of ECD	<p><b>Evidence Generation</b></p> <ul style="list-style-type: none"> <li>• Districts testing peer to peer support initiative</li> </ul> <p><b>Dialogue and Advocacy</b></p> <ul style="list-style-type: none"> <li>• Social mobilisation and behaviour and social change communication activities were conducted for families with young children</li> <li>• Additional people reached with messages on safe hygiene practices and stunting reduction including feeding practices</li> <li>• HHs with children reached with behaviour change communication messages on responsive caregiving</li> </ul>
Systemic challenges around healthcare/nutrition, childcare, ECD, social protection, WASH, coordination and private sector engagement	<p><b>Capacity-Building</b></p> <ul style="list-style-type: none"> <li>• Capacity-building of CHWs to deliver comprehensive packages of nutrition services</li> <li>• Pre-primary teachers were trained in early learning and school readiness</li> <li>• Businesses were sensitized on children's rights, business principles, and the importance of ECD and established child-friendly workspaces</li> </ul> <p><b>Evidence Generation</b></p> <ul style="list-style-type: none"> <li>• Mapping of existing ECD services was done</li> <li>• Baseline, capacity gap analysis and mid-term review were conducted</li> </ul> <p><b>Innovation and cross-sectoral linkages</b></p> <ul style="list-style-type: none"> <li>• Children from expanded public works households were screened for malnutrition and provided with food supplementation</li> </ul> <p><b>PPPs</b></p> <ul style="list-style-type: none"> <li>• Effective linkages established between local businesses and nutrition projects/ECD centres</li> <li>• ECD services delivered through community spaces, and religious and private facilities were expanded and improved to better provide ECD services</li> </ul>

### Preliminary Conclusions: Relevance

**REL 1:** The findings indicate overlaps between DHCR outcomes and strategies with those of national and development partners' policies and plans (in particular for nutrition and ECD sectors), which illuminate the Programme's relevance. Ample evidence is available to suggest an inclusive process to involve key stakeholders in the design—including extensive consultations, joint reviews, validation meetings and bilateral meetings. Although there is evidence of significant changes in the context and beneficiary needs due to several factors (including government restructuring, changes in policy mandates and COVID-19), there is limited evidence of the Programme making design-level adjustments in terms of changes in results framework and budget.

**REL 2:** The relevance is evident as the Programme used both primary and secondary data (involving baseline 2019, capacity gap analysis, ethnographic study) to understand the local dynamics and needs to inform the Programme's design. The selection of programme districts is driven by multi-factor vulnerability assessment. Programme design (strategies/interventions) is appropriate for addressing both the demand and supply-side barriers to malnourishment and development delays such as: capacity-building (of both duty-bearers and rights-holders); dialogue and advocacy (for uptake of promoted behaviour); public-private partnership (for linkages with businesses and ECD centres); and evidence generation (for effective decision-making).

## 4.2 Coherence

**EQ2 – To what extent did the Programme utilise internal (in terms of synergies, interlinkages) and external (in terms of complementarities, harmonization) coherence?**

The coherence criterion has one key question and one sub-question.

**EQ2.1 – Was the Programme consistent (or otherwise) with internal and external nutrition and ECD priorities?**

The findings are grouped into two sub-sections, whereby the first sub-section presents findings around internal coherence i.e., interventions that were jointly implemented/coordinated by different UNICEF units (WASH, Health, Social Protection, Communication for Development (C4D), ECD, Nutrition). The second sub-section outlines external coherence i.e., mechanisms/process (pre/during the Programme) adopted to identify the synergies with other programmes and/or partners to leverage complementarities and to avoid duplication.

### **Internal Coherence**

Find below key findings on how the Programme worked across different sections within UNICEF and leveraged the strengths and resources available within UNICEF RCO.

6. Refer to section 4.1 (under relevance) for findings on coherence/alignment of DHCR's outcomes and strategies with those of GoR's sectoral policies and plans.
7. Desk review indicates that UNICEF's Deputy Representative and relevant section chiefs (Nutrition, ECD, WASH, Education and Social Protection) remained involved during the proposal development stage.<sup>76</sup> These consultations aimed to jointly strategize and identify priority interventions for areas required across different sectors and levels in order to achieve stunting reduction and improvement of child development outcomes.
8. Discussions with UNICEF indicate that the task forces for each programme component convened on a monthly basis, allowing the section chiefs and other technical officers to discuss progress and ongoing challenges. However, the evaluation team did not find any evidence on the occurrence and outcome of these meetings.
9. At the design stage, an integrated UNICEF initiative was ongoing (funded by the IKEA Foundation), which focused on ECD, nutrition, health, WASH, child protection and social protection in 10 districts. As per the consultations with UNICEF, lessons learned and best practices from this initiative fed into DHCR programming. The evaluation team did not find any evidence on how this initiative helped during the planning phase.
10. Joint monitoring visits (every two months) by relevant sections were made to DHCR target districts to report on the progress made and bottlenecks impeding the progress. Respondents from UNICEF shared that these visits have strengthened collaborative targeting and helped in efficient use of resources.

### **External Coherence**

Find below key findings on how the Programme worked with external actors to leverage synergies and avoid geographic and intervention overlaps. Findings related to the coordination systems and their efficacy are included under the effectiveness section (4.4).

11. The findings indicate commissioning of multiple studies (between 2014 and 2015) to map stakeholders and interventions. These studies enabled key DHCR actors to plan and implement interventions (including targeting of beneficiaries and locations) to avoid duplication with other actors. The studies carried out include: Nutrition Stakeholder & Action Mapping (2015), ECD Mapping Study (2014) and Mapping of WASH Coverage (2015).
12. At the beginning of DHCR, selection criteria (based on human capital indicators) were used to define the universe for DHCR interventions, which was further discussed with key public sector and development actors during the proposal stage consultations. This enabled overcoming potential duplication and overlaps with similar initiatives. Discussions with UNICEF suggest that the selection of districts took a considered view not to overlap with United States Agency for International Development (USAID)-led integrated Nutrition-WASH intervention districts (implemented in eight districts). The target districts do not overlap with USAID-supported interventions.
13. Forums used for coordination are mentioned below. These forums have increased ownership and improved coordination around various initiatives including nutrition, ECD, WASH, child protection and social protection:
  - For integrated multi-sectoral programme interventions, an overall coordination mechanism at the central level included the Food, Nutrition and WASH technical working group (serving as the SUN country network), the SUN UN network, the SUN civil society network and the SUN donor network.
  - In 2017, the National Secretariat for Nutrition was set up and transformed into the NECDP

"UNICEF developed a joint action plan with the government and partners keeping in view the priorities and policies of the government to address the malnutrition situation in the country." – **Government Official**

"There was a technical working group chaired by NCDA and co-chaired by UNICEF; other development partners were also part of the technical working group." – **UNICEF**

<sup>76</sup> UNICEF-EKN Phase II approved proposal.

- (and later NCDA) in order to coordinate nutrition and ECD initiatives. UNICEF co-chaired coordination, whereas, the members of the Secretariat included line ministries, EKN, development partners and civil society organizations.
- The national ECD Sub-cluster, chaired by NCDA and co-chaired by UNICEF and NCDA, enhanced coordination at national and decentralized levels; and increased participation and integration of key thematic areas of health, nutrition, education, WASH and protection.
14. The Programme built effective linkages with the public sector to implement DHCR activities whilst supporting the key stakeholders on systems strengthening. Some key initiatives are mentioned below:<sup>77</sup>
- Collaboration with the Rwandan Women Parliamentary Forum (FFRP) to influence central and decentralized governments to increase their commitment and accountability for nutrition.
  - UNICEF partnered with the Ministry of Health, district authorities and a local partner, Society for Family Health (SFH), to enable a holistic district-led approach to improving household sanitation.
  - Conducted a capacity gap analysis which identified gaps in knowledge, awareness and skills related to results-based management (RBM). In response, UNICEF in coordination with Rwanda Management Institute (RMI), trained key stakeholders on RBM and public finance principles with the potential to improve project governance in Rwanda, particularly in managing nutrition-relevant programmes.
  - UNICEF partnered with Rwanda Health Communication Centre (RHCC) and MoH to develop common sanitation and hygiene messages for use by all partners nationally. By 2021, UNICEF reached 1,417,000 people in 11 districts with key sanitation and hygiene messages. Furthermore, DHCR also partnered with religious networks, celebrities and theatres to reach community members with stunting reduction messages.
  - UNICEF partnered with the Workforce Development Authority to facilitate production of an ECD kit (play and learning materials) to support children's stimulation in ECD spaces.
  - UNICEF partnered with government agencies for scale-up of ECD work including National Agricultural Export Development Board, Rwanda Mining Petroleum and Gas Board, Rwanda Agriculture and Animal Resources Board.
15. Partnerships with the private sector have resulted in expansion of ECD centres in the country. By 2021, DHCR engaged with 32 businesses on ECD with partnerships across different fields, for example with telecoms—providing data free access to information on nutrition and ECD; engagement of new sectors such as rice and mining in providing child friendly workspaces, peer to peer support to motivate investors to invest in ECD.

#### Preliminary Conclusions: Coherence

**COH 1:** Programme design managed to leverage internal coherence in terms of engagement of multiple sections within UNICEF and evolve a programme that addresses the multiple dimensions that cause stunting and undermine holistic child development. The evaluation team found limited evidence around how programme design translated into more collaborative implementation across UNICEF sections, which merits better documentation in order to understand the purpose and functionality.

**COH 2:** The Programme took a systematic approach to leverage external complementarities across stakeholders. Key enablers include: i) conducting studies to map stakeholders and interventions to develop a holistic view of actors and interventions; ii) collaborative consultations during the proposal stage to ensure there were no duplication of efforts; iii) partnering with relevant government and private entities to design and implement DHCR interventions; iv) use of existing platforms (NECDP, SUN network, national ECD sub-cluster, child development technical working group, religious network, celebrities) to coordinate, collaborate, plan and reflect with other development partners and relevant government agencies to implement DHCR activities, whilst avoiding duplication and overlap.

### 4.3 Efficiency

**EQ3 – To what extent did DHCR allocate and deploy resources (time, funds, capacity-building - through nutrition and ECD materials, management arrangements) to achieve intended results?**

This section has one main question and two sub questions.

**EQ3.1 – Did DHCR deploy resources (time, funds, capacity-building - through nutrition and ECD materials, management arrangements) to achieve intended results?**

It should be noted that the efficiency assessment remains incomplete due to unavailability of complete performance data (progress and expenditures shared until March 2021). Furthermore, as discussed under section 1.2 (sub-section on programme beneficiaries), the evaluation team has used 8.5 million

<sup>77</sup> Progress Reports.

figure as the total number of beneficiaries reached out by the Programme, with a caveat that the number hints at double counting.

The findings and analysis are structured across four resource inputs and other elements i.e., time, funds, capacity-building (through nutrition and ECD materials), and management arrangements. Findings are primarily drawn from the secondary data, however where appropriate, stakeholders' views (primary data) are included to complement these findings.

#### DHCR Efficiency vis-à-vis Allocated Time

Find below key findings around adequacy of time to achieve intended results (including achieved results). Moreover, the findings list key factors (internal and external) that caused delays in implementation, hence undermined achievements, and the measures undertaken to mitigate the time delays.

16. The readers may note that the original programme life cycle was from 2017-2020 (extension was sought till June 2022), during which DHCR intended to reach **500,000** direct beneficiaries (including children and families) with nutrition (for example through Vitamin A supplementation, micro nutrition, deworming, ready-to-use therapeutic food (RUFT) and iron folic supplementation) and ECD (care facilities, play groups, toy libraries) services. Targets for other beneficiaries (for instance, through sensitisation activities, capacity-building initiatives, WASH support) were not determined at the design stage. Against the direct beneficiary target, the Programme managed to reach **8.5 million**<sup>78</sup> beneficiaries (data available up to March 2021), however, this number hints at doubt counting of beneficiaries.
17. Programme implementation faced multiple delays. For instance, the Programme's roll-out was delayed by several months due to frequent changes or realignment of relevant governmental partners (i.e., establishment of the NECDP in late 2017) caused delays in securing additional approvals from the new partners. The re-arrangements required briefing new parent/primary departments and seeking requisite administrative approvals to proceed with activities. Later, the outbreak of COVID-19 resulted in both slow down and in some cases suspension of community related activities such as ECD centres.
18. As outlined above, the Programme sought a no-cost extension for June 2022. This was warranted for underutilisation of allocated funds i.e., the Programme only used three-fourths of the allocated funds by March 2021 (more details to follow).

"Projects have experienced delays in receiving materials due to delay in funds releasing from the Ministry of Finance, the donor delayed provision of funds, due to rainy season and COVID-19." – **Government**

"I think UNICEF is very timely on this fund's allocation, they did not delay any cash disbursement. At least when it comes to cash transfers and payment modalities as well as fund liquidation and reporting, I think we are in positive terms with UNICEF. We did not encounter any major challenges on that one." – **Implementing Partner**

#### DHCR Efficiency vis-à-vis Allocated Funds

19. The allocated funds for DHCR come to **\$27.4 million** for the complete life cycle (including extension). The Programme managed to reach **8.5 million** beneficiaries (it should be noted that this number may not be accurate due to double counting) far exceeding the beneficiary outreach targets, while spending only 79 percent (\$21,712,256) of allocated funds. To the evaluation team, the massive over-achievement rate (for outreach targets) without using the allocated budget raises questions about whether budgeting was realistic.
20. None of the key implementers made reference to fund shortages and/or delays in funds provision. The Programme sought a no-cost extension to use the remaining funds, which was granted.

#### DHCR Efficiency vis-à-vis Allocated Materials

21. The evaluation team did not find any delay/stock-out of supplies or material such as therapeutic food for SAM treatment.
22. However, the reports do indicate delays/shortages in supplies of MNPs in 2019-2020, due to changes in the supply chain management system of GoR. During interaction with the evaluation team, some key informants flagged inadequate availability/distribution of ECD material (books, toys, etc.) specifically during the outbreak of COVID-19.

"You wouldn't expect the implementation to be the same since there were other factors like Covid that affected the prices and the borders that were closed. For instance, the price of a sack of cement before Covid was Rwf 8,000 and during Covid it cost Rwf 13,000. This is something that was not counted on while planning." – **Implementing Partner**

#### Management Arrangements

23. The Programme managed to evolve a 'hybrid' management model whereby UNICEF provided technical assistance, GoR took lead in the implementation, and additional support was provided by

<sup>78</sup> Number changed by UNICEF on May 25, 2022.

IPs and the private sector (especially for ECD services). The fact that the Programme managed to massively over-achieve the outreach targets, suggests that the hybrid management arrangements worked efficiently. Although limited secondary data is available regarding management arrangements being efficient, the evaluation team gathered from the respondents that it worked well and enabled efficient delivery. Some even pointed to the fact that CSO partners facilitated outreach to hard-to-reach communities.

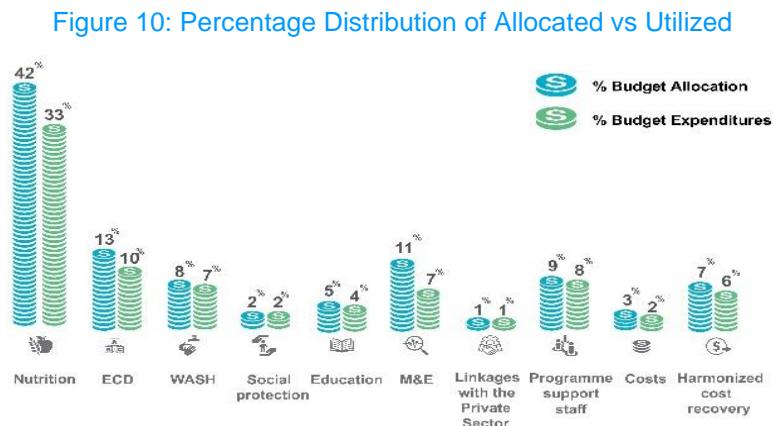
24. The UNICEF RCO team members shared that the scale and complexity of the Programme tested the capacity of available staff within UNICEF CO. Although they managed to deliver the results, they may have had provided more oversight if they had more human resources within UNICEF.
25. The Programme engaged with a range of stakeholders for varied functions, where each was to work with and coordinate with others at multiple levels. The evaluation team did not receive much documented evidence on how these actors worked with each other and what type of challenges they faced. It could be that this information is available, however it has not been shared with the evaluation team.

#### **EQ3.2 – Are unit costs comparable to other sectors? Could the same results be achieved with fewer resources by applying alternative strategies?**

The findings are grouped into two sections, where the first presents balanced resource allocations vs components and the second section includes cost/beneficiary calculations. Data availability affected the analysis below. For instance, the evaluation team only received expenditures data for 2017-2021 (March), whereas the budget is available for the whole programme cycle i.e., 2017-2022 (June). The data does not provide justification/rationale for budgetary revisions.

#### **Balanced Funds Allocations across Components/Outcomes**

26. Figure 10 presents the cost distributions (including expenditures) across seven components. Across the components, nutrition (outcome 1) remains at the top with 42 percent of total funds allocated from 2017-2022, of which 50 percent were used by the end of 2020 (expenditure data is available for 2017-March 2021). This is followed by ECD for which the allocated funds were 13 percent. For other components the allocated funds range from 2 percent to 11 percent. Refer to Appendix 30 for the calculations.



27. As DHCR was primarily a nutrition intervention, around which other thematic interventions were cobbled, the allocation of 2/5 of the funds looks reasonable. There is no basis for the evaluation team to judge whether the funds allocation across components was rationale and balanced.
28. The evaluation team used financial data (budget vs actual for 2017-2021 March) to plot the allocations and expenditures over time (see Figure 11). The exhibit suggests that the Programme burnout rate (budget vs actual) was much lower in 2017 and 2018, compared to 2019 and 2020. This to a degree reflects more efficient funds utilisation (and possibly better performance) in the latter half of the Programme. Refer to Appendix 30 for the calculations.

**Figure 11: Year wise Budget Planned and Utilised**



#### **Cost per Beneficiary**

Find below beneficiary cost calculations for multiple outcomes and also cumulative costs. It should be noted that the evaluation team had expenditures data up to March 2021 and there is possible multiple counting of beneficiaries.

29. Figure 12 exhibits planned vs actual per beneficiary costs across outcomes.

**For all outcomes the planned costs are lower than actual costs.**

For instance, for nutrition actual cost is \$7.10/beneficiary as against planned \$9.15/beneficiary.

Similarly, for ECD it is \$55.83/beneficiary against the planned \$73.07. Refer to Appendix 30 for the calculations.

30. At the aggregate level (for the whole Programme), the (average) actual cost per beneficiary comes to \$2.05 (against the planned \$2.65). This shows that Programme delivered results more efficiently, at least against the planned cost per beneficiary calculations. Refer to Appendix 30 for the calculations.

31. DHCR includes interventions across different thematic areas, therefore, a comparison between DHCR and a similar programme was not possible.

32. The cost/beneficiary comparison between EKN I and EKN II, suggests that EKN Phase II was relatively more efficient. For EKN I, the (average) cost per beneficiary stood at \$2.15,<sup>79</sup> which remained consistent for EKN II at \$2.05.

Figure 13: Cost per Beneficiary by Outcome



Figure 12: Cost/Beneficiary for Phase I and II



#### Preliminary Conclusions: Efficiency

**EFY 1:** The evaluation team is unable to draw conclusions on the Programme's efficiency due to unavailability of performance data from March to December 2021. The Programme reached to 8.5 million beneficiaries against a target of 0.5 million (the number hints to double counting of beneficiaries reached out by different interventions). In addition, the number was reached while using only 79 percent of allocated funds. As a result, it seems that the Programme set lower targets in comparison to the resources available.

**EFY 2:** The evaluation team is unable to conclude if the Programme demonstrated balanced distribution of funds across outcomes. Nevertheless, this being a flagship intervention to improve nutrition, the allocation of 42 percent funds appears reasonable. The combined allocations for nutrition and ECD come to around 55 percent (more than half of the funds). Temporally, the allocations were relatively higher in the first half of the Programme.

**EFY 3:** The average per beneficiary cost appears reasonable at \$2.05 for the Programme. For all outcomes the average/beneficiary cost is lower than planned (based on data available) which further reinforces the assumption that the Programme may have set low targets. The cost comparison between EKN I and EKN II underlines EKN II was as cost efficient as EKN I (in terms of cost/beneficiary).

## 4.4 Effectiveness

### EQ4 – To what extent did DHCR achieve the intended results (outcomes and outputs), including public sector capacity development (including communities), and factors that influenced achievement (or non-achievement of results)?

The criterion has three key questions with four sub-questions. The measurement of effectiveness faced constraints that are listed below.

- The effectiveness measurement is made using planned vs achieved results at the outcome level. The outcome achievement data is only available from 2017 to March 2021, whereas no data is available for last nine months of the Programme's life (from April to December 2021). The Programme sought a one year and a half year no extension and will close on 30 June 2022.
- The outcomes 1 (Nutrition), 3 (WASH), 6 (Integrated Multisectoral Interventions) and 7 (Private Sector Linkages) have not been rated on the effectiveness scale. Due to incomplete outcome achievement data (not available for one or more outcome indicators) or in one case (i.e., for outcome 7), the progress data is available but without targets, constraining rating.

<sup>79</sup> End-Project Review of the Project for Improving Child Nutrition in Four Countries in Sub-Saharan Africa - Final Report 2017.

- The HH survey (undertaken as part of the evaluation) has been used to make comparisons between baseline and endline surveys. As noted in the limitation section above, a majority of the households from the baseline survey were ineligible to participate in the endline survey. These households were replaced with other households within the same villages carrying similar geographic and socio-economic characteristics. The findings remain valid.

#### EQ4.1 – To what extent did DHCR achieve the intended results (outcomes)?

The findings for this criterion are structured into three sections. The first section offers an overview of programme effectiveness vis-à-vis its achievements (in terms of planned vs achieved outcomes); the second section focuses on comparison of baseline (2019) and endline (2022) numbers across key components (Nutrition, ECD, WASH and Social Protection) to offer a perspective on the Programme's effectiveness; and the third section discusses the target-setting process and stakeholder participation.

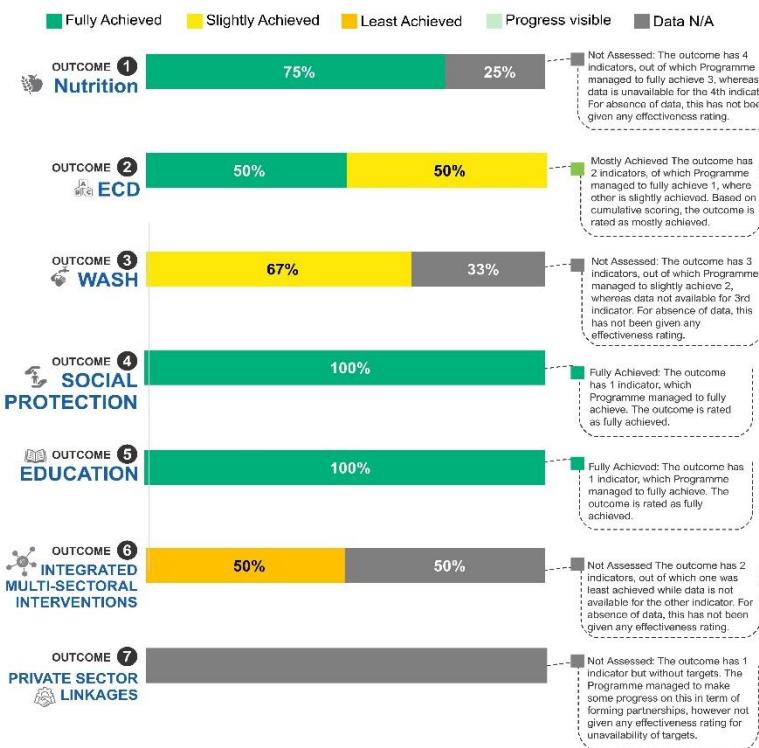
#### Planned vs Achieved Outcomes

The evaluation has primarily used the Programme's secondary data where each outcome is assessed for level of achievements vis-a-vis planned outcome targets/indicators. To make the assessment more objective, the evaluation team has rated each outcome on a scale of relative effectiveness, by applying the following rating criterion:

Fully Achieved	Mostly Achieved	Slightly Achieved	Least Achieved	Not Achieved
91 – 100%	66 - 90%	36 - 65%	11 - 35%	0 - 10%

Find below the visual presentation of outcome level achievements:

Figure 14: Programme's Outcome-level Achievements



33. The Programme has 7 outcomes and 18 outputs. Outcome level achievements are used to provide commentary on the Programme's effectiveness (a summary is provided here; for a detailed matrix of outcome and output achievements, refer to Appendix 28). The Programme's overall progress against seven outcome indicators is presented below. Against seven outcome indicators, complete data is only available for three outcomes.

#### Programme Effectiveness: Baseline and Endline Comparison for Key Components (Nutrition, Health, ECD, WASH and Social Protection)

This section brings together findings around the Programme's effectiveness by offering a comparison between the baseline (undertaken in 2019) and endline survey (HH survey mirroring the baseline was undertaken as part of the evaluation in 2022). The comparison focuses on selected aspects across

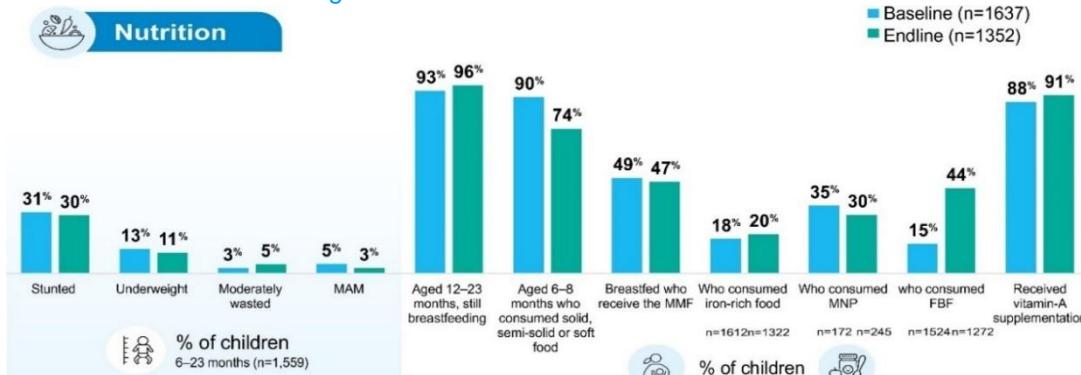
different programme components i.e., Nutrition, Health, ECD, WASH and Social Protection. A comparative table for all indicators covered in the baseline and endline is attached as Appendix 29.

The readers may note that the endline survey (2022) was carried out in the same communities where the baseline (2019) was administered. Moreover, it used the identical sampling approach and household selection criteria (data is from seven districts only). The only point of departure is that the endline survey tool is a redacted version of the baseline HH survey tool (covers only 46 indicators against 119 in the baseline). Please note that the redacted version was implemented after agreement with UNICEF RCO. The findings and analysis for each component are given below:

### **Nutrition**

For the nutrition component, the endline covered 11 indicators out of 19 indicators covered in the baseline. The following visual (Figure 15) offers a baseline and endline comparison for selected indicators (for a consolidated table of all components and indicators, please refer to Appendix 29).

Figure 15: Baseline vs Endline: Nutrition

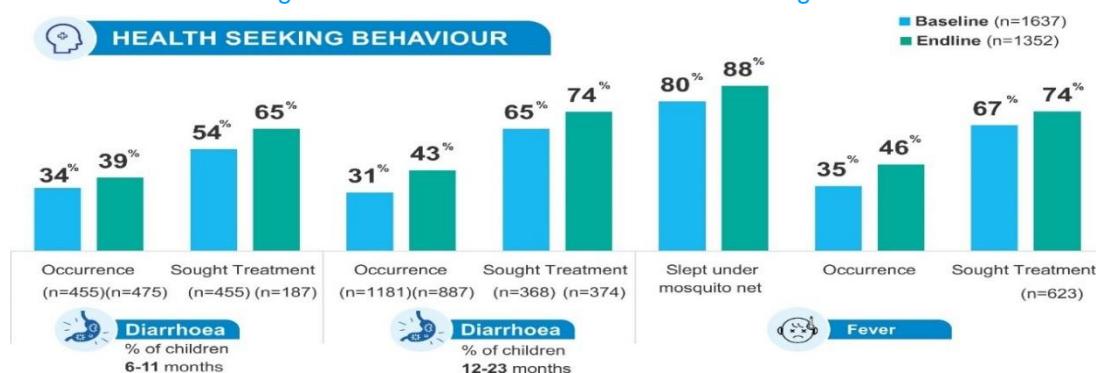


34. The comparison suggests a declining trend in stunting for 6-23 months (reduced from an average **31.3 percent to 29.7 percent**), underweight (reduced from 13 percent to 11 percent); and moderate acute malnutrition (from 5 percent to 3 percent). The data does not indicate a significant shift in terms of gender—as more boys are stunted in 2022 than girls (21.6 percent vs 19.4 percent), as was noted in the 2019 (35.3 percent vs 27.2 percent).
35. Data indicates an increase in number of children moderately wasted i.e., 3 percent to 5 percent. This merits further exploration. One plausible factor could be COVID-19-driven impact on livelihoods and food inflation, adversely effecting households' ability to purchase adequate food.

### **Health Seeking Behaviours**

For the health component, the endline covered 8 indicators out of 17 indicators included in the baseline. The following visual (Figure 16) offers a baseline and endline comparison for selected indicators (for a consolidated table of all components and indicators, please refer Appendix 29).

Figure 16: Baseline vs Endline: Health Seeking Behaviour

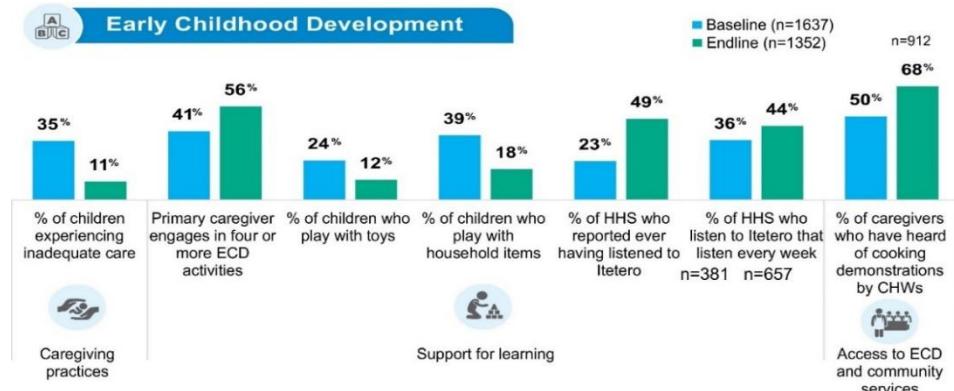


36. The comparison indicates that there are more people who are now using mosquito nets than at the time of the baseline (increased by 8 percent). The data shows an incremental trend in occurrence of diarrhoea (by 5 percent for 6-11 months and 12 percent for 12-23 months), which again merits further exploration. Despite increase in episodes of diarrhoea, it is encouraging to note that the percentage of caregivers who sought treatment for diarrhoea and fever has also increased (65 percent to 74 percent).

## **ECD**

For the ECD component, the endline covered only 7 indicators from the baseline (of the total 18). The following visual (Figure 17) offers a baseline and endline comparison for selected indicators (for a consolidated table for all components and indicators, please refer Appendix 29).

Figure 17: Baseline vs Endline: ECD

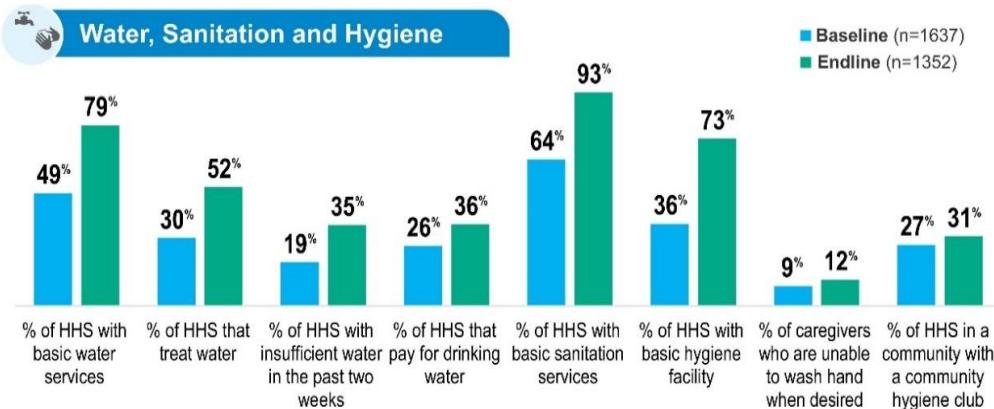


37. The data indicates an incremental trend in caregiver support and involvement in learning activities and improved access to ECD and community services e.g., primary caregivers engaging in ECD activities; HHs listening to relevant radio station e.g., Itetero, caregiving practices and access to ECD and community services. The data indicates a declining trend of children playing with toys (from 24 percent to 12 percent) and household items (from 39 percent to 18 percent). This could be because of supply shortages of toys due to COVID-19.

## **WASH**

For the WASH component, the endline covered eight out of nine indicators included in the baseline. The following visual offers a baseline and endline comparison for selected indicators (for a consolidated table of all components and indicators, please refer Appendix 29).

Figure 18: Baseline vs Endline: WASH

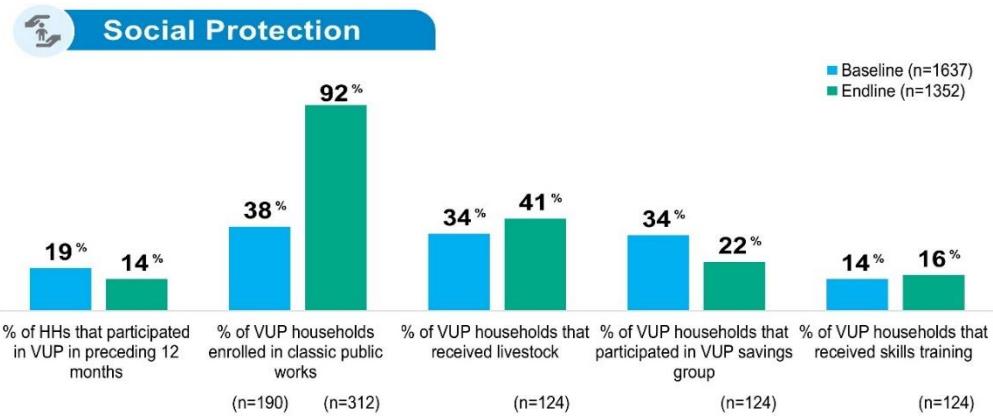


38. The data indicates an improved access to WASH services and availability of Community Hygiene Clubs. The data indicates increase in percentage of households with insufficient water in the past two weeks, and households who pay for drinking water.

## **Social Protection**

For the social protection component, the endline covered only 5 indicators from the baseline (of the total 26). The following visual (Figure 19) offers a baseline and endline comparison for selected indicators (for a consolidated table for all components and indicators, please refer Appendix 29).

Figure 19: Baseline vs Endline: Social Protection



39. Data indicates a decrease in participation in Vision 2020 Umurenge Programme (VUP) and Saving Groups in the last 12 months. The data indicates a substantial increase in the percentage of VUP households enrolled in classic public works from 37.5 percent to 91.6 percent.

#### EQ4.2 – What factors either enabled or hindered DHCR achievements? How did achievements affect yearly planning?

The findings are structured into two parts i.e., i) enabling and disabling factors and their effects on programme achievements; and ii) process of target setting and stakeholder participation.

#### Internal and External Factors

A host of enabling and disabling factors, both internal and external, affected programme achievements. Find below the matrix that outlines those factors that either facilitated or hindered the implementation and achievement of results. The findings are drawn from primary and secondary data.

Table 9: Enabling and Disabling Factors and Implications for DHCR

Enabling Factors	Implications for DHCR Implementation
Alignment to public sector policies/priorities resulting in active engagement/support from public sector partners	There is evident alignment of objectives of DHCR with GoR's policies, priorities and plans. Moreover, the focus on strengthening public service delivery systems enabled buy-in of the public sector, using public sector apparatus of MoH, NCDA, MIGEPROF and MINALOC, among others.
The design to encourage community-based models (community driven) has resulted in fostering volunteerism, greater community engagement and ownership of interventions. This bodes well for continuation of community interventions.	The Programme has organized communities into multiple groups such as saving and lending groups, Umugoroba w'ababyeyi, Umuganda and others. The groups are trained and provided assistance to continue implementing activities and appear on track to continue. By placing community groups at the centre, the Programme has successfully engaged them in planning and implementation, which is both encouraging and enabled leveraging community resources. This has contributed to increased level of community ownership of the local initiatives, which bodes well for their continuation.
The Programme took a proactive and adaptive programming approach, whereby it used the available forums/activities to implement COVID-19 precautionary campaigns.	To mitigate the challenges imposed by COVID-19, the Programme adapted and made requisite changes in its implementation approaches. Messages on preventive measures on COVID-19 were developed and disseminated through national and community radio programmes, including radio dramas and talk shows.
Disabling factors	Implications for DHCR Implementation
Frequent administrative reforms resulted in shifting mandates and coordination of key public sector actors causing operational delays	Institutional changes at the national level around ECD and nutrition, along with shifting mandates between government institutions, restructuring role of ministries, and creating new entities such as the MINLOG Secretariat, NCDA, Rwanda Medical Centre (RMC), the Food and Drug Agency (FDA) and the National Food and Nutrition Secretariat, resulted in considerable delays and dilution of achieved results.
COVID-19 pandemic resulted in suspension of activities and supply disruptions.	Restrictions on movement during COVID-19 and subsequent closure of ECD centres (for 2020), impeded the progress made in the ECD component. Furthermore, scheduled trainings in 2020 were interrupted which were converted in online/remote trainings.
Frequent transfer/turnover of district officials	A high turnover at the decentralised level has been reported. Nutrition governance at the local level related to the design, development and implementation of district plans for the elimination of malnutrition (DPEMs) is hampered, because of the high turnover of district government staff.

## Annual Target Setting and Stakeholders' Participation

40. The literature review indicates that DHCR targets were set in 2016 (at the start of programming) and continued until the end of the programme cycle i.e., 2020. These targets were not revised in view of the Programme's no-cost extension until June 2022.
41. The annual target for stunting was reduced from 4.5 percent to 1.5 percent per year based on findings from the mid-term review. The Comprehensive Food and Vulnerability Assessment (CFSVA) 2018 showed a decrease in stunting from 38 percent in 2015 to 35 percent in 2018, i.e., 1 percent per year. The evidence of slowed progress made the Programme's annual reduction of 4.5 percent look quite ambitious. As a result, the target was reduced to 1.5 percent point per year (to reduce stunting from 38 percent to 32 percent by end of 2021).
42. The targets for impact level indicators (reduction in stunting and young child's holistic development) were set at the national level (for 30 districts) while the Programme interventions were targeted in 14 districts. The Programme did not use the baseline numbers for stunting from each district (conducted in 2019) to develop/add district-specific targets.
43. The KII respondents shared of their satisfaction of the process applied for target setting. Key informants suggested that targets were set at the design stage after consultative meetings with them and the district authorities. Moreover, annual work plans were produced through consultations with the relevant stakeholders, which also included timelines and budgets.

"For target setting, UNICEF worked with the government and with partners to produce realistic and doable estimates and district management provides data for target setting." UNICEF

## EQ4.3 – How successful was DHCR in building public sector (in nutrition and ECD) and community capacities for efficacious nutrition and ECD services for children 0-6?

The Programme had a considered focus on building public sector and community capacities for improved and sustained nutrition and ECD services for children aged 0-6 years. The findings for this sub-question are divided into two parts where the first outlines the public sector capacity development achievements and later highlights community level capacity development. It should be noted that findings below overlap and complement those listed for sustainability (where the focus in sustainability is on continuity of services), hence should be read in conjunction with the section on sustainability.

### Public Sector Capacity Development

The Programme contributed to building public sector capacity. The evaluation team has used the enabling environment model/framework<sup>80</sup> (five components: policy and strategy; institutional arrangements and coordination; financing and budgeting; monitoring and evaluation; and capacity-building) for assessment of public sector capacity development for delivery of effective implementation of multi-sectoral interventions. Find below the matrix that outlines the key achievements vis-à-vis public sector capacity development.

**Table 10: Key Achievements vis-à-vis Public Sector Capacity Development**

Enabling Environment Framework	Key Achievements
<b>Policy and Strategy</b>	<ul style="list-style-type: none"> <li>UNICEF supported the establishment of multiple policies and strategies including: National Nutrition Policy; National ECD Strategic Plan; Made in Rwanda ECD Kit; National Kitchen Garden Toolkit; National Food-Based Dietary Guidelines, National Adolescent Nutrition Guidelines, National Parenting Curriculum, National Curriculum for the Community Health Workers; and the National Maternal, Infant and Young Child Nutrition (MIYCN) package.<sup>81</sup> These policies and strategies will continue to enable and guide GoR to plan and deliver multi-sectoral interventions. Most of these services set local standards for service delivery, defined institutional mandates and coordination arrangements, and set strategic priorities for the GoR to continue to deliver quality services.</li> </ul>
<b>Institutional Arrangements and Coordination</b>	<ul style="list-style-type: none"> <li>Multi-sectoral ECD coordination mechanisms were established at national and district levels. To support policy implementation, the national ECD technical working group, co-chaired by UNICEF and MIGEPROF, was established.<sup>82</sup> The working group enabled districts to effectively plan, coordinate and monitor the implementation of programme activities.<sup>83</sup></li> <li>The national ECD Sub-cluster, co-chaired by UNICEF and NCDA, enhanced coordination at national and decentralized levels; and increased participation and integration of key thematic areas of health, nutrition, education, WASH and protection.</li> <li>NECDP (restructured into NCDA) provided leadership and strategic direction and coordinated all key government ministries, departments and development partners working on DHCR. NCDA is a newly</li> </ul>

<sup>80</sup> <https://agora.unicef.org/pluginfile.php/69724/course/summary/WASH%20Guidance%20Note%20Draft%20Updated%20LR.pdf>.

<sup>81</sup> Programme Document:03. EKN- I annual progress report for 2017- as of 31 March 2018.

<sup>82</sup> Programme Document:03. EKN- I annual progress report for 2017- as of 31 March 2018.

<sup>83</sup> Programme Document:04. EKN- II annual progress report for 2018- as of 29 March 2019.

**Table 10: Key Achievements vis-à-vis Public Sector Capacity Development**

Enabling Environment Framework	Key Achievements
	<p>formed organisation with new staff members and organisational structure. The progress and support provided by UNICEF to NECDP may be impeded by the new structure.<sup>84</sup></p> <ul style="list-style-type: none"> <li>While the Programme utilized and supported multiple coordination platforms, primary and secondary data reflect that the district level coordination remained weak due to high staff turnover.</li> </ul>
<b>Financing and Budgeting</b>	<ul style="list-style-type: none"> <li>DHCR was primarily funded by EKN. Due to the Programme's advocacy and support, ECD is part of annual budgets in 14 target districts.<sup>85</sup></li> <li>UNICEF partnered with the Rwanda Utilities Regulatory Authority (RURA) to strengthen private operator financial and commercial management by providing tools and training to RURA and private operators. RURA is using the new reporting system, including an online reporting tool which strengthens oversight and requires improved financial management to fulfil reporting requirements. This system is being used nationally in all 27 rural districts.</li> <li>The Programme trained 170 government officials on nutritional governance (RBM) in 17 districts with the highest levels of stunting. Participants were district-based officials in the fields of project monitoring and evaluation (PM&amp;E), Health, Nutrition, Agronomy, NECDP, WASH and Social Affairs. Although the training was successful, primary and secondary data suggest a rapid turn-over of district officials hampered the impact of the training.</li> </ul>
<b>Monitoring and Evaluation (M&amp;E)</b>	<ul style="list-style-type: none"> <li>The Programme conducted joint monitoring visits (GoR and UNICEF); programme assessments (baseline, mid-term review, nutrition monitoring missions, endline survey) and national surveys (DHS 2019-2020; CFSVA 2018; ethnographic study) to generate evidence for informed decision making.</li> <li>UNICEF strengthened the capacity of 3,030 district, sector and cell staff to promote and monitor household sanitation.</li> <li>A monitoring and evaluation system has been established in all 14 targeted districts including development of a child rights-based monitoring database, which includes baseline data for ECD-nutrition multisectoral interventions. For real-time monitoring, the database is updated on a quarterly basis.</li> </ul>
<b>Capacity-Building</b>	<ul style="list-style-type: none"> <li>40 master trainers were trained on the MYICN package. Master trainers then trained 633 trainers from all health centres.</li> <li>647 ECD caregivers (425 female and 222 male) were trained.</li> <li>Sector education officers (440), pre-service teachers (556), and ECE tutors (225), were trained on early learning.</li> <li>170 government officials were trained on nutrition governance.</li> <li>KII respondents expressed their satisfaction with the Programme's capacity-building initiatives. However, a major constraint to efficacy of this component remained the high turnover reported at the district level. This may impede the gains achieved by the DHCR during its implementation.</li> </ul>

### **Community Capacity Development:**

Although the Programme laid adequate focus on community mobilisation and capacity development, there was not a documented strategy and plan. To respond to the question and consolidate findings, the evaluation team applied a multi-dimensional framework to assess effectiveness of community capacity development. The key components of the framework include: 1) Community mobilisation/organization and linkage-building; 2) Knowledge and skills development; 3) Material assistance; 4) Monitoring and social accountability. Find below the matrix that outlines the key achievements across these three components.

**Table 11: Key Achievements vis à vis Community Capacity Development**

Capacity-Building Components	Key Achievements
<b>Community mobilisation and building linkages</b>	<ul style="list-style-type: none"> <li>The Programme contributed to community mobilization by supporting groups for parents, caregivers, community members and ECD centre caregivers. The Programme laid focus on creating linkages such as training on smart spending curriculum in the community-based savings groups to promote members' prioritization of resources to improve nutrition.</li> <li>Through the partnership with religious networks, 19,171 people were reached with stunting reduction messages. 136,708 people reached through gatherings in places of worship.</li> <li>Social mobilisation efforts through theatre for development reached 157,650 people. Sixty performances were completed by local theatres and ten theatre performances were conducted by Urunana DC celebrity actors to create demand for ECD around tea plantations in six districts.</li> <li>A total of 189,221 families with children (0-6 years) were reached with behaviour change communication messages on responsive caregiving. This was implemented through direct outreach to families via faith-based organizations and a radio programme called "Itetero" and a local community theatre called</li> </ul>

<sup>84</sup> Programme Document:05. EKN- IV annual progress report for 2020 \_ as of 26 March 2021.

<sup>85</sup> Nutrition Monitoring Mission 2019.

**Table 11: Key Achievements vis a vis Community Capacity Development**

Capacity-Building Components	Key Achievements
	<p>"Urunana". As a result, more families are aware of the importance of early investment in life of children and the negative effects of stunting on child growth and development.</p> <ul style="list-style-type: none"> <li>Discussions with community members show that most of the members benefitted from the social mobilization efforts with improved knowledge, awareness and practices around nutrition, WASH and early education.</li> </ul>
<b>Knowledge and Skill Development</b>	<ul style="list-style-type: none"> <li>The Programme conducted various skill development initiatives namely, kitchen gardening, nutritious food cooking, childcare and learning.</li> <li>The Programme invested in the training of caregivers (500) and tea pickers (70 percent female and 30 percent male) on childcare and development. The Programme capacitated 956 latrine builders by providing training on construction that has ultimately supported communities in improving sanitation.</li> <li>DHCR supported a training-of-trainers on the national Kitchen Garden Programme and subsequent cascade training down to village level in the 14 target districts reaching 6,726 farmer promoters and 416 youth volunteers.</li> <li>The Programme supported several districts in establishing community-based saving and lending (SILC) groups which allow community members to access micro-loans to support income generating activities.</li> <li>21,111 parents enrolled in the ECD programme which trained parents on skills and knowledge for providing nurturing and responsive care to their children.</li> </ul>
<b>Materials Assistance</b>	<ul style="list-style-type: none"> <li>Data on quantity of different supplies provided to the community members is not available to the evaluation team, therefore it would not be possible to provide any commentary on it. However, the Programme provided material assistance to the community under various interventions such as ready-to-use therapeutic food (RUTF) for treatment of SAM without complications, MNPs supplements to be distributed amongst children 6-23 months for anemia prevention.</li> <li>Children attending programme supported ECD centres were provided with food, books and toys.</li> <li>Programme assisted farmers were provided with fruits, seeds, chickens (eggs were used for children) and fertilizers. Discussions with farmers indicate that crop yield has increased in the past five years and the reason for the increase in the yield was the provision of new seeds and the use of modern fertilizers.</li> </ul>
<b>Monitoring and Social Accountability</b>	<ul style="list-style-type: none"> <li>Discussions with community members indicate that routine monitoring was conducted by health workers (for identification, registration and treatment of malnourished children and pregnant and lactating women (PLW), however there is no evidence of direct involvement of community in these monitoring activities. In addition, awareness on availability of a feedback mechanism is limited in community members.</li> </ul>

**EQ5 – To what extent has DHCR been planned and implemented in a coordinated manner, challenges faced, and to what extent is DHCR replicable?**

The criterion has one key question and one sub-question.

**EQ5.1 – Has DHCR been planned and implemented in a cohesive and effective manner? What coordination mechanisms were in place, constraints faced, and which aspects are replicable?**

The description below must be read in conjunction with findings in section 4.2 (coherence). The findings in coherence were focused on outlining the systems and processes applied for external coordination, however here the focus is on how effective those mechanisms have been in enabling coordinated planning and delivery, and the challenges it faced. The findings are grouped at both national and sub-national levels that enabled cohesive planning and implementation.

#### **DHCR Coordination Arrangements**

Find below the matrix that outlines national and sub-national coordination forums either formed or strengthened (those existed earlier) to enable cohesive planning and implementation of DHCR activities. The section further outlines the constraints faced and how those affected synchronized planning and implementation.

**Table 12: DHCR Coordination Forums and Contributions**

Coordination Forums / Levels	Key Findings
<b>National Level</b>	<ul style="list-style-type: none"> <li>The Nutrition Technical Working Group (NTWG) was set up in 2013 (before DHCR) and continued to act as a multisectoral coordination platform for nutrition. Under DHCR, UNICEF coordinated and supported the NTWG that included other components like WASH, child protection and early childhood development.</li> <li>NECDP was mandated to coordinate and implement ECD, WASH and nutrition activities. These were previously the responsibility of Rwanda Biomedical Centre. NECDP was later transformed into NCDA.</li> <li>Coordination with CSOs engaged in nutrition activities was enhanced by supporting the SUN Civil Society Alliance in Rwanda.</li> <li>To support policy implementation, the national ECD technical working group, co-chaired by UNICEF and MIGEPROF, was established. GoR also established a National ECD Programme Coordination Structure under MIGEPROF to oversee stunting reduction and ECD programme implementation.</li> </ul>

**Table 12: DHCR Coordination Forums and Contributions**

Coordination Forums / Levels	Key Findings
	<ul style="list-style-type: none"> <li>The national ECD sub-cluster, co-chaired by UNICEF and NCDA, enhanced coordination at national and decentralized levels; and increased participation and integration of key thematic areas of health, nutrition, education, WASH and protection.</li> <li><b>Constraints:</b> Discussions with key stakeholders indicate that frequent restructuring of institutions (particularly of NECDP to NCDA) have had impact on institutional mandate and reporting lines, and resulted in delays and impeded the efficacy of DHCR interventions.</li> </ul>
<b>Sub-National Level</b>	<ul style="list-style-type: none"> <li>To support DHCR implementation, district-based committees for elimination of malnutrition were established in 14 districts. The Programme contributed to strengthening the capacities of these committees by enhancing their skills around planning, monitoring and implementation of results-based programs for improved results. Eventually, District Plans for Elimination of Malnutrition (DPEM) were formed in all 14 districts.</li> <li>At the district level, multi-sectoral coordination mechanisms or platforms were established (under MIGEPROF) for planning, coordination, monitoring and implementation of stunting reduction and ECD programmes and are functional in all 14 targeted districts. In 2019, ECD became part of annual budgets of the targeted 14 districts.</li> <li>Joint Action Development Forums (JADF) were established under DHCR implementation. These forums serve as a place for joint planning or to have technical discussions among partners and CSOs to avoid duplication of efforts and efficient use of funds and resources.</li> <li>UNICEF supported the operationalization of monitoring and evaluation systems in all 14 targeted districts with baseline and endline assessment of key indicators in nutrition, WASH, ECD and social protection sectors.</li> <li><b>Constraints:</b> The stakeholders identified frequent staff changes/turnover (as staff in key departments may stay for few months in a role) as a limiting factor. This required repeated investments in introducing programme interventions to new staff and loss of training investment when staff moved out of the district.</li> </ul>

#### **Preliminary Conclusions: Effectiveness**

**EFF 1:** The effectiveness measurement remains inconclusive due to the fact that out of seven outcomes, only three could be rated for relative effectiveness. For four outcomes i.e., 1, 3, 6 and 7, either data is not available for some indicators or for some i.e. 7, there are no targets to compare performance data with. Out of the remaining three outcomes, two outcomes (i.e., 4 and 5) are assessed as 'Fully Achieved' and outcome 2 is rated as 'Mostly Achieved'.

**EFF 2:** The evaluation team has compared the baseline (2019) with the endline (2022) to assess the relative effectiveness of programme components i.e., nutrition, health, ECD, WASH and social protection. From the 46 indicators assessed as part of the endline (for seven districts), the evaluation concludes that the Programme is 'Partially Effective'. In 46 indicators, the evaluation found incremental change in 28 indicators (61 percent) covering mostly WASH and health components. There are 18 indicators (39 percent of the total) where the evaluation noted declining trends. The plausible explanation is COVID-19 and its impact on incomes, poverty and restricted mobility. The indicators where the comparison shows decrease, merit further exploration.

**EFF 3:** The key enablers for the Programme are: alignment with GoR priorities resulting in ownership and commitment of public sector partners; use of community-based models (community-driven) resulting in community engagement and ownership; adaptive measures taken during COVID-19. The disabling factors that hindered achievements include institutional changes (NECDP becoming NCDA); frequent public sector staff turnover (in districts); and COVID-19 disruptions and restrictions.

**EFF 4:** The Programme is largely a success in strengthening public sector and packaging as integrated services. As part of system strengthening efforts, the Programme appears to be relatively more successful (or effective) with respect to two elements (out of five) of Enabling Environment i.e., policy and strategy (supported GoR to develop multiple policies and strategies) and monitoring and evaluation (supported GoR to conduct national surveys and improve nutritional governance). The Programme remained partially successful in terms of: capacity-building (undermined by high staff turnover reported at the district level); financing and budgeting (for limited focus); and institutional arrangements and coordination (stakeholders reported gaps in district level coordination).

**EFF 5:** The Programme remained effective in community mobilization and capacity development. The community capacity development is assessed with respect to community mobilization and linkages development; skills and knowledge development; materials assistance; and monitoring and social accountability. The Programme successes are evident in organizing communities (for collective actions); wider community participation and engagement; leveraging influence of local influencers, i.e., religious leaders, theatres, faith-based organizations; and provision of skills and supplies. All these factors contributed to cultivating ownership and mobilizing community for collective benefit.

**EFF 6:** The Programme has been effective in terms of taking a methodical approach to mapping external stakeholders and using this information to organize new forums for stakeholder coordination. Moreover, it also worked to strengthen the existing forums. Where these forums enabled cohesive planning and implementation, these faced challenges around frequent changes in government-led coordination structures and their mandates at the national level. This caused confusion amongst stakeholders and impaired joint planning of activities. At the district level, high turnover of district officials affected sub-national coordination.

## **4.5 Impact**

### **EQ6 – To what extent did the Programme contribute to achieving the desired impact?**

The impact criterion has one key evaluation question and one sub-question.

#### **EQ6.1 – Did DHCR contribute to the achievement of intended impacts (in stunting reduction and developmental readiness of 0-6 children) in target districts and in the country?**

The findings are divided into two parts, whereby the first part presents findings on contributions to the intended impact and the second highlights the unintended impact.

### **Programme's Contributions to Intended Impact**

The Programme intended to contribute to following impact targets for children (under 6):

- I. **Impact 1:** Prevalence of stunting among children U5 reduced
- II. **Impact 2:** Young children's holistic development improved

Find below the Programme contributions to the achievement of two impact indicators.

#### **Impact 1: Reduction in stunting among children U5**

44. The Programme's revised target<sup>86</sup> to reduce national stunting was from 38 percent to 32 percent (decrease by 6 percent) by the end of 2021. The national data suggests that stunting rates have come down from **38 percent (RDHS 2014-2015)** to **33 percent (RDHS 2019-2020)**.<sup>87</sup> The Programme may have contributed to the reduced national stunting rate due to nutrition-specific and nutrition-sensitive interventions in 14 target districts. District level stunting data is not available in the RDHS, and the evaluation team has used primary data for baseline and endline comparison.
45. For programme districts, the evaluation team undertook comparative analysis of the Programme's baseline (undertaken in 2019) and endline survey (undertaken as part of the evaluation in 2022). Comparisons were done for seven target districts to assess the Programme's contributions to reduce stunting among children aged 6-23 months. Data shows that the prevalence of stunting has decreased by **1.6 percent** from the baseline value of **31.3 percent** (95 percent CI: 29.0 percent – 33.6 percent) to an endline value of **29.7 percent** (95 percent CI: 27.18 percent – 32.38 percent).<sup>88</sup> This demonstrates lower achievement for programme districts (in comparison to national-level stunting reduction), which begs further exploration. The baseline and endline numbers for each target district are mentioned below:

**Table 13: Prevalence Rate of Stunting (Baseline vs Endline)**

Districts		Baseline (2019)			Endline (2022)		
	Total N	n	%	Total N	n	%	
<b>Sex of the Child</b>							
Male	773	273	35.3%	662	143	21.6%	
Female	779	212	27.2%	690	134	19.4%	
<b>Intervention Districts</b>							
Burera	248	99	39.90%	187	57	30.50%	
Gatsibo	201	41	20.40%	188	46	24.50%	
Gicumbi	184	54	29.30%	214	70	32.70%	
Karongi	220	71	32.30%	151	43	28.50%	
Ngororero	211	54	25.60%	216	54	25.00%	
Nyaruguru	234	64	27.40%	225	70	31.10%	
Rutsiro	254	102	40.20%	171	62	36.30%	
<b>Overall</b>	<b>1552</b>	<b>485</b>	<b>31.30%</b>	<b>1352</b>	<b>402</b>	<b>29.70%</b>	

46. To corroborate these findings a paired t-test was undertaken to assess whether significant difference exists between baseline and endline data. The range for stunting within programme districts at baseline with 95 percent confidence interval was: [30.73 percent, 35.76 percent]; whereas at endline the same confidence interval<sup>89</sup> it was: [26.96 percent, 32.66 percent]. Hence an average difference/reduction of 3.4 percent has been determined.
47. Similarly, to further validate the existence of significant difference between baseline and endline stunting data, we have used the hypothesis that stunting rate is reduced up to 4 percent ( $H_0: Stunting\ Rate \leq 4\%$ ) valid with P-Value 0.001 for one sided left tail hypothesis. The difference in stunting rate within seven programme districts between endline and baseline, using 95 percent Confidence Interval, was: [-4.7 percent, 2.8 percent]. Hence, the stunting rate has been reduced up to 4.7 percent (valid with P-value less than 0.05).
48. Geographically, the highest prevalence of overall stunting was reported in Rutsiro with 40.2 percent of sampled children stunted, followed by Burera, at 39.9 percent. Three out of seven districts reported an increase in prevalence of stunting including Gatsibo, Gicumbi and Nyarguru from their

<sup>86</sup> Annual reduction from 4.5% to 1.5% per year.

<sup>87</sup> Data collection took place between November 2019 to June 2020.

<sup>88</sup> The evaluation team used WHO Anthro Survey Analyser to compute z-score; and during this process was able to identify and red flag children who are in need of immediate health attention. List of Vulnerable Children in Need of Immediate are annexed as Appendix 31.

<sup>89</sup> Confidence interval provides two-tailed estimates (i.e., left side and right side). Left tailed  $\mu_{-}(d) \leq 0$ : Post treatment results are decreased Right tailed  $\mu_{+}(d) > 0$ : Post treatment results are increased. Using left side of confidence interval (endline – baseline) Stunting rate is: [-4.7%, 0]. Hence, reflecting a difference of up to 4%.

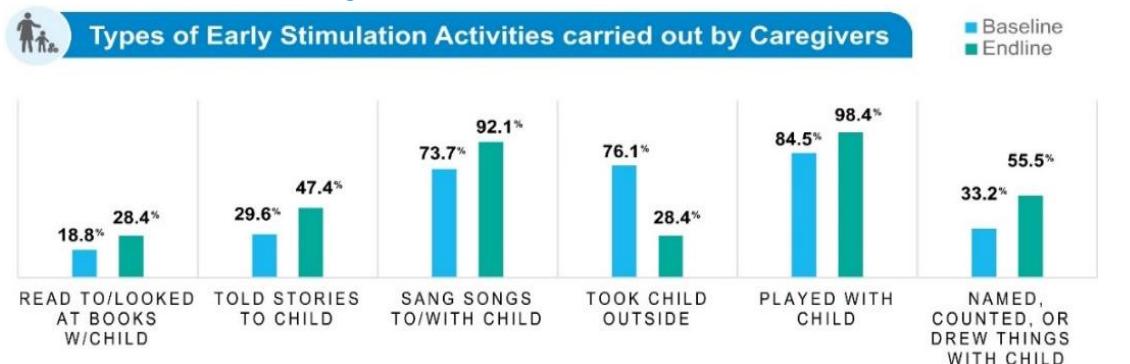
baseline values. In comparison, four other districts saw a decrease in the prevalence of stunting including Burera, Karongi, Ngororero and Rutsiro. The evaluation team did not find any evidence to explain the upward trend in prevalence of stunting in half of the districts which may require further exploration.

49. In both baseline and endline surveys, a similar trend is reported where boys (35.3 percent in 2019 and 21.6 percent in 2022) were more likely to be stunted than girls (27.2 percent in 2019 and 19.4 percent in 2022). This is partially explained by cultural practices where girls are more likely to stay home and the uptake of food/number of meals is higher as compared to boys.
50. Discussions with stakeholders and community members corroborated the findings that the Programme contributed to reducing the rate of stunting at national level. In addition to reduction in stunting, the stakeholders also highlighted that there has been a positive impact on knowledge, attitudes and behaviour of parents and caregivers. This was done by providing frequent mobilization sessions to equip them with knowledge and capacities.

### **Impact 2: Improvement in Young Children's Holistic Development**

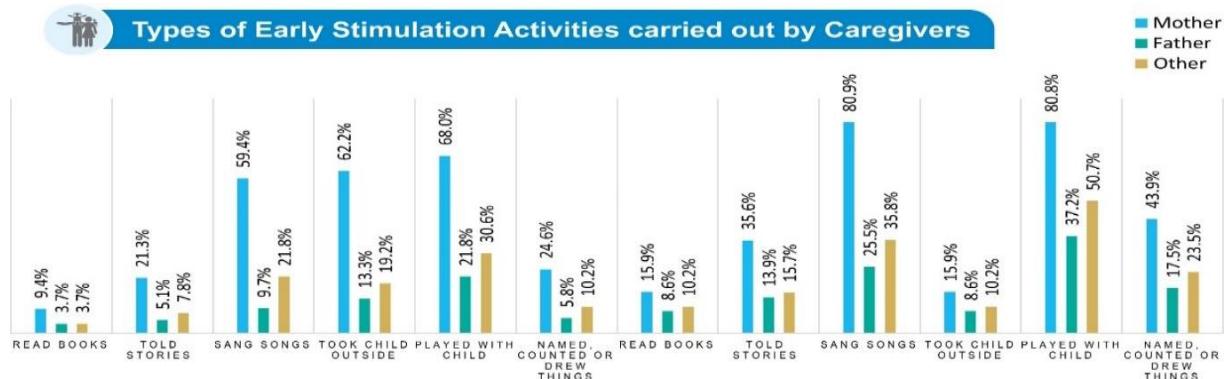
51. For the holistic development impact indicator (for children aged 36-59 months), the numbers indicate an incremental trend. Against the baseline number of 63 percent (RDHS 2014-2015 among children aged 36-59 months), the RDHS 2019-2020 shows that number at 76 percent (among children aged 24-59 months). Due to difference of age intervals between RDHS 2014-2015 and RDHS 2019-2020, these two values are not comparable.
52. For programme districts, the data comparison is available for selected (not all) holistic development factors/indicators (between the programme baseline (2019) and evaluation endline (2022)). The trend analysis indicates that for most early stimulation activities (by caregivers) there is improvement in numbers, with exception of taking the child outside, which can be explained by the restrictions imposed due to COVID-19 (percentage dropped from **76.1 percent to 28.4 percent**). Figure 20 below shows the comparison between endline and baseline on different types of early stimulation activities.

Figure 20: Baseline vs Endline: ECD



53. Figure 21 below shows role of mothers and fathers in child development activities. Fathers were reported to be involved in telling stories and playing with children.

Figure 21: Promoted Early Stimulation Activities by Caregiver



## Programme's Contributions to Unintended Impact

54. Stakeholders referred to positive changes in parenting and in particular the involvement of father/men in responsible parenting. The community respondents referred to a shift in men's behaviour, whereby they are more inclined to invest in saving groups and use the money for their family's well-being, instead of spending it on alcohol consumption (which was a dominant behaviour prior to programming).

### Preliminary Conclusions: Impact

**IMP 1:** The Programme may have contributed to impact achievement of stunting reduction (U5). The national stunting numbers indicate reduction from 38 percent to 33 percent (from 2015-2020), which equals the Programme target of achieving 5 percent reduction in stunting rates nationally (please note that target was revised downwards after midterm review of DHCR). In addition, this measurement is for the national level whereas the Programme was implemented in 14 of the 30 districts. For Programme districts however, the numbers show a reduction of 1.6 percent (in 7 out of 14 programme districts – for 6-23 months) between 2019-2022. The lower results for programme districts (in comparison to national numbers) beg further enquiry.

**IMP 2:** For the second impact indicator, the child holistic development was at 63 percent (RDHS 2014-2015 – among 36-59 months) to 76 percent (RDHS 2019-2020, 24-59 months). Due to variation in age group in both RDHS, comparison between the two values is not possible. For programme districts, comparison remains incomplete (for all indicators that make up holistic development) for baseline (2019) and endline evaluation survey (2022), however for most of these factors there is an upward trend in uptake of early stimulation activities.

**IMP 3:** The unintended impact is evident in terms of improvement in the involvement of fathers in child development activities including shift in behaviour to save money rather than using money for personal expenses.

## 4.6 Sustainability

### EQ7 – To what extent did DHCR enable the GoR's ownership, capacity development and institutionalisation of nutrition and ECD interventions, and what factors either influenced or are likely to influence sustainability?

The sustainability criterion has one key question and two sub-questions.

### EQ7.1 – Which DHCR results/interventions are likely/unlikely to be sustainable and what are the contributory factors? Will programme achievements result in securing more funds from current/new donors to support nutrition and ECD activities?

The findings are structured into two parts whereby the first part lists DHCR strategies/interventions and results that are likely to be sustainable or otherwise, including the contributory factors. The second part dwells upon the likelihood of securing more funds from current/new donors (for continuation of nutrition and ECD activities) keeping in view programme achievements.

### Sustainability of Programme Interventions and Results

This section puts together the findings (and to a degree analysis) of activities and results that may be sustainable or otherwise. The findings are drawn from both primary and secondary data and are presented in a matrix form. It should be noted that the Programme operated without a documented exit/sustainability plan. In the absence of a plan, the evaluation team has used the Programme's strategies and results that are likely or unlikely to be sustainable and their contributory factors.

Table 14: Sustainability Prospects for DHCR Interventions/Results

Programme Strategies	Results Achieved (2017 – 2021) <sup>90</sup>	Evaluator's Rating and Assessment
Capacity-building	<ul style="list-style-type: none"> <li>• 40 master trainers were trained on the MYICN package. Master trainers trained 633 trainers from all health centres across the country.</li> <li>• 647 ECD caregivers (425 females and 222 males) were trained.</li> <li>• Sector education officers (440), pre-service teachers (556), and ECE tutors (225), were trained on early learning.</li> <li>• 170 government officials were trained on nutrition governance.</li> <li>• Capacity strengthening of 3,030 district, sector and cell staff to promote and monitor household sanitation.</li> <li>• 2,545 households were provided financial literacy/savings and loans training.</li> <li>• 1,459 religious volunteers were trained as advocates for ECD and proper nutrition for stunting reduction.</li> <li>• 1,166 private sector employees sensitized on nutrition/ECD.</li> </ul>	Partially Sustainable: Training packages and knowledge/skills acquired by public sector workers and community members are likely to be sustainable. The training contents are available to the respective public departments and there is a willingness to continue using them. However, the rapid turn-over of staff at the district level affects the prospects of sustainability of capacity development on multisectoral approaches to address child malnutrition and reduces the capacity for nutrition governance.
Dialogue and advocacy	<ul style="list-style-type: none"> <li>• UNICEF supported a high-level three-day workshop on nutrition budget analysis with participation of all parliamentarians and senators.</li> </ul>	Partially Sustainable: Through successful advocacy, ECD has

<sup>90</sup> The evaluation team does not have access to Programme progress from March to December 2021.

**Table 14: Sustainability Prospects for DHCR Interventions/Results**

Programme Strategies	Results Achieved (2017 – 2021) <sup>90</sup>	Evaluator's Rating and Assessment
	<p>The workshop was successful in raising the awareness of remaining programmatic and budgetary gaps for nutrition in the country.</p> <ul style="list-style-type: none"> <li>A total of 190,835 families with children (0-6 years) were reached with behaviour change communication messages on responsive caregiving. 420,801 people have been reached through community outreach sessions, including parenting sessions, thematic mini campaigns and FGDs.</li> <li>Through various strategies including advocacy and peer to peer support, 15 tea companies have invested in 23 ECD centres, using their own resources. ECD remained part of the annual budgets of all the 14 focus districts of this programme.</li> </ul>	transformed into GoR's main development priorities, and it remained part of the annual budgets of all target districts. DHCR has also raised awareness in target districts, however, there is a continued need for sensitisation. There is a continued for other development actor/public agency to take up the responsibility to provide this support.
Evidence generation	<ul style="list-style-type: none"> <li>Initiated an ethnographic study to answer the 'why' in food, feeding and handwashing practices. The study included extensive observation of actual nutrition practices in communities, and thereby provides 'deep' knowledge on the actual practices of caregivers in relation to nutrition. The study provided an opportunity to relevant stakeholders to inform programming for behaviour change moving forward.</li> <li>The national mapping of ECD services was completed.</li> <li>Worked to improve the availability of up-to-date national nutrition data by providing technical and financial support to the ongoing Rwanda DHS. This resulted in the inclusion of new indicators on micronutrient powder consumption and a micronutrient survey component which will provide updated data on micronutrient deficiencies.</li> <li>A capacity gap analysis of key stakeholders was conducted in 2018 with an aim to formulate an integrated capacity development plan for relevant stakeholders. This plan has resulted in development partners (including UNICEF) to devise informed capacity-building initiatives.</li> </ul>	<b>Most Likely to Sustain:</b> The technical and financial support provided by DHCR has generated evidence and will continue to provide guidance/framework for future interventions. For instance, the ECD mapping exercise provided baseline data for the national and decentralized ECD programming. Specifically, it provided data on availability and location of ECD spaces which can guide similar initiatives in the future.
Public-private partnerships (PPPs)	<ul style="list-style-type: none"> <li>Partnered with 11 tea companies that invested in establishing and operationalizing 20 ECD centres. Peer to peer field visits resulted in six additional companies committing to invest in child-friendly workspaces, two of whom are in finalization stages of construction.</li> <li>The success in the tea sector motivated similar initiatives in other sectors, with two rice cooperatives partnering with UNICEF on a pilot basis and ready to invest in establishing child-friendly workspaces.</li> <li>UNICEF sensitized 150 managers and staff of tea companies (70 percent female and 30 percent male) on child rights and business principles and their role in reducing stunting. Additionally, UNICEF conducted training for 500 caregivers and tea pickers (70 percent female and 30 percent male) on child-care and development.</li> </ul>	<b>Most likely to Sustain:</b> Tea companies are committed to operate ECD centres. With employer-supported childcare in place, parents of young children can spend more time working, which in turn translates to increased production by the tea company. It also means less attrition of trained pickers, improved company-community relations, increased productivity and enhanced corporate reputation for the company.
Innovation and cross-sectoral linkages	<ul style="list-style-type: none"> <li>For integrated multi-sectoral programme interventions an overall coordination mechanism at the central level included the Food, Nutrition and WASH technical working group (serving as the SUN country network), the SUN UN network, the SUN civil society network and the SUN donor network.</li> <li>National Secretariat for Nutrition was set up and transformed into the NECDP (later NCDA) in order to coordinate nutrition and ECD initiatives. UNICEF co-chaired coordination, whereas, the members of the Secretariat included line ministries, EKN, development partners and civil society organizations.</li> <li>At the district level, multi-sectoral coordination mechanisms or platforms were established for planning, coordination, monitoring and implementation of stunting reduction and ECD programmes and are functional in all 14 targeted districts.</li> </ul>	<b>Partially Sustainable:</b> The Programme supported and worked with multiple coordination mechanisms; however, primary data suggest that coordination remained weak with little documentation on the results these coordination activities were able to generate. At the subnational level, there is a continued need to strengthen the coordination structures for integrated implementation.

### Future Funding Scenario

- The DHCR supported various interventions under components including nutrition, ECD, WASH, social protection and education. Desk review indicates multiple initiatives by UNICEF, WFP, FAO, WHO and World Bank that warrant continuity of key Programme interventions.
- For instance, for nutrition, multiple development partners including Clinton Health Access Initiative, Inc., Foreign Commonwealth Development Office, Japan International Cooperation Agency, UNICEF, USAID, WFP and World Health Organisation will continue to work in Rwanda around

- nutrition-specific and sensitive interventions and approaches from 2021 to 2023.<sup>91</sup> In addition, GoR's commitment and ownership is evident as the budget allocations to different nutrition-related interventions have increased from **FRW 8.4 billion in 2017/18 to FRW 47.8 billion in 2021/22.**<sup>92</sup>
57. In addition, UNICEF, WHO, FAO and WFP are implementing Joint Nutrition Project Phase III (July 2021- June 2025) in Rutsiro and Ngororero districts (both DHCR districts) which aims to support the GoR's efforts to reduce stunting in Rwanda.<sup>93</sup>
  58. Desk review indicates that the World Bank is implementing various initiatives for developing human capital mainly around health, education, social protection, agriculture and multi-sectoral human capital support for: i) prevention and reduction of child stunting; ii) supporting policy and institutional reforms related to the delivery and coverage of human capital related services (education, social protection, health and early childhood development); iii) strengthening the social protection programs and delivery systems and to improve access of poor and vulnerable households to human capital and economic inclusion services.<sup>94</sup> Refer to Appendix 32 for more details.
  59. ECD, as indicated in previous sections, has transformed into GoR's main development priorities, and it remained part of the annual budgets of all target districts.
  60. Social protection budget depicts an increasing trend over the past five years, from **FRW 79.4 billion in 2016/17 to FRW 198 billion in 2020/21.** About two percent of GDP is allocated to non-contributory social protection interventions, which is consistent with that spent on similar social protection programs in other developing countries. As a share of the total national budget, the social protection budget increased from 4.1 percent to 6.1 percent during the same period. The increasing trend in the social protection budget allocations both in real terms and as a share of GDP indicates the government's commitment to strengthen and expand social protection programs to ensure inclusive and pro-poor development.<sup>95</sup>

**EQ7.2 – Has DHCR cultivated ownership and strengthened capacities within relevant public stakeholders and how does the GoR intend to sustain programme activities (in terms of budget allocation, policy, planning, implementation, management and monitoring)?**

61. The evaluation team has applied the enabling environment framework comprised of five elements essential for building public sector capacities. The subsequent section should be read in conjunction with findings included under effectiveness (section 4.4).
  - **Policy and Strategy:** The Programme assisted GoR in developing relevant policy frameworks (National Nutrition Policy, National ECD Strategic Plan, Made in Rwanda ECD Kit, National Food-Based Dietary Guidelines). These policies showcase GoR's commitment to provide evidence-based guidance to direct future implementation of nutrition and ECD interventions.
  - **Institutional Arrangements and Coordination:** Institutional embedding of DHCR interventions lay with NCDA—a newly formed body with a new structure and human resources. This is a potential danger for the embedding of DHCR and its interventions where NCDA is still developing the new structure. Similarly, the Programme has utilised and contributed to strengthening several coordination platforms (national ECD technical working group, national ECD sub-cluster, SUN network, among others). As discussed under section 4.4, the efficacy of the district-level coordination system is limited and requires continued support in the future.
  - **Financing and Budgeting:** The Programme was funded by the EKN and by the end of implementation, the GoR, donors and multilateral organisations (such as World Bank) have taken up funding of multiple interventions. There is a continued need for advocacy for replication and upscaling of DHCR activities in other districts.
  - **M&E:** The Programme conducted joint monitoring visits (GoR and UNICEF); Programme assessments (baseline, mid-term review, nutrition monitoring missions, endline survey) and national surveys (DHS 2019-2020; CFSVA 2018; ethnographic study) to generate evidence for informed decision-making. These studies, to a degree, remained under-utilised during implementation, and it is unclear how GoR plans to benefit from programme-supported M&E activities in the future.
  - **Capacity-Building:** DHCR paid much attention to capacity development of national and subnational government staff in order to promote nutrition governance at all levels. DPEMs play an essential role in combatting both acute and chronic malnutrition at the district levels, in line

<sup>91</sup> As per the nutrition intervention matrix by development partners shared by UNICEF.

<sup>92</sup> Nutrition Budget Brief - Investing in Children's Wellbeing in Rwanda (2021/2022)

<sup>93</sup> Joint Project Phase III: Effectively Fighting Stunting in Rwanda.

<sup>94</sup> Rwanda: human capital for inclusive growth DPF series policy and results matrix

<sup>95</sup> Social Protection Budget Brief - Investing in inclusiveness 2020/21

with national policy. The capacity building requires continued support which various interventions (as indicated in future funding sub section) intend to support in target districts.

#### **Preliminary Conclusions: Sustainability**

**SUS 1:** The Programme operated without a documented sustainability/exit plan; hence the evaluation team is unable to comment on success around its implementation. From the data, it appears that programme strategies of evidence generation (with availability of requisite data for future interventions) and PPPs (commitment by private companies to continue supporting ECD centres) show higher prospects of sustainability. Whereas strategies such as capacity-building, dialogue and advocacy, and cross-sectoral linkages are relatively less likely to be sustainable due continued need for implementation with no commitment from GoR or any other development partner to implement them. The Programme has seen limited success with mobilising other donors to contribute to the Programme's continuity and the Programme is currently not being implemented as EKN II funding is finished.

**SUS 2:** There is evident interest and willingness by the GoR agencies to continue and replicate the Programme which has translated into securing additional public sector financial commitment for DHCR components (such as nutrition, ECD and social protection). Initiatives by UN agencies and World Bank show that the development partners are committed to continue supporting GoR in reducing stunting and improving holistic in Rwanda.

## **4.7 HRBA, Gender Equality and Equity**

### **EQ8 – To what extent did DHCR incorporate human rights-based/child rights approaches (HRBA/CR), gender equality, and equity principles and approaches, and results created thereof?**

To demonstrate a concerted focus on evaluating integration (in terms of the Programme's design and implementation) of cross cutting priorities (for UNICEF), a separate criterion has been added with includes assessment of HRBA, gender equality and equity. There is one key question with three sub-questions, one each for the three cross-cutting priorities.

#### **EQ8.1 – Did DHCR (design and implementation) incorporate the HRBA/CR principles?**

This section brings together findings and analysis around the Programme's compliance with the HRBA<sup>96</sup> principles i.e., Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality (often referred to as PANEL). The findings are corroborated by both secondary and primary data.

#### **Integration of HRBA in DHCR Design and Implementation**

Following is the evaluation team's assessment on DHCR's compliance with key HRBA principles.

**Table 15: DHCR Compliance with HRBA principles**

HRBA Principles	Findings and Evaluation Team's Assessment
Participation <sup>97</sup>	The Programme's design and implementation remained inclusive. First a broad-based consultative process (featuring bi-lateral meetings, stakeholder consultation workshops and government validation meetings) was taken to inform programme design. Key public sector partners (including district administrations) were engaged to identify overlaps and avoid duplication. Communities were consulted and involved in the identification of problems and solutions (in the form of FGDs), which influenced programme design. A range of community groups—religious volunteers, community volunteers, ECD animateurs, community mobilizers, religious leaders—participated in sensitisation activities as agents for change.
Accountability <sup>98</sup>	The document review does not point to programme-led community feedback and/or a grievance management system. Nevertheless, the communities referred to an existing practice of informing the CHWs and community leaders of any feedback they may have, which continued to be practised through DHCR.
Non-discrimination and Equality <sup>99</sup>	The interventions remained largely non-discriminatory (did not discriminate based on identity factors) with the exception of prioritisation of households/beneficiaries on the basis of Ubudehe. <sup>100</sup> While this positive discrimination towards more vulnerable households is useful, discussions with community members indicate instances of exclusion of some deserving households that did meet criteria for inclusion. In addition, community members shared that concentrated focus was not paid to disabled and teenage/single mothers.
Empowerment <sup>101</sup>	The Programme enabled improved knowledge and awareness among community members around causes of stunting and delayed child development and has empowered them to make better choices. The community-led

<sup>96</sup> ENNHRI, 'Human Rights Based Approach', <http://ennhri.org/about-nhris/human-rights-based-approach/>.

<sup>97</sup> **Participation:** Everyone is entitled to active participation in decision-making processes which affect the enjoyment of their rights.

<sup>98</sup> **Accountability:** Duty-bearers are held accountable for failing to fulfil their obligations towards rights-holders. There should be effective remedies in place when human rights breaches occur.

<sup>99</sup> **Non-discrimination and Equality:** All individuals are entitled to their rights without discrimination of any kind. All types of discrimination should be prohibited, prevented and eliminated.

<sup>100</sup> Rwanda's system of Ubudehe (OO-bOO-dAY-h'eI). Rwandans are assigned to socioeconomic categories from 1 to 5, with 5 reserved for the wealthiest and 1 the poorest. Ubudehe categories are determined at the community level and remain relatively fixed unless circumstances change drastically. Ubudehe is a function of one's income, personal possessions and general quality of life.

<sup>101</sup> **Empowerment:** Everyone is entitled to claim and exercise their rights. Individuals and communities need to understand their rights and participate in the development of policies which affect their lives.

**Table 15: DHCR Compliance with HRBA principles**

HRBA Principles	Findings and Evaluation Team's Assessment
	structures have created ownership and empowered communities to plan and address issues around malnutrition and child development.
<b>Legality<sup>102</sup></b>	The Programme draws legal basis from the children rights enshrined in CRC 1989 <sup>103</sup> (that GoR is signatory) and other legal instruments safeguarding child development and access to services. Moreover, the legality is evident from the Programme's compliance with GoR sectoral policies and plans including National ECD Policy (2016) and National Nutrition and Food Policy Objectives (2014).

#### **EQ8.2 – Does programme design and implementation reflect integration of gender equality?**

This description presents key findings around the integration of gender equality at design and implementation levels. A light touch analysis of the integration of UN System-wide Action Plan (UN-SWAP) on Gender Equality and Empowerment of Women (GEEW),<sup>104</sup> has been incorporated.

#### **Integration of Gender Equality in DHCR Design and Implementation**

This sub-section informs highlights how gender-based assessment informed the Programme's design and implementation. In addition, the section includes viewpoints on how the Programme has beneficiated both genders and to what extent the causes of inequality between boys and girls have been addressed.

#### **Design Stage**

62. A Programme-supported gender assessment was not undertaken to inform its design. However, the Programme leveraged the findings of the Gender Equity Assessment of the VUP Programme (2012); Nutrition, Markets and Gender Survey (2016); and RDHS (2014-2015). In addition, it carried consultative sessions with stakeholders (public and communities) to understand gender (age and sex related) needs and barriers and thus the interventions were designed in consideration.
63. The barriers identified across gender equality included: (i) more stunting in children from HHs that have open defecation systems; (ii) opportunities for women are often limited to hard physical work that can be harmful to breastfeeding mothers with young children; (iii) time burden on women also translates into increased rates of stunting; (iv) women who spend more time in agriculture are less likely to breastfeed their children.
64. Review of the Programme's financial statements does not reflect separate expenditures for gender-specific results. In addition, the Programme results framework do not provide gender-disaggregated targets (or achievements) for relevant indicators.

#### **Implementation Stage**

65. The programme implementation included gender-sensitive interventions. For instance, both male and female community members were sensitized on the importance of improving nutrition, breastfeeding, better hygiene practices, etc. Furthermore, the programme supported the construction of gender-segregated toilets and promotion and inclusion of female participation in capacity-building initiatives addressed the specific needs of women and girls. The setting up of ECD centres by tea companies resulted in mothers working for more hours (without having to worry about children), which in turn boosted their income.
66. As the Programme did not collect gender-disaggregated data, the evaluation team is unable to assess the progress/results achieved. Comparison of the results of the baseline (2019) and endline (2022) underscore that the prevalence of stunting in children aged 6-23 months decreased, although it is higher for boys (35.3 percent in 2019 and 21.6 percent in 2022) than girls (27.2 percent in 2019 and 19.4 percent in 2022) in the targeted districts. This is partially explained by cultural practices where girls are more likely to stay home and the uptake of food/number of meals is higher as compared to boys.
67. An improvement in participation of fathers in child development activities was reported. An endline evaluation (2020) in 10 UNICEF-supported districts showed that 63.3 percent of children have fathers engaged in activities that promote their learning and school readiness compared to 57 percent at baseline (2017).
68. The evaluation team has reviewed the Programme's results framework to assess if the design incorporated gender equality principles as per the UN-SWAP 2.0.<sup>105</sup> There are 17 indicators broadly divided under results-based management: oversight; accountability; human and financial resources; capacity; and knowledge, communication and coherence. Of the six indicators that the evaluation team was able to assess, the Programme was found to be compliant on three indicators

<sup>102</sup> **Legality:** Approaches should be in line with the legal rights set out in domestic and international laws.

<sup>103</sup> <https://www.ohchr.org/en/resources/educators/human-rights-education-training/7-convention-rights-child-1989>

<sup>104</sup> <https://www.unsystem.org/content/un-system-wide-action-plan-gender-equality-and-empowerment-women-swap>.

<sup>105</sup> <https://gendercoordinationandmainstreaming.unwomen.org/sites/default/files/2022-02/UNSWAP%202.0%20Brochure%202021.pdf>

and non-compliant on other three. Refer to Appendix 33 which includes gender equality indicators and the evaluation team's assessment of the Programme's compliance and non-compliance with those indicators.

### **EQ8.3 – To what extent did DHCR appropriately assess, identify and address the needs of vulnerable groups (including vulnerable girls and boys aged 0-6 years); are there any groups that are not covered by the Programme?**

This description presents key findings around the integration of equity at design, implementation and results.

#### **Integration of Equity in DHCR Design, Implementation and Results**

This sub-section informs whether DHCR undertook an equity assessment to inform targets, interventions and resource allocations and includes a discussion on how the Programme has benefited vulnerable groups and to what extent the causes of inequity have been addressed.

**Table 16: Integration of Equity in DHCR Design, Implementation and Results**

<b>Design</b>	<b>Implementation</b>	<b>Results</b>
No evidence is available to suggest that the Programme undertook a structured equity assessment. It mainly relied on secondary evidence to inform its design. Moreover, the Programme's logframe does not include a single indicator/target that captures equity parameters.	Desk review and primary data analysis underscore that programme implementation focused on children and women, and specifically targeted the poorest and vulnerable groups. Moreover, the social protection, ECD and nutrition sections were integrated to benefit the vulnerable groups inclusive of children and women. The programme on Kitchen Garden, savings and lending activities were aimed to increase financial accessibility, especially among women from the poorest households	As per the endline survey results, highest prevalence of stunting was reported in Rutsiro District (out of seven districts that were part of the survey), with 36.3 percent of sampled children stunted. Rutsiro had one of the highest stunting rate (as per the Programme baseline) and remains vulnerable even after the end of DHCR.
The Programme targeted vulnerable districts for DHCR implementation. Districts were ranked based on equity criteria that included the prevalence of stunting, poverty rates, household food insecurity, access to improved drinking water and improved sanitation.	Further, discussions with UNICEF underline that the Programme had extended its technical and financial support to local government to develop a database of household profiling systems, where information was collected on key welfare indicators. The database was completed in March 2020 with the coverage of around 95 percent of households in the country. UNICEF had worked on tools and guidelines for para social workers and district workforces to update the database with more regular data, especially among the vulnerable groups. The whole purpose of the database was to monitor the welfare status once HHs had access social protection programmes and to ensure they were not left behind.	In baseline, the burden of overall stunting was higher in children in Ubudehe 1 (41.1 percent) compared with other categories (less than 30 percent). Discussion with community members indicates that there were people who were put in the wrong category, particularly the third category and did not receive supplements and other essential services, thus cueing the issue with targeting. The majority of the respondents acknowledged and appreciated that health counsellors catered for everyone irrespective of their social class.

#### **Preliminary Conclusions: HRBA, GE and Equity**

**HRBA 1:** Programme design and implementation is found largely consistent with HRBA principles. Consistency with the principle of participation is evident at varied levels, such as engagement of rights-holders, duty-bearers and influencers. The Programme is found to be largely non-discriminatory with exception of exclusion of deserving families who were excluded from programme services for not meeting the Ubudehe criteria/rating. The Programme-supported feedback and grievance management system is unavailable. However, the communities can refer complaints to CHWs and local leaders. The Programme is consistent with local laws and international rights conventions.

**GE 1:** The Programme is found to be partially compliant to gender equality. The Programme design offers limited gender disaggregation, as no indicator calls for collection of gender disaggregated data (impact, outcome or output indicators). Moreover, the Programme design did not conduct a gender assessment but utilised secondary evidence to inform its design. The Programme implementation is assessed as gender responsive as both male and female community members were sensitised on promoted behaviour; gender-segregated toilets were built in schools to address the needs of women and girls; female participation increased in committees and capacity-building initiatives; setting up of ECD centres by tea companies promoted work-life balance (women could work without having to worry about children). Results from the evaluation endline survey underscore that while the prevalence of stunting in children aged 6-23 months decreased, it still continues to be higher for boys than girls in the targeted districts [21.6 percent (boys) and 19.4 percent (girls)].

**EQY 1:** The Programme is found to be mostly compliant with equity principles. The Programme's geographical targeting was based on equity parameters including prevalence of stunting, poverty rates, household food insecurity and access to improved drinking water and improved sanitation. Mostly, the interventions remained non-discriminatory; however, beneficiary prioritisation was done on the basis of Ubudehe (categorisation) which requires revisiting as in some cases deserving HHs did not receive benefits as they were incorrectly categorised. More interventions are needed for people with disabilities, and teenage mothers and their children also were not prioritized for the interventions.

# 5

## Conclusions, Lessons Learnt and Recommendations



## Chapter 5: Conclusions, Lessons Learnt and Recommendations

This chapter comprises three sections i.e., conclusions, lessons learnt and recommendations. The first section lists evaluation conclusions drawn primarily from the findings and preliminary conclusions. The second section outlines the key lessons learnt (including good practices) framed as such to demonstrate replicability across sectors and similar contexts. The last section lists evaluation recommendations.

### 5.1 Conclusions

Find below evaluation conclusions that synthesize preliminary conclusions for each evaluation criterion.

**Relevance:** The Programme is concluded to be relevant for addressing priority needs – stunting and holistic child development and addressing both supply and demand side bottlenecks. There are evident overlaps (in terms of programme outcomes and strategies) with GoR public sector policies and plans, hence is concluded to be consistent or coherent with GoR's sectoral priorities. Use of the multi-variable child deprivation framework enabled effective and equitable targeting of districts.

**Coherence:** The Programme design managed to leverage internal coherence (within UNICEF); however only limited evidence is available on how successful the Programme has been in leveraging comparative strengths of multiple UNICEF sections during implementation. The Programme is concluded to have taken a systematic approach (featuring mapping exercises and forming/strengthening collaborative forums) to bring together actors across different sectors, which enabled leveraging resources of different actors and avoiding duplication. The Programme demonstrated successful implementation of public-private partnership (via engagement of tea companies for ECD), and it merits continuity and scale-up.

**Effectiveness:** The effectiveness measurement remains inconclusive due to data limitations. Out of seven outcomes, only three could be rated for relative effectiveness. From these, two outcomes (i.e., 4 and 5) are assessed as 'Fully Achieved' and outcome 2 is rated as 'Mostly Achieved'.<sup>106</sup> The evaluation assessed the Programme's effectiveness by offering a comparison between the baseline (2019) and endline (2022) on selected aspects across different components (Nutrition, Health, ECD, WASH and Social Protection). The evaluation team concludes that the Programme is 'Partially Effective' on 46 indicators assessed as part of the evaluation. A positive change in 28 indicators was reported (mostly covering WASH and Health components), whereas the remaining 18 indicators show a declining trend. Possible explanation of mildly encouraging results is COVID-19 and its associated economic impact on communities, however this merits further enquiry.

The Programme's achievements are the result of a few enabling factors, which include: i) alignment with GoR priorities resulting in ownership and commitment of public sector partners; ii) use of community-based models (community driven) resulting in community engagement and ownership; and iii) adaptive measures taken during COVID-19. Some disabling factors were identified as institutional changes (NECDP mandate transferred to NCDA); frequent public sector staff turnover (in districts); and COVID-19 disruptions and restrictions. The Programme has been largely effective in strengthening the public sector especially with respect to policy and strategy (supported GoR to develop relevant polices and strategies) and monitoring and evaluation (supported to improve nutritional governance). It remained relatively less effective in terms of capacity-building (hampered by high turnover of district officials); financing and budgeting (for limited focus) and institutional arrangements and coordination (institutional restructuring and changes in mandates). The Programme remained effective in community mobilization and capacity development that contributed to cultivating ownership with respect to organizing communities (for collective actions); wider community participation and engagement; leveraging influence of local influencers, i.e., religious leaders, theatres, faith-based organizations; and provision of skills and supplies.

The Programme has been effective in terms of organizing and strengthening forums for stakeholder coordination. Where these forums enabled cohesive planning and implementation, they faced challenges around frequent changes in government-led coordination structures and their mandates at the national level. This caused confusion amongst stakeholders and impaired joint planning of activities.

**Efficiency:** The evaluation team was unable to conclude on the Programme's efficiency due data limitation (progress not available from March– December 2021). From the numbers shared by UNICEF (with a risk of multiple counting of beneficiaries), the Programme reached out to 8.5 million beneficiaries (against a target of 0.5 million) while using only 79 percent of funds begs the question of appropriate targeting. Given the Programme's focus on nutrition and ECD, the allocation of over 55 percent of

<sup>106</sup> The evaluation team applied a rating scale where Mostly Achieved means 61-90% of intended targets achieved whereas Fully Achieved means 91-100% of intended targets achieved.

resources to these two components justifies the allocation of resources. The cost/beneficiary of \$2.05 looks reasonable as it is lesser than the planned cost (\$2.65).

**Impact:** The Programme intended to contribute to stunting reduction and child holistic development. For stunting, programme targeted reduction in stunting (in U5) by 6 percent at the national level (target reduced after MTE), which it may have contributed to the national numbers that came down from **38 percent (RDHS 2014-2015) to 33 percent (RDHS 2019-2020)**. It should be noted that the Programme was implemented in 14 out of 30 total districts. The Programme's baseline (2019) and endline (2022) comparison (for 6-23 months) in seven programme districts indicates an overall decrease of **1.6 percent** i.e., average reduction from 31.3 percent to 29.7 percent. This national vs programme district data indicates lower impact in programme districts, which merits further enquiry. Child holistic development has improved from 63 percent (RDHS 2014-2015 – among 36-59 months) to 76 percent (RDHS 2019-2020, 24-59 months), however, due to variation in age group in RDHS, comparison between the two values is not possible. The data for impact measurement for programme districts is incomplete, however the evaluation team noted a positive change for most of the contributing factors to holistic development (covered in the evaluation endline survey). The unintended impact is evident in terms of greater involvement by fathers in child development and shift in behaviours to save money for improved family nutrition over spending for personal consumption (ex. alcohol).

**Sustainability:** The Programme has operated without an exit plan. The design and implementation laid adequate focus on creation of an enabling environment. The data indicates that strategies and interventions under evidence generation and PPP have relatively higher likelihood to be sustainable over others i.e., capacity development, dialogue and advocacy, and cross-sectoral linkages. There is evident interest and willingness in the GoR to continue and replicate DHCR interventions which has translated into securing additional public sector financial contribution for components including nutrition, ECD and social protection. Initiatives by UN agencies and World Bank also highlight the development partners commitment to continue supporting GoR in reducing stunting and improving holistic in Rwanda.

#### **Non-DAC Criteria**

**HRBA:** The Programme is consistent with the HRBA principles including: participation by facilitating multi-stakeholders and multi-layered partnerships; empowerment (by enabling access to knowledge leading to perceived sense of empowerment in community members for better food, health and child nurturing choices); and legality (compliant with child rights provisions enshrined in international and regional treaties). The Programme demonstrated weaker consistency with the principle of accountability for limited opportunities for rights-holders to hold service providers accountable and non-discrimination and equality (exclusion of some families who were not given access to programme services due to not meeting Ubudehe criteria/rating).

**Gender Equality:** The evaluation team concludes that the Programme is partially compliant with gender equality principles. At the design level, the logframe does not include any indicator that allows for gender disaggregation and the design was not informed by a structured gender assessment. The Programme's implementation shows inclusion of interventions that were meant to address gender barriers. For instance, sensitisation of both male and female community members on promoted behaviour; gender-segregated toilets were built in schools to address the needs of women and girls; female participation in committees and capacity-building initiatives; setting up of ECD centres by tea companies promoted work-life balance. Results from the evaluation endline survey show that the prevalence of stunting in children aged 6-23 months continues to be higher for boys than girls in the targeted districts.

**Equity:** The Programme is concluded to be mostly compliant with equity principles. A structured equity assessment was not conducted although the Programme relied on national surveys (including RDHS and CFSVA) to identify vulnerable districts. The logframe does not include any indicator that would allow for equity disaggregation (rich/poor; urban/rural). The selection of target districts was driven by equity (prevalence of stunting, poverty rates, household food insecurity, access to improved drinking water and improved sanitation) as the targeted districts showed higher vulnerability to malnutrition and development delays. The Programme reports reflect minimal disaggregation based on equity indicators (rural/urban; rich/poor).

**Conclusions on the way forward:** The Programme has been largely successful in creating momentum as is evident from contributions to intended impact. There is evident public sector willingness to continue implementation which has translated into increased public sector financial contribution to DHCR components. Still, the situation merits continued engagement of UNICEF RCO with GoR, possibly in a different role. For UNICEF the focus must shift to policy advocacy and development of a medium to long term road map, documentation of good practices, successes and business cases. The GoR must continue to allocate public financial allocations to DHCR interventions. The private sector holds the key

and GoR must find ways to stimulate corporate social responsibility and incentivise businesses (through tax breaks and other incentives) to become partners in delivery social goods. The GoR must continue working with external stakeholders to leverage their presence and resources and strengthen community engagement mechanisms including local coordination to sustain interest and ownership of other actors including communities. These ideas have been crystallised into actions in the recommendations.

## 5.2 Lesson Learnt

Find below the key lessons learnt around design and implementation. The lessons learnt are drawn from both primary and secondary data, with the evaluation team's own judgement of good practices that have come up as potentially replicable ideas. Keeping in view GEROS guidance, these are framed as such to demonstrate their replicability across similar contexts and sectors.

1. The extensive engagement with stakeholders in programme design and rollout phases, wider consultations and bilateral meetings have proven useful in securing inputs and fostering broader ownership for the intervention. This has come up as a good practice and should be encouraged for future. This remains relevant for not only for Rwanda but other developing contexts and sectors, where multi-stakeholders' efforts are critical for system strengthening.
2. The Programme has proven successful in using a systematic approach to map stakeholders (through multiple exercises) and leverage information for improved external coherence. Where the process to form/strengthen external coordination forums is apparent, the documentation of how such forums coordinate (at multiple levels) and contribute to improved coordination across actors and sectors, appears missing. It would be important if such exercises are documented for the whole life cycle (process, actions and results) to benefit from documentation in future.
3. The Programme has been effective in private sector/businesses engagement for both social impact and business continuity. The engagement with tea companies and cooperatives proved a win-win relationship for all involved. Where it benefitted children (who stayed at ECD centres and have had holistic access to early learning, good nutrition, hygiene and protection services), it benefitted women and families with additional income (for being able to work for longer hours), and businesses with happy employees willing and available to contribute more. This remains a good practice and should be replicated in other contexts and sectors where private sector could be encouraged to contribute to social impact.

## 5.3 Recommendations

Find below the evaluation recommendations drawn from the findings and conclusions. The recommendations lay focus on shifting responsibility on to GoR to keep up the momentum of DHCR achievements. The framing of recommendations has been done keeping in view the key actors that have played part in the Programme design and implementation and continue to hold significance for the future e.g., GoR and UNICEF RCO. The structure includes broader recommendations followed by specific actions (expanding on the 'what' and 'how'). To ease implementation, each action is tagged to one or more relevant actors (as primary and secondary stakeholders) considered relevant and responsible to take action. Moreover, each action is prioritized as either immediate, short term or medium term.<sup>107</sup> Where applicable, the recommended actions are referenced to specific preliminary conclusions.

The process of developing recommendations included a series of questions (in each evaluation instrument or tool) that asked stakeholders (UNICEF, public sector partners, donors and communities) to understand their experiences and aspirations for the future. The recommendations were presented to stakeholders (including ERG members) in a validation / dissemination session and the evaluation team then incorporated stakeholder perspectives. Recommendations have also benefitted from the expertise and experiences of the evaluation team.

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<sup>107</sup> Immediate: 3-6 months and Short-term: 6-12 months.

**Table 17: Recommendations**

Recommendation	Priority	Responsibility (Primary/Secondary)
<b>For GoR</b>		
<p>The EKN Phase II has demonstrated successful implementation of integrated interventions involving multiple stakeholders at various levels to address stunting and enable holistic development of children. The intervention merits continuity with greater ownership from GoR at both strategic and operational levels, whilst engaging with range of development partners with continued interest to support GoR. The continuity and upscaling may require following actions on the part of GoR:</p> <ol style="list-style-type: none"> <li>1. Seek technical assistance to undertake a broader review of national nutrition and ECD policies and to translate policy frameworks in a Child Development Road Map (for next 5-10 years), which should leverage the structures and systems (developed and strengthened as part of EKN II implementation). <b>[REL#1, 2]</b></li> <li>2. Undertake an extensive stock-taking exercise whilst using the enabling environment framework – sector governance, financing, M&amp;E, capacity development and coordination, to map the systemic strengths and gaps, and use the assessment to inform the both the roadmap formulation (as outlined above) and putting measures in place for continuity of interventions. <b>[SUS#1,2]</b></li> <li>3. Seek technical assistance to document the interventions, forums, and successes to make a case for additional public financial allocations whilst demonstrating results. There is considerable information that lies with stakeholders that may need to be collected and processed systematically to develop business case/s for continuation and replication of EKN II supported interventions. <b>[SUS#1]</b></li> <li>4. The Programme has proven the benefits of community engagement approaches—community forums, consultations, local communal activities, theatres, religious groups, for demand creation and cultivating local ownership and traction. This is critical for mobilising and organizing communities for greater community good, and for sustained community interest. The future must leverage pledges by local community leaders/warriors – Imihigo.<sup>108</sup> <b>[COH# 2, EFF#5]</b></li> <li>5. Work with businesses and cooperatives where mothers are engaged mostly to evolve and implement workable public-private partnership models, offering a win-win equation for everyone involved. This has proved effective with tea companies (where they established ECD centres) and may need to be taken to others. The GoR may need to review existing policy framework/s and encourage further incentives for businesses to become partners in social impact and demonstrate effective corporate social responsibility (CSR). <b>[COH#2]</b></li> <li>6. The GoR may undertake assessment of systems/services with the lens of equity, human rights and gender equality, with the view to integrate them into future nutrition and ECD services. The relevant service providers must place a considered focus on: definition of vulnerable groups (such as single mothers, people with disability, and others) and separate financial allocations for such groups; engagement of community leaders/activists in services monitoring and social accountability; mechanisms to stay engaged with CHWs, village leaders, Isibo leaders, and cell leaders through local governments; prioritisation of children in need regardless of whatever Ubudehe category they fall in. <b>[GE#1, HRBA#1, EQU#1]</b></li> </ol>	Immediate	<u>Primary Responsibility</u> <ul style="list-style-type: none"> <li>• Ministry of Health (MINISANTE)</li> <li>• Ministry of Gender and Family Promotion (MIGEPROF)</li> <li>• Ministry of Local Government (MINALOC)</li> <li>• Ministry of Education (MINEDUC)</li> <li>• Ministry of Agriculture (MINAGRI)</li> <li>• Ministry of Finance and Economic Planning (MINECOFIN)</li> </ul> <u>Secondary Responsibility:</u> UNICEF, IPs, private sector
<b>For UNICEF</b>		
<p>The technical assistance provided by UNICEF RCO and demonstrated success of EKN II, underlines its continued relevance and need for transition in the role (including change of strategy) of UNICEF to continue to assist and support GoR for the children and mothers of Rwanda. The end of EKN II with no firm commitments from donors to continue funding, UNICEF may need to rethink strategy for sustenance of EKN interventions and results at all levels. Find below list of actions that UNICEF RCO may need to prioritise for the future:</p> <ol style="list-style-type: none"> <li>1. Remain engaged with GoR and extend technical assistance with above mentioned actions (for GoR) such as policy reviews and revisions, sector stocktaking exercise/s, formulation of stunting reduction and child holistic development road maps, documentation</li> </ol>	Short-term	<u>Primary Responsibility</u> UNICEF, IPs., NGOs  <u>Secondary responsibility</u> Other UN agencies and development partners

<sup>108</sup> Imihigo had its roots in a pre-colonial Rwandan cultural practice whereby leaders or warriors would publicly vow to achieve certain goals—and face public humiliation if they failed. The modern Imihigo process linked this traditional Rwandan practice with planning, monitoring and oversight.

**Table 17: Recommendations**

Recommendation	Priority	Responsibility (Primary/Secondary)
<p>of business cases and successes of EKN II, and facilitating donors' and GoR engagement for continuity of EKN momentum and successes. [REL#1,2], [SUS#1,2]</p> <p>2. Assess the current level of documentation around processes, systems, standards, sector coordination and monitoring &amp; evaluation (to guide GoR-led implementation) and identify need for additional documentation to enable GoR to be able to deliver quality services. This may require working with multiple agencies and forums to assess the need for system documentation as to enable them to deliver standardised services. [SUS#1,2], [EFF#4]</p> <p>3. Continue to use the documentation—business cases, successes and others, for policy advocacy with GoR to prioritise nutrition and ECD interventions and increase public allocations for relevant public sector entities. [SUS#1,2]</p> <p>4. For future similar interventions, at the design stage, set realistic impact targets and use district-based targets rather than overall targets, whilst keeping in view the contextual variations in terms of baseline, risk exposure, and overall level of development. In addition, commission exploratory studies to understand the district-specific context which may explain the increase in stunting in some of the target districts. [IMP#1]</p> <p>5. The budgeting process for similar future interventions must link costs to results/outcomes. Moreover, planning should include development of a realistic budget as DHCR planned versus utilised costs were lower for all outcomes. [ECY#1]</p> <p>6. Document the best practices around creating win-win partnerships between private and public sector. Use the documentation for wider advocacy around greater engagement of private sector in public services delivery. Moreover, advise on introducing incentives (tax breaks etc) for businesses to frame CSR strategies as to create social impact. [SUS#1,2], [COH#2]</p> <p>7. Advocate for and support greater integration of equity, human rights and gender equality into future nutrition and ECD services. A considered focus must be placed on: clear definition of vulnerable groups (such as single mothers, people with disabilities, and others) and separate financial allocations for such groups; greater focus on engaging local leaders and warriors; engagement of community leaders/activists in social accountability; mechanisms to stay engaged with CHWs, village leaders, Isibo leaders, and cell leaders through local governments; prioritisation of children in need regardless of whatever Ubudehe category they fall in. [GE#1, HRBA#1, EQU#1]</p>		

## Appendix 1: TERMS OF REFERENCE

### Terms of Reference

Developing Human Capital in Rwanda – Harnessing the Power of Integrated Programming for Nutrition and ECD	
<b>Position Title</b>	Institutional Consultancy to Conduct Endline Evaluation of the Developing Human Capital in Rwanda Programme (DHCR)
<b>Level</b>	High-Profile Professional Institution
<b>Duration</b>	Four (4) months
<b>Start Date</b>	From: July 2021
<b>Reporting to</b>	To: October 2021 UNICEF Rwanda, PME

### Background and Justification

Human capital development is one of the fundamental pillars contributing to any country's socio-economic development. As such, investment in children's early years is critical for their growth and development and productivity in adulthood. It is on this premise that Rwanda has prioritized programmes for the wellbeing of children at early age. Rwanda has recently released results of key indicators of the Demographic Health Survey (DHS 2019-2020) which shows the nutritional status of children under age 5 according to the three anthropometric indices. The report shows that 33% of children under the age of 5 in Rwanda are stunted. A higher proportion of children in rural areas (36%) than urban areas (20%) are stunted. The same report reveals geographical disparities where children in North province (41%) and West province (40%) are more likely to be stunted than the children who live in other areas. Evidence shows that stunting is strongly correlated to mother's education level as well as poverty. Children of mothers with no education are more likely to be stunted than those whose mothers have been to school. Stunting is inversely related to wealth quintile; 49% of children in the lowest wealth quintile are stunted, as compared with 11% of children in the highest quintile.

As of 2020, only 1% of children in Rwanda are wasted and less than 1% are severely wasted. Overall, 6% of children under age 5 are overweight. The results show that 8% of all children under age 5 are underweight and 1% are severely underweight. The proportion of children who are underweight is greater in rural areas (9%) than urban areas (4%). Underweight is strongly associated with mothers' education; 11% of children whose mothers have no education compared to less than 1% of children whose mothers have more than a secondary education. Underweight is inversely related to wealth; 12% of children in the lowest wealth quintile are underweight, as compared with 2% of children in the highest quintile.

The same DHS 2019-2020 provides the situation of child feeding practices which contributes to the nutritional status of children. The results show that 81% of children under age 6 months are exclusively breastfed, this is a slight decrease from the 87% figure reported in 2014-15. Timely introduction of complementary feeding measured among children aged 6-8 months, on the other hand, now stands at 79%, a significant improvement from 2015 when this was only 56%. Still, only 22% of children 6-23 months are receiving a minimum acceptable diet.

Despite solid progress since 2017, poverty is still widespread in Rwanda. According to the latest Integrated Household Living Conditions Survey (EICV5), 38.2% of the population live below the national poverty line, and 16% below the extreme poverty line. Geographically, the poverty rate fell substantially in Kigali City, and somewhat in Northern Province, but rose in the Southern and Western provinces. While 18% of the population lives in urban areas, only 7% of the poor reside in towns and cities, with the remaining 93% live in rural areas. Kigali city has 13% of the total population but only 5% of the poor. Poverty rates between 2014 and 2017 dropped insignificantly by 0.9 percentage points in total poverty and 0.4 percentage points in extreme poverty.

Children under 18 represent 44.5 per cent of the total population in Rwanda (NISR projections, 2020). The **Multiple Overlapping Deprivations Analysis (MODA)** published by UNICEF in 2018 showed that 39% of children aged 0-17 years are multi-dimensionally poor based on analyses of EICV4 and DHS5 data. Access to improved sanitation in rural and urban areas is the highest deprivation amongst children 24-59 months (64 per cent), while in the 0-23 months age group 66 per cent of children are deprived in the nutrition dimension. Deprivations in nutrition, health and sanitation overlap significantly for children aged 0-23 months (27 per cent) whereas children aged 24-59 months face significant overlapping deprivations in the health, water and sanitation dimensions (20 per cent).

Short-term **consequences** of stunting for children include increased morbidity and mortality; decreased cognitive, motor and language development; increased healthcare expenditures; and opportunity costs related to the care of sick children. Long-term consequences include an increase in non-communicable diseases, low school performance and decreased work capacity. The Baseline study for this programme conducted in 2019 suggested that despite increasing access to certain services, the poorest households remain disproportionately vulnerable to food insecurity, are more likely to compromise on the normal food intake and are less likely to seek medical treatment for children when they have fever or diarrhoea and have disproportionately high malnutrition indicators compared to the richer households included in the study. The same study suggests that Diarrhoea is among the leading causes of death and the leading cause of malnutrition among children under-five globally. Malnourished children and those with impaired immunity are at highest risk of life-threatening diarrhoea. The most common interventions deployed in prevention of diarrhoea include safe drinking water, use of improved sanitation and hand washing with soap. Diarrhoea should be treated with oral rehydration salts (ORS) or a recommended homemade fluid – a solution of clean water, sugar and salt.

DHS 2019/2020 recently released looked at trends of last 5 years immediately preceding the survey, the infant mortality rate was 33 deaths per 1,000 live births. The child mortality rate was 13 deaths per 1,000 children surviving to age 12 months, **while the overall under-5 mortality rate was 45 deaths per 1,000 live births**. Seventy-three percent of all deaths among children under age 5 in Rwanda take place before a child's first birthday, with 42% occurring during the first month of life. However, child mortality accounts for 29% of all under-5 deaths.

An ECD baseline study conducted by UNICEF in 2014 among young children in poor rural areas highlighted significant developmental gaps in terms of problem-solving, communication and personal-social skills, as well as gross-motor and fine-motor development. While the country is awaiting the DHS 2019-20 results on Early Childhood Development (ECD) and other indicators to be released, the previous survey showed that close to one third of children 36 to 59 months are developmentally not on track in literacy-numeracy, physical, social-emotional and learning domains.

In order to address the above challenges, UNICEF has supported the Government of Rwanda to model and scale up integrated approaches to delivery of programmes addressing the needs and rights of young children in Rwanda. This includes the Developing Human Capital in Rwanda - Harnessing the Power of Integrated Programming for Nutrition and ECD Programme, for which UNICEF received funds from the Embassy of the Kingdom of the Netherlands. The five-year programme aims to improve selected nutrition and development outcomes of children 0-6 years of age with a focus on 14 districts in Rwanda<sup>109</sup> through implementation of integrated nutrition-specific, nutrition-sensitive, ECD, Education, WASH and Social Protection interventions (see Annex 1 – results framework for more details on interventions). The programme contributes to the objectives of the National Child Development Agency (NCDA) of scaling up provision of integrated child development services and reducing stunting. The programme has a strong equity focus by promoting inclusion of the poorest households and addressing gender equity gaps where applicable.

A DHCR Programme baseline study was conducted in the start of the programme and this will now be complemented by an endline evaluation. The endline evaluation will assess the progress made in terms of impacting human capital development, changes achieved from the baseline, and documenting best practices and lessons learnt to inform future programming. The endline evaluation report will be used to inform national programming and implementation of respective thematic policies for children.

## OVERVIEW OF THE INITIATIVE TO BE EVALUATED

The overall goal of the proposed multi-sectoral programme has been to establish optimal conditions for children to achieve their full potential and build a strong foundation to develop into adolescents with key problem-solving and socio-emotional competencies, in order to increase human capital development in Rwanda. The DHCR programme interventions have focused on young children, from pregnancy to six years of age, including their parents and families, thereby ensuring a continuum of care that enhances and sustains optimal child growth and development. To achieve the expected impact of developing human capacity, the programme invested the budget of \$25 million.

The Developing Human Capital in Rwanda programme (DHCR) was designed to respond to complex and cross-sectoral issues affecting children's holistic development. Thus, a multi-sectoral approach was needed to address both immediate and underlying causes affecting the attainment of optimal child growth and development. Evidence has shown that integrated multi-sectoral services have synergistic effects and contribute to the greatest reductions in stunting and improvements in child development. As

<sup>109</sup> Nyamagabe, Ngororero, Rutsiro, Gakenke, Burera, Rubavu, Nyaruguru, Karongi, Gicumbi, Nyamasheke, Gatsibo, Rusizi, Nyagatare, Musanze.

such, the focus of the programme has been on the provision of an integrated package of services. The programme deploys a number of strategies to enhance delivery of integrated services and to induce required behaviour change, including systems strengthening through capacity building, behavior-change communication and coordination for integrated services at central, decentralized and community levels.

Overall goal of the programme: Increased human capital development in Rwanda with two programmatic impact: 1) Prevalence of stunting among children under 5 years reduced and 2) Young children's holistic development improved. The programme has two impact indicators: 1) Prevalence of stunting among children under 5 in targeted districts and 2) % of children developmentally on track in targeted sectors/districts. The detailed theory of change (ToC) of the programme is available under annexes (Annex 3).

The programme has been geared towards influencing national child-friendly policies and DHCR Programme priorities fully aligned with the Government of Rwanda's development policies and programmes, such as VISION 2020 and the National Strategy for Transformation (NST), and specific policies such as early childhood development policy, nutrition policy, social policy, and sectoral development programmes.

Gender and equity considerations have been integral part of the programme informed by gender assessments including Markets and Gender Survey (2016). Programme interventions took into account identified issues around gender, youth, equity and disability have been built into the programme across all programme interventions areas including social protection, health, nutrition, ECD, WASH, CP and Education.

The main partners for the programme are both government institutions and civil society organizations, United National agencies (WFP, WHO, FAO) which include the following:

1. Partners for **Early Childhood Development (ECD)** haven been the National Child Development Agency (NCDA), AVSI, Imbuto Foundation, Anglican Church of Rwanda, ADEPE, Rwanda Interfaith Council on Health (RICH)
2. Partners for **nutrition include** MIGEPROF, NCDA, RBC, MINAGRI, World Relief, Civil Society Alliance for Nutrition (SUN), Fourteen districts, Rwanda Women Parliamentary Forum, Rwanda Management Institute (RMI)
3. **Education** partnered with the International Education Exchange (IEE)
4. Partners for **Water Sanitation and Hygiene (WASH)** are four districts, World Vision, Society of Family Health (SFH)
5. Partners for **Social Policy and Research (SPR)** include Local Administrative entities Development Agency (LODA), World Relief

#### **Intended impact and outcomes of the Programme:**

At impact level, the programme intends to contribute to:

- Reduction in the prevalence of stunting among children younger than five years of age in targeted Districts.
- Improvements in young children's holistic development.

At outcome level, the programme broadly intends to:

- Strengthen delivery of integrated services across programme components at community level;
- Strengthen existing government systems in place to delivery sector-specific specific and integrated services;
- Strengthen coordination and targeting of services to cover the most vulnerable populations; and
- Improve the knowledge base to address programming gaps, facilitate scaling up and inform policy development. (Social Policy)

#### **Programme components:**

The programme includes the following broad components:

1. Nutrition-specific interventions implemented nationally (i.e. across all 30 districts of the country) mainly through the health sector and nutrition-sensitive interventions implemented in the 14 target districts through integrating nutrition into other social sectors, including agriculture and social protection;
2. Provision of comprehensive ECD services and education at District and community levels;

3. Provision of WASH services and education to targeted communities, schools and ECD centres;
4. Support to the provision of child-sensitive social protection (expanded public works) and sensitization targeting extremely poor households in selected communities (Sectors);
5. Provision of equitable pre-primary education in selected communities; and
6. Strengthening planning, management, coordination and monitoring, as well as cross-cutting behaviour change component in support of the integrated programme.

Each programme component encompasses a complex set of measures and activities (Annex I) aimed at supporting service delivery at community level while strengthening government systems and services to promote universal access and replication.

#### **Programme target groups and coverage:**

The programme targets young children aged 0-6 years ('the first critical years of life') and their parents, families and communities in order to achieve stunting reduction and improved child development outcomes. In addition, the programme targets existing service providers in order to strengthen their capacities for component-specific and integrated service delivery.

It is expected that this comprehensive approach will directly benefit at least 500,000 children and families in Rwanda. Indirectly, the majority of Rwanda's population will benefit from the positive change in policy measures, service delivery and social norms, as well as by further potential replication of the interventions by the government (during and beyond the funding period).

The programme has been implemented over a period of 5 years, from 2016 to 2021, with a focus on 14 Districts (out of 30). The districts were selected based on a number of criteria, including stunting prevalence, poverty levels, the identified needs for programme delivery, and the potential to build on the results already achieved through ongoing UNICEF programmes.

Whereas the programme aimed at promoting access to services at district level the focus on integrated interventions was done in selected Sectors in each District. The Sectors were selected in liaison with the respective district government offices and were prioritized based on a possibility to overlap existing government programmes and UNICEF programme interventions. It is expected that the focus of this evaluation will cover the same sectors in the programme intervention areas in order to assess the potential impact of the integrated package of interventions on child nutrition and development.

#### **Purpose**

- The purpose of the proposed consultancy is to conduct an in-depth independent evaluation on the five-year multi-sector DHCR Programme in 14 districts of Rwanda with a focus on sectors, where UNICEF supported the GoR to provide an integrated package of nutrition and ECD services to children and their families in order to reduce child stunting and promote child development.
- The consultant will aim to ensure that evaluations are implemented according to the quality standards of the Organization for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC), and that feedback from data on children, parents/caregivers, and stakeholders are given primary consideration. The consultant will ensure that the results are disseminated in an effective manner to improve future programme performance and contribute to the on-going national programmes on fighting stunting and promoting child development.
- The purpose of the evaluation is to better understand how and under what conditions the interventions and the activities implemented under the DHCR Programme are functioning and to assess the extent to which the initiative has met its objectives and achieved expected results. The results from this evaluation will inform decisions by the GoR to scale up and continue implementation of similar approaches including adjustments needed. This information will also be useful for UNICEF as well as development partners in determining continued relevance of the programme and provide information on replicability in other districts.

#### **Objectives**

The main purpose of this summative evaluation is to assess the achievements and results of the DHCR for nutrition and ECD programme in Rwanda.

More specifically the evaluation objectives are to:

1. Assess the impact of the DHCR in terms of progress in key indicators of the programme's result framework (logframe) by comparing baseline data with endline data on these indicators.
2. Provide feedback to the Government of Rwanda (MIGEPROF, MINEDUC, MINISANTE, MINALOC, and NCDA) and UNICEF Rwanda office, Embassy of the Kingdom of the Netherlands (EKN) and partners on the relevance, effectiveness, efficiency, sustainability of the programme;
3. Assess the extent to which the **equity and gender considerations** have been addressed in the DHCR programme interventions in ensuring the reduction of stunting and promotion of development of children aged 0-6 especially the most vulnerable girls or boys in 14 districts,
4. Assess the overall involvement of UNICEF in the DHCR Programme as well as its management of the interventions;
5. Assess the **extent to which the partners and agencies** contributed to the results;
6. Identify the different **bottlenecks** that were constraining the achievement of the objectives of DHCR programme and propose the possible mitigation measures; and
7. Identify **areas for improvements and good practices**, including lessons drawn from innovations in the design and delivery of integrated programming, document lessons learned from implementation and propose recommendations based on evidence to ensure equitable and quality nutrition and ECD opportunities in an effective, efficient and sustainable way for all children aged 0-6 especially the most vulnerable girls or boys.

#### **Intended use of the evaluation**

Users	Intended use
The Kingdom of the Netherlands	Provide feedback to the donor on the accomplishments of programme goals and objectives to inform future investments in the field.
Authorities in Rwanda	Provide feedback for the future development of policies and strategies for improving nutrition and ECD through integrated and multisectoral interventions.
Other Stakeholders	Inform on the effectiveness of programmes and provide guidance for the organization of systems and services.
Communities and families	Feedback on progress, lessons and best practices on child growth and development.
UNICEF	Guide on future programming especially for the effectiveness and relevance of the organization's theory of change on vital and health services.

## **SCOPE OF THE EVALUATION**

### **Programmatic Scope**

This evaluation will cover the DHCR Programme implementation period from 2016 to 2021. As the interventions have been conducted in 14 targeted districts in Rwanda, the geographical coverage of this evaluation will focus on same districts and sectors which were covered during the baseline to be able to assess the impact of the programme.

The integrated nutrition and ECD package focused on children 0-6 years of age, boys and girls in areas most affected by high stunting levels, while the nutrition and ECD package addressed the key needs of vulnerable children, boys and girls in under-served areas. As such, the evaluation will put specific focus on gender, equity and child rights dimensions of DHCR Programme.

While nutrition and ECD and related cross sectoral areas aimed at addressing stunting and child development, this evaluation will assess these components in more detail. This will include a review of the **appropriateness** of the UNICEF DHCR programme design in these sectors, including the delivery modalities for target population groups and innovative approaches promoting integrated service delivery piloted at community level. It will include a review of implementation by analysing coverage, results, effectiveness, quality, and efficiency. It will also include a review of the quality and use of evidence, assessing how well the response has used previous evidence such as reviews and EKN Phase I

evaluation to inform or adapt current programming, and what systems are in place to monitor the situation and UNICEF's performance. The analysis will take into consideration the generation / use of information as well as gender and equity issues. The evaluation will investigate stakeholder collaboration for nutrition governance and promotion of ECD as well as coordination of all actors to achieve required synergy for proper programme implementation.

### **Geographic scope**

The geographic scope will be limited to 14 districts which has been targeted for DHCR programme. It is recognized that considerations of sampling which might orient areas to visit for evaluation purposes, as well as COVID-19 restrictions which might pause some challenges. Despite these challenges, the scope of the evaluation will still cover all the 14 districts. It is important to note that there might be **spill over effect of the programme which came as a result of the programme interventions at national level.**

### **EVALUATION QUESTIONS**

It is expected that the evaluation be articulated under the five main OECD/DAC evaluation criteria (Relevance, efficiency, effectiveness, coherence, impact and sustainability) as well as coordination considering that DHCR Programme covered nutrition and ECD services and integrated development interventions in targeted districts. The different criteria must be made explicit in the technical proposal and the inception report.

The list of key evaluation questions below is indicative and is intended to present an overview of UNICEF's expectations. They can be useful to develop the evaluation framework and the methodology after the signature of the contract and the first meetings on the terms of reference of the evaluation:

#### *Relevance:*

- How relevant is the objectives of the DHCR Programme with regards to the national and districts nutrition and ECD priorities, strategies and programmes?
- To what extent did DHCR Programme adapt to remain relevant to the changing context?
- Have the interventions implemented under DHCR Programme begun with an adequate needs assessment/Baseline?
- How did the different stakeholders participate in the DHCR Programme interventions' design? To what extent did the local communities contribute to implementing the interventions?
- To what extent does the DHCR Programme provide nutrition and ECD opportunities to all the children aged 0-6 in 14 districts in Rwanda, considering the local context and differentiated needs of girls and boys?
- Are there some groups in needs but not covered by DHCR Programme and why?

#### *Coherence:*

- To what extent are the DHCR Programme design and its components in line with the overall national nutrition and ECD priorities?
- To what extent were the policies of the different actors involved in DHCR Programme complementary or contradictory in addressing key nutrition and ECD needs of children?
- To what extent is the objectives and output of the DHCR Programme in Rwanda in line with the other partners' priorities in Rwanda?

#### *Efficiency:*

- To what extent did the management of DHCR Programme ensure a timely and efficient utilization of resources to deliver the outputs from the implementation of the different interventions?
- How efficient have the financial resources of DHCR Programme interventions been used to optimize the programme's achievements?
- Have there been delays in fund allocation and utilization that may have affected the impact of the programme?

- To what extent were the DHCR Programme interventions coordinated with other sectors within UNICEF such as WASH, Health, Social Protection, C4D, Nutrition, and ECD?
- Did the unit cost of the interventions comparable to the standards costs applied by other sectors?
- To what extent have the provision of nutrition and ECD materials, the capacity development of national and local leaders been efficient? Could the same results be achieved with fewer resources?

*Effectiveness:*

- To what extent did the DHCR Programme meet its objective, outputs and key interventions as stated in the programme design document?
- What process has been used to set the targets every year, who participated in the process?
- To what extent have the partnership between key stakeholders and integrated approach to programming contributed to reducing stunting and contributed to child development for children aged 0-6 especially the most vulnerable girls of boys in the targeted 14 districts?
- To what extent has the implementation of DHCR Programme been in line with the principles of adhering to quality standards, and the principles of human rights and gender equality and equity and why?
- What are the key successes achieved by the interventions of the DHCR Programme? How have these successes been used to adjust the targets, shift programme focus and improve implementation?
- How timely were these interventions conducted to provide equitable and quality nutrition and ECD opportunities for children aged 0-6 especially the most vulnerable girls of boys?
- What were the major factors influencing the achievement or non-achievement of the DHCR Programme?
- To what extent did the DHCR Programme reach the children (0-6 years) in 14 districts in the country, especially the most vulnerable girls and boys?
- What effects has the DHCR Programme produced on the capacities of the nutrition and ECD sector and institutions at national and district level and local communities to ensure that all children, access to equitable nutrition and ECD services in Rwanda?
- Is there evidence of the DHCR Programme contributing to the raising the awareness of the nutrition and ECD on the importance to increase resources to ensure reduction of stunting and ECD services for children aged 0-6 years across the country, especially those living in the 14 targeted districts?

*Impact:*

- Is there evidence of the DHCR Programme contributing to the reduction of stunting and increasing developmental readiness for children aged 0-6 years in target districts in the country, especially the most vulnerable girls and boys and those living in the targeted districts?
- Is there evidence of the DHCR Programme contributing to improve the quality of nutrition and ECD in the targeted districts in the country?
- What were the drivers, barriers and bottlenecks to the DHCR programme's success that may support policy makers and programme designers adjust interventions going forward?

*Sustainability:*

- To what extent are the benefits of the DHCR Programme interventions likely to continue after the programme?
- To what extent will the outcomes and outputs achieved by the DHCR Programme contribute to leverage more funding and resources from current donors and new donors to maintain or increase financial support to nutrition and ECD?
- To what extent did the experiences of the programme feed into policy discussions to ensure institutionalization and sustainability of interventions by the GoR?

- To what extent have the interventions created opportunities for Rwanda institutions at national and district level to strengthen its leadership of DHCR Programme in terms of government budget allocation, planning, implementation, management and monitoring?
- Did the implementation of DHCR Programme build capacities at national and district level in terms of resources, skills to help ensure continuous positive changes in the fight against malnutrition and increase opportunities for ECD for children aged 0-6 years?
- What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?

**Coordination:**

- How well have the interventions under DHCR Programme been delivered in a cohesive and effective manner in terms of strategic planning, gathering data and managing information, mobilizing resources and ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework with Rwanda authorities and providing leadership?
- Were plans for coordination in place, and followed by all the stakeholders?
- What were the main constraints and support to coordination? How was good coordination achieved, and is it replicable in other situations?

**Methodology**

The proposed methodology for this evaluation is quasi-experimental design and will be complemented by comparing baseline situation before and after interventions and evaluators will consider mixed methods by including quantitative and qualitative during the process of evaluating the impact of this programme. The evaluation should also embed human rights-based approach, gender equality and equity lenses in its data collection and analysis, and reflect these findings in the draft and final report.

**Data collection** (observing COVID-19 protocols)

The data collection will engage a broad range of stakeholders at country level to ensure comprehensive data as well as buy-in from all stakeholders in terms of the findings and recommendations of the evaluation. Relevant government line ministries and institutions will be involved from the very beginning in the development of TOR, Inception Report, and Final Report. The National Child Development Agency (NCDA) will be work closely with UNICEF on this evaluation. Other stakeholders will participate in the Evaluation Reference Group (ERG) and proper clearances will be sought from government institutions such as the National Ethics Committee (RNEC) and the National Institute of Statistics of Rwanda (NISR). The evaluation will intentionally involve different government ministries including the Ministry of Health (MOH) and the Rwanda Biomedical Center (RBC), Ministry of Agriculture (MINAGRI), Ministry of Local Government (MINALOC), Ministry of Family and Gender Promotion (MIGEPROF).

Key sources of information will include:

- **Document review:** Documents will be reviewed at the inception stage to frame the evaluation. Documents to be reviewed will include documentation related to the programme, national policies and strategies, assessments and studies related to the programme.
- **Analysis of secondary data:** Secondary data will mainly include available administrative data and other monitoring data to determine if the initiative has reached its objectives quantitatively. The evaluation team should assess the quality and availability of data during the inception phase.
- **Collection of primary data:** Data on key impact, outcome and output indicators will be collected in order to allow for comparison with the baseline evaluation to assess progress and, ultimately, impact.
- **Focus group interviews with:**
  - Caregivers/parents
  - Community workers/volunteers
  - Districts staff (DPEM)

- Government staff (Ministries and NCDA)
- **Key informant interviews with:**
  - Government staff (at central level and district level)
  - UNICEF staff
  - NGO staff/ Development Partners working in nutrition and ECD
- **Site visits to selected sites**
  - Observation and onsite verification

### Evaluation instruments

To conduct a comparative study, the DHCR evaluation will use the same data collection assessment tool which were used during the baseline study subject to a few adjustments depending on changes in the programme context. This tool is based on internationally recognized measures covering household characteristics, child development, nutrition, health, caregiving practices, and access to services. See table below for details on the study measures.

	<b>Domain</b>	<b>Specific components</b>
<b>Demographics</b>		
Socioeconomic status	Demographic and Health Survey_ENREF_7 Wealth Index, and Ubudehe classification	
Family composition	Demographic and Health Survey Questionnaire and UNICEF Multiple Indicator Cluster Survey Round 5 (MICS 5) Demographic Sections	
Household expenditures	Selected items – Integrated Household and Living Conditions Survey (EICV 5)	
Participation in savings groups and household savings	Selected items – Integrated Household and Living Conditions Survey (EICV 5)	
<b>Caregiver characteristics</b>		
Education and literacy	MICS 5, selected Items from woman's background section	
<b>Family care and child development</b>		
Parenting practices	MICS 5 appropriate caregiving and child discipline modules	
Decision-making	Selected items from UNICEF and Harvard University Study in the Democratic Republic of the Congo	
Access to services	Selected items MICS5 ECD module; Young Lives Study ECD module	
Caregiver-child relationships	Observation of mother-child interaction	
Developmental milestones	Development Index (CREDI) and the Malawi Developmental Assessment Tool (MDAT)	
<b>WASH</b>		
Access to water and sanitation	Demographic and Health Surveys and MICS JMP survey modules_ENREF_7	
Handwashing and hygiene behaviors	Demographic and Health Surveys_ENREF_7	
<b>Health</b>		
Access to insurance	Early Childhood Development and Family (ECD&F) Baseline Questionnaire	
Deworming	Demographic and Health Survey Questionnaire	
Prevalence of diarrhoea, fever and cough in past two weeks	Demographic and Health Survey Questionnaire	
Maternal and child health history	Demographic and Health Survey Questionnaire	
<b>Nutrition</b>		
Anthropometrics	Height, weight, middle-upper arm circumference (MUAC)	
Infant and young child feeding	24-hour dietary recall for children from MICS5 used to calculate minimum dietary diversity, minimum meal frequency and minimum acceptable diet	
Access to programmes	Demographic and Health Surveys (Vitamin A, Deworming) and items created for this survey (kitchen gardens, Fortified Blended Foods/Shisha Kibondo, micronutrient powder)	
<b>Food Security</b>		
Food insecurity experiences	CFSVA Food Insecurity and Coping Questions, Reduced Coping	

	Strategy Index (rCSI), Food Insecurity Experience Scale (FIES)
Food access	Months of Adequate Household Food Provisioning (MAHFP)
	<b>Social Protection</b>
VUP participation	ECD&F Baseline Questionnaire, Integrated Household and Living Conditions Survey (EICV5), and items created for this survey

A detailed methodology will be developed by the contracted evaluators in the inception phase. This will include an overview of the different data collection tools, including interview guides and focus group guides, that will be used to answer each of the evaluation questions. Considering the number of geographic locations, the inception report should take the same geographical locations as per the baseline survey for data collection for the purposes of comparing the situation before and after intervention and determine the progress made.

Data collected should consider gender aspects as well as age aspects by disaggregating data when relevant. Ethical considerations must be considered in line with UNICEF guidelines.

#### **Expected Deliverables and payment schedule**

To facilitate progress and ensure timely delivery of outputs, the consultant will submit an initial inception report, including timeframe for a desk review, data collection and interviews and a final report including annexes of the lessons learned documents, observations and way forward as well as a summary list of outputs/deliverables.

<b>Deliverables</b>	<b>Timeline/ Deadline</b>	<b>Schedule of payment</b>
1. Draft and Final inception report with an outlined methodology, data collection tools, time frame and proposed outline of the evaluation report	30 July 2021	1st payment (20%)
2. Getting necessary evaluation permits/ethical clearance	25 August 2021	
3. Data collection, Data Analysis, and draft Evaluation report	30 September 2021	2nd payment (30%)
4. Final report and knowledge product (to be determined – e.g. Summary Report, Brief, or Poster) meeting UNICEF standards and incorporating all comments from the reference group.	25 October 2021	3rd payment (50%)
5. Validation workshop with key stakeholders to present the findings and recommendations	28 October 2021	
6. Handover of all documents	30 October 2021	

#### **Reporting Requirements**

The final evaluation report should meet UNICEF evaluation standards, with focused and actionable recommendations. The report should include at minimum:

- Title page and opening pages
- Executive summary
- Object of evaluation - Programme description including theory of change
- Purpose objectives and scope of Evaluation
- Evaluation methodology, including sampling strategy and methodological limitations, ethical issues and how they were addressed.
- Findings
- Conclusions and lessons learned
- Recommendations
- Annexes TOR, data collection tools and consent forms, and list of documents and secondary data used

#### **Time frame**

Activities	2021			
	July	August	September	October
Desk review, formulation of methodology				
Inception report				
Data collection/field work				
Analysis/ report writing				
Production of final reports and knowledge products				
Validation and handover documents				

### **Desired Qualification, experience, specialised skills and knowledge**

The evaluation is planned to be conducted by an institution or by a registered consultancy group/firm. The team will be comprised of a team leader and team member(s), ensuring gender balance with qualifications, skills and experience stated below. If the evaluation is carried out by an international firm, the team leader will ensure that a national expert is included in the team. The composition of the evaluation team should be multidisciplinary as appropriate with areas of technical competence, analytical skills, such as gender analysis and facilitation skills relevant to the nutrition and ECD interventions

The Team Leader should have at least a master's degree in Nutrition, Early Childhood Education (ECD), Sociology, Anthropology, Social Sciences or related fields with at least 10 years' experience in programme evaluation and must have completed at least two high quality programme evaluations in that period, at least two of them being related to integrated nutrition and ECD programme. Presentation of sample work is required.

The team members will be selected based on the following criteria:

- Experience with and strong skills in quantitative and qualitative research and impact evaluation.
- More than 5-year working experience and expertise in the area of nutrition and ECD or related areas, preferably from Africa.
- Knowledge of the nutrition and ECD system in Rwanda, is an asset
- Knowledge of UNICEF Evaluation Policy, OECD-DAC criteria, and UNEG norms and standards
- Knowledge of the UN Convention on the Rights of the Child
- Excellent report writing skills
- Excellent report writing skills and communication and presentation skills both in written and spoken English
- At least one team member should be fluent in Kinyarwanda
- Ability to work to strict deadlines
- Previous experience in working with UNICEF desirable

### **Administrative Issues**

The team of consultants will work under the direct supervision of UNICEF Rwanda, Planning Monitoring and Evaluation, Evaluation Reference Group (ERG) normally known as the Evaluation Steering Committee mainly composed by UNICEF and NCDA and other selected representatives from stakeholder involved in the programme. The roles and responsibilities of these groups are technical and administrative during the implementation of this evaluation. While UNICEF team will play both roles of administrative and technical, ERG and NCDA will provide technical support during the evaluation process.

### **Conditions**

As per UNICEF policy, payment is made against approved deliverables. The selected team of consultants will be governed by, and subject to UNICEF's General Terms and Conditions for institutional contracts.

## **Risks**

There are no risks anticipated to the successful delivery of this assignment. However, COVID-19 situation and the impact of vaccination and lockdowns due to new waives might require to observe certain protocols.

## **Ethical Considerations**

The evaluation will also comply with all ethical considerations including ensuring informed consent of participants. It is the responsibility of the consultant under the support of UNICEF and NCDA to process the necessary evaluation permits and ethical clearance/visa before starting data collection. All products and data developed or collected for this agreement are the intellectual property of UNICEF. The consultant may not publish or disseminate the final report, or any other documents produced from this work without the express permission of and acknowledgement of UNICEF.

The consultants will make their own arrangements to use their own materials. However, UNICEF will facilitate by availing the conference room for smaller meetings for only the consultant team and ERG to discuss the progress if the evaluation and present inception report, draft report, final report and validation.

## Appendix 2: Intervention Context around ECD and Stunting

### Country Context - Rwanda

Rwanda is a country with a population of 12.9 million people (2020),<sup>110</sup> with 49.1% male compared to 50.8% female population.<sup>111</sup> Located in Central/Eastern Africa, Rwanda shares borders with Democratic Republic of the Congo, Uganda, Tanzania and Burundi. The surface area of the country is 26,340 sq. km<sup>112</sup> divided into (5) five provinces. The provinces include Northern, Southern, Eastern, Western and municipality of Kigali. The official languages are Kinyarwanda (spoken by majority Rwandans), English, French and Swahili. A strong focus on homegrown policies and initiatives contributed to significant improvement in access to services and human development indicators. Growth averaged 7.2% over the decade to 2019.<sup>113</sup> Measured by the national poverty line, poverty declined from 77% in 2001 to 38.2% in 2016, while life expectancy at birth improved from 33.4 years in the 1990s to 69 in 2019.<sup>114</sup>

In terms of COVID impact, the lockdown and social distancing measures, critical to control the COVID-19 pandemic, sharply curtailed economic activities in 2020, resulting in the country's gross domestic product (GDP) to have dropped by 0.2% in 2020, compared to a projected expansion of 8% before the COVID-19 outbreak.<sup>115</sup> The combination of poor nutrition, limited health services, learning losses from school closures, and the likelihood that some children (particularly adolescent girls and children from poor households) may never return to school because of the COVID-19 have the potential to threaten decades of progress in human capital development. The administrative map of Rwanda is illustrated in Figure 2.<sup>116</sup>

### Intervention - Early Childhood Development and Stunting

The description below gives an overview of the global and regional context of early childhood development (including stunting), then dwells on the specifics of the sector within Rwanda.

**Early Childhood Development and Stunting:** Early Childhood Development (ECD) is defined as the process by which a young child acquires essential physical, motor, cognitive, social, emotional and language skills.<sup>117</sup> In lieu of the importance of ECD, UNICEF developed "Nurturing Care", a framework for helping children survive and thrive to transform health and human potential (as indicated in Figure).<sup>118</sup> Children who do not receive adequate health, nutrition, early stimulation, learning opportunities, care and protection, tend to have lowered cognitive, language and psychosocial outcomes as well as executive functioning, which translates to lowered academic achievement. Poor school performance leads to inadequate preparation for economic opportunities and, eventually, the perpetuation of intergenerational poverty cycles.<sup>119</sup> Stunting (height to age measurement) is an indicator of chronic undernutrition and is caused by inadequate intake of nutritious food, frequent illnesses such as diarrhoea and intestinal worms, poor care practices, and lack of access to health and other essential services, especially in the first 1,000 days of a child's life but with potential effects lasting a lifetime.<sup>120</sup>

Figure: Domains of Nurturing Care



ECD is part of the transformative agenda for 2030, making it an international priority for the 21<sup>st</sup> century. Global targets in **education, health, nutrition (includes reduction in stunting)** and **protection** (as indicated in Figure 4) address key outcomes to realise young children's developmental potential. ECD also adds value to different strategic frameworks and partnerships, working towards the SDG goals,

<sup>110</sup> Retrieved from: World Bank Statistics.

<sup>111</sup> Ibid.

<sup>112</sup> [www.nisr.gov.rw](http://www.nisr.gov.rw)

<sup>113</sup> <https://www.worldbank.org/en/country/rwanda/overview>.

<sup>114</sup> [www.nisr.gov.rw](http://www.nisr.gov.rw)

<sup>115</sup> <https://www.worldbank.org/en/news/press-release/2021/02/08/covid-19-pandemic-pushes-rwanda-into-recession-severely-impacts-human-capital>

<sup>116</sup> Map No. 3717 Rev. 11.1 United Nations.

<sup>117</sup> UNICEF'S Programme Guidance for Early Childhood Development, 2017.

<sup>118</sup> [9789241514064-eng.pdf \(who.int\)](http://9789241514064-eng.pdf)

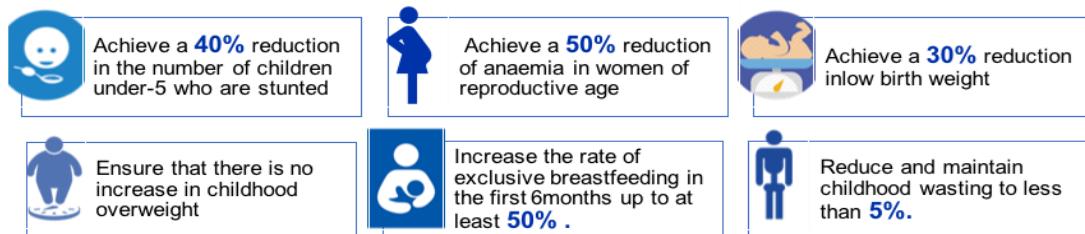
<sup>119</sup> Early Childhood Policies in Sub-Saharan Africa: Challenges and Opportunities, 2012.

<sup>120</sup> <https://www.unicef.org/esa/reduce-stunting>

such as Every Woman Every Child (EWEC),<sup>121</sup> Global Partnership for Education (GPE),<sup>122</sup> Scaling Up Nutrition (SUN),<sup>123</sup> and the Global Partnership to End Violence Against Children (GPEVAC).<sup>124</sup> These inclusions present both opportunities and challenges in policy setting, planning, budgeting, programming and monitoring results for young children.

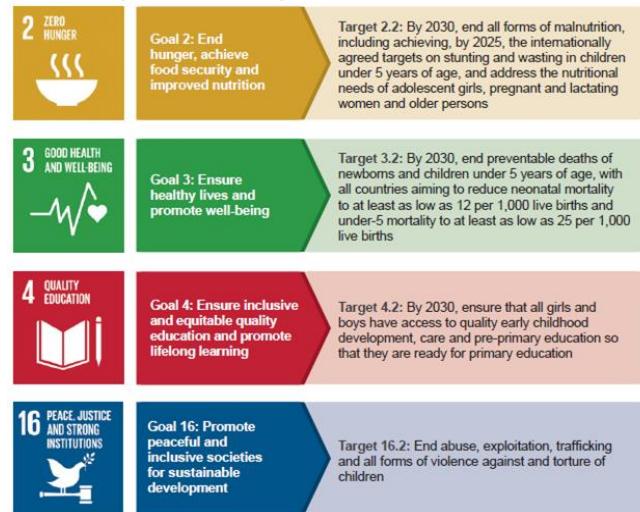
**Global & Regional Context:** Today, there are millions of young children not reaching their full potential because of limited support available during early development. For instance, in low- and middle-income countries across the world, 250 million children under the age of five are at risk of not reaching their developmental potential because of poverty and stunting (or low height for age).<sup>125</sup> Nearly two out of five (20% of total) stunted children are living in South Asia, whilst another two live in sub-Saharan Africa (in 2019).<sup>126</sup> The underlying reasons are similar across regions and include factors such as: poor maternal health and nutrition, inadequate infant and young child feeding practices, and infections.<sup>127</sup> In 2012, a resolution was passed by the World Health Assembly to endorse a 'Comprehensive Implementation Plan on Maternal, Infant, and Young Child Nutrition'. The plan outlines a set of six global nutrition targets to be achieved by 2025 – including reduction in stunting.<sup>128</sup>

Figure: WHO's Global Nutrition Targets



In the Eastern and Southern Africa (ESA) region, provision of ECD services has become a key policy and development goal of majority governments. By August 2020, slightly over half of the 21 ESA countries had developed a national ECD policy or strategic framework.<sup>129</sup> For some countries, ECD is an integral part of sectoral policies and strategic frameworks especially on health and education. Despite this progress, there are evident gaps in implementation of these policies and frameworks including lack of i) detailed financing strategies, ii) multisectoral coordination mechanisms and iii) accountability relationships for services delivered and resources.<sup>130</sup> Nearly three quarters of children between 0-6 years are not accessing early childhood education on average. As of 2019, average attendance rate in early childhood education<sup>131</sup> is estimated at only 24%.

Figure: Stunting and ECD in the SDGs



<sup>121</sup> EWEC movement aims to intensify national and international commitment and action by governments, the UN, multilaterals, private sector and civil society to keep women's, children's and adolescents' health and well-being at the heart of development.

<sup>122</sup> GPE supports lower-income countries to improve equitable access, quality and learning outcomes in the early years by providing technical and financial support.

<sup>123</sup> SUN is a movement led by countries committed to the understanding that good nutrition is the best investment of the future. The political leaders of SUN countries agree to engage all sectors of central and local governments in efforts to improve nutrition.

<sup>124</sup> GPEVAC is a platform that aims to raise awareness, catalyse leadership commitments, mobilise new resources, promote evidence-based solutions, and support those working to end all forms of violence, abuse and neglect of children.

<sup>125</sup> <https://www.worldbank.org/en/topic/earlychildhooddevelopment#1>

<sup>126</sup> Global Nutrition Report 2020: Action on equity to end malnutrition

<sup>127</sup> [https://www.who.int/nutrition/topics/globaltargets\\_stunting\\_policybrief.pdf](https://www.who.int/nutrition/topics/globaltargets_stunting_policybrief.pdf)

<sup>128</sup> [https://apps.who.int/iris/bitstream/handle/10665/149018/WHO\\_NMH\\_NHD\\_14.2\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/149018/WHO_NMH_NHD_14.2_eng.pdf)

<sup>129</sup> Quantifying Heckman: Are Governments in Eastern and Southern Africa Maximizing Returns on Investments in Early Childhood Development, 2021.

<sup>130</sup> Ibid.

<sup>131</sup> <https://data.unicef.org/resources/jme-report-2021/>

The statistics on stunting in ESA region (a proxy for the incidence of developmental delays) have increased in countries of Sub-Saharan Africa despite plummeting globally (refer to Box#2 for more statistics).<sup>132</sup> There are considerable challenges such as lack of funding, proper budget allocation, lack of technical expertise and robust monitoring system from government. Some countries in the region have made progress in reducing the prevalence of stunting, and the average prevalence in ESAR has declined from **46% in 2000 to 32% in 2020**.<sup>133</sup> However, the average annual rate of reduction in stunting is lower than the average population growth rates. The net effect is that the number of stunted children is increasing within the region.

**ECD and stunting in Rwanda:** In the past decade, Rwanda has made decent progress in achieving child-related Millennium Development Goals (MDGs), including reductions of maternal and infant mortality, universal access to primary education and poverty reduction. Despite improvement in development and economic growth, Rwanda continues to face some significant challenges, particularly pertaining to the first critical years of children's lives. Additionally, poverty is still widespread as per the 2017's Integrated Household Living Conditions Survey (EICV5), 38.2% of the population live below the national poverty line and 16% below the extreme poverty line. The high prevalence of stunting and the proportion of children not reaching their full developmental potential is due to the combined effects of **inadequate dietary intake** (as only one in six children enjoys all recommended feeding practices),<sup>134</sup> insufficient nutrition intake of pregnant and lactating women<sup>135</sup>, **repeated infection, inadequate psychosocial stimulation** (only about half of the parents surveyed engaged in activities that stimulate a child's development and early learning), and **a lack of opportunities for optimal child development** (RDHS 2019 - 2020).

**Vulnerability & Exposure:** Threats to early childhood development and proper nutrition are greatest among children living in the poorest households, where children are less likely to receive support for early learning at home and more likely to be exposed to multiple risk factors due to poor standards of housing (refer to Box 3 for relevant statistics).<sup>136</sup> Another reason for prevalence of stunting remains largely dependent on the educational and wealth status of the primary caregivers.<sup>137</sup> As per the RDHS 2019-20, the proportions of children who are stunted and underweight declined substantially with increasing mother's educational level. For instance, the prevalence of stunting among children whose mothers have no education is 45% compared with 6% among those whose mothers have more than a secondary education. Stunting and underweight are inversely related to household wealth.<sup>138</sup>

**Policy Framework Around ECD and Stunting:** As a signatory to the global and regional frameworks such as the United Nations Convention on the Rights of Children (UNCRC),<sup>139</sup> Education for All (EFA),<sup>140</sup> SDGs (2, 3, 4 and 16 – as explained above) and standards on the rights of the child, Rwanda is committed to using ECD as a platform for ensuring the fulfilment of the rights of children. In this regard, the country has put in place several policies and strategies to tackle challenges related to early childhood development (including stunting). For instance, the National ECD Policy<sup>141</sup> that set the conditions to develop community led integrated ECD programmes and through strengthening and coordinating essential inter-sectoral and sectoral services for children and parents. The National ECD Program Strategic Plan (NECDP SP 2018-2024) calls for the development of an integrated approach that addresses cross-cutting issues of childcare, education, growth and development, safety, health and nutrition, and food security. The National Early Childhood Development Programme (2017) oversees all nutrition promotion and ECD activities within the country, and sets standards, curricula and implementation approaches to provide national guidance to programme implementers.

<sup>132</sup> Accelerating the scale up of early childhood and maternal nutrition interventions through regional platforms and partnerships in Africa & Asia.

<sup>133</sup> <https://data.unicef.org/resources/jme-report-2021/>

<sup>134</sup> Breastfeeding: Minimum two or three meals per day and at least four different types of food.

<sup>135</sup> <https://thedocs.worldbank.org/en/doc/554941595276442131-0090022020/original/TF0A4965ASARwandaNutritionSituationAnalysisNovember212018FINALwithlogo.pdf>

<sup>136</sup> Phase II donor proposal to the Embassy of the Kingdom of the Netherlands.

<sup>137</sup> [Impact of WASH on Key Social and Health Outcomes.pdf \(communityledtotalsanitation.org\)](https://communityledtotalsanitation.org/)

<sup>138</sup> RDHS 2019-20

<sup>139</sup> Article 27: Right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

<sup>140</sup> Aims to strengthen the capacities of member states to design, develop, and implement curricula that ensure the equity, quality, development-relevance and resource efficiency of education and learning systems.

<sup>141</sup> The policy aims to ensure all Rwandan children achieve their potential, are healthy, well-nourished and safe, and their mothers, fathers and communities become nurturing caregivers through receiving integrated early childhood development services.

### Appendix 3: Weighted Values for Selection of DHCR Districts<sup>142</sup>

District	Stunting level (CFSVA 2015)	Poverty Rates (EICV 2015)	HH Food Insecurity (CFSVA 2015)	Improved drinking water (EICV2015)	Improved sanitation	Weighted Value	Partners		Timeframe	Rank
Weighting Value	50%	20%	10%	10%	10%		NUTR	WASH	(Nutrition)	
Nyabihu	68%	40%	39%	86.20%	72.20%	62%	USAID	PAJER, SNV, EKN*	2015-2020	
Nyamagabe	57%	42%	43%	79.90%	83.70%	57%	One UN - SDC	PAJER	Dec-16	1
							UNICEF - EKN	EKN		
Ngororero	54%	50%	23%	81.20%	84.70%	56%				2
Rutsiro	46%	51%	57%	77.50%	83.40%	55%	One UN - SDC		Dec-16	3
							UNICEF - EKN	EKN		
Gakenke	51%	42%	23%	84.50%	92.10%	54%	UNICEF - GoN	PAJER, EKN	Aug-17	4
Burera	48%	50%	27%	88.00%	81.20%	54%	UNICEF - GoN	SNV	Aug-17	5
Rubavu	48%	36%	26%	98.40%	91.90%	53%	UNICEF - GoN	SNV, EKN	Aug-17	6
Nyaruguru	47%	48%	36%	73.80%	70.70%	51%	USAID		2015-2020	7
							UNICEF - EKN	EKN	Dec-16	
Karongi	45%	45%	35%	82.80%	77.40%	51%	UNICEF - EKN	PAJER, EKN	Dec-16	8
Gicumbi	40%	55%	13%	90.60%	89.70%	50%	UNICEF - EKN	PAJER, EKN	Dec-16	9
Nyamasheke	34%	62%	34%	79.90%	92.50%	50%	UNICEF - EKN	PAJER	Dec-16	10
Gatsibo	43%	44%	15%	74.30%	86.30%	48%	UNICEF - EKN	PAJER	Dec-16	11
Rusizi	37%	35%	36%	83.90%	90.50%	47%	UNICEF - GoN		Aug-17	12
Nyagatare	39%	44%	11%	72.50%	95.10%	46%		EKN		13
Nyanza	34%	38%	33%	89.60%	80.90%	45%	USAID	PAJER EKN	2015-2020	
Musanze	35%	35%	20%	95.30%	84.20%	44%	UNICEF - GoN	SNV	Aug-17	14

<sup>142</sup> The only two districts that were most in need of support and were not selected were Nyabihu and Nyanza; they were excluded because USAID and its implementing partners were already covering these districts with nutrition interventions.

## Appendix 4: Programme Stakeholders

Details of each stakeholder role is given in table below.

Components	Partners	Role in the Programme
Early Childhood Development	National Development (NCDA) Child Agency	<ul style="list-style-type: none"> <li>-To coordinate all activities that support early childhood development program</li> <li>-To enhance the capacities of parents and the Rwandan community in providing adequate education</li> <li>-To develop a national partnership and coordination framework aimed at promoting and protecting the child's rights<sup>143</sup></li> </ul>
	AVSI	<ul style="list-style-type: none"> <li>-To ensure equitable access to quality education for preschool and school-aged vulnerable children</li> <li>- capacity building of teachers and strengthening parent-teachers' committees</li> <li>-To offer psychosocial, medical and legal supports to violence and abuse victims.<sup>144</sup></li> </ul>
	Imbuto Foundation	To ensure that programmes are delivered effectively, with quality, and in a given timeframe. <sup>145</sup>
	Anglican Church of Rwanda	Involved in rural development, medical work, vocational training, education, and in the struggle against HIV/AIDS <sup>146</sup>
	ADEPE	<ul style="list-style-type: none"> <li>- To assist vulnerable people especially youth and women in enabling them to improve their living conditions</li> <li>- To help the youth and women learn via a constant professional training as well as promoting human rights<sup>147</sup></li> <li>-Supported in building an early childhood development centre<sup>148</sup></li> </ul>
	Rwanda Interfaith Council on Health (RICH)	To ensure that programmes are delivered effectively, with quality, and in a given timeframe. <sup>149</sup>
Nutrition	Ministry of Family and Gender Promotion (MIGEPROF)	To ensure strategic coordination of policy implementation in the areas of gender and family promotion, women's empowerment and child rights protection <sup>150</sup>
	NCDA	<ul style="list-style-type: none"> <li>-To coordinate all activities that support early childhood development program</li> <li>-To enhance the capacities of parents and the Rwandan community in providing adequate education</li> <li>-To develop a national partnership and coordination framework aimed at promoting and protecting the child's rights<sup>151</sup></li> </ul>
	RBC	<ul style="list-style-type: none"> <li>- implements innovative health interventions</li> <li>- promotes high quality, affordable, and sustainable health care services<sup>152</sup></li> </ul>
	MINAGRI	To address food security as a foundation for adolescents having good nutrition, with funds from other donors. <sup>153</sup>
	World Relief	Collaborated with UNICEF in pilot testing of Nutrition Sensitive Social Protection Interventions for further scaling-out. <sup>154</sup>
	Civil Society Alliance for Nutrition (SUN)	<ul style="list-style-type: none"> <li>-Collaboration with the Government to integrate nutrition into policies</li> <li>- to advocate for nutrition-related issues such as research on under nutrition and stunting<sup>155</sup></li> </ul>
	Rwanda Women Parliamentary Forum	To help women gain more visibility in decision-making, educating them to have the appropriate knowledge and ability <sup>156</sup>
	Rwanda Management Institute (RMI)	Provide building of youth and women through training <sup>157</sup> capacity
Education	Rwanda Education Board	-To promote the use of information and communication technology in basic education

<sup>143</sup> <https://www.ncda.gov.rw/about-ndca#:~:text=NCDA%20general%20mission,of%20his%20or%20her%20rights>.

<sup>144</sup> <https://www.avsi.org/en/country/rwanda/15/>

<sup>145</sup> UNICEF-EKN Phase II approved proposal pg61

<sup>146</sup> <https://www.oikoumene.org/member-churches/province-of-the-anglican-church-in-rwanda>

<sup>147</sup> <https://adepewv.org/>

<sup>148</sup> <https://www.undp.org/content/rwanda/en/home/presscenter/articles/2020/10/News0.html>

<sup>149</sup> 07. UNICEF-EKN Phase II approved proposal pg61

<sup>150</sup> <https://www.migepronf.gov.rw/about#:~:text=7%20Ave%2C%20Kigali>

The%20Ministry%20of%20Gender%20and%20Family%20Promotion%20(MIGEPROF)%20is%20the,the%20implementation%20of%20gender%20agenda

<sup>151</sup> <https://www.ncda.gov.rw/about-ndca#:~:text=NCDA%20general%20mission,of%20his%20or%20her%20rights>

<sup>152</sup> <https://rbc.gov.rw/index.php?id=629>

<sup>153</sup> UNICEF-EKN Phase II approved proposal pg22

<sup>154</sup> DHCR Monitoring Report Aug 2021 pg20

<sup>155</sup> <https://scalingupnutrition.org/news/civil-society-organizations-unite-to-scale-up-nutrition-in-rwanda/#:~:text=The%20SUN%20CSA%20in%20Rwanda%20will%20contribute%20to%20this%20effort,sector%20to%20expand%20markets%20of>

<sup>156</sup> [https://repositorio.iscte-iul.pt/bitstream/10071/15619/4/master\\_eszter\\_zaborszky.pdf](https://repositorio.iscte-iul.pt/bitstream/10071/15619/4/master_eszter_zaborszky.pdf)

<sup>157</sup> <https://dutable.com/2014/01/04/rwanda-management-institute-rmi/>

		-Capacity building of teachers -Contribute to the development of education policy <sup>158</sup>
	International Education Exchange (IEE)	Supports the efforts of the ministry of education through Rwanda Education Board to create and produce lifelong learning skills in children through providing them with quality education. <sup>159</sup>
Water Sanitation and Hygiene (WASH)	Society of Family Health (SFH)	-Promote appropriate nutritional practices -Conducts product demonstrations and community dialogues through hygiene clubs to sensitize communities on proper hygiene and sanitation <sup>160</sup>
	World Vision	To ensure that programmes are delivered effectively, with quality, and in a given timeframe. <sup>161</sup>
	Ministry of Health (MINISANTE)	To provide health services through support from other donors. <sup>162</sup>
Social Protection	Ministry of Local Government (MINALOC)	The Ministry in charge of coordinating stunting reduction in Rwanda <sup>163</sup> Construct improved sanitation services in ECD centres and schools.
	Local Administrative entities Development Agency (LODA)	Scale-up of expanded (Nutrition Sensitive Social Protection) public works. <sup>164</sup>
	World Relief	Collaborated with UNICEF in pilot testing of Nutrition Sensitive Social Protection Interventions for further scaling-out. <sup>165</sup>

<sup>158</sup> <https://www.reb.gov.rw/about-reb>

<sup>159</sup> <https://www.iee.rw/our-services/#:~:text=IEE%20supports%20the%20efforts%20of,providing%20them%20with%20quality%20education>.

<sup>160</sup> <https://sfhrwanda.org.rw/our-work/wash/>

<sup>161</sup> UNICEF-EKN Phase II approved proposal pg61

<sup>162</sup> UNICEF-EKN Phase II approved proposal pg20

<sup>163</sup> UNICEF-EKN Phase II approved proposal pg8

<sup>164</sup> DHCR Monitoring Report Aug 2021 (pg18)

<sup>165</sup> DHCR Monitoring Report Aug 2021 pg20

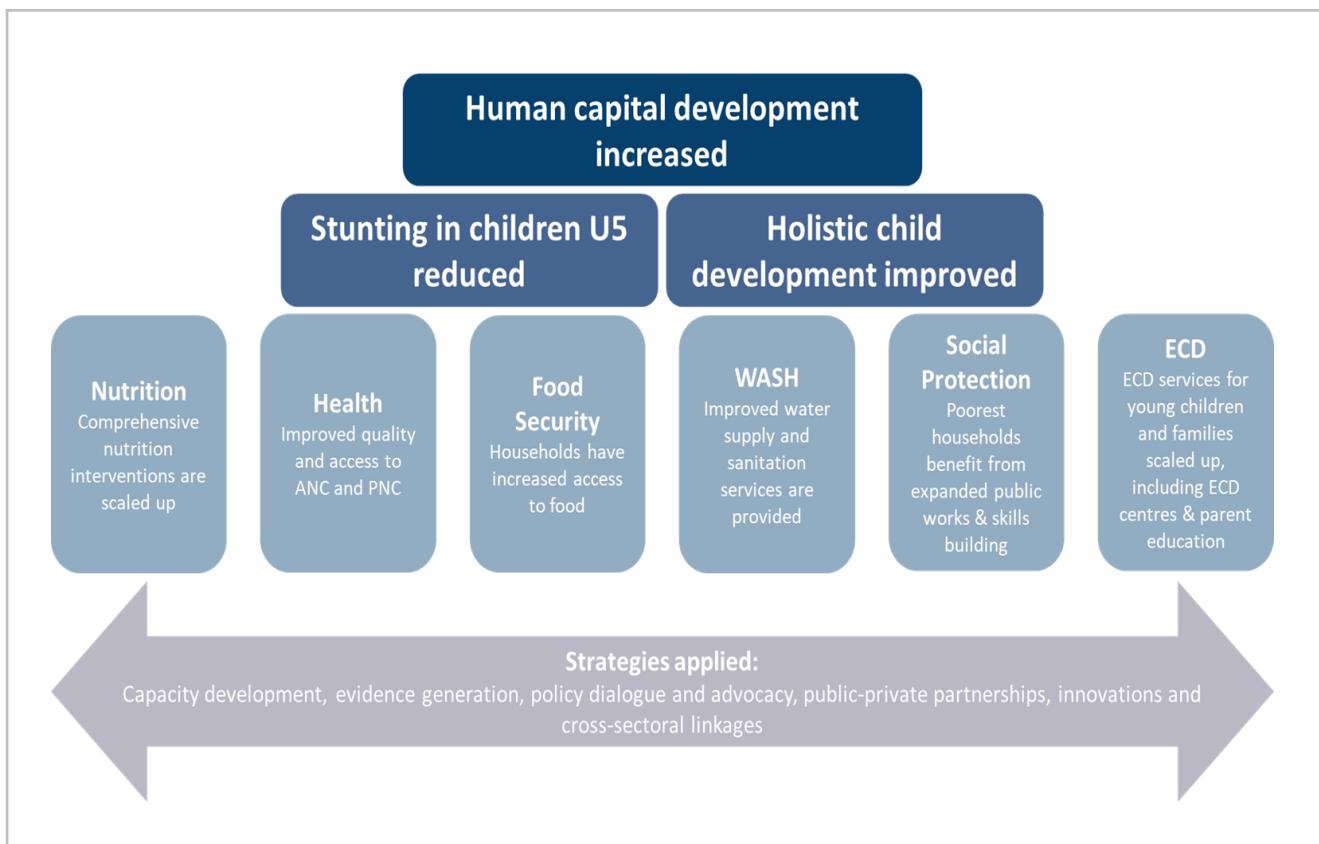
## **Appendix 5: Programme Beneficiaries**

The table below quantifies direct beneficiaries by category:



DHCR\_Beneficiaries  
data-25052022.xlsx

## Appendix 6: DHCR Theory of Change



## Appendix 7: Evaluation Matrix

Key Evaluation Questions	Sub Questions	Indicators	Data Collection Methods	Information Sources
<b>Relevance</b>				
		<ul style="list-style-type: none"> <li>How relevant is the objectives of the DHCR Programme with regards to the national and districts nutrition and ECD priorities, strategies and programmes? <b>EQ1.1</b></li> <li>To what extent did DHCR Programme adapt to remain relevant to the changing context? <b>EQ1.1</b></li> <li>Have the interventions implemented under DHCR Programme begun with an adequate needs assessment/Baseline? <b>EQ1.2</b></li> <li>How did the different stakeholders participate in the DHCR Programme interventions' design? To what extent did the local communities contribute to implementing the interventions? <b>Part 1 - EQ1.1 &amp; Part 2- EQ5.1</b></li> <li>To what extent does the DHCR Programme provide nutrition and ECD opportunities to all the children aged 0-6 in 14 districts in Rwanda, considering the local context and differentiated needs of girls and boys? <b>Covered under Equity EQ8.2</b></li> <li>Are there some groups in need but not covered by DHCR Programme and why? <b>Covered under Equity EQ8.2</b></li> </ul>		
<b>EQ1 –</b> To what extent is DHCR design (objectives and strategies) was informed by national/local nutrition and ECD needs (children 0-6 including of the most disadvantaged), included the relevant stakeholders, and evolved to accommodate changing context?	<b>EQ1.1 –</b> How relevant is the DHCR design –objectives, components and strategies, to GoR and partners' nutrition and ECD policies/plans, and continues to remain consistent with them ?	<p><b>1.1.1</b> Key Programme stakeholders referred to the Programme's objectives, components and results as institutional priorities (around nutrition and ECD).</p> <p><b>1.1.2</b> Evidence of institutional priorities (of key DHCR partners) and overlaps with those of Programme objectives and interventions</p> <p><b>1.1.3</b> Evidence and stakeholders' views (<i>UNICEF, MOH, NCDA, MIGEPROF, and MINAGRI</i>) on level of participation in Programme's design</p> <p><b>1.1.4</b> Evidence and key Programme stakeholders identified number and types of changes in Programme interventions in view of any evolving contextual factors.</p>	<ul style="list-style-type: none"> <li>KIIs</li> <li>Thematic Analysis</li> </ul> <ul style="list-style-type: none"> <li>Literature Review</li> <li>Tables (overlaps)</li> </ul> <ul style="list-style-type: none"> <li>Literature Review</li> <li>Key Informant Interviews</li> </ul> <ul style="list-style-type: none"> <li>Key Informant Interviews</li> <li>Thematic Analysis</li> <li>Literature Review</li> <li>Descriptive Analysis</li> </ul>	Documents including UNICEF Country Programme Document; Baseline report; among others.  KIIs with stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA, among others.
	<b>EQ1.2 –</b> Was the Programme design adequately informed and appropriate to address needs of children aged 0-6 (including the most disadvantaged)?	<p><b>1.2.1</b> Evidence of pre/during-Programme assessment undertaken and identified local nutrition and ECD needs (for children aged 0-6 years).</p> <p><b>1.2.2</b> Number and types of Programme interventions that Programme stakeholders identified as having been informed of the listed/known local nutrition and ECD needs.</p>	<ul style="list-style-type: none"> <li>Literature Review</li> <li>Descriptive Analysis</li> </ul> <ul style="list-style-type: none"> <li>Key Informant Interviews</li> <li>Thematic Analysis</li> </ul>	
<b>Coherence</b>				
		<ul style="list-style-type: none"> <li>To what extent are the DHCR Programme design and its components in line with the overall national nutrition and ECD priorities? For evident overlap with relevance, this is covered under <b>EQ1.1</b></li> <li>To what extent were the policies of the different actors involved in DHCR Programme complementary or contradictory in addressing key nutrition and ECD needs of children? <b>EQ2.1</b></li> <li>To what extent is the objectives and output of the DHCR Programme in Rwanda in line with the other partners' priorities in Rwanda? For evident overlap with relevance, this is covered under <b>EQ1.1</b></li> </ul>		

<b>EQ2</b> – To what extent did Programme utilise internal (in terms of synergies, interlinkages) and external (in terms of complementarities, harmonization) coherence?	<b>EQ2.1</b> – Was the Programme consistent (or otherwise) with internal and external nutrition and ECD priorities?	<b>2.1.1</b> Views of key stakeholders on mechanisms/process (pre/during Programme) adopted to identify the synergies with other Programmes or partners for drawing complementarities and to avoid duplications.	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Literature Review</li> <li>• Descriptive Analysis</li> <li>• Thematic Analysis</li> </ul>	Documents including UNICEF Country Programme Document; Vision 2020; Baseline report; among others.	
		<b>2.1.2</b> Number and types of Programme interventions that were jointly implemented / coordinated by different units (WASH, Health, Social Protection, C4D, ECD, Nutrition) of UNICEF.	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> <li>• Key Informant Interviews</li> <li>• Thematic analysis</li> </ul>	KIIs with stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA, among others	
<b>Efficiency:</b>					
<ul style="list-style-type: none"> <li>• <b>To what extent did the management of DHCR Programme ensure a timely and efficient utilization of resources to deliver the outputs from the implementation of the different interventions? EQ3.1</b></li> <li>• <b>How efficient have the financial resources of DHCR Programme interventions been used to optimize the programme's achievements? EQ3.1</b></li> <li>• <b>Have there been delays in fund allocation and utilization that may have affected the impact of the programme? EQ3.1</b></li> <li>• <b>To what extent were the DHCR Programme interventions coordinated with other sectors within UNICEF such as WASH, Health, Social Protection, C4D, Nutrition, and ECD? - Covered this under Coherence EQ2.1.</b></li> <li>• <b>Did the unit cost of the interventions comparable to the standards costs applied by other sectors? EQ3.2</b></li> <li>• <b>To what extent have the provision of nutrition and ECD materials, the capacity development of national and local leaders been efficient? Could the same results be achieved with fewer resources? EQ 3.1 &amp; EQ3.2</b></li> </ul>					
<b>EQ3</b> – To what extent did DHCR allocate and deploy resources (time, funds, capacity building - through nutrition and ECD materials, management arrangements) to achieve intended results?	<b>EQ3.1</b> – Did DHCR deploy resources (time, funds, capacity building - through nutrition and ECD materials, management arrangements) to achieve intended results?	<b>3.1.1</b> Key DHCR stakeholders referred to allocated resources (time, funds, capacity building, material) being sufficient vis a vis planned results	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>	Programme financial documents (budgets, expense sheets); Progress Reports, and others	
		<b>3.1.2</b> Evidence of any delays in fund allocation and its effect on implementation	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>	KIIs with key programme stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA.	
		<b>3.1.3</b> Evidence and key DHCR stakeholders expressed satisfied with management (national/district level) mechanisms (engagement of all concerned personnel, regular contact) to achieve results with allocated resources.	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>		
		<b>EQ3.2</b> – Are unit costs comparable to other sectors? Could same results be achieved with fewer resources by applying alternative strategies?	<b>3.2.1</b> Evidence of balanced resources allocations and utilization vis-à-vis components (including average cost per beneficiary and comparison with regional/global numbers).	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>	
<b>Effectiveness</b>					
<ul style="list-style-type: none"> <li>• <b>To what extent did the DHCR Programme meet its objective, outputs and key interventions as stated in the programme design document? EQ4.1</b></li> <li>• <b>What process has been used to set the targets every year, who participated in the process? EQ4.2</b></li> <li>• <b>To what extent have the partnership between key stakeholders and integrated approach to programming contributed to reducing stunting and contributed to child development for children aged 0-6 especially the most vulnerable girls of boys in the targeted 14 districts? EQ5.1</b></li> </ul>					

- To what extent has the implementation of DHCR Programme been in line with the principles of adhering to quality standards, and the principles of human rights and gender equality and equity and why? - Covered this under HRBA and GE EQ8.1 & EQ8.2.
- What are the key successes achieved by the interventions of the DHCR Programme? How have these successes been used to adjust the targets, shift programme focus, and improve implementation? EQ4.2
- How timely were these interventions conducted to provide equitable and quality nutrition and ECD opportunities for children aged 0-6 especially the most vulnerable girls of boys? - Covered this under Equity 8.2.
- What were the major factors influencing the achievement or non-achievement of the DHCR Programme? EQ4.2
- To what extent did the DHCR Programme reach the children (0-6 years) in 14 districts in the country, especially the most vulnerable girls and boys? - Covered this under Equity 8.2.
- What effects has the DHCR Programme produced on the capacities of the nutrition and ECD sector and institutions at national and district level and local communities to ensure that all children, access to equitable nutrition and ECD services in Rwanda? EQ4.3
- Is there evidence of the DHCR Programme contributing to the raising the awareness of the nutrition and ECD on the importance to increase resources to ensure reduction of stunting and ECD services for children 0-6 years across the country, especially those living in the 14 targeted districts? EQ4.3

Coordination:

- How well have the interventions under DHCR Programme been delivered in a cohesive and effective manner in terms of strategic planning, gathering data and managing information, mobilizing resources and ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework with Rwanda authorities and providing leadership? EQ5.1
- Were plans for coordination in place, and followed by all the stakeholders? EQ5.1
- What were the main constraints and support to coordination? How was good coordination achieved, and is it replicable in other situations? EQ5.1

EQ4 – To what extent did the DHCR Programme achieve the intended results (outcomes and outputs) including public sector capacity development (including communities), and factors that influenced achievement (or non-achievement of results)?	EQ4.1 – To what extent did DHCR Programme achieve the intended results (outputs, outcomes)?	4.1.1 Evidence of Programme's achievement vis a vis planned outputs/outcomes.	• Literature Review • Household Survey • Comparative Analysis	Documents including Programme Results Framework, Programme Progress Reports, annual assessments, baseline report, and others
	EQ4.2 – What factors either enabled or hindered DHCR achievements? How achievements affect the yearly planning?	4.1.2 Key Programme stakeholders identified enabling and disabling factors and how did those affect the Programme achievements.	• Key Informant Interviews • Thematic Analysis	
		4.2.1 Evidence and key Programme stakeholders identified the process taken to set yearly targets and their level of participation in it	• Key Informant Interviews • Thematic Analysis	
		4.2.2 Key Programme stakeholders referred to Programme successes used to adjust the targets, shift programme focus and improve implementation	• Key Informant Interviews • Thematic Analysis	KIs with key programme stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA.  Household Survey with male and female parents / caregivers (of children 6-23) in target districts
	EQ4.3 – How successful was DHCR in building public sector (in nutrition and ECD) and community capacities for efficacious nutrition and ECD services for children 0-6?	4.3.1 Evidence and key stakeholders' views on DHCR Programme's contribution to capacities built of the nutrition and ECD sector, institutions and local communities	• Key Informant Interviews • Thematic Analysis	
EQ5 – To what extent has DHCR been planned and implemented in a coordinated manner,	EQ5.1 – Has DHCR been planned and implemented in a cohesive and effective manner? What coordination mechanisms were in place,	4.3.2 Community views on DHCR Programme's contribution to capacities built of local communities and number of interventions implemented by local communities	• Focus Group Discussions • Thematic Analysis Focus Group	FGDs with parents/caregivers; district staff; community workers.
		5.1.1 Evidence and key stakeholders' views on DHCR Programme's strategies (strategic planning, data gathering, resource mobilisation, accountability, and partnership) efficacy and cohesiveness to achieve intended results.	• Key Informant Interviews • Thematic Analysis	

challenges faced and is replicable?	constraints faced, and which aspects are replicable?	<b>5.1.2</b> Evidence of coordination plans placed and followed by stakeholders.	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>		
		<b>5.1.3</b> Key DHCR stakeholders expressed satisfaction on Programme's coordination arrangements (including constraints faced or support provided).	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>		
		<b>5.1.4</b> Programme stakeholders' views on replicability of DHCR's coordination arrangements for similar programmes	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>		
<b>Impact</b>					
<b>EQ6 – To what extent did the Programme contribute to achieve desired impact?</b>	<b>EQ6.1 – Did DHCR Programme contribute to the achievement of intended impact (in stunting reduction and developmental readiness of 0-6 children) in target districts and in the country?</b>	<b>6.1.1</b> Evidence of (disaggregated by age, sex, location): - Reduction in prevalence of stunting in children under five - Young children's holistic development improved	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>	Documents including DHS, Baseline, Comprehensive Food and Vulnerability Assessment.	
		<b>6.1.2</b> Key Programme stakeholders' views on types and extent of impact of Programme interventions on stunting and ECD for children aged 0-6 years.	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>	Household Survey with male and female parents / caregivers (of children 6-23) in target districts	
		<b>6.1.3</b> Community respondents (all groups) views on types and extent of impact of Programme interventions on stunting and ECD for children aged 0-6 years.	<ul style="list-style-type: none"> <li>• Focus Group Discussions</li> <li>• Thematic Analysis</li> </ul>	KIIs with key stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA.	
		<b>6.1.4</b> Evidence of unintended (positive and negative) impact Programme may have contributed to.	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>	FGDs with parents/caregivers; district staff; community workers.	
<b>Sustainability</b>					
<ul style="list-style-type: none"> <li>• To what extent are the benefits of the DHCR Programme interventions likely to continue after the programme? <b>EQ7.1</b></li> <li>• To what extent will the outcomes and outputs achieved by the DHCR Programme contribute to leverage more funding and resources from current donors and new donors to maintain or increase financial support to nutrition and ECD? <b>EQ7.1</b></li> <li>• To what extent did the experiences of the programme feed into policy discussions to ensure institutionalization and sustainability of interventions by the GoR? <b>EQ7.2</b></li> <li>• To what extent have the interventions created opportunities for Rwanda institutions at national and district level to strengthen its leadership of DHCR Programme in terms of government budget allocation, planning, implementation, management and monitoring? <b>EQ7.2</b></li> <li>• Did the implementation of DHCR Programme build capacities at national and district level in terms of resources, skills to help ensure continuous positive changes in the fight against malnutrition and increase opportunities for ECD for children aged 0-6 years? <b>EQ7.2</b></li> <li>• What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project? <b>EQ7.1</b></li> </ul>					

<b>EQ7</b> – To what extent did the DHCR Programme enable the GoR's ownership, capacity development and institutionalisation of nutrition and ECD interventions, and factors that either influenced or likely to influence sustainability?	<b>EQ7.1</b> – Which of DHCR Programme results/interventions are likely/unlikely to sustain and the contributory factors? Will Programme achievements result in securing more funds from current/new donors to support nutrition and ECD activities?	<p><b>7.1.1</b> Evidence and stakeholders' views on number of DHCR interventions and results that likely or unlikely to sustain and underlying reasons.</p> <p><b>7.1.2</b> Stakeholders views on Programme results contributing to securing more funding from new/current donors</p>	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> <li>• Literature / Document Review</li> </ul> <ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul>	Documents including programme progress reports, research reports, surveys  KIs with key programme stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA.  FGDs with parents/caregivers; district staff; community workers.
	<b>EQ7.2</b> – Has DHCR cultivated ownership and strengthened capacities within relevant public stakeholders and how does GoR's intend to sustain the Programme activities (in terms of budget allocation, policy, planning, implementation, management and monitoring)?	<p><b>7.2.1</b> Key DHCR public stakeholders (listed the strengthened public capacities to sustain interventions and results (<i>including budget allocation, planning, implementation, management and monitoring</i>)).</p> <p><b>7.2.2</b> Key DHCR stakeholders' views on types of measures undertaken to enable continuity of interventions/results after the Programme ends.</p> <p><b>7.2.3</b> Evidence of Programme results feeding into policy discussions for institutionalization and sustainability of interventions by the GoR</p>	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> </ul> <ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul> <ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul>	
<b>HRBA, Gender Equality and Equity</b>				
<b>EQ8</b> – To what extent did the DHCR Programme incorporate human rights-based/child rights approaches (HRBA/CR), gender equality, and equity principles and approaches and results created thereof?	<b>EQ8.1</b> – Did the DHCR Programme (design and implementation) incorporate the HRBA/CR principles?	<p><b>8.1.1</b> Evidence and key DHCR stakeholders' views on interventions complying with HRBA principles of: Participation; Accountability; Non-discrimination; Equality; Empowerment; &amp; Legality</p>	<ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Thematic Analysis</li> <li>• Document Review</li> </ul>	Documents including references to UN Convention of Human Rights and Gender; Programme Monitoring data, reports  KIs with key programme stakeholders including but not limited to UNICEF, MoH, MINAGRI, NCDA.  FGDs with parents/caregivers; district staff; community workers.
	<b>EQ8.1</b> – Does DHCR Programme design and implementation reflect integration of gender equality?	<p><b>8.2.2</b> Evidence of structured gender assessment undertaken and having informed the Programme design and implementation – targets, interventions, resources, and implementation.</p> <p><b>8.2.3</b> Stakeholders and community respondents' views on: - Programme benefitting the men, women, boys, girls - Programme interventions successfully addressed the causes of inequality between boys and girls.</p>	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul> <ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Focus Group Discussions</li> <li>• Thematic Analysis</li> </ul>	
	<b>EQ8.3</b> – To what extent did DHCR Programme appropriately assess, identify, and address the needs of vulnerable groups (including vulnerable girls and boys aged 0-6 years); are there any groups that are not covered by the Programme?	<p><b>8.3.1</b> Evidence of DHCR Programme undertaking an equity assessment to inform targets, interventions, and resource allocations</p> <p><b>8.3.2</b> Key Programme stakeholders' and community views on: - Programme interventions to promote equity - Results produced for children aged 0-6 especially vulnerable groups - Programme interventions that successfully addressed the underlying reasons for inequity</p>	<ul style="list-style-type: none"> <li>• Literature Review</li> <li>• Descriptive Analysis</li> </ul> <ul style="list-style-type: none"> <li>• Key Informant Interviews</li> <li>• Focus Group Discussions</li> <li>• Thematic Analysis</li> </ul>	

## **Appendix 8: Rationale Behind the Departure from the Proposed Design**

It is important to note that initially Quasi-Experimental Design was proposed for this Endline study but after desk review and discussion with UNICEF, few issues were highlighted regarding data contamination including:

1. DHCR activities were rolled out in 2017 which was before the baseline was conducted (in 2018). In this case, using baseline data for comparison between treatment and control districts will confound the impact.
2. The DHCR Baseline was conducted in only 7 out of 14 programme districts for nutrition specific intervention. There are other organizations which are working in remaining 16 districts of Rwanda for nutrition specific intervention. The level of support and coverage of the Core Nutrition Activities (CNAs) also varies among different districts both in number of partners supporting the district, the number of CNAs implemented, and the coverage of beneficiaries for these CNAs.<sup>166</sup> This poses a problem of data contamination in sampling and spill-over.
3. The target audience for reducing stunting is children between 6 – 23 months as preventive measures are most effective when targeted at this age bracket. For a quasi-experimental design, children below age 5 from Program districts and control districts could have been chosen using probabilistic matching based on the certain matching variables; however, it sounds doable theoretically but may pose problems in practicality later on. Also, the selected sample is not representative at the district level as DHS is nationally representative. District representative sample from the DHS is not possible.
4. Most importantly, this is a summative evaluation, not an impact assessment. Both contribution and comparative analysis are enough for the said purpose.

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<sup>166</sup> <https://www.unnetworkforsun.org/sites/default/files/2018-06/Rwanda%20Mapping%20-%20Highlights.pdf>

## Appendix 9: List of Programme Documents Reviewed

Document Title	Download/Shared by	Type	Code
01. 2020-Baseline-Evaluation-DHCR-Programme-Full-Report.pdf	UNICEF	Baseline	LFA
02. DHCR Districts Rwanda.pptx	UNICEF	Report	RM
03. EKN- I annual progress report for 2017- as of 31 March 2018.xlsx	UNICEF	Progress reports	RM
04. EKN- II annual progress report for 2018- as of 29 March 2019.xlsx	UNICEF	Progress reports	RM
05. EKN- IV annual progress report for 2020_ as of 26 March 2021.xlsx	UNICEF	Progress reports	RM
06. EKN-III annual progress report for 2019- as of 31 March 2020.xlsx	UNICEF	Progress reports	RM
07. UNICEF-EKN Phase II approved proposal.docx	UNICEF	Proposal	CNP
08. RNEC template Parental Informed consent and Child Assent form.doc	UNICEF	Forms	RM
09. Rwanda National Strategy for Transformation 7YGP_Final.pdf	UNICEF	Strategy	SPD
10. DHCR Monitoring Report Aug 2021.pdf	UNICEF	Monitoring	RM
11. EKN Mid-Term Review (MTR) Report_Compressed 2019.docx	UNICEF	Monitoring	RM
12. KAP early nurturing_final report 2014.pdf	UNICEF	Survey	SRV
13. Rwanda Mapping - Highlights.pdf	UNICEF	Report	RM
14. NCDA Support Letter for DHCR Progr Evaluation.pdf	UNICEF	Letter	PCA
15. RBC Support Letter for DHCR Programme Evaluation.pdf	UNICEF	Letter	PCA
16. Rwanda_Vision_2020_revised_2012_.pdf	UNICEF	Report	RM
17. Rwanda_Statistical_YearBook_2020 (1).pdf	UNICEF	Situation Analysis	SitAn
18. 2017-ECD-and-Family-Endline-Evaluation.pdf	AAN	Report	RM
19. An-assessment-of-male-engagement-in-integrated ECD.pdf	AAN	Report	RM
20. Mencare in rwanda-101120.pdf	AAN	Report	RM
21. ECD_INTEGRATED_ECD_MODELS_GUIDELINES.pdf	AAN	Guidelines	Guid e
22. RICH_Rwanda-interfaith-response-to-promote-ECD.pdf	AAN	Report	RM
23. 2018-UNICEF-Rwanda-Private-Sector-Engagement-Strategy.pdf	AAN	Strategy	SPD
24. Business Case for Employer-supported Childcare.pdf	AAN	Proposal	CNP
25. RAB_Twigire_Muhinzi_Extension Model.pdf	AAN	Report	RM
26. twigire_muhinzi_reflection_note_2016.pdf	AAN	Report	RM
27. Nutrition monitoring mission 2019.pdf	AAN	Report	RM
28. Rapid nutrion stakeholders and action mappingvf.pdf	AAN	Report	RM
29. Annual results report 2016_WASH.pdf	AAN	Report	RM
30. WHO and UNICEF Joint Monitoring Programme (JMP) Indicators.pdf	AAN	Framework	LFA
31. Education_Sector_Strategic_Plan_2018_2024.pdf	AAN	Strategy	SPD
32. Governance_Descentralization_Sector_Strategic_Plan.pdf	AAN	Strategy	SPD
33. MNCH_national_strategy2013-2018.pdf	AAN	Strategy	SPD
34. MIn Finance_Eco Dev-Rwanda Vision 2020.pdf	AAN	Strategy	SPD
35. National_Agriculture_Policy_-_2018.pdf	AAN	Policy	SPD
36. National_Food_and_Nutrition_Policy.pdf	AAN	Policy	SPD
37. NATIONAL_POLICY_FOR_FAMILY_PROMOTION.pdf	AAN	Policy	SPD
38. revised-RWA 2011 - ECD policy.pdf	AAN	Policy	SPD
39. Social_Protection_Policy_Adopted.pdf	AAN	Policy	SPD
40. 2017-Roadmap-Implementation-Child-Sensitive-Public-Works.pdf	AAN	Strategy	SPD
41. PN_Rwanda_Making_Rwanda's_Vision_2020_VUP.pdf	AAN	Strategy	SPD
42. Rwanda _DHS 2014-15.pdf	AAN	Survey	SRV
43. Integrated Household Living EICV5 2016- 2017.pdf	AAN	Survey	SRV
44. Rwanda DHS 2019-20_Final Report.pdf	AAN	Survey	SRV
45. UNICEF_ECD_Programme_Guidance._September._2017.pdf	AAN	Guidelines	Guid e
46. UNICEF Global-social-protection-programme-framework-2019.pdf	AAN	Framework	LFA
47. UNICEF Strategy for Health 2016-2030.pdf	AAN	Strategy	SPD
48. 2018-Situation-Analysis-Rwanda-Children-Summary.pdf	AAN	Strategy	SPD
49. UNICEF Nutrition Strategy 2020-2030.pdf	AAN	Situation Analysis	SitAn
50. 2019-UNICEF-Rwanda-Country-Profile.pdf	AAN	Report	RM
51. 2020-EKN-Capacity-Gap-Analysis-Full-Report.pdf	AAN	Report	RM
52. Rwanda National Strategy for Transformation.pdf	AAN	Strategy	SPD
53. Rwanda-2020-COAR.pdf	AAN	Country Document	CPD

Document Title	Download/Shared by	Type	Code
54. CRS - Rwanda EKN Project.pdf	AAN	Report	RM
55. 2019-UNICEF-Rwanda-Country-Profile.pdf	AAN	Report	RM
56. EKN Phase I Final Report.pdf	AAN	Report	RM
57. Nutrition Sensitive Agriculture Mainstreaming Guideline_FINAL.pdf	AAN	Guidelines	Guide
58. rwanda_home_gardens_-_to_consume_or_to_sell.pdf	AAN	Guidelines	Guide
59. Rwanda-First-Programmatic_HCD-Policy-Financing.pdf	AAN	Situation Analysis	SitAn
60. Training-of-trainers-manual School gardens.pdf	AAN	Policy	SPD
61. WorldBank_DHCR_P171554.pdf	AAN	Guidelines	Guide
62. 2016_Annual_Statistical_booklets_V9_08_03_2018.pdf	AAN	Report	RM
63. NECDP Strategic Plan 2018-2024.pdf	AAN	Situation Analysis	SitAn
64. Integrated Household Living EICV6 2019- 2020.pdf	AAN	Strategy	SPD
65. 2018 11 22 Comparison EKN I EKN II ECD I	UNICEF	Survey	SRV
66. 2019 06 25 Figures EKN baseline	UNICEF	Survey	SRV
67. 2018 10 11 MDAT EKN baseline	UNICEF	Survey	SRV
68. DHCR_FIND 04 Efficiency Poor coordination.pdf	AAN	Article	Guide
69. DHCR_FIND Joint Action Development Forum-JADF.pdf	AAN	Article	Guide
70. DHCR_Hom Garden Design.pdf	AAN	Guidelines	Guide
71. DHCR_Summarized_Home Garden Guide-compressed (1).pdf	AAN	Guidelines	Guide
72. USAID _ Feed the Future_HINGA WEZE ACTIVITY.pdf	AAN	Report	RM
73. ENDLINE STUDY REPORT - MIYCN - ABM 17-12-2021.pdf	UNICEF	Report	RM
74. MNSSPI Endline Evaluation Report-30-04-22 Final.docx	UNICEF	Report	RM
75. Nutrition Budget Brief 2020-21.pdf	UNICEF	Report	RM
76. Nutrition Budget Brief 2021-22.pdf	UNICEF	Report	RM
77. Nutrition intervention matrix by development partners.pdf	UNICEF	Report	RM
78. Social Protection Brief 2020-21.pdf	UNICEF	Report	RM
79. Social Protection Budget Brief 2021-22.pdf	UNICEF	Report	RM
80. Training Report on Para-social workers (Smart Spending and VSLAs).pdf	UNICEF	Report	RM
81. UN-SDC Nutrition Phase III Proposal revised 02.12.21_JMU (003).pdf	UNICEF	Report	RM
82. WB portfolio linked to Human Capital 2017-2027.pptx	UNICEF	Report	RM

## Appendix 10: Evaluation Quantitative Tool - Household Survey

### EKN Anthropometric Survey 2018

1. Initials of the data collectors who is taking measurements.
2. Did caregiver present the ID card during the interview?
  - a. Yes
  - b. No
3. Family's ID Code \_\_\_\_\_ (Family's ID Code number)
4. Scan the barcode on the anthropometric appointment card \_\_\_\_\_
5. Birthday of the child \_\_\_\_\_ (age of child in month)
6. Primary caregivers are illiterate
  - a. Yes
  - b. No
7. Child's initial
8. Sex of the Child
  - a. Male
  - b. Female
9. Caregiver's initial
10. District Name \_\_\_\_\_
11. Sector Name \_\_\_\_\_
12. Cell \_\_\_\_\_
13. Village \_\_\_\_\_
14. How was the child's weight assessed? \_\_\_\_\_ (BMI-for-age percentiles)
15. Weight of Caregiver and child together (kg) \_\_\_\_\_ (Caregiver and child Great. weight in kg)
16. Weight of Caregiver alone (kg) \_\_\_\_\_
17. Weight of the child calculated \_\_\_\_\_
18. Child's length (for children under 2 years) in cm \_\_\_\_\_
19. Child's height (for children aged 2 or more years) in cm \_\_\_\_\_
20. Enter child's MUAC (mm) \_\_\_\_\_ (Child Mid-Upper Arm Circumference)
21. Is the child currently enrolled in a health center malnutrition program? If MUAC is less than 125mm
  - a. Yes
  - b. No
22. Has the child been referred to a malnutrition program? If MUAC is less than 125mm
23. Is the caregiver the child's biological mother?
  - a. Yes
  - b. No
24. Mother alone (kg) if the caregiver is the biological mother of the child \_\_\_\_\_
25. Caregiver's height (cm) if the caregiver is the biological mother of the child \_\_\_\_\_
26. Have participant in any VUP programme?
  - a. Yes
  - b. No

### DHCRS Main Survey

1. Child and Caregiver Information		
1.1	Select the sex of the child	a) Male b) Female
1.2	Age of the child	_____ (in months)
1.3	Enter the caregiver's sex	a) Male b) Female

1.4	What is the relationship of the caregiver to the child?	a) Biological Father b) Biological Mother c) Grandparents d) Other _____
1.5	Age of the caregiver	_____ (in years)
1.6	Has caregiver ever attended school?	a) Yes b) No
1.7	What is the highest education level caregiver completed?	a) Primary b) Secondary c) Tertiary d) Other _____
1.8	Does caregiver have any disability or chronic illness?	a) Yes b) No
1.9	What is caregiver's marital status?	a) Married b) Widowed c) Divorced d) Separated e) Others _____
<b>2. Family Composition</b>		
2.1	Besides you, is there another primary caregiver for the child that lives in the home currently?	a) Yes b) No
2.2	What is the other caregiver's relationship to {child name}?	_____
2.3	In total, how many people live in your household	Total Number of Household members
2.4	Including the index child (\${child name}), how many children under 5, who usually live in your home, are in the household?	Total Number of Children under 5 years of age
<b>3. Information on Head of Household</b>		
3.1	Are you the head of household?	a) Yes b) No
3.2	What is your relationship to the head of household?	a) Son b) Daughter c) Brother d) Sister e) Other _____
3.3	What sex is the head of household?	a) Male b) Female
<b>4. Child's Health Milestone Assessment</b>		
4.1	Compared with other children, does or did {child name} have any serious delay in <b>sitting, standing, or walking</b> ?	a) Yes b) No
4.2	Compared with other children, does \${child name} have difficulty <b>seeing</b> , either in the daytime or at night?	a) Yes b) No
4.3	Does {child name} appear to have difficulty <b>hearing</b> ? (Uses hearing aid, hears with difficulty, completely deaf?)	a) Yes b) No
4.4	Does {child name} have difficulty in <b>walking or moving</b> his/her arms or does he/she have <b>weakness</b> and/or <b>stiffness in arms or legs</b> ?	a) Yes b) No
4.5	Does {child name} sometimes have <b>fits, become rigid, or lose consciousness</b> ?	a) Yes b) No
4.6	Does {child name} <b>learn to do things like other children</b> his/her age?	a) Yes b) No
4.7	Compared with other children of the same age, does {child name} appear in any way <b>mentally backward, dull or slow</b> ?	a) Yes b) No
<b>5. Household &amp; Other Assets</b>		
5.1	What is your official ubudehe status? (Poor family)	a) Ubudehe 1 b) Ubudehe 2 c) Ubudehe 3
5.2	Has your ubudehe status changed in the past two years?	a) Yes b) No
5.3	How many rooms in this house?	Rooms in the household
5.4	How many beds do you own?	Beds in the household
5.5	Does your household have any mosquito nets that can be used while sleeping?	a) Yes b) No
5.6	How many mosquito nets does your household have?	Number of mosquito nets

5.7	Does this household own any livestock, herds, other farm animals, or poultry?	a) Yes b) No
5.8	In the past 12 months, have you acquired any new livestock?	a) Yes b) No
5.9	Have you received any training in how to care for livestock to keep them alive?	a) Yes b) No
5.10	Does your household own farming land include pastures for livestock?	a) Yes b) No
5.11	Land size during last season (including pasture for livestock)?	_____ own land
5.12	Is any member of this household covered by health insurance?	a) Yes b) No
<b>6. Disposable Income, Savings &amp; Wealth Information</b>		
6.1	Do you have electricity in this household?	a) Yes b) No
6.2	Do you possess a radio?	a) Yes b) No
6.3	Do you possess a mobile phone?	a) Yes b) No
6.4	Do you own a bicycle?	a) Yes b) No
6.5	Main material of the exterior walls. Record observation.	_____ Main material of the exterior walls
6.6	On average, how much do you spend on purchasing food (including salt, oil etc) each week?	_____ Amount spent on purchasing food
6.7	Last week, did you consume any home-grown or home-made food?	a) Yes b) No
6.8	Did you spend money on medical expenses/health care in the past 3 months (money could have been paid in direct cash or credit)?	a) Yes b) No
6.9	How much money did you spend (including credit)?	Amount of money spent on medical expenses
6.10	Did you spend money on education, school fees, uniform, etc. in the past 3 Months (money could have been paid in direct cash or credit)?	a) Yes b) No
6.11	How much money did you spend (including credit)?	Amount of money spent on education expenses
6.12	Are there members of your household who saves with any formal savings institution (i.e., SACCO commercial bank)?	a) Yes b) No
6.13	How much has your household deposited on average each month?	Amount of money saved every month in a formal saving institution
6.14	Are there members of your household who saves with a tontine/community savings group?	a) Yes b) No
6.15	How much has your household deposited on average each month?	Amount of money saved every month in a community saving group
<b>7. WASH</b>		
7.1	What is the main source of drinking water for your household?	Main source of drinking water
7.2	Do you pay for this drinking water?	a) Yes b) No
7.3	Do you do anything to the water to make it safer to drink?	a) Yes b) No
7.4	In the past two weeks, has there been any time when your household did not have sufficient quantities of drinking water when needed?	a) Yes b) No
7.5	We would like to learn about the places that households use to wash their hands. Can you please show me where members of your household most often wash their hands?	Place for hand washing
7.6	Observe presence of water at the place for handwashing. Verify by checking the tap/pump, or basin, bucket, water container or similar objects for presence of water.	Presence of water at the place for hand washing
7.7	Do you have any soap or detergent or ash in your household for washing hands?	a) Yes b) No
7.8	Is soap, detergent or ash present at the place for handwashing? Record your observation.	Check all that apply.

		Presence of soap or detergent or ash for hand washing at the place for hand washing
7.9	Are there critical times you always make sure to wash your hands?	a) Yes b) No
7.10	Are you able to wash your hands when you want to?	a) Yes b) No
7.11	What kind of toilet facility does your household use?	Toilet facility
7.12	Do you share this toilet facility with other households?	a) Yes b) No
7.13	Does your community have a Community Hygiene Club?	a) Yes b) No
<b>8. Child Health</b>		
8.1	Where did you give birth to {child name}?	Place of giving birth
8.2	Did you breastfeed your baby within the first hour after delivery?	a) Yes b) No
8.3	When {child name} was born, was he/she very large, larger than average, average, smaller than average, or very small?	a) Very Large b) Larger Than Average c) Average d) Smaller Than Average e) Very Small
8.4	Was {child name} weighed at birth?	a) Yes b) No
8.5	How much did {child name} weigh?	Weight at birth in Kg
8.6	In the two months after {child name} was born, did any health care provider or a traditional birth attendant check on his/her health?	a) Yes b) No
<b>9. Health Seeking Behavior for Children</b>		
9.1	Was {child name} given any drug for intestinal worms in the last 6 months?	a) Yes b) No
9.2	Within the last six months, was {child name} given a vitamin A dose (like this/any of these)?	a) Yes b) No
9.3	Has {child name} had diarrhoea in the last 2 weeks?	a) Yes b) No <b>Skip to Q9.7</b>
9.4	Did you seek advice or treatment for the diarrhoea from any source?	a) Yes b) No
9.5	Where did you seek advice or treatment?	Place of seeking advice or treatment
9.6	Did you use a fluid made from a special packet called ORS PACKET?	a) Yes b) No
9.7	Has {child name} been ill with a fever at any time in the last two weeks?	a) Yes b) No
9.8	Did you seek advice or treatment for the illness from any source?	a) Yes b) No
9.9	When {child name} had an illness with a cough, did he/she have difficulty breathing?	a) Yes b) No
9.10	Was the fast or difficult breathing due to a problem in the chest or to a blocked or runny nose?	Fast or difficult breathing due to a problem in the chest or to a blocked or runny nose
9.11	Where did you seek advice or treatment?	Place of seeking advice or treatment for an illness with a cough
9.12	In the past month, has {child name} seen a health provider or community health worker to measure his/her growth?	a) Yes b) No
9.13	Did {child name} sleep under a mosquito net last night?	a) Yes b) No
<b>10. Social Protection</b>		
10.1	Have you participated in any VUP programs?	a) Yes b) No
10.2	Which VUP programs have you participated in?	Multiple VUP program
10.3	How many members of your household have participated in VUP programs?	Household members who have participated in VUP programs

10.4	When did you most recently participate in a VUP program?	<u>Recent participation in a VUP program</u>
10.5	If yes, did you receive livestock as part of the program?	a) Yes b) No
10.6	If yes, did you receive any skills training as part of the program?	a) Yes b) No
10.7	If yes, are you part of a savings group as part of the program?	a) Yes b) No
10.8	If yes, did you receive any agricultural inputs as part of the program (such as fertilizer)?	a) Yes b) No
10.9	If yes, did you receive any agricultural tools as part of the program (such as a hoe)?	a) Yes b) No
10.10	Are you currently pregnant?	a) Yes b) No
10.11	Have you given birth in the past 6 months?	a) Yes b) No
10.12	If yes, are you enrolled in the FBF/Shisha Kibondo program?	a) Yes b) No
10.13	Do you have a child who is enrolled in the FBF / Shisha Kibondo program?	a) Yes b) No
<b>11. Infant and young child feeding practices</b>		
11.1	Has {child name} ever been breastfed?	a) Yes b) No
11.2	Is {child name} still being breastfed?	a) Yes b) No
11.3	Did {child name} drink ORS (oral rehydration solution) yesterday, during the day or night?	a) Yes b) No
11.4	Did {child name} drink or eat any micronutrient powder/Ongera yesterday, during the day or night?	a) Yes b) No
11.5	How many times during the past 7 days did you give your child MNP/Ongera?	<u>Number of times during the past 7 days the child get MNP/Ongera</u>
<b>12. Infant and young child's current diet – Liquid food</b>		
Please list or name the type of food you provided to your 6-23 months child/children during the last 24 hours.		
12.1	Plain water?	a) Yes b) No
12.2	Juice or juice drinks?	a) Yes b) No
12.3	Clear broth or clear soup?	a) Yes b) No
12.4	Milk, such as tinned, powdered, or fresh animal milk?	a) Yes b) No
12.5	Thin porridge?	a) Yes b) No
12.6	Infant formula?	a) Yes b) No
12.7	Any other liquids?	a) Yes b) No
12.8	How many times did {child name} drink milk?	<u>Number of times child drunk milk yesterday</u>
12.9	How many times did {child name} drink infant formula?	<u>Number of times child drunk infant formula yesterday</u>
<b>13. Infant and young child's current diet – Solid food</b>		
13.1	FBF/Shisha Kibondo?	a) Yes b) No
13.2	Any commercially fortified baby food, e.g., cerelac, fosfatine, SOSOMA?	a) Yes b) No
13.3	Any biscuits, cookies or crisps (potato chips)?	a) Yes b) No
13.4	Bread, rice, noodles, porridge, or other foods made from grains?	a) Yes b) No
13.5	Pumpkin, carrots, squash, or sweet potatoes that are yellow or orange inside?	a) Yes b) No
13.6	White potatoes, white yams, manioc, cassava, or any other foods made from roots?	a) Yes b) No

13.7	Any dark green, leafy vegetables?	a) Yes b) No
13.8	Ripe mangoes, papayas or any other locally available vitamin a-rich fruits? (Tree tomatoes, passion fruit)	a) Yes b) No
13.9	Any other fruits or vegetables?	a) Yes b) No
13.10	Liver, kidney, heart or other organ meats?	a) Yes b) No
13.11	Any meat, such as beef, pork, lamb, goat, chicken, or duck?	a) Yes b) No
13.12	Eggs?	a) Yes b) No
13.13	Fresh or dried fish or shellfish? (Includes sambaza, small, dried fish, sardines)	a) Yes b) No
13.14	Any foods made from beans, peas, lentils, or nuts?	a) Yes b) No
13.15	Yogurt, Cheese or other food made from milk?	a) Yes b) No
13.16	How many times did \${child name} drink or eat yogurt?	Number of times the child drink or eat yogurt yesterday
13.17	OILS AND FATS: oil, fats or butter added to food or used for cooking	a) Yes b) No
13.18	When did you start to give {child name} food and drink other than breast milk?	Select multiple complementary feeding
<b>14. Meal Frequency for Child</b>		
14.1	How many times did \${child name} eat any solid, semi-solid or soft foods yesterday during the day or night?	Number of times a child ate any solid, semi-solid or soft foods yesterday
<b>15. Household food security</b>		
15.1	Yesterday, how many times did the adults in this household eat?	Number of times adults ate in the previous day
15.2	Is this unusual at this time of year?	a) Yes b) No
15.3	Yesterday, how many times did the children (<15-year-old) in this household eat?	Number of times children <=15 years old ate in the previous day
15.4	Is this usual for your children at this time of year?	a) Yes b) No
<b>16. ECD Index</b>		
16.1	How many children's books or picture books do you have for {child name}?	Children's books in the household
16.2	Does he/she play with: homemade toys (such as dolls, cars, or other toys made at home)?	a) Yes b) No
16.3	Does he/she play with: toys from a shop or manufactured toys?	a) Yes b) No
16.4	Does he/she play with: household objects (such as bowls or pots) or objects found outside (such as sticks, rocks, animal shells or leaves)?	a) Yes b) No
16.5	Read books to or looked at picture books with {child name}?	Select Multiple
16.6	Told stories to {child name}?	Select Multiple
16.7	Sang songs to {child name} or with \${child name}, including lullabies?	Select Multiple
16.8	Took \${child name} outside the home, compound, yard or enclosure?	Select Multiple
16.9	Played with {child name}?	Select Multiple
16.10	Named, counted, or drew things to or with {child name}?	Select Multiple
<b>17. Access to ECD and Child Care Services</b>		
17.1	On how many days in the past week was {child name} left alone for more than an hour?	Number of days in the past week the child was left alone for more than an hour
17.2	On how many days in the past week was {child name} left in the care of another child, that is, someone less than 10 years old, for more than an hour?	

		Number of days in the past week the child was left in the care of another child, that is, someone less than 10 years old, for more than an hour
17.3	Does {child name} attend any organized learning or early childhood education programme, such as a private or government facility, including kindergarten or community childcare?	a) Yes b) No
17.4	In the past 7 days, about how many hours did {child name} go to that place:	If the child attend ECD/ or any organized learning, days in the past 7 days, the child went to that place
17.5	Who runs this program?	Select one AECD
17.6	Do you pay any fees or purchase any materials so that your child may attend?	Select multiple AECD
17.7	How much money do you pay each month for your child to attend?	Amount of money paid each month for the child to attend ECD
17.8	Have you heard of the cooking demonstration programs put on by community health workers?	a) Yes b) No
17.9	Have you ever attended the cooking demonstrations?	a) Yes b) No
17.10	How many times in the past month have you attended?	Number of times in the caregiver attended the cooking demonstration in the past month
17.11	Are there any other programs you have attended focused on parenting or raising young children?	a) Yes b) No
<b>18. ITETERO</b>		
18.1	Have you ever listened to the radio program, ITETERO?	a) Yes b) No
18.2	How often do you or your child listen to ITETERO?	Select one ITETERO frequency
18.3	When do you or your child listen to ITETERO?	Select multiple ITETERO time
18.4	Would you recommend ITETERO to other parents or children?	a) Yes b) No
<b>19. Donor Mapping of Households</b>		
19.1	There are other donors working in this district; could you tell us if you know of any other programmes or donors in your vicinity?	a) Yes b) No If yes, then ask for names: _____
19.2	Has your household been part of any other nutrition related activity other than UNICEF?	a) Yes b) No If yes, then ask for names: _____

## Appendix 11: Household Survey Details (sample, coverage, HH selection)

For the quantitative section, the Evaluators have used before-after analysis. The HHS was undertaken for a pre-determined sample of 1353 HHs in 7 treatment districts. This approach is adopted from the Programme baseline and helped understand the change in indicators mentioned below:

- **Impact 1:** Prevalence of stunting among children under five years reduced.
- **Outcome 1:** Children under 5 utilize effective nutrition / health interventions.
- **Outcome 2:** Young children and families utilise quality ECD services, and parents/primary caregivers apply improved childcare and stimulation practices.
- **Outcome 3:** Families with young children in the targeted districts use improved water, sanitation and hygiene services.
- **Outcome 4:** Poorest households with children under 5 in 10 districts/sectors have benefitted from child-sensitive public works.

For the baseline, a comprehensive assessment tool was designed to measure several internationally recognised areas covering household characteristics, child development, nutrition, health, caregiving practices, and access to services. As the endline was implemented in a COVID environment, the Evaluators have refined the baseline tool to focus on those indicators that directly feed into the Programme's log-frame (refer to Appendix 10 for HH endline tool). Therefore, the Household Survey tool included the following:

**Table: Domains in Household Questionnaire**

Sr. #	Domain	Specific components
1	Child and Caregiver Information	Sex only, Sex, Relationship to the child, Age, Literacy, Marital status, illness
2	Family Composition	Relationship to the child, total household members, U5 children
3	Information on Head of Household	Head of Household, relationship to the child, sex of the head
4	Child's Health Milestone Assessment	Child's assessment regarding early childhood development milestones, i.e., sitting, walking, seeing, hearing (questions on cognitive and motor skills)
5	Household & Other Assets	Ubudehe (Rwandan socio-economic stratification system) status, number of rooms, owner of the bed, net, farm animals, land etc.
6	Disposable Income, Savings & Wealth Information	Electricity, radio, mobile phone etc., expenditure on food items, education, savings etc.
7	WASH	Drinking source, hygiene practice, shared latrine etc
8	Child Health	Information on vitals at childbirth, progress in first two months
9	Health Seeking Behavior for Children	Information on intestinal worms, ORS, coughing, health facility access, mosquito net
10	Social Protection	Participation in VUP, elements of VUP the household received
11	Infant and young child feeding practices	Information on breastfeeding, etc
12	Infant and young child's current diet – Liquid food	Infant formula, water, juice, soup etc
13	Infant and young child's current diet – Solid food	Fruits, vegetables, meat, grains, milk, yoghurt etc.
14	Meal Frequency for Child	Consumption of semi-solid or solid food
15	Household food security	Frequency of meals for adults and children
16	ECD Index	Availability of children's books, toys, participation in songs, stories, drawing and spent time outdoors
17	Access to ECD and Child Care Services	Child's time alone in the past week, child's enrolment in ECD centre, fees for the centres, cooking demonstration programmes, etc.
18	ITETERO	Awareness about ITETERO, feedback
19	Donor Mapping of Household	Determination if and to what extent the household was beneficiary of other Nutrition programmes

### Target Group (Population)

The study population of the survey are the households that were selected for the Programme baseline in seven districts (out of 14 intervention districts) where the baseline assessment. Districts include

Burera, Gatsibo, Gicumbi, Karongi, Ngororero, Nyaruguru and Rutsiro. The baseline study targeted these areas for the high level of poverty and presence of social protection programmes, including expanded and classic public works. In each district, one sector was selected as the study site.<sup>167</sup>

### **Survey Respondents**

In line with the baseline study, the target respondents for the survey were caregivers of children ages 6–23 months and their children. For the endline Evaluation, the Evaluators also enrolled siblings of the original respondents aged 6–23 months at the time of data collection. This design optimised opportunities to follow intervention impact in children enrolled at baseline as well as assess whether children ages 6–23 months in the same households are doing better overall compared with before intervention implementation.

### **Sample Size**

Household having 6-23 months old child selection was made using two stage sampling method. At stage one 53 Primary Sampling Units (Villages/Localities were selected at random from seven districts. At stage 2, all households in PSU were listed as household having 6-23 months old child (target household) and non-target household.

Total of 1,352 eligible households were identified in sampling frame during household listing, therefore meeting was held with client & stakeholder to give updated status of household listing and decision on sample size adjustment because population of targeted households are only 1352 and 411 were interviewed during baseline survey. It was decided all identified targeted households will be selected as sample for the survey. The Cochran's sample size formula generates 1362 sample with the assumption that about 9.4 per cent of all the households had children between 6–23 months, as well as two-sided alpha significance level of 0.05, plus a margin of error of  $\pm 1.55$  per cent. Finite Population Correction (FPC ) factor minimize the sample upto 678 for finite population 1352 households. The number of households surveyed from seven districts decreases the standard error of estimate 4% to just 1.55%.

For your information Excel sheet is attached

<b>Sample Size Estimator - SRS</b>	
Confidence Coefficient	95%
Margin of Error	0.0155
Event Prevalence Rate(Estimated)	0.094
Normal Dist	1.96
Population Size	1,352
<b>Estimated Sample</b>	
	1362
Sample with finite population factor	678

### **Sampling Strategy**

For the endline Evaluation, the Evaluators applied the same distribution of sample across seven districts as it was implemented in the baseline study. The sample allocation per district is indicated below:

**Table : Sample Distribution (per district)**

<b>Districts</b>	<b>Sample Size</b>
Nyaruguru	187
Karongi	188
Rutsiro	214
Ngororero	151

<sup>167</sup> Baseline Report.

Burera	216
Gicumbi	225
Gatsibo	171
<b>Total</b>	<b>1352</b>

District	Sector	Cell	Village
Burera	Rugengabari	Nyanamo	Kamonyi, Kabuyenge, Kiziba, Murambo, Bwenjeli, Kabira, Kabukoko
Gatsibo	Remera	Nyagakombe	Akababito, Karufuri, Nyaruuhoko
		Butiruka	Icyerekezo, Gasabo, Akabuga, Urushenyi
Gicumbi	Manyagiro	Ryaruyumba	Taba, Gatsyata, Nyantarure, Muturirwa, Rugasa, Rusabira, Gatungo, Nyarukombe
		Kabuga	Kigarama
Karongi	Rwankuba	Rubazo	Ruhinga, Nyaruyaga, Bucyurabuhoro
		Nyakamira	Nyarushekera, Mahembe, Musango
		Nyarusanga	Karambo, Kigogwe
Ngororero	Ndaro	Bijyojo	Kibuga, Rutonde, Gasave, Kavumu, Birima, Bijyojo, Runyon, Cyajongo
		Bitabage	Gituza
Nyaruguru	Nyagisozi	Mwoya	Nyagashubi, Mwoya, Muhombo, Agatovu, Nkomero, Bwerankori
Rutsiro	Mukura	Mwendo	Nyarubande, Kabisasa, Gafu, Gako, Kabeza, Kagogo, Nyove
7	7	12	53

### Household & Respondent Selection Method

A total of 1,637 households participated in the Programme Baseline conducted, and this Endline study collected data from the same households. The survey respondent is caregivers of children ages 6–23 months and their children. UNICEF has provided lists of homes that participated in the baseline, which were used to identify the households that still have eligible children (6-23 months old). Considering that the children that were 6-23 months old at baseline are no longer eligible to participate in the final Evaluation, it is also possible that some of the caregivers may have given birth to children falling in the age bracket and therefore qualify to be part of the final Evaluation.

### Anthropometric measurements

The anthropometric measurement associated with stunting (height for age), wasting (weight for height) and underweighting (weight for age) were done using scales and height boards supplied by UNICEF to health facilities. The local partner, Research Hub, has a training manual for Anthropometric measurement (*attached on the next page*) which were adapted for children between 0 – 23 months (the age group that was targeted in DHCR baseline). Under this, each household and child were assessed on: Weight of Caregiver and child, Child's length (for children under two years) in cm and Child's height (for children aged two or more years). In lieu of COVID, only enumerators who are vaccinated were hired to carry out this exercise, and the team were tested for Covid-19 before the training. During the fieldwork, it was ensured that the equipment was sanitised after each use.

### Anthropometric Measurement Training Manual

#### Setting up the equipment

- Ensure that all equipment is clean, working, and correctly adjusted so that it measures accurately.
- Standing scales and measuring boards should be placed on a hard, flat, and level surface during measurement.
- Hanging scales should be securely hung with adequate room for taking measurements.
- Measurements may be taken outdoors, weather permitting. If measuring outdoors is uncomfortable due to heat, rain, or interference from other people, move indoors or to a secluded place to conduct measurements
- Using a respectful, kind, and gentle tone, explain the reason for taking the measurement and the procedures involved and ask if the parent/caregiver has any questions

**Consent Before beginning any measurement,**

- Consent/assent must have been obtained from the caregiver/parent. If caregiver/parent refuses to participate, respect this decision and do not take any measurement.
- Always thank the parent/caregiver.
- Stop/do not measure if:
  - The parent/caregiver being measured refuses.
  - The person being measured is distressed or too sick

### Measurer Preparation

- The measurer should have clean hands before holding or positioning the child being measured.
- The measurer should remove any objects from her/his hands and wrists, such as big watches or bracelets, so as not to interfere with the measurement

### Individuals with Special Needs

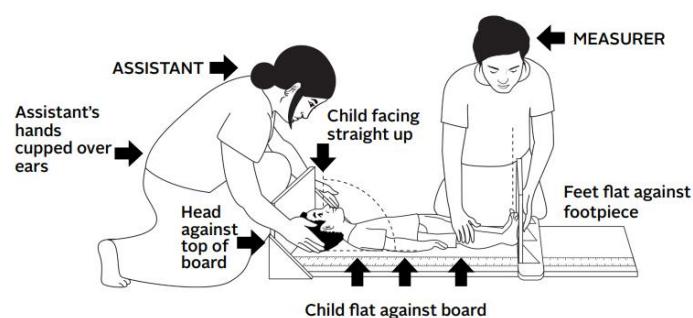
- In the event of the child having conditions that affect their ability to stand; straighten their arms, legs or back; or hold themselves steady, adapt measurement protocols or provide additional assistance to the individual being measured.
- Interpretation of measurements may also be more challenging.
- When conducting anthropometry for a survey, measurers should measure the individual and note his/her impairment or condition on the survey form.

### Things to keep in mind

- Follow the protocols: Following each step of every procedure every time measurements are taken improves quality.
- Though some procedures may seem simple and repetitive, never take them for granted or omit any step.
- Keep hands free of sharp objects: For safety, hold pencils or pens only while recording measurements, not while positioning or holding the person being measured.
- Measure one person at a time: If you are measuring more than one person, it is important to complete and record all measurements for one person before beginning to measure another person. This will help prevent errors in recording measurements and respects the time of the person being measured.
- Always supervise the person being measured; do not leave him/her unattended to on or near anthropometric equipment. This prevents the person from being injured (e.g., tripping on, falling off or cutting him/herself with equipment).
- Carefully record measurements
- Measurements should be recorded in the appropriate spaces as marked on the health card, questionnaire, or other relevant document.
- When recording an individual's age, it is best to record the exact age, if possible. However, while it is important to know and record the date of birth, the date of measurement, and the exact age of an individual (especially for children),
- Record measurements clearly and accurately to the precision required for each measure. Record weight to the nearest two decimal points.
- If using a pen, cross out the error completely and write the correct measurement.
- Repeated measurements if needed.
- Involve the parent/caregiver: Being weighed and/or measured can be an uncomfortable or frightening experience for a child. The parent/caregiver can assist in positioning, carrying, and/or calming the child being measured, helping the child to feel secure and remain still. This will help achieve an accurate measurement and reduce the child's stress

### Measuring height of children below 59 months

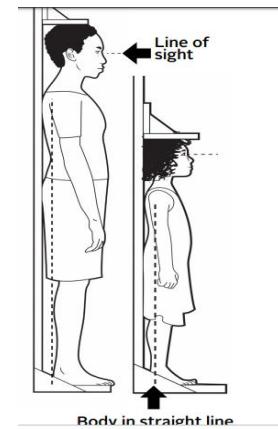
- Show the measuring board to the parent/caregiver and explain that the board will be used to measure the child's length/height.
- Inform the parent/caregiver that her / his help may be needed.
- Ask the parent/caregiver to remove the child's shoes and anything on her/his head or hair, such as a hat or hair ornament, that may interfere with the length/height measurement.



- Make sure the surface of the measuring board is clean before placing the child on it.
- Measure children while they are lying down. This measurement is known as “length” or “recumbent length.”
- Place the measuring board on a hard, flat surface.
- Place the footboard firmly against the heels of both of the child’s feet.
- Ensure that the child’s legs are straight at the knees and that the knees are positioned correctly.
- Check the child’s position to ensure that she/he is lying straight just before taking length measurement.
- Read, record, and plot measurements carefully

### **Measuring Height in Children 59months old**

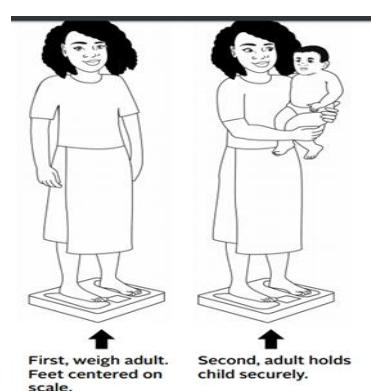
- Place the measuring board on a hard, flat (level) surface vertically against a wall, table, tree, etc. Make sure the board is stable.
- Ask the parent/caregiver to place the child on the board and kneel in front of the child. The measurer should kneel on the left side of the child, with the trained assistant kneeling on the child’s right (or the parent/caregiver moving to that position)
- Determine whether the child’s heel should be against or away from the back of the measuring board by drawing an imaginary line from the tip of the shoulder to the heel (called the “mid-axillary line”). This line should be perpendicular ( $90^{\circ}$ ) to the base of the measuring board where the person is standing.
- Lift the child’s chin so his/her eyes look straight ahead. Make sure the person’s line of sight (i.e., the Frankfort plane) is parallel to the ground and perpendicular (i.e.,  $90^{\circ}$ ) to the back of the measuring board. For a child, squat in front of him/her at eye level and gently hold the child’s head in position.
- With the help of the parent/caregiver, ensure that:
- The person’s arms hang down at his/her sides and the shoulders are level.
- The person’s weight is distributed evenly on both feet.
- The person’s buttocks touch the back of the board. In addition: For most preschool-age children who are underweight or normal weight, the back of the head, shoulder blades, calves, and heels will touch the back of the measuring board.
- For heavy or obese children, the shoulder blades and back of the calves will probably not touch the back of the measuring board, and the back of the head and heels also might not touch it.
- Check the person’s position and readjust as necessary. For children who have difficulty standing fully straight, gently pushing the stomach can help them stand straight.
- Ask the caregiver to gently and firmly slide the measuring board’s movable headpiece down until it touches the crown of the person’s head (compresses the hair).
- Read aloud the height indicated by the headpiece to the nearest 0.1 cm.
- Record and/or plot the height clearly and accurately on the health card, questionnaire, or other relevant document.
- Remove the headpiece from the person’s head, and gently help him/her to get off the board. Return a child to the parent/caregiver.
- Check the recorded or plotted height for accuracy and legibility.



### **Standing Scale with Taring Feature**

#### **Procedure:**

- Zero the scale. The method used to zero the scale depends on the type of scale being used.
- Some scales can be zeroed by covering the solar panel for 1 second. When the readout says 0.0 and an image of a mother and baby is displayed, the scale is ready to be used. Other scales require that someone step on the scale.
- Ask the parent/caregiver to step onto the center of the scale and stand still. Wait until the weight of the parent/caregiver displays and remains fixed in the display panel. If no parent/caregiver is available,
- Tare the scale while the parent/caregiver is on it.



- Place the child in the parent/caregiver's arms and ask the parent/ caregiver to remain still. The parent/caregiver should try to calm the child and prevent him/her from moving.
- The child's weight will appear in the display.
- Read the child's weight aloud.
- Check the recorded or plotted weight for accuracy and legibility.

### **Edema measurement**

- This is a condition characterized by the presence of fluids in the body. Malnutrition is one of the many causes of the condition. To ascertain the presence of edema;
- apply moderate thumb pressure on the back of the foot or ankle for about 5 seconds
- repeat with other foot
- Edema is present if the impression of the thumb remains for some time



## **Appendix 12: Evaluation Qualitative Tools – KII Guides**

### **Guide Questions - Key Informant Interviews (KIIs)**

These guides are meant to generate a discussion with key informants and then guide the conversation. The evaluators might not ask all questions and probes to all respondents. The evaluators will determine if they need to adjust the questions or probes based upon what they are learning in the initial interviews and which areas of inquiry need more or less focus. The guide covers the following stakeholders:

1. Interview with UNICEF
2. Interview with GoR (MoH, MINAGRI, NCDA, MIGEPROF)
3. Interview with CSOs/IPs/Private Sector
4. Interview with District Officials

## **Key Informant Interview – UNICEF**

Good Morning/Afternoon/Evening! Hi, my name is \_\_\_\_\_ and I work with AAN Associates, Pakistan. These are my colleagues' \_\_\_\_\_ (moderator to introduce the other member(s) present and their role in the interview). On behalf of UNICEF Rwanda, we are conducting an evaluation of the Developing Human Capital in Rwanda. As part of data collection and taking into account the key role of your office/department/section, we would like to take an interview from you for this evaluation, in which we will ask you various questions on the Programme. We hope that you will allow us to interview you for this evaluation. As UNICEF staff with direct knowledge of the Programme, your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview.

The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help UNICEF to better plan and implement this Programme. This will also enable UNICEF to revisit its current strategies and future plans to support Government of Rwanda for improving and strengthening early childhood development and nutrition services. The interview should take an hour to complete.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time.

This conversation will be recorded, so that we do not miss any of your comments. Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Do you have any questions about the evaluation or the interview at this time?

May I begin the interview now?

### **INTRODUCTORY QUESTIONS**

1. Could you describe your position and role in the organization?
  - a. How long have you been in the current role? What was your previous role (only ask if the person is newly appointed)?
  - b. Were you directly involved in Programme design and/or implementation? What was your role?

### **RELEVANCE**

1. Are you aware of any national/subnational assessment/s carried out to identify local nutrition and ECD needs in 14 target districts, either pre or during Programme implementation? Kindly refer us to specific assessments.
  - a. What issues/needs were identified for children 0-6 years in target districts - please elaborate.
2. Are you aware of DHCR's/EKN programme objectives and interventions? In your view, how did DHCR design and implementation address local nutrition and ECD needs that were identified through national/subnational assessments, please elaborate?
  - a. Any specific local nutrition and ECD needs that the Programme design (including objectives or interventions) did not respond to? Please elaborate.
3. In your view, what has changed in the operating context within target districts since 2016– in terms of social, economic, political, etc., and how did these affect the Programme implementation?
  - a. In your view how did Programme respond to these changes?
  - b. Please share any specific examples where Programme interventions and implementation modalities may have changed?
  - c. Please do share your thoughts if those changes helped address the changes in the context (ask for level of satisfaction – as timely and appropriate)?
  - d. Please share evidence of changes made.
4. Were you or your organisation involved in the Programme design (interventions, targets, logical framework)? What process was undertaken to ensure participation of all relevant stakeholders?
  - a. If yes, are you satisfied with your or organisation's level of participation in the design phase? Could participation have improved?

## **COHERENCE**

5. Are you aware of DHCR/EKN Programme's objectives and components? Please share your thoughts how these objectives and components are aligned with GoR's ECD and nutrition priorities for children aged 0-6 years.
  - a. Please share specific plans/policies that the Programme responds to.
  - b. Do you see if DHCR/EKN objectives and results contradict the objectives and interventions of GoR (if at all), please elaborate and make clear reference?
6. Please share with us the background about the process undertaken to identify public/private partners for Programme implementation?
  - a. Did the Programme undertake any mapping exercise to identify synergies with other similar programmes/partners to avoid duplication?
  - b. Were there any missed opportunities for potential partnerships that could have avoided duplications?

## **EFFICIENCY**

7. In your view, did the Programme have sufficient resources (human, financial, and technical) to achieve the intended results?
  - a. What was the criteria/approach to distribute resources across different components/outputs?
  - b. If not sufficient, did the Programme ask for additional resources?
  - c. And did the programme receive them? If not, why?
8. In your view, did the DHCR/EKN Programme face any delays in funds allocation or utilisation that had an impact on implementation? If yes, then can you elaborate on the specific delays - probe specifically on any potential utilisation delays caused by COVID-19 related restrictions?
  - a. How did the programme address these delays and their impact on the implementation?
  - b. How would you propose that the reasons for the delays could be addressed for future programmes?
9. Please share with us how the management mechanism (national and subnational) for the DHCR Programme worked?
  - a. Are you satisfied with the level of engagement of all relevant stakeholders?
  - b. Has the Programme's management mechanism been able to:
    - i. Trace and report on Programme's progress and delays to the relevant stakeholders?
    - ii. Provide/inform Programme to make informed decisions for instance programmatic or financial adjustments?
  - c. In your opinion, what can be improved in the management system for future programme?
10. Did the Programme undertake any cost-saving measures?
  - a. Were there any alternative approaches that were not implemented but that could have saved cost?

## **EFFECTIVENESS**

11. In your opinion, what are the most significant achievements of the Programme in reducing stunting and promoting holistic early childhood development for children aged 0-6 years?
  - a. Are there any outputs and outcomes that Programme could not achieve (partly or fully), what are the reasons for low achievements?
  - b. What are the most significant un-intended results (positive and negative) that Programme was able to achieve or contribute to?
  - c. Who benefitted (or otherwise) from these unintended results?
12. In your views, what are some of the key enabling factors which helped the programme in implementation, management and delivering results?
  - a. In your view, what are some of the factors which hindered the programme progress and achievements of results?

- b. Did the Programme take any mitigation measures to address these factors? Please elaborate.
13. Can you explain the process that was undertaken to set yearly targets?
- a. Who participated in this process? Are you satisfied with your or your organisation's level of participation in this process?
  - b. If and how were contextual changes incorporated in the target setting process?
  - c. Any gaps/lessons learned for future?
14. What are Programme's contributions in strengthening government stakeholders' capacities?
- a. How have these strengthened capacities contributed to effectively deliver nutrition and ECD services?
  - b. Any gaps in capacity building initiatives that could have potentially contributed to improved achievement of results?
15. In your opinion, were Programme strategies (such as planning, data extraction, accountability) implemented in coherently?
- a. Were there any gaps that could be improved for future?
16. Are there any Programme interventions that were supported by other divisions/units/sections in your organization?
- a. Please give us specific instances/interventions where other divisions/units/sections may have supported the implementation?
  - b. How did it benefit the Programme (cost and time reduction, quality etc.)?
  - c. Can you share any evidence to support your claim? Are you satisfied with support you received internally?
17. What were the coordination mechanisms (national and district) that were put in place for Programme implementation?
- a. In your opinion, were these mechanisms adequate for the implementation of DHCR programme?
  - b. Were there any guidelines/SOPs to establish accountability of relevant stakeholders? How participation of these stakeholders ensured?
  - c. What constraints were faced if any?
  - d. Which aspects of the coordination mechanisms do you view as replicable?
18. What is the DHCR's/EKN monitoring mechanism?
- a. Who is involved in conducting monitoring visits?
  - b. What is the frequency of monitoring visits? Is it the same for each district?
  - c. Are there any monitoring tools available that are used during each visit? How were the monitoring tools developed?
  - d. Is this monitoring data used for any decision making? How?
  - e. Any suggestions/ideas around improving the monitoring mechanism?

## **IMPACT**

19. In your opinion, has the situation for nutrition and ECD (especially for children under the age of 6 years) in Rwanda changed over the past 5 years?
- a. What has been the Programme's contribution to observed change?
  - b. Are there any specific communities or groups for which the results are quite different? Who are these sub-groups? Why the results are different for these sub-groups?
20. Can you think of any results (both positive and negative) that the Programme did not intend to achieve?
- a. In your view, did Programme take action to mitigate the negative effects? Please elaborate? Please list those measures and how did they address the negative effects/impact?

## **SUSTAINABILITY**

21. In your opinion, which of the Programme interventions and results are likely or unlikely will continue beyond Programme life/2021?
- In your views, what key factors are making the Programme results sustainable/unsustainable?
  - Which associated assumptions are likely to support or hinder the continuation of Programme interventions and results?
  - What strategies/approaches do you think may have contributed to strengthen the government's capacity to sustain Programme's interventions and results?
  - What are the plans for the future of the DHCR/EKN Programme? Did the Programme's achievement help in securing more funding? Please elaborate.
22. In your view, what was the Programme's contribution to strengthening public capacities to sustain the Programme interventions and results? [Probe for each: planning, adopting, allocating more resources, management, monitoring].
- Any gaps/missed opportunities that could have contributed to ensuring sustainability of Programme interventions and results?
23. As a stakeholder, what measures have you taken (or are planning to take) to enable continuity of Programme interventions after it ends (e.g., new positions been created, funds been allocated by govt etc.)?
- In your opinion, has there been any change in sense of ownership for nutrition and ECD initiatives within relevant public stakeholders from the DHCR/EKN programme?
  - Has the Programme developed an exit strategy or sustainability plan? How has that been implemented and how has that contributed to sustaining the interventions? Please elaborate.

#### **HRBA, GENDER EQUALITY, EQUITY**

24. Has the Programme been assessed with HRBA lens, such as enabling access to child rights, balanced investments on services delivery improvement, focus on communities to raise awareness of entitlements and obligations and others?
- How did Programme ensure compliance with HRBAP principles of: Participation, Accountability, Non-discrimination, Equality, Empowerment, and Legality? Can you share some evidence?
25. Was there any gender assessment (pre and during implementation) to understand the context and address gender specific needs (of boys, girls, mothers, fathers)? What were key bottlenecks or barriers (both supply and demand) that were identified for nutrition and ECD using gender lens?
- How did the Programme incorporate gender needs at the design phase? Were there any specific interventions that catered to gender specific inequities around nutrition and ECD within target districts? Please elaborate.
  - Can you share any specific results where the Programme has been able to address gender specific inequalities in target districts?
  - Any suggestions on how gender integration (at design and integration) could be improved for future programmes.
26. Did the Programme conduct an equity assessment to identify marginalized/vulnerable group and understand their nutrition and ECD needs?
- How was the Programme design and implementation informed to cater to the needs of the marginalized/vulnerable group?
  - In your opinion, has the Programme contributed to the address nutrition and ECD needs in vulnerable/marginalized communities? Any evidence to back this?
  - Which Programme strategies/interventions may have contributed to this change?
  - In your view, what are the main ongoing challenges faced by marginalized vulnerable groups in improving their nutrition and ECD needs?
  - In your view, what should change in the future to determine and respond to these current needs of marginalized/vulnerable group?

## **Key Informant Interview – Government Ministries**

Good Morning/Afternoon/Evening! Hi, my name is \_\_\_\_\_ and I work with AAN Associates, Pakistan. These are my colleagues' \_\_\_\_\_ (moderator to introduce the other member(s) present and their role in the interview). On behalf of UNICEF Rwanda, we are conducting an evaluation of the Developing Human Capital in Rwanda. As part of data collection and taking into account the key role of your office/department/section, we would like to take an interview from you for this evaluation, in which we will ask you various questions on the Programme. We hope that you will allow us to interview you for this evaluation. As MoH/NCDA/ MINEDUC/MINAGRI/MIGEPROF staff and with direct knowledge of the Programme, your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview.

The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help UNICEF and GoR to better plan and implement this Programme. This will also enable UNICEF to revisit its current strategies and future plans to support Government of Rwanda for improving and strengthening early childhood development and nutrition services. The interview should take an hour to complete.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time.

This conversation will be recorded, so that we do not miss any of your comments. Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Do you have any questions about the evaluation or the interview at this time?

May I begin the interview now?

### **INTRODUCTORY QUESTIONS**

1. Could you describe your position and role in the organization?
  - a. How long have you been in the current role? What was your previous role (only ask if the person is newly appointed)?
  - b. Were you directly involved in Programme design and/or implementation? What was your role?

### **RELEVANCE**

1. Are you aware of any national/subnational assessment/s carried out to identify local nutrition and ECD needs in 14 target districts, either pre or during Programme implementation? Kindly refer us to specific assessments.
  - a. What issues/needs were identified for children 0-6 years in target districts - please elaborate.
2. Are you aware of DHCR's/UNICEF ECD/Nutrition programme objectives and interventions? In your view, how did DHCR design and implementation address local nutrition and ECD needs that were identified through national/subnational assessments, please elaborate?
  - a. Any specific local nutrition and ECD needs that the Programme design (including objectives or interventions) did not respond to? Please elaborate.
3. In your view, what has changed in the operating context within target districts since 2016– in terms of social, economic, political, etc., and how did these affect the Programme implementation?
  - a. In your view how did Programme respond to these changes?
  - b. Please share any specific examples where Programme interventions and implementation modalities may have changed?
  - c. Please do share your thoughts if those changes helped address the changes in the context (ask for level of satisfaction – as timely and appropriate)?
  - d. Please share evidence of changes made.

4. Were you or your organisation involved in the Programme design (interventions, targets, logical framework)? What process was undertaken to ensure participation of all relevant stakeholders?
  - a. If yes, are you satisfied with your or organisation's level of participation in the design phase? Could participation have improved?

## COHERENCE

5. Are you aware of DHCR/UNICEF nutrition/ECD Programme's objectives and components? Please share your thoughts how these objectives and components are aligned with GoR's ECD and nutrition priorities for children aged 0-6 years.
  - a. Please share specific plans/policies that the Programme responds to.
  - b. Do you see if DHCR objectives and results contradict the objectives and interventions of GoR (if at all), please elaborate and make clear reference?

## EFFICIENCY

6. In your view, did the Programme have sufficient resources (human, financial, and technical) to achieve the intended results?
  - a. In your view, did the DHCR Programme face any delays in funds allocation or utilisation that had an impact on implementation? If yes, then can you elaborate on the specific delays - probe specifically on any potential utilisation delays caused by COVID-19 related restrictions?
  - b. How did the programme address these delays and their impact on the implementation?
  - c. How would you propose that the reasons for the delays could be addressed for future programmes?
7. Please share with us how the management mechanism (national and subnational) for the DHCR Programme worked?
  - a. Are you satisfied with the level of engagement of all relevant stakeholders?
  - b. Has the Programme's management mechanism been able to:
    - i. Trace and report on Programme's progress and delays to the relevant stakeholders?
    - ii. Provide/inform Programme to make informed decisions for instance programmatic or financial adjustments?
  - c. In your opinion, what can be improved in the management system for future programme?
8. Did the Programme undertake any cost-saving measures?
  - a. Were there any alternative approaches that were not implemented but that could have saved cost?

## EFFECTIVENESS

9. In your opinion, what are the most significant achievements of the Programme in reducing stunting and promoting holistic early childhood development for children aged 0-6 years?
  - a. Are there any outputs and outcomes that Programme could not achieve (partly or fully), what are the reasons for low achievements?
  - b. What are the most significant un-intended results (positive and negative) that Programme was able to achieve or contribute to?
  - c. Who benefitted (or otherwise) from these unintended results?
10. In your views, what are some of the key enabling factors which helped the programme in implementation, management and delivering results?
  - a. In your view, what are some of the factors which hindered the programme progress and achievements of results?

- b. Did the Programme take any mitigation measures to address these factors? Please elaborate.
11. Can you explain the process that was undertaken to set yearly targets?
- Who participated in this process? Are you satisfied with your or your organisation's level of participation in this process?
  - If and how were contextual changes incorporated in the target setting process?
  - Any gaps/lessons learned for future?
12. What are Programme's contributions in strengthening government stakeholders' capacities?
- How have these strengthened capacities contributed to effectively deliver nutrition and ECD services?
  - Any gaps in capacity building initiatives that could have potentially contributed to improved achievement of results?
13. In your opinion, were Programme strategies (such as planning, data extraction, accountability) implemented in coherently?
- Were there any gaps that could be improved for future?
14. What were the coordination mechanisms (national and district) that were put in place for Programme implementation?
- In your opinion, were these mechanisms adequate for the implementation of DHCR programme?
  - Were there any guidelines/SOPs to establish accountability of relevant stakeholders? How participation of these stakeholders ensured?
  - What constraints were faced if any?
  - Which aspects of the coordination mechanisms do you view as replicable?

## **IMPACT**

15. In your opinion, has the situation for nutrition and ECD (especially for children under the age of 6 years) in Rwanda changed over the past 5 years?
- What has been the Programme's contribution to observed change?
  - Are there any specific communities or groups for which the results are quite different? Who are these sub-groups? Why the results are different for these sub-groups?
16. Can you think of any results (both positive and negative) that the Programme did not intend to achieve?
- In your view, did Programme take action to mitigate the negative effects? Please elaborate? Please list those measures and how did they address the negative effects/impact?

## **SUSTAINABILITY**

17. In your opinion, which of the Programme interventions and results are likely or unlikely will continue beyond Programme life/2021?
- In your views, what key factors are making the Programme results sustainable/unsustainable?
  - Which associated assumptions are likely to support or hinder the continuation of Programme interventions and results?
  - What strategies/approaches do you think may have contributed to strengthen the government's capacity to sustain Programme's interventions and results?

- d. What are the plans for the future of the DHCR Programme? Did the Programme's achievement help in securing more funding? Please elaborate.
18. In your view, what was the Programme's contribution to strengthening public capacities to sustain the Programme interventions and results? [Probe for each: planning, adopting, allocating more resources, management, monitoring].
- a. Any gaps/missed opportunities that could have contributed to ensuring sustainability of Programme interventions and results?
19. As a stakeholder, what measures have you taken (or are planning to take) to enable continuity of Programme interventions after it ends (e.g., new positions been created, funds been allocated by govt etc.)?
- a. In your opinion, has there been any change in sense of ownership for nutrition and ECD initiatives within relevant public stakeholders from the DHCR programme?
  - b. Has the Programme developed an exit strategy or sustainability plan? How has that been implemented and how has that contributed to sustaining the interventions? Please elaborate.

#### **HRBA, GENDER EQUALITY, EQUITY**

20. Has the Programme been assessed with HRBA lens, such as enabling access to child rights, balanced investments on services delivery improvement, focus on communities to raise awareness of entitlements and obligations and others?
- a. How did Programme ensure compliance with HRBAP principles of: Participation, Accountability, Non-discrimination, Equality, Empowerment, and Legality? Can you share some evidence?
21. Was there any gender assessment (pre and during implementation) to understand the context and address gender specific needs (of boys, girls, mothers, fathers)? What were key bottlenecks or barriers (both supply and demand) that were identified for nutrition and ECD using gender lens?
- a. How did the Programme incorporate gender needs at the design phase? Were there any specific interventions that catered to gender specific inequities around nutrition and ECD within target districts? Please elaborate.
  - b. Can you share any specific results where the Programme has been able to address gender specific inequalities in target districts?
  - c. Any suggestions on how gender integration (at design and integration) could be improved for future programmes.
22. Did the Programme conduct an equity assessment to identify marginalized/vulnerable group and understand their nutrition and ECD needs?
- a. How was the Programme design and implementation informed to cater to the needs of the marginalized/vulnerable group?
  - b. In your opinion, has the Programme contributed to the address nutrition and ECD needs in vulnerable/marginalized communities? Any evidence to back this?
  - c. Which Programme strategies/interventions may have contributed to this change?
  - d. In your view, what are the main ongoing challenges faced by marginalized vulnerable groups in improving their nutrition and ECD needs?
  - e. In your view, what should change in the future to determine and respond to these current needs of marginalized/vulnerable group?

## **Key Informant Interview – CSOs/IPs/Private Sector**

Good Morning/Afternoon/Evening! Hi, my name is \_\_\_\_\_ and I work with AAN Associates, Pakistan. These are my colleagues' \_\_\_\_\_ (moderator to introduce the other member(s) present and their role in the interview). On behalf of UNICEF Rwanda, we are conducting an evaluation of the Developing Human Capital in Rwanda. As part of data collection and taking into account the key role of your office/department/section, we would like to take an interview from you for this evaluation, in which we will ask you various questions on the Programme. We hope that you will allow us to interview you for this evaluation. As implementing partner/CSOs staff, your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview.

The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help UNICEF and GoR to better plan and implement this Programme. This will also enable UNICEF to revisit its current strategies and future plans to support Government of Rwanda for improving and strengthening early childhood development and nutrition services. The interview should take an hour to complete.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time.

This conversation will be recorded, so that we do not miss any of your comments. Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Do you have any questions about the evaluation or the interview at this time?

May I begin the interview now?

### **INTRODUCTORY QUESTIONS**

1. Could you describe your position and role in the organization?
  - a. How long have you been in the current role? What was your previous role (only ask if the person is newly appointed)?
  - b. Were you directly involved in Programme design and/or implementation? What was your role?

### **RELEVANCE**

1. Are you aware objectives and interventions of UNICEF's programme on ECD/Nutrition?
  - a. Any specific local nutrition and ECD needs that the Programme design (including objectives or interventions) did not respond to? Please elaborate.
2. In your view, what has changed in the operating context within target districts since 2016– in terms of social, economic, political, etc. and how did these affect the Programme implementation?
  - a. Did your organization make any implementation changes to respond to these changes?
  - b. Please share any specific examples where Programme interventions and implementation modalities may have changed?
  - c. Please do share your thoughts if those changes helped address the changes in the context (ask for level of satisfaction – as timely and appropriate)?

### **COHERENCE**

3. Are you aware of DHCR Programme's objectives and components? Please share your thoughts how these objectives and components are aligned with GoR's ECD and nutrition priorities for children aged 0-6 years.
  - a. Please share specific plans/policies that the Programme responds to.
  - b. Do you see if DHCR objectives and results contradict the objectives and interventions of GoR (if at all), please elaborate and make clear reference?

### **EFFICIENCY**

4. In your view, did your organization receive sufficient resources (human, financial, and technical) to achieve the intended results?

- a. Did your organization face any delays in funds allocation or utilisation that had an impact on implementation? If yes, then can you elaborate on the specific delays - probe specifically on any potential utilisation delays caused by COVID-19 related restrictions?
  - b. How did your organisation address these delays and their impact on the implementation?
  - c. How would you propose that the reasons for the delays could be addressed for future programmes?
5. Please share with us how the management mechanism (national and subnational) for the DHCR Programme worked?
  - a. Are you satisfied with the level of engagement of all relevant stakeholders?
  - b. In your opinion, what can be improved in the management system for future programme?
6. Did the Programme undertake any cost-saving measures?
  - a. Were there any alternative approaches that were not implemented but that could have saved cost?

## EFFECTIVENESS

7. In your opinion, what are the most significant achievements of the Programme in reducing stunting and promoting holistic early childhood development for children aged 0-6 years?
  - a. What are the most significant un-intended results (positive and negative) that Programme was able to achieve or contribute to?
  - b. Who benefitted (or otherwise) from these unintended results?
8. In your views, what are some of the key enabling factors which helped the programme in implementation, management and delivering results:
  - a. In your view, what are some of the factors which hindered the progress and achievements of results?
  - b. Did your organisation take any mitigation measures to address these factors? Please elaborate.
9. In your opinion, were Programme strategies (such as planning, data extraction, accountability) implemented in coherently?
  - a. Were there any gaps that could be improved for future?
10. What were the coordination mechanisms (national and district) that were put in place for Programme implementation?
  - a. In your opinion, were these mechanisms adequate for the implementation of DHCR programme?
  - b. Were there any guidelines/SOPs to establish accountability of relevant stakeholders? How participation of these stakeholders ensured?
  - c. What constraints were faced if any?
  - d. Which aspects of the coordination mechanisms do you view as replicable?

## IMPACT

11. In your opinion, has the situation for nutrition and ECD (especially for children under the age of 6 years) in Rwanda changed over the past 5 years?
  - a. What has been the Programme's contribution to observed change?
  - b. Are there any specific communities or groups for which the results are quite different? Who are these sub-groups? Why the results are different for these sub-groups?
12. Can you think of any results (both positive and negative) that the Programme did not intend to achieve?
  - a. In your view, did Programme take action to mitigate the negative effects? Please elaborate? Please list those measures and how did they address the negative effects/impact?

## SUSTAINABILITY

13. In your opinion, which of the Programme interventions and results are likely or unlikely will continue beyond Programme life/2021?
- In your views, what key factors are making the Programme results sustainable / unsustainable?
  - Which associated assumptions are likely to support or hinder the continuation of Programme interventions and results?
  - What strategies/approaches do you think may have contributed to strengthen the government's capacity to sustain Programme's interventions and results?
14. In your view, what was the Programme's contribution to strengthening public capacities to sustain the Programme interventions and results? [Probe for each: planning, adopting, allocating more resources, management, monitoring].
- Any gaps/missed opportunities that could have contributed to ensuring sustainability of Programme interventions and results?

#### **HRBA, GENDER EQUALITY, EQUITY**

15. How did Programme ensure compliance with HRBAP principles of: Participation, Accountability, Non-discrimination, Equality, Empowerment, and Legality? Can you share some evidence?
16. Are you aware of any gender assessment (pre and during implementation) that was carried out to understand the context and address gender specific needs (of boys, girls, mothers, fathers)? What were key bottlenecks or barriers (both supply and demand) that were identified for nutrition and ECD using gender lens?
- Were there any specific interventions that catered to gender specific inequities around nutrition and ECD within target districts? Please elaborate.
  - Can you share any specific results where the Programme has been able to address gender specific inequalities in target districts?
  - Any suggestions on how gender integration (at design and integration) could be improved for future programmes.
17. Did the Programme conduct an equity assessment to identify marginalized/vulnerable group and understand their nutrition and ECD needs?
- How was the Programme design and implementation informed to cater to the needs of the marginalized/vulnerable group?
  - In your opinion, has the Programme contributed to the address nutrition and ECD needs in vulnerable/marginalized communities? Any evidence to back this?
  - Which Programme strategies/interventions may have contributed to this change?
  - In your view, what are the main ongoing challenges faced by marginalized vulnerable groups in improving their nutrition and ECD needs?
  - In your view, what should change in the future to determine and respond to these current needs of marginalized/vulnerable group?

## **Key Informant Interview – District Officials**

Good Morning/Afternoon/Evening! Hi, my name is \_\_\_\_\_ and I work with AAN Associates, Pakistan. These are my colleagues' \_\_\_\_\_ (moderator to introduce the other member(s) present and their role in the interview). On behalf of UNICEF Rwanda, we are conducting an evaluation of the Developing Human Capital in Rwanda. As part of data collection and taking into account the key role of your office/department/section, we would like to take an interview from you for this evaluation, in which we will ask you various questions on the Programme. We hope that you will allow us to interview you for this evaluation. As district officials, your inputs are important to us and we would very much appreciate your uninterrupted availability for this interview.

The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help UNICEF and GoR to better plan and implement this Programme. This will also enable UNICEF to revisit its current strategies and future plans to support Government of Rwanda for improving and strengthening early childhood development and nutrition services. The interview should take an hour to complete.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer, let us know and we will go on to the next question. You can also stop the interview at any time.

This conversation will be recorded, so that we do not miss any of your comments. Please be assured that the information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Do you have any questions about the evaluation or the interview at this time?

May I begin the interview now?

### **INTRODUCTORY QUESTIONS**

1. Could you describe your position and role in the organization?
  - a. How long have you been in the current role? What was your previous role (only ask if the person is newly appointed)?
  - b. Were you directly involved in Programme design and/or implementation? What was your role?

### **RELEVANCE**

1. Are you aware of DHCR's/EKN or UNICEF nutrition/ECD programme objectives and interventions?
  - a. Any specific local nutrition and ECD needs that the Programme design (including objectives or interventions) did not respond to? Please elaborate.
2. In your view, what has changed in the operating context in this district since 2016– in terms of social, economic, political, etc., and how did these affect the Programme implementation?
  - a. Were there any implementation changes to respond to these changes?
  - b. Please share any specific examples where Programme interventions and implementation modalities may have changed?
  - c. Please do share your thoughts if those changes helped address the changes in the context (ask for level of satisfaction – as timely and appropriate)?

### **COHERENCE**

3. Are you aware of DHCR Programme's objectives and components? Please share your thoughts how these objectives and components are aligned with GoR's ECD and nutrition priorities for children aged 0-6 years.
  - a. Please share specific plans/policies that the Programme responds to.
  - b. Do you see if DHCR objectives and results contradict the objectives and interventions of GoR (if at all), please elaborate and make clear reference?

### **EFFICIENCY**

4. In your view, did your district have sufficient resources (human, financial, and technical) for implementation of Programme-specific activities?
  - a. Which department gets the funds; how are the costs allocated; any issues/delays around funding mechanism.
  - b. For delays, can you elaborate on the specific delays - probe specifically on any potential utilisation delays caused by COVID-19 related restrictions? How were these delays addressed?
  - c. Suggestions on how cost could have been reduced or could be reduced for future activities.
5. Please share with us how the district-level management mechanism for the DHCR Programme worked?
  - a. Are you satisfied with the level of engagement of all relevant stakeholders within your district?
  - b. In your opinion, what can be improved in the management system for future programme?

## **EFFECTIVENESS**

6. In your opinion, what are the most significant achievements of the Programme in reducing stunting and promoting holistic early childhood development for children aged 0-6 years?
  - a. Are results similar for all communities or are there households that may have not benefitted from the Programme interventions?
  - b. What are the most significant un-intended results (positive and negative) that Programme was able to achieve or contribute to? Who benefitted (or otherwise) from these unintended results?
7. In your opinion, has the DHCR programme been effective in building linkages between communities and health facilities for nutrition and ECD centres?
  - a. If yes, then ask reasons for effectiveness; if no, ask for reasons on how strong linkages can be built between communities and health centres.
  - b. How do you plan and review performance and how you coordinate with relevant national government ministries and UNICEF for day-to-day management, reporting, data transmission etc.?
  - c. What challenges did your district face (if any) in implementation? If you face any issue/s on the ground, how do you get this resolved, please share recent example?
  - d. How could implementation be improved for the future?
8. Has your district used information from DevInfo databases for decision-making regarding the service delivery on nutrition and ECD related initiatives for families with children under 5 years of age?
  - a. If yes, then how does the database help them in planning and implementing nutrition and ECD specific interventions?
  - b. How many personnel in the district are trained on the DevInfo database?
  - c. Any challenges in using the DevInfo database and how to address them for future?
9. Can you tell us if you or someone from your office was part of any ECD service mapping?
  - a. Regarding ECD, could you tell us how many ECD&F centres are operational in your district?
  - b. Have the services in the ECD centres improved in the last 5 years? Have these changes resulted in parents/caregivers enrolling their young children in the centre?
  - c. How can service be further improved?
10. Can you tell us, how many improved water points and latrines were constructed in your district in the last 5 years?
  - a. Did you or anyone one from your office receive training on maintenance of water supply and sanitation systems?

- b. Do you think that the relevant people in your district have the capacity to manage, maintain and operate sanitation systems? (Probe: If no, ask for reasons. What could be done different for better management of sanitation systems)
11. In your opinion, how effective has the government been in scaling up expanded public works for households with children under 5 years of age?
- Have you or anyone from your office (can be Administrative Sector Integrated ECD Committees, Cell and Imidugudu) been trained on delivery of child sensitive social protection?
  - How the delivery of these services can be improved for the future?
12. What were the district-level coordination mechanisms that were put in place for Programme implementation?
- In your opinion, were these mechanisms adequate for the implementation of programme activities?
  - Did you receive any guidelines/SOPs to ensure accountability of relevant stakeholders in your district? How participation of these stakeholders ensured?
  - What constraints were faced if any?

## **IMPACT**

13. In your opinion, has the situation for nutrition and ECD (especially for children under the age of 6 years) in your district changed over the past 5 years?
- What could be the reasons behind this change?
  - Are there any specific communities or groups for which the results are quite different? Who are these sub-groups? Why the results are different for these sub-groups?

## **SUSTAINABILITY**

14. In your opinion, which of the Programme interventions and results are likely or unlikely to continue in your district beyond 2021?
- What actions have your department undertaken to ensure sustainability of the Programme activities?
  - What needs to be done so activities could be sustained in your district?

## **HRBA, GENDER EQUALITY, EQUITY**

15. How did Programme ensure compliance with HRBAP principles of: Participation, Accountability, Non-discrimination, Equality, Empowerment, and Legality? Can you share some evidence?
16. Were bottlenecks or barriers (both supply and demand) for nutrition and ECD similar or different for boys and girls in your district?
- Was there any specific intervention/s implemented to address gender inequities around nutrition and ECD within your district? Please elaborate.
  - Can you share any specific results where the Programme has been able to address gender specific inequalities in target districts?
17. Are there any households/communities more vulnerable who are unable to access nutrition and ECD services in your district?
- Were there any specific interventions implemented to cater to the needs of the marginalized/vulnerable group?
  - In your opinion, has the Programme contributed to the address nutrition and ECD needs in vulnerable/marginalized communities? Any evidence to back this?
  - In your view, what are the main ongoing challenges faced by marginalized vulnerable groups in improving their nutrition and ECD needs?
  - In your view, what should change in the future to determine and respond to these current needs of marginalized/vulnerable group?

## Appendix 13: KIIs Participants

In total **39 KIIs** were planned and conducted involving **35 Male (81%), and 8 Female (19%)** from various institutions. The KIIs were held by the international core Evaluation team, and National Consultant. Few key personnel were interacted multiple times to complete the discussion on all evaluation aspects. The Following table mentions all such details.

KII #	Sr. #	Designation	Organization	Gender	Govt./IP/UNICEF	Level
1	1	Director of Good Governance	MINALOC	F	Govt.	District
2	2	Director of Health	MINISANTE	M	Govt.	District
3	3	Director of Education	MINEDU	M	Govt.	District
4	4	Gender Family and Promotion Officer	MIGEPROF	M	Govt.	District
5	5	Water and sanitation Officer	WASAC	M	Govt.	District
6	6	Hospital Nutritionist	Burera Hospital	M	Hospital	District
7	7	Director of Health	MINISANTE	M	Govt.	District
8	8	Director of Agriculture	MINAGRI	M	Govt.	District
9	9	Director of Education	MINEDU	M	Govt.	District
10	10	Gender Family and Promotion Officer	MIGEPROF	F	Govt.	District
11	11	ECD Officer	NCDA	M	Govt.	District
12	12	Nutrition Department	Munini Hospital	M	Hospital	District
13	13	Water and sanitation support engineer	WASAC	M	Govt.	District
14	14	Director of Good Governance	MINALOC	M	Govt.	District
15	15	Director of Health	MINISANTE	M	Govt.	District
16	16	Director of Agriculture	MINAGRI	M	Govt.	District
17	17	Director of Education	MINEDU	M	Govt.	District
18	18	Director of Good Governance	MINALOC	M	Govt.	District
19	19	Gender Family and Promotion Officer	MIGEPROF	M	Govt.	District
20	20		WASAC	M	Govt.	District
21	21	ECD Focal point	NCDA	M	Govt.	District
22	22	Hygiene and Sanitation Officer	WASAC	M	Govt.	District
23	23	MCCH_Nutritionist	MoH/RBC	M	Govt.	National
23	24	MCCH_Teschnical Assistant_Nutritionist	MoH/RBC	M		
24	25	MIYCN Specialist	NCDA	M	Govt.	National
25	26	Excutive Secretary	RICH	M	IPs	National
25	27	Excutive Secretary	RICH	M		
26	28	National Coordinator	ADEPE	M	IPs	National
27	29	Head of Department of Nutrition and Hygiene	MIGEPROF NCDA	F	Govt.	National
28	30	Country Representative,	AVSI	F	IPs	National
29	31	ECE education officer	REB	M	Govt.	National
30	32	Education Unit Coordinator	Imbuto Foundation	M	IPs	National
30	33	Head of Resource Mobilization and Partnership	Imbuto Foundation	F		
31	34	Director of Water and sanitation	RURA	M	Govt.	National
32	35	Policy Officer	EKN	M	Donor	National
33	36		LODA	M	Govt.	National
34	37	Traditional Commodities Division Manager	NAEDB	M	Govt.	National
35	38	ECD Specialist	UNICEF	M	UNICEF	National
36	39	Partnerships Specialist	UNICEF	F	UNICEF	National
37	40	Nutrition Specialist	UNICEF	F	UNICEF	National
38	41	Chief WASH	UNICEF	M	UNICEF	National
38	42	WASH	UNICEF	M		
39	43	Chief Social Policy & Research	UNICEF	F	UNICEF	National

## **Appendix 14: Evaluation Qualitative Tools – FGD Guides**

### **Guide Questions - Focus Group Discussions (FGDs)**

These guides are meant to generate a discussion with focus groups and then guide the conversation. The evaluators might not ask all questions and probes to all respondents. The guide covers the following stakeholders:

1. Parents/Caregivers/Community Influencers
2. Health Workers (CHWs/CHVs)
3. ECD Caregivers

## **FGD Tool for Parents/Caregivers/Community Influencers**

### **Relevance/Coherence**

1. In your community, were children under five malnourished/stunted (Instructions: explain stunting – children height is not as per the age)? Probe further by asking the following:
  - a. What were the reasons for children (U5) to be malnourished/stunted? [Probe: was it due to limited knowledge of dietary requirement of children by mothers, knowledge about food types and nutritious values, unavailability of different types of food/nutritious food, or others – take note of all reasons identified by respondents].
  - b. Do you know about any particular households where children were either stunted or more likely to be stunted?
2. In 2016, were children aged 0-6 years attending organized early childhood education programmes?
  - a. If no, what were the reasons for children (U6) for not enrolling in early childhood education programmes [Probe: lack of access to ECD centres; lack of trained ECD teachers; lack of demand of ECD services from parents]
  - b. Do you know about any particular households where children were either stunted or more likely to be stunted?

### **Effectiveness**

3. In the last 4-5 years, are you aware of any nutrition activities happening in your community?
  - a. What type of activities (e.g., provision of supplements, counselling, treatment of SAM/MAM) are being implemented in your community?
  - b. Do you think mothers are more aware of their own and their children nutrition needs? Has this resulted in increased demand for nutrition services for instance more visits to health centres, better diet, improved maternal and infant health?
4. Let us talk about some crops, vegetables, and livestock that you may be growing.
  - a. What type of vegetables and agricultural crops are you cultivating these days? Probe: list all types of vegetables and crops they are currently growing.
  - b. Has there been any change in the type of crops/vegetables/livestock that you are growing/rearing compared to five years ago? If there are any differences: what made them change their practices? [Probe: did they receive any training or seeds and what has been the effect of growing different produce in your own and your child's health and nutrition]
5. Are you aware of any early childhood development and family (ECD&F) centres in your community?
  - a. What is the mandate of these centres? Who can benefit from these centres?
  - b. Have any of you enrolled your child in a ECD centre? [Instructions: take note of how many have their children enrolled?]
  - c. What has been your experience thus far? Are teachers trained and were your children provided with interesting learning material such as toys, story books, etc.?
  - d. Would you recommend other parents/caregivers to enroll their children? Why/why not? What could be done to improve services of these ECD centres?
6. Latrines are important to prevent diseases like diarrhoea, worms etc. Could you tell us, how many new latrines were built in the last 5 years in your area?
  - a. Did you receive any training on how to maintain sanitation in the latrine?
  - b. How do you as a community ensure the maintenance and cleanliness of the latrines?

- c. Did your community receive any messages on safe hygiene practices in the past 1-3 years? If yes, how many of you have received those? [Instructions: count how many have received these messages? Can you recall what was information passed on in those messages (Instructions: take note of the messages).]
- d. Do you think there are certain groups of people/households in your community who may not receive such messages? [Probe: identify the type of households (poor, households with members who have disabilities, households located in hard-to-reach areas)] Why they did not receive these messages and what can be done to reach them?
- e. Do you think these WASH facilities have resulted in improved health of mothers and young children within your community? How could these services be improved for the future?

### **Impact**

- 7. Do you think there has been a change in the stunting children under five within your community? Which specific activities/interventions may have contributed to this change?
  - a. Are there any differences in preschool enrolment rates within your community? Which specific activities/interventions may have contributed to this change?
  - b. Can you think of any unintended results/achievements as a result of UNICEF assistance within your community? [Probe: list both positive and negative in terms of awareness sessions, supplies, training of service providers, improved nutrition and ECD services, WASH facilities, enrolment in social protection programme)

### **HRBA, GE, Equity**

- 8. Are you aware of any feedback mechanism in your community through which you can launch or complain about lack of food, health services for pregnant and lactating women, ECD services, etc.?
  - a. What is the mechanism? How many have you used it? [Instructions: take note of how many have used it]
  - b. How satisfied are you with the response that you may have received from government representatives?
- 9. Why are boys more prone to stunting in your community? Are there differences in feeding practices within your community?
  - a. In the last five years, do you think there has been any change in the prevalence of stunting between boys and girls? What could be the reasons behind this change?
  - b. In your opinion, are mothers (including pregnant and lactating) more aware of their nutrition needs and have adequate access to services to cater to them?
  - c. Are parents/caregivers more aware of the importance of organised early childhood education programmes? In the last five years, has there been a change in the enrollment in pre-primary schooling within your community [Probe: if the changes are consistent for boys and girls?]
- 10. Are there any particular households where children (0-5) are more prone to malnutrition or lack of access to ECD services? [Probe: identify the type of households (poor, households with members who have disabilities, households located in hard-to-reach areas); what were the reasons behind their vulnerability]
  - a. What should be done to reach out to these households?

## FGD Tool for Health Workers

### Relevance/Coherence

1. In your community, were children under five malnourished/stunted (Instructions: Explain stunting – children height is not as per the age)? Probe further by asking the following:
  - a. What were the reasons for children (U5) to be malnourished/stunted? [Probe: was it due to limited knowledge of dietary requirement of children by mothers, knowledge about food types and nutritious values, unavailability of different types of food/nutritious food, or others – take note of all reasons identified by respondents].
  - b. Do you know about any particular households where children were either stunted or more likely to be stunted?
2. In 2016, were children aged 0-6 years attending organized early childhood education programmes?
  - a. If no, what were the reasons for children (U6) for not enrolling in early childhood education programmes [Probe: lack of access to ECD centres; lack of trained ECD teachers; lack of demand of ECD services from parents]
  - b. Do you know about any particular households where children were more likely to not access ECD services?

### Effectiveness

3. In your opinion, did nutrition-specific interventions result in any change in this community's health and nutrition status? Probe specifically:
  - a. Improving access to food; increasing availability of ECD facilities; enhancing availability of supplies; availability of trained health staff; increasing awareness of the community; early detection and treatment of cases; enhanced connectivity between the health system and vulnerable population. Elaborate reason for views.
  - b. What are its shortcomings in each area of work? Why?
  - c. What more needs to be done? What would you recommend has areas of improvement or additional focus?
4. Did you receive any training on maternal, infant and young child nutrition (MIYCN) and responsive feeding? [Instructions: take note of how many have been trained and for what]
  - a. How useful was the training and training material (including equipment - height/length measuring boards) in helping you understand maternal, infant and young child nutrition? [Probe: was the training time/duration sufficient?]
  - b. Were trainers fully conversant with the subject, locally available and trained well?
  - c. If a health worker leaves or is transferred, what actions are taken by the health facility to train/prepare the replacement?
  - d. Any recommendations on how to improve trainings or refreshers.
5. Are you involved in disseminating , awareness messages including minimum dietary requirements, breastfeeding, iron and vitamin intake, ANC/PNC visits, etc?
  - a. How were these messages disseminated and what was your role as community health workers/volunteers?
  - b. Can you recall what information was passed on in those messages (Instructions: take note of the messages)
  - c. Were these messages easily accepted by the community? [Probe: was there a difference in how information was accepted and applied by men vs. women]
  - d. What are the challenges of disseminating food and nutrition messages to this community? [Probe: what can be done to address these challenges]

- e. Do you think there are certain groups of people/households in your community who may not receive such messages? [Probe: identify the type of households (poor, households with members who have disabilities, households located in hard-to-reach areas)] Why they did not receive these messages and what can be done to reach them?
- 6. What type of coordination structures are available for the implementation of Programme activities?
  - a. Were there any guidelines/SOPs to establish accountability of relevant stakeholders?
  - b. How frequently stakeholders met/interacted? How participation of these stakeholders ensured?
  - c. What constraints were faced if any?
  - d. Were coordination plans placed? Were these plans followed?
  - e. Are you satisfied with the coordination mechanism? What should be changed for future?

### **Efficiency**

- 7. In your opinion, were supplies (RUFT, supplements, vitamins) adequate?
  - a. Were there any delays in provision of supplies in the last five years?
  - b. If there were any gaps, how were they addressed if at all?
  - c. What more needs to happen? What are the lessons learnt and recommendations for future programming?
  - d. How did the health workers manage to respond to shortages?
- 8. Are you satisfied with the workload and the incentives provided against your services? (Probe for HR adequacy, Selection criteria of CHWs/CHVs, any challenges in provision of services)
  - a. In your opinion, are children with SAM timely identified for further treatment within this community?
  - b. What are your suggestions to improve workload management?

### **Impact**

- 9. Do you think there has been a change in the stunting children under five within your community? Which specific activities/interventions may have contributed to this change?
  - a. Are there any differences in preschool enrolment rates within your community? Which specific activities/interventions may have contributed to this change?
  - b. Can you think of any unintended results/achievements as a result of UNICEF assistance within your community? [Probe: list both positive and negative in terms of awareness sessions, supplies, training of service providers, improved nutrition services, WASH facilities, enrolment in social protection programme)

### **Sustainability**

- 10. In your community, which of these activities and results/benefits are likely to sustain and why? Probe for each: capacity building of service providers, supplies, monitoring and evidence generation, awareness/demand creation
  - a. Which of these activities may not sustain and please elaborate the reasons for non-sustainability? What could be done to make these more sustainable?
  - b. What changes should be made and/or new interventions should be added if the Programme is scaled up to other districts?

### **HRBA, GE, Equity**

- 11. As part of your training have you been educated on what are entitlements of the service users (parents/caregivers) and if there are protocols/standards of service delivery for you?
  - a. Do people/users face any problems using health services, what are usual problems the face?

- b. Do they have any forums to register complaints, if they are unhappy with quality of services?  
How complaints are addressed?
  - c. Any suggestions on how to improve the feedback mechanism?
12. Why are boys more prone to stunting in your community? Are there differences in feeding practices within your community?
- a. In the last five years, do you think there has been any change in the prevalence of stunting between boys and girls? What could be the reasons behind this change?
  - b. In your opinion, are mothers (including pregnant and lactating) more aware of their nutrition needs and have adequate access to services to cater to them?
13. Are there any particular households where children (0-5) are more prone to malnutrition?  
[Probe: identify the type of households (poor, households with members who have disabilities, households located in hard-to-reach areas); what were the reasons behind their vulnerability]
- a. What should be done to reach out to these households?

## FGD Tool for ECD Caregivers

### Relevance/Coherence

1. In your community, were children under five malnourished/stunted (Instructions: Explain stunting – children height is not as per the age)? Probe further by asking the following:
  - a. What were the reasons for children (U5) to be malnourished/stunted? [Probe: was it due to limited knowledge of dietary requirement of children by mothers, knowledge about food types and nutritious values, unavailability of different types of food/nutritious food, or others – take note of all reasons identified by respondents].
  - b. Do you know about any particular households where children were either stunted or more likely to be stunted?
2. In 2016, were children aged 0-6 years attending organized early childhood education programmes?
  - a. If no, what were the reasons for children (U6) for not enrolling in early childhood education programmes [Probe: lack of access to ECD centres; lack of trained ECD teachers; lack of demand of ECD services from parents]
  - b. Do you know about any particular households where children were more likely to not access ECD services?

### Effectiveness

3. In your opinion, did ECD-specific interventions result in any change in this community's pre-primary school enrolment rates? Probe specifically:
  - a. New ECD&F sites/spaces available; additional caregivers trained; increased demand for ECD services, access to multi-sectoral ECD coordination mechanisms. Elaborate reason for views.
  - b. What are its shortcomings in each area of work? Why?
  - c. What more needs to be done? What would you recommend has areas of improvement or additional focus?
4. Did you receive any training recently? [Instructions: take note of how many have been trained and for what]
  - a. How useful was the training and training material (including children story books and toys) in helping you do your job as a ECD caregiver? [Probe: was the training time/duration sufficient?]
  - b. Were trainers fully conversant with the subject, locally available and trained well?
  - c. Any recommendations on how to improve trainings or refreshers.
5. What type of coordination structures are available for the implementation of Programme activities?
  - a. Were there any guidelines/SOPs to establish accountability of relevant stakeholders?
  - b. How frequently stakeholders met/interacted? How participation of these stakeholders ensured?
  - c. What constraints were faced if any?
  - d. Were coordination plans placed? Were these plans followed?
  - e. Are you satisfied with the coordination mechanism? What should be changed for future?

### Efficiency

6. Were there any delays in provision of required supplies (toys and books)? [Probe: any specific delays caused by COVID-19 related restrictions?
  - a. If yes, how did the staff at your centre cater to these delays and what effect it had on service provision?

### Impact

7. Are there any differences in preschool enrolment rates within your community? Which specific activities/interventions may have contributed to this change?
  - a. Can you think of any unintended results/achievements as a result of UNICEF assistance within your community? [Probe: list both positive and negative in terms of awareness sessions,

supplies, training of service providers, improved ECD services, WASH facilities, enrolment in social protection programme)

#### **Sustainability**

8. In your community, which of these activities and results/benefits are likely to sustain and why? Probe for each: capacity building of service providers, supplies, monitoring and evidence generation, awareness/demand creation
  - a. Which of these activities may not sustain and please elaborate the reasons for non-sustainability? What could be done to make these more sustainable?
  - b. What changes should be made and/or new interventions should be added if the Programme is scaled up to other districts?

#### **HRBA, GE, Equity**

9. As part of your training have you been educated on what are entitlements of the service users (parents/caregivers) and if there are protocols/standards of service delivery for you?
  - a. Do people/users face any problems using health/ECD services, what are usual problems they face?
  - b. Do they have any forums to register complaints if they are unhappy with quality of services? How are complaints addressed?
  - c. Any suggestions on how to improve the feedback mechanism?
10. Are parents/caregivers more aware of the importance of organised early childhood education programmes? In the last five years, has there been a change in the enrollment in pre-primary schooling within your community [Probe: if the changes are consistent for boys and girls?]
11. Are there any particular households where children (0-5) are more prone to lack of access to ECD services? [Probe: identify the type of households (poor, households with members who have disabilities, households located in hard-to-reach areas); what were the reasons behind their vulnerability]
  - a. What should be done to reach out to these households?

## Appendix 15: FGDs Participants

In total **30 FGDs** were conducted including **293 participants (154 Male-47%, and 139 Female-53%)** from Burera, Nyaruguru, and Rutsiro districts. The discussions were held with various groups, which includes, the CHW, ECD, Farmers, Fathers, Influencers and Mothers. The following table shows further details regarding these FGDs.

FGD#	Participants	Group	District	Sector	Village	Age	Gender
1	1	Fathers	Burera	Rugengabali	Nyanamo	30	M
1	2	Fathers	Burera	Rugengabali	Nyanamo	36	M
1	3	Fathers	Burera	Rugengabali	Nyanamo	28	F
1	4	Fathers	Burera	Rugengabali	Nyanamo	42	M
1	5	Fathers	Burera	Rugengabali	Nyanamo	47	F
1	6	Fathers	Burera	Rugengabali	Nyanamo	54	F
1	7	Fathers	Burera	Rugengabali	Nyanamo	27	M
1	8	Fathers	Burera	Rugengabali	Nyanamo	36	F
1	9	Fathers	Burera	Rugengabali	Nyanamo	33	F
1	10	Fathers	Burera	Rugengabali	Nyanamo	47	M
2	1	CHW	Burera	Rugengabari	Nyanamo	27	M
2	2	CHW	Burera	Rugengabari	Nyanamo	32	M
2	3	CHW	Burera	Rugengabari	Nyanamo	50	F
2	4	CHW	Burera	Rugengabari	Nyanamo	42	F
2	5	CHW	Burera	Rugengabari	Nyanamo	40	F
2	6	CHW	Burera	Rugengabari	Nyanamo	40	F
2	7	CHW	Burera	Rugengabari	Nyanamo	29	M
2	8	CHW	Burera	Rugengabari	Nyanamo	61	M
2	9	CHW	Burera	Rugengabari	Nyanamo	53	F
2	10	CHW	Burera	Rugengabari	Nyanamo	27	F
3	1	Influencers	Burera	Rugengabari	Nyanamo	43	M
3	2	Influencers	Burera	Rugengabari	Nyanamo	33	M
3	3	Influencers	Burera	Rugengabari	Nyanamo	32	M
3	4	Influencers	Burera	Rugengabari	Nyanamo	32	M
3	5	Influencers	Burera	Rugengabari	Nyanamo	68	M
3	6	Influencers	Burera	Rugengabari	Nyanamo	31	M
3	7	Influencers	Burera	Rugengabari	Nyanamo	22	F
3	8	Influencers	Burera	Rugengabari	Nyanamo	33	M
3	9	Influencers	Burera	Rugengabari	Nyanamo	29	M
3	10	Influencers	Burera	Rugengabari	Nyanamo	36	M
4	1	ECD	Burera	Rugengabari	Nyanamo	40	F
4	2	ECD	Burera	Rugengabari	Nyanamo	28	F
4	3	ECD	Burera	Rugengabari	Nyanamo	42	M
4	4	ECD	Burera	Rugengabari	Nyanamo	40	F
4	5	ECD	Burera	Rugengabari	Nyanamo	33	F
4	6	ECD	Burera	Rugengabari	Nyanamo	21	F
4	7	ECD	Burera	Rugengabari	Nyanamo	21	M
4	8	ECD	Burera	Rugengabari	Nyanamo	27	F
4	9	ECD	Burera	Rugengabari	Nyanamo	29	F
4	10	ECD	Burera	Rugengabari	Nyanamo	22	F
5	1	Fathers	Burera	Rugengabari	Nyanamo	39	M
5	2	Fathers	Burera	Rugengabari	Nyanamo	35	M
5	3	Fathers	Burera	Rugengabari	Nyanamo	28	M
5	4	Fathers	Burera	Rugengabari	Nyanamo	29	M
5	5	Fathers	Burera	Rugengabari	Nyanamo	21	M
5	6	Fathers	Burera	Rugengabari	Nyanamo	22	M
5	7	Fathers	Burera	Rugengabari	Nyanamo	25	M
5	8	Fathers	Burera	Rugengabari	Nyanamo	27	M
5	9	Fathers	Burera	Rugengabari	Nyanamo	30	M
5	10	Fathers	Burera	Rugengabari	Nyanamo	27	M
6	1	Mothers	Rutsiro	Rugengabari	Nyanamo	19	F
6	2	Mothers	Rutsiro	Rugengabari	Nyanamo	34	F
6	3	Mothers	Rutsiro	Rugengabari	Nyanamo	20	F
6	4	Mothers	Rutsiro	Rugengabari	Nyanamo	37	F
6	5	Mothers	Rutsiro	Rugengabari	Nyanamo	30	F
6	6	Mothers	Rutsiro	Rugengabari	Nyanamo	30	F

FGD#	Participants	Group	District	Sector	Village	Age	Gender
6	7	Mothers	Rutsiro	Rugengabari	Nyanamo	34	F
6	8	Mothers	Rutsiro	Rugengabari	Nyanamo	21	F
6	9	Mothers	Rutsiro	Rugengabari	Nyanamo	33	F
6	10	Mothers	Rutsiro	Rugengabari	Nyanamo	45	F
7	1	ECD	Burera	Rugengabari	Nyanamo	33	F
7	2	ECD	Burera	Rugengabari	Nyanamo	50	F
7	3	ECD	Burera	Rugengabari	Nyanamo	61	M
7	4	ECD	Burera	Rugengabari	Nyanamo	24	M
7	5	ECD	Burera	Rugengabari	Nyanamo	39	M
7	6	ECD	Burera	Rugengabari	Nyanamo	25	M
7	7	ECD	Burera	Rugengabari	Nyanamo	38	F
7	8	ECD	Burera	Rugengabari	Nyanamo	29	M
7	9	ECD	Burera	Rugengabari	Nyanamo	30	F
7	10	ECD	Burera	Rugengabari	Nyanamo	28	F
8	1	Influencers	Burera	Rugengabari	Nyanamo	47	M
8	2	Influencers	Burera	Rugengabari	Nyanamo	42	F
8	3	Influencers	Burera	Rugengabari	Nyanamo	40	M
8	4	Influencers	Burera	Rugengabari	Nyanamo	37	M
8	5	Influencers	Burera	Rugengabari	Nyanamo	54	M
8	6	Influencers	Burera	Rugengabari	Nyanamo	46	M
8	7	Influencers	Burera	Rugengabari	Nyanamo	35	M
8	8	Influencers	Burera	Rugengabari	Nyanamo	24	M
8	9	Influencers	Burera	Rugengabari	Nyanamo	43	F
8	10	Influencers	Burera	Rugengabari	Nyanamo	26	M
9	1	CHW	Burera	Rugengabari	Nyanamo	40	F
9	2	CHW	Burera	Rugengabari	Nyanamo	34	M
9	3	CHW	Burera	Rugengabari	Nyanamo	35	M
9	4	CHW	Burera	Rugengabari	Nyanamo	43	M
9	5	CHW	Burera	Rugengabari	Nyanamo	42	M
9	6	CHW	Burera	Rugengabari	Nyanamo	50	F
9	7	CHW	Burera	Rugengabari	Nyanamo	47	F
9	8	CHW	Burera	Rugengabari	Nyanamo	72	F
9	9	CHW	Burera	Rugengabari	Nyanamo	32	M
9	10	CHW	Burera	Rugengabari	Nyanamo	60	F
10	1	Influencers	Rutsiro	Mukura	Mwendo	47	M
10	2	Influencers	Rutsiro	Mukura	Mwendo	30	M
10	3	Influencers	Rutsiro	Mukura	Mwendo	40	M
10	4	Influencers	Rutsiro	Mukura	Mwendo	45	F
10	5	Influencers	Rutsiro	Mukura	Mwendo	32	M
10	6	Influencers	Rutsiro	Mukura	Mwendo	31	M
10	7	Influencers	Rutsiro	Mukura	Mwendo	36	M
10	8	Influencers	Rutsiro	Mukura	Mwendo	64	M
10	9	Influencers	Rutsiro	Mukura	Mwendo	39	M
10	10	Influencers	Rutsiro	Mukura	Mwendo	31	M
11	1	ECD	Nyaruguru	Nyagisozi	Mwoya	28	F
11	2	ECD	Nyaruguru	Nyagisozi	Mwoya	40	F
11	3	ECD	Nyaruguru	Nyagisozi	Mwoya	36	F
11	4	ECD	Nyaruguru	Nyagisozi	Mwoya	40	F
11	5	ECD	Nyaruguru	Nyagisozi	Mwoya	42	M
11	6	ECD	Nyaruguru	Nyagisozi	Mwoya	36	F
11	7	ECD	Nyaruguru	Nyagisozi	Mwoya	39	F
11	8	ECD	Nyaruguru	Nyagisozi	Mwoya	65	F
11	9	ECD	Nyaruguru	Nyagisozi	Mwoya	46	F
11	10	ECD	Nyaruguru	Nyagisozi	Mwoya	35	F
12	1	Influencers	Nyaruguru	Nyagisozi	Mwoya	38	M
12	2	Influencers	Nyaruguru	Nyagisozi	Mwoya	26	F
12	3	Influencers	Nyaruguru	Nyagisozi	Mwoya	33	M
12	4	Influencers	Nyaruguru	Nyagisozi	Mwoya	41	F
12	5	Influencers	Nyaruguru	Nyagisozi	Mwoya	35	M
12	6	Influencers	Nyaruguru	Nyagisozi	Mwoya	42	M
12	7	Influencers	Nyaruguru	Nyagisozi	Mwoya	60	F
12	8	Influencers	Nyaruguru	Nyagisozi	Mwoya	51	M
12	9	Influencers	Nyaruguru	Nyagisozi	Mwoya	54	F

FGD#	Participants	Group	District	Sector	Village	Age	Gender
12	10	Influencers	Nyaruguru	Nyagisozi	Mwoya	46	M
13	1	Influencers	Nyaruguru	Nyagisozi	Mwoya	32	M
13	2	Influencers	Nyaruguru	Nyagisozi	Mwoya	44	M
13	3	Influencers	Nyaruguru	Nyagisozi	Mwoya	52	F
13	4	Influencers	Nyaruguru	Nyagisozi	Mwoya	24	F
13	5	Influencers	Nyaruguru	Nyagisozi	Mwoya	24	F
13	6	Influencers	Nyaruguru	Nyagisozi	Mwoya	23	M
13	7	Influencers	Nyaruguru	Nyagisozi	Mwoya	20	M
13	8	Influencers	Nyaruguru	Nyagisozi	Mwoya	40	M
13	9	Influencers	Nyaruguru	Nyagisozi	Mwoya	41	M
13	10	Influencers	Nyaruguru	Nyagisozi	Mwoya	62	M
14	1	Fathers	Nyaruguru	Nyagisozi	Mwoya	46	M
14	2	Fathers	Nyaruguru	Nyagisozi	Mwoya	29	M
14	3	Fathers	Nyaruguru	Nyagisozi	Mwoya	46	M
14	4	Fathers	Nyaruguru	Nyagisozi	Mwoya	32	M
14	5	Fathers	Nyaruguru	Nyagisozi	Mwoya	42	M
14	6	Fathers	Nyaruguru	Nyagisozi	Mwoya	40	M
14	7	Fathers	Nyaruguru	Nyagisozi	Mwoya	26	M
14	8	Fathers	Nyaruguru	Nyagisozi	Mwoya	37	M
14	9	Fathers	Nyaruguru	Nyagisozi	Mwoya	48	M
15	1	CHW	Nyaruguru	Nyagisozi	Mwoya	51	F
15	2	CHW	Nyaruguru	Nyagisozi	Mwoya	43	M
15	3	CHW	Nyaruguru	Nyagisozi	Mwoya	37	F
15	4	CHW	Nyaruguru	Nyagisozi	Mwoya	47	F
15	5	CHW	Nyaruguru	Nyagisozi	Mwoya	42	M
15	6	CHW	Nyaruguru	Nyagisozi	Mwoya	45	F
15	7	CHW	Nyaruguru	Nyagisozi	Mwoya	50	F
15	8	CHW	Nyaruguru	Nyagisozi	Mwoya	32	M
15	9	CHW	Nyaruguru	Nyagisozi	Mwoya	35	F
15	10	CHW	Nyaruguru	Nyagisozi	Mwoya	42	F
16	1	Influencers	Rutsiro	Mukura	Mwendo	47	M
16	2	Influencers	Rutsiro	Mukura	Mwendo	69	M
16	3	Influencers	Rutsiro	Mukura	Mwendo	53	M
16	4	Influencers	Rutsiro	Mukura	Mwendo	35	M
16	5	Influencers	Rutsiro	Mukura	Mwendo	62	M
16	6	Influencers	Rutsiro	Mukura	Mwendo	53	M
16	7	Influencers	Rutsiro	Mukura	Mwendo	47	M
16	8	Influencers	Rutsiro	Mukura	Mwendo	65	M
16	9	Influencers	Rutsiro	Mukura	Mwendo	39	M
16	10	Influencers	Rutsiro	Mukura	Mwendo	48	M
17	1	ECD	Rutsiro	Mukura	Mwendo	38	M
17	2	ECD	Rutsiro	Mukura	Mwendo	33	F
17	3	ECD	Rutsiro	Mukura	Mwendo	35	M
17	4	ECD	Rutsiro	Mukura	Mwendo	37	F
17	5	ECD	Rutsiro	Mukura	Mwendo	39	F
17	6	ECD	Rutsiro	Mukura	Mwendo	27	M
17	7	ECD	Rutsiro	Mukura	Mwendo	48	F
17	8	ECD	Rutsiro	Mukura	Mwendo	32	M
17	9	ECD	Rutsiro	Mukura	Mwendo	46	F
18	1	ECD	Rutsiro	Mukura	Mwendo	38	M
18	2	ECD	Rutsiro	Mukura	Mwendo	33	F
18	3	ECD	Rutsiro	Mukura	Mwendo	35	M
18	4	ECD	Rutsiro	Mukura	Mwendo	37	F
18	5	ECD	Rutsiro	Mukura	Mwendo	39	F
18	6	ECD	Rutsiro	Mukura	Mwendo	27	M
18	7	ECD	Rutsiro	Mukura	Mwendo	48	F
18	8	ECD	Rutsiro	Mukura	Mwendo	32	M
18	9	ECD	Rutsiro	Mukura	Mwendo	46	F
19	1	ECD	Rutsiro	Mukura	Mwendo	33	M
19	2	ECD	Rutsiro	Mukura	Mwendo	35	M
19	3	ECD	Rutsiro	Mukura	Mwendo	47	M
19	4	ECD	Rutsiro	Mukura	Mwendo	43	F
19	5	ECD	Rutsiro	Mukura	Mwendo	32	F

FGD#	Participants	Group	District	Sector	Village	Age	Gender
19	6	ECD	Rutsiro	Mukura	Mwendo	33	M
19	7	ECD	Rutsiro	Mukura	Mwendo	46	F
19	8	ECD	Rutsiro	Mukura	Mwendo	47	F
19	9	ECD	Rutsiro	Mukura	Mwendo	49	M
20	1	Farmers	Rutsiro	Mukura	Mwendo	36	F
20	2	Farmers	Rutsiro	Mukura	Mwendo	50	M
20	3	Farmers	Rutsiro	Mukura	Mwendo	38	M
20	4	Farmers	Rutsiro	Mukura	Mwendo	35	M
20	5	Farmers	Rutsiro	Mukura	Mwendo	52	M
20	6	Farmers	Rutsiro	Mukura	Mwendo	36	M
20	7	Farmers	Rutsiro	Mukura	Mwendo	38	F
20	8	Farmers	Rutsiro	Mukura	Mwendo	38	F
20	9	Farmers	Rutsiro	Mukura	Mwendo	55	M
20	10	Farmers	Rutsiro	Mukura	Mwendo	47	M
21	1	CHW	Rutsiro	Mukura	Mwendo	57	F
21	2	CHW	Rutsiro	Mukura	Mwendo	63	F
21	3	CHW	Rutsiro	Mukura	Mwendo	42	F
21	4	CHW	Rutsiro	Mukura	Mwendo	27	M
21	5	CHW	Rutsiro	Mukura	Mwendo	46	M
21	6	CHW	Rutsiro	Mukura	Mwendo	33	M
21	7	CHW	Rutsiro	Mukura	Mwendo	46	F
21	8	CHW	Rutsiro	Mukura	Mwendo	27	F
21	9	CHW	Rutsiro	Mukura	Mwendo	59	F
22	1	Mothers	Rutsiro	Mukura	Mwendo	27	F
22	2	Mothers	Rutsiro	Mukura	Mwendo	32	F
22	3	Mothers	Rutsiro	Mukura	Mwendo	50	F
22	4	Mothers	Rutsiro	Mukura	Mwendo	35	F
22	5	Mothers	Rutsiro	Mukura	Mwendo	27	F
22	6	Mothers	Rutsiro	Mukura	Mwendo	38	F
22	7	Mothers	Rutsiro	Mukura	Mwendo	23	F
22	8	Mothers	Rutsiro	Mukura	Mwendo	31	F
22	9	Mothers	Rutsiro	Mukura	Mwendo	24	F
22	10	Mothers	Rutsiro	Mukura	Mwendo	31	F
23	1	Mothers	Burera	Rugengabali	Nyanamo	22	F
23	2	Mothers	Burera	Rugengabali	Nyanamo	30	F
23	3	Mothers	Burera	Rugengabali	Nyanamo	25	F
23	4	Mothers	Burera	Rugengabali	Nyanamo	22	F
23	5	Mothers	Burera	Rugengabali	Nyanamo	30	F
23	6	Mothers	Burera	Rugengabali	Nyanamo	25	F
23	7	Mothers	Burera	Rugengabali	Nyanamo	21	F
23	8	Mothers	Burera	Rugengabali	Nyanamo	37	F
23	9	Mothers	Burera	Rugengabali	Nyanamo	21	F
23	10	Mothers	Burera	Rugengabali	Nyanamo	16	F
24	1	Mothers	Nyaruguru	Nyagisozi	Mwoya	34	F
24	2	Mothers	Nyaruguru	Nyagisozi	Mwoya	24	F
24	3	Mothers	Nyaruguru	Nyagisozi	Mwoya	33	F
24	4	Mothers	Nyaruguru	Nyagisozi	Mwoya	48	F
24	5	Mothers	Nyaruguru	Nyagisozi	Mwoya	31	F
24	6	Mothers	Nyaruguru	Nyagisozi	Mwoya	33	F
24	7	Mothers	Nyaruguru	Nyagisozi	Mwoya	33	F
24	8	Mothers	Nyaruguru	Nyagisozi	Mwoya	45	F
24	9	Mothers	Nyaruguru	Nyagisozi	Mwoya	43	F
24	10	Mothers	Nyaruguru	Nyagisozi	Mwoya	25	F
25	1	Mothers	Rutsiro	Mukura	Mwendo	28	F
25	2	Mothers	Rutsiro	Mukura	Mwendo	31	F
25	3	Mothers	Rutsiro	Mukura	Mwendo	23	F
25	4	Mothers	Rutsiro	Mukura	Mwendo	24	F
25	5	Mothers	Rutsiro	Mukura	Mwendo	37	F
25	6	Mothers	Rutsiro	Mukura	Mwendo	27	F
25	7	Mothers	Rutsiro	Mukura	Mwendo	32	F
25	8	Mothers	Rutsiro	Mukura	Mwendo	27	F
25	9	Mothers	Rutsiro	Mukura	Mwendo	25	F
25	10	Mothers	Rutsiro	Mukura	Mwendo	27	F

FGD#	Participants	Group	District	Sector	Village	Age	Gender
26	1	CHW	Nyaruguru	Nyagisozi	Mwoya	58	M
26	2	CHW	Nyaruguru	Nyagisozi	Mwoya	60	M
26	3	CHW	Nyaruguru	Nyagisozi	Mwoya	47	M
26	4	CHW	Nyaruguru	Nyagisozi	Mwoya	42	F
26	5	CHW	Nyaruguru	Nyagisozi	Mwoya	47	F
26	6	CHW	Nyaruguru	Nyagisozi	Mwoya	57	F
26	7	CHW	Nyaruguru	Nyagisozi	Mwoya	43	F
26	8	CHW	Nyaruguru	Nyagisozi	Mwoya	62	F
26	9	CHW	Nyaruguru	Nyagisozi	Mwoya	26	F
26	10	CHW	Nyaruguru	Nyagisozi	Mwoya	47	F
27	1	ECD	Nyaruguru	Nyagisozi	Mwoya	47	F
27	2	ECD	Nyaruguru	Nyagisozi	Mwoya	48	F
27	3	ECD	Nyaruguru	Nyagisozi	Mwoya	42	F
27	4	ECD	Nyaruguru	Nyagisozi	Mwoya	46	F
27	5	ECD	Nyaruguru	Nyagisozi	Mwoya	32	F
27	6	ECD	Nyaruguru	Nyagisozi	Mwoya	33	F
27	7	ECD	Nyaruguru	Nyagisozi	Mwoya	43	M
27	8	ECD	Nyaruguru	Nyagisozi	Mwoya	44	F
27	9	ECD	Nyaruguru	Nyagisozi	Mwoya	36	F
27	10	ECD	Nyaruguru	Nyagisozi	Mwoya	68	F
28	1	Farmers	Nyaruguru	Nyagisozi	Mwoya	60	M
28	2	Farmers	Nyaruguru	Nyagisozi	Mwoya	53	M
28	3	Farmers	Nyaruguru	Nyagisozi	Mwoya	21	F
28	4	Farmers	Nyaruguru	Nyagisozi	Mwoya	41	F
28	5	Farmers	Nyaruguru	Nyagisozi	Mwoya	30	F
28	6	Farmers	Nyaruguru	Nyagisozi	Mwoya	48	M
28	7	Farmers	Nyaruguru	Nyagisozi	Mwoya	52	M
28	8	Farmers	Nyaruguru	Nyagisozi	Mwoya	34	M
28	9	Farmers	Nyaruguru	Nyagisozi	Mwoya	30	M
28	10	Farmers	Nyaruguru	Nyagisozi	Mwoya	24	F
29	1	CHW	Rutsiro	Mukura	POSTE DE SANTE	33	M
29	2	CHW	Rutsiro	Mukura	POSTE DE SANTE	38	F
29	3	CHW	Rutsiro	Mukura	POSTE DE SANTE	47	M
29	4	CHW	Rutsiro	Mukura	POSTE DE SANTE	36	F
29	5	CHW	Rutsiro	Mukura	POSTE DE SANTE	56	F
29	6	CHW	Rutsiro	Mukura	POSTE DE SANTE	60	M
29	7	CHW	Rutsiro	Mukura	POSTE DE SANTE	47	F
29	8	CHW	Rutsiro	Mukura	POSTE DE SANTE	63	F
30	1	CHW	Burera	Rugengabari	Nyanamo	39	M
30	2	CHW	Burera	Rugengabari	Nyanamo	35	M
30	3	CHW	Burera	Rugengabari	Nyanamo	28	M
30	4	CHW	Burera	Rugengabari	Nyanamo	29	M
30	5	CHW	Burera	Rugengabari	Nyanamo	21	M
30	6	CHW	Burera	Rugengabari	Nyanamo	22	M
30	7	CHW	Burera	Rugengabari	Nyanamo	25	M
30	8	CHW	Burera	Rugengabari	Nyanamo	27	M
30	9	CHW	Burera	Rugengabari	Nyanamo	30	M
30	10	CHW	Burera	Rugengabari	Nyanamo	27	M

## Appendix 16: Field Observations / Evidence

The below photographs have been taken during field visits as part of data collection. These photographs are not meant to indicate data collection activities (HHS, KIIs, FGDs etc.), those are presented in another separate appendix.





FGD with Nyaruguru CHWs



FGD with Nyaruguru Community Influencers



FGD with Nyaruguru Farmers



FGD with Nyaruguru Mothers



FGD with Burera Community Influencers



FGD with Burera CHWs



FGD with Burera ECD caregivers



FGD with Rutsiro Community Influencers



FGD with Rutsiro ECD caregivers



FGD with Rutsiro Mothers



FGD with Rutsiro Farmers



FGD with Rutsiro Fathers

## Appendix 17: Training Agenda

**Date:** December 2021 and 2<sup>nd</sup> Week of January

**Duration:** 5-6 days

**Venue:** Kigali, Rwanda

### Training Objectives

1. Participants develop a reasonable understanding of the UNICEF/EKN supported Developing Human Capital in Rwanda.
2. Participants are given an orientation of evaluation focus, key evaluation questions, approach/design and methods, underlying logic model and evaluation hypothesis.
3. Participants receive technical guidance on understanding all aspects of evaluation tools with focus on household survey questionnaire, particularly the nature and significance of all questions, relevant explanation of key terms, instructions to record responses, skip patterns.
4. Participants understand field protocols (usage of electronic devices, coordination, communication, safety and security), ethical norms and standards to be implemented during data collection particularly while interacting with research subjects (fathers, mothers and other participants of KIIs and FGDs), the evaluation team's expectations on reporting and the outputs of data collection.
5. Participants completely understand evaluation team's expectations on the quality assurance aspects for implementation during data collection, processing and analysis of the collected data and reporting requirements.
6. Finalization of field plan.

### Participants:

**AAN Team:** Team Lead; Evaluation Manager; ECD and Nutrition Experts, and Country Coordinator

### National Partner:

1. Survey Manager
2. District Supervisors / Regional Trainer(s)
3. Enumerators
4. Quality Assurance Staff
5. Data Management Team

The session-wise agenda for each day is given in the matrix below.

DAY ONE			
Time	Activity	Method / Materials	Roles and Responsibilities
10:00- 10:25	Introduction <ul style="list-style-type: none"> <li>▪ Brief Introduction of AAN Associates and AAN Evaluation Team (5 minutes)</li> <li>▪ Brief Profile of the partner and Core Team (5 minutes)</li> <li>▪ Other Participants (5 minutes)</li> <li>▪ Review of Agenda (if required, the proposed agenda will be updated before proceeding to next agenda item / Q &amp; A – (5-10 minutes)</li> </ul>	<ul style="list-style-type: none"> <li>• Self-Introduction</li> </ul>	All Participants
10:25-11:10	Overview of the DHCN Programme in Rwanda <ul style="list-style-type: none"> <li>▪ Context – Legal Framework</li> <li>▪ Programme Objectives</li> <li>▪ Key Strategies and Interventions</li> <li>▪ Introduction to key elements of Programme Theory of Change</li> <li>▪ Key Stakeholders &amp; Role in the Programme</li> <li>▪ Geographical Coverage and Scope</li> <li>▪ Q&amp;A</li> </ul>	<ul style="list-style-type: none"> <li>• PPT</li> <li>• Notes</li> </ul>	National partner staff will prepare presentation and moderate the session. AAN to share relevant content/information (excerpts from inception report) to enable the partner to prepare or the session and present.
11:10-11:30 Tea Break			
11:30-12:00	Overview of Evaluation <ul style="list-style-type: none"> <li>▪ Evaluation Objectives &amp; Purpose</li> <li>▪ Evaluation Matrix (DAC Criteria and Questions)</li> <li>▪ Outline of Evaluation Methods</li> </ul>	<ul style="list-style-type: none"> <li>• PPT</li> <li>• Notes</li> </ul>	AAN

	<ul style="list-style-type: none"> <li>▪ Quantitative (Household Survey),</li> <li>▪ Qualitative (FGDs, KIIs, field observations/notes)</li> <li>▪ Evaluation Scope and Coverage</li> </ul>		
12:00-05:00	<p>Overview of Quantitative Methods (Household Survey)</p> <ul style="list-style-type: none"> <li>▪ Key Definitions/Terms</li> <li>▪ Survey geographic coverage / Sampling Frame/Distribution</li> <li>▪ Types of Questions, skip patterns and how to record appropriate responses</li> </ul>	<ul style="list-style-type: none"> <li>• PPT / Questionnaire</li> </ul>	National partner to take lead in moderating the session

DAY TWO-THREE			
Time me	Activity	Method / Material	Roles and Responsibilities
09:00-05:00	<p>Overview of Quantitative Methods (Household Survey)</p> <ul style="list-style-type: none"> <li>▪ Detailed Discussion on each question of HHS questionnaire including the instructions, focus and significance of each question</li> <li>▪ Q&amp;A</li> </ul>	<ul style="list-style-type: none"> <li>• PPT / Questionnaire</li> </ul>	AAN team to support the moderator in explaining any aspect/question of the HHS tool.

DAY FOUR-FIVE			
Time	Activity	Method / Material	Roles and Responsibilities
09:00-05:00	<p>Overview of Qualitative Methods (KIIs)</p> <ul style="list-style-type: none"> <li>▪ Types of Tools</li> <li>▪ Role of the Interviewer and note taker</li> <li>▪ Audio recordings (responsibility)</li> <li>▪ Pictorial evidence</li> <li>▪ Reporting format for KIIs</li> <li>▪ Transcriptions</li> <li>▪ Q&amp;A</li> </ul>	<ul style="list-style-type: none"> <li>• PPT</li> <li>• Questionnaire</li> </ul>	National partner Manager to moderate the session AAN Team to support

DAY SIX			
Time	Activity	Method / Material	Roles and Responsibilities
09:00-09:40	<ul style="list-style-type: none"> <li>▪ Overview of the online data entry, cleaning, and management system;</li> <li>▪ Instructions/SOPs to be implemented for data recording, transmission, backup and uploading of data on central server.</li> <li>▪ Complete demonstration of how AAN team in Pakistan can access data and with what frequency.</li> <li>▪ Quality Assurance Protocols</li> <li>▪ Coordination and Communication protocols</li> <li>▪ Safety and security measures to be ensured before, during and after field work</li> <li>▪ AAN to share details of the external monitoring by AAN and UNICEF and the reporting template</li> </ul>	<ul style="list-style-type: none"> <li>• PPT</li> </ul>	National partner Manager  AAN
09:40-10:00	<ul style="list-style-type: none"> <li>▪ Ethical and normative considerations for implementation during field work (greetings, informed consent, positive attitude, respect to cultural norms/traditions, safety, security, interviewing in friendly environment and others)</li> <li>▪ Compliance to Human Rights &amp; Gender norms during data collection</li> </ul>	<ul style="list-style-type: none"> <li>• Local partner</li> </ul>	National partner Survey Manager to moderate the session  AAN Team to support
10:00 to 12:00	<ul style="list-style-type: none"> <li>▪ Sharing of final instructions, field plan and departure of field team for pre-testing</li> </ul>	<ul style="list-style-type: none"> <li>• Notes</li> </ul>	National partner Survey Manager to moderate the session
12:00-05:00	<p>Micro-planning for HHS administration and qualitative data collection</p> <ul style="list-style-type: none"> <li>▪ Formation of field teams</li> </ul>	<ul style="list-style-type: none"> <li>• PPT</li> </ul>	National partner Survey Manager  AAN Team

	<ul style="list-style-type: none"> <li>▪ Finalization of field team's deployment and logistics plan</li> <li>▪ Establishing the general protocols for Fieldwork</li> <li>▪ Logistics</li> <li>▪ Security</li> <li>▪ Communication channels</li> </ul>		
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**Expected Training Outputs:**

1. Clarity established on agreed field plan, quality assurance measures to be enforced in field and other protocols of data collection.
2. Detailed Field Plan
3. Brief Training Report (3-4 pager) to be prepared by the national partner to capture key highlights of the training event.

## **Appendix 18: Quality Assurance Measures Implemented**

### **General Quality Control During Fieldwork**

The following key measures were implemented to ensure the quality assurance of all the processes during field data collection; In addition to these measures, the evaluators implemented various safety and protective protocols (See next section) to ensure that all research participants/respondents and evaluators themselves are not exposed to any possible risk under COVID-19 pandemic.

**Continued support and supervision:** The consultants (both international and national) with support from the local partner provided support and supervision in the field whenever necessary.

**Ethical clearance** was obtained with the support of UNICEF RCO

**Experienced staff** was engaged for field data collection.

**Comprehensive training** of all the field staff was ensured. The core team trained the master trainers at regional level, which in turn trained the other staff.

**Gender balanced staff** was deployed

**Informed Consent** from each respondent was taken by explaining the purpose of their activity and its relevance to them.

**Collection of Field Evidence** of the events was done with prior approval from the concerned respondents/participants of the KIIs and FGDs.

**Confidentiality and anonymity of the participants** was maintained, and findings were summarized to an appropriate level of aggregation without revealing the identity of respondents.

### **Quality Assurance of Household Survey Processes**

The quality assurance of the household survey was achieved through the following steps:

A senior National team **staff member** accompany randomly selected field teams during the initial days of data collection to observe, **double-check work**, and provide **on-site feedback to enumerators**;

All **questionnaires** were tracked and accounted for by assigning identification numbers;

**Interview log sheets** (record completed questionnaires and rescheduled appointments) submitted by enumerators daily and verified by supervisors;

Supervisors **assess/check the completed questionnaires** at the end of each day; and where required supervisors have a coaching session with each enumerator to highlight any inconsistencies or inaccuracies in the completed interviews

Any **errors, lessons, and corrective measures** discussed by each field team daily during evening meetings and shared with other teams through supervisors;

All team members **remained in contact** to ensure a shared understanding of approaches, data collection processes, challenges, and mitigation measures;

Data entry was done automatically with the use of **CAPI devices for survey administration**. The CAPI based interview inherits several ‘in-built’ quality checks around ‘skip patterns’ in the questionnaire logic

**10% of the data entry was cross checked or verified/validated by contacting the ‘relevant households’ either through making second field visits<sup>168</sup> to them or through phone calls (who have provided their contact numbers):**

### **Independent (Survey) Quality Monitoring:**

In addition to the quality control measures mentioned above, the Evaluators identified and deployed a team of independent field monitors who carried out the following activities:



**Spot-checking:** The team performed a spot-checking exercise on 5% of the total sampled respondents.



**Field Protocols Monitoring:** Through its local partner, the Evaluation Team observed all enumeration teams to check whether the asking of questions, recording of responses and treatment of respondents is compliant with the standards.



**Accompanying Interview:** The field monitors observed fieldwork protocols to ensure that respondents are selected appropriately, and that the replacement procedure is carried out according to standards/guidelines. At least 10% of total interviews were observed and supervised for on-spot counselling to the enumerators to ensure quality data collection.

<sup>168</sup> Second visit refers to the field supervisor’s or quality assurance staff’s visit to the household for asking some selected questions again to verify the recorded responses, after the first interview by the enumerator – or by making phone call to the respondent for the same purpose.

## Appendix 19: Spot-check Tool

**Checklist No:** \_\_\_\_\_

Date: Province:  
 District: Village:  
 Supervisor: Enumerator Name:  
 Observed Interview Form No: Field Monitor:

S#	Contents	Codes 1. Yes 2. No	Explain
<b>General</b>			
1.	Enumerator has survey materials and enumeration kit (guidelines)		
2.	Enumerator has tablet/smart phone with the survey application installed, and power bank to recharge the device		
3.	Daily survey briefing was undertaken in the morning (ask enumerator) before departure to the field		
4.	Field enumerator understands the significance of maintaining low profile and are dressed-up properly (as per the context)		
<b>Interview Specific</b>			
5.	Enumerator implemented/followed the appropriate criteria for selection of household's selection criteria/sampling procedure / SOPs		
6.	Enumerator implemented/followed the respondent selection/eligibility criteria		
7.	Enumerator appropriately introduced himself/herself, purpose of the interview/observation, and duration of the interview explicitly		
8.	Enumerator has taken consent from the respondent before proceeding with the interview question		
9.	enumerator uses appropriate language using local dialects to make respondent feel comfortable and to get most useful information		
10.	Has enumerator responded to respondents' questions well and respondent, if asked/not been able to understand the question/s fully		
11.	Enumerator recorded each response appropriately following question specific instructions and skip patterns		
12.	Enumerator has done adequate probing (where required) to get/note complete information		
13.	Enumerator have thanked the respondent at the end and asked for any question's respondent might have		
14.	Enumerator shared problems faced during field or interview with his supervisor		
15.	Enumerator has sought permission to get into the house to make household observations		
<b>If Supervisor is available in Village</b>			
14.	Supervisor has had a briefing session in the morning (daily pre-field work session)		
15.	Tasks clearly defined to each of the team member		
16.	Supervisor was available (where required intervenes) to ensure that each enumerator has implemented/followed the households selection criteria/sampling procedure/SOPs		
17.	Supervisor was available (where required intervenes) to ensure that each enumerator has implemented/followed the respondent selection/eligibility criteria		
18.	Supervisor was available (where required intervenes) to ensure that each enumerator has taken consent of respondent sharing complete information as given on the questionnaire		

19.	Supervisor was available (where required intervenes) to ensure that each enumerator used appropriate language using local dialects to make respondent feel comfortable and to get most useful information		
20.	How well has the supervisor handled any unwanted/unforeseen situation		
21.	The supervisor has extra tablets to provide to enumerators given ones have malfunctioned.		

Any other key field observation:

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Quality Monitor Report

Please list the key findings or assessments of the enumerators work, explain those issues that you are not satisfied with and include suggestions to address issues in future.

- Findings /Observations:

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- Suggestions:

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Please list the key findings or assessments of the supervisors work, explain those issues that you are not satisfied with and include suggestions to address issues in future.

- Findings /Observations:

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- Suggestions:

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## FGD Observation Checklist

Date of Observation: \_\_\_\_\_

<b>Monitor's Information</b>				
Monitor's Name		Contact Number		
<b>Geographical Information</b>				
Region Name		Province/district/sector/cell/village Name		
Village Name				
<b>FGD Details</b>				
Moderator's Name		Note-taker's Name		
FGD Group	<input type="checkbox"/> FGD with Parents/Caregivers/Community Influencers <input type="checkbox"/> FGD with Health Workers (CHWs/CHVs) <input type="checkbox"/> FGD with ECD Caregivers			
Monitoring/Observation Milestones	Option Please record the reason(s)/details, where applicable in the next column	Observation/Remarks	Corrective Measure(s) Needed	
Was the recruitment of the participants as per the criteria? (See Annex-A)	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Was attendance taken at the start of the FGD?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Was there any last minute change in the FGD participants?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator explain purpose of FGD to the participants before starting the discussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator establish rapport with the participants to make them comfortable enough to ask questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator read to/took consent of the participants prior to FGD for the FGD session, recording and taking photos	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Was the recording of the FGD started on time?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator properly explain all questions to the respondent?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator remain neutral and avoid making assumptions about during the FGD?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator follow the FGD guide?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator lead participants towards desired answers?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the moderator undertake requisite probing?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

For Face to Face FGD: Did the moderator and note taker have reasonable dressing and attitude during the FGD?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the moderator voice audible to all the participants?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the moderator ask the question in local or understandable language?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the moderator give enough time to all the participants for response?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the moderator ensuring participation of all the respondents to the extent possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the moderator leave any question unanswered from participants? Note: If yes, Please note down those questions and reason(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Were there any questions that the moderator did not ask at all? Note: If yes, Please note down those questions and reason(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
How was the behaviour of the moderator with the participants?	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Bad		
How was the behaviour of the note-taker with the participants?	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Bad		
Was the note-taker taking notes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did any participant leave in the mid of FGD session?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, was this noted?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Was the note-taker taking photos?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Additional Observations & Comments:**

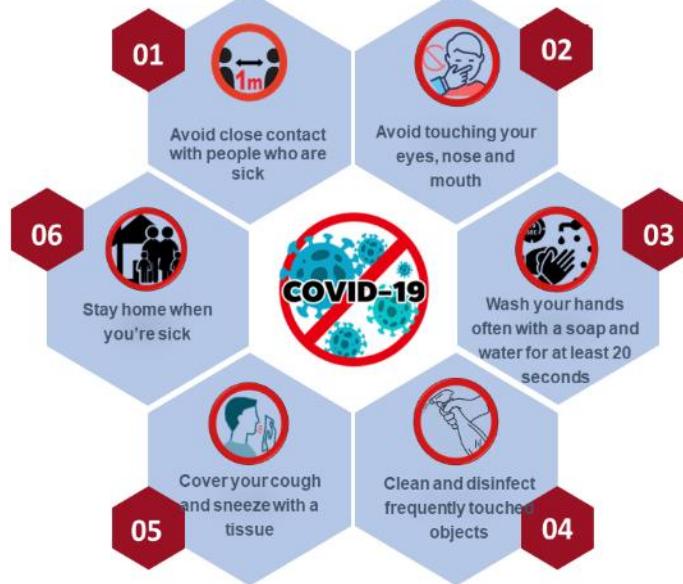
**Signature of the Monitor:** \_\_\_\_\_

## Appendix 20: COVID-19 Specific Safety and Protective Protocols

During Data Collection, the evaluators adopted some necessary precautionary measures to cope with COVID-19 situation. These measures included:

- a) Maintaining safe distance between each participant (KII, FGDs, workshop/consultative sessions) by making seating arrangements accordingly. This would be done in advance through local partner.
- b) The evaluators (including the local partner and national experts) will provide the disposable face masks to the participants to wear it before entering to place of FGDs.
- c) Simple disposable gloves will be provided to the participants to ensure that each stationary item (paper, pencil etc.) if used during interaction, remain out of contact of the participant.
- d) The Evaluators will ensure that local partner provide hand-sanitizer to use by the participants during interaction with evaluators.
- e) All evaluation team members (international team and national staff) will always carry hand-sanitizers before visiting any office to conduct KII or other formal/informal meetings during field mission.
- f) For simple/necessary refreshment during training and FGDs, disposable individual consumables (glass, plates etc.) would be used.
- g) Each participant would be dealt with respect, politeness and honour while ensuring above arrangements.
- h) The evaluators will be flexible to opt for any other evolving but considerably necessary precautionary measure that may evolve during discussions with UNICEF team, Government staff and local team to comply with and respect for national context due to COVID-19.

Figure: Safety and Protective Protocols under COVID-19 Situation



## **Appendix 21: Ethical Approval Process and Letter**

The ethical approval application for DHCR was submitted to the Rwanda National Ethics Committee (RNEC) on November 16<sup>th</sup>, 2021, by Mr. Valens. The application requested a special expedited approval as the field work needed to be finished before Christmas and New year holidays. The RNEC requested presentation on the DHCR Endline Evaluation study on November 29<sup>th</sup>, 2021. After presentation, they requested to change contact details on consent form and requested transport or monetary benefit for the FGD participants. These adjustments were made in the final application to RNEC after which the approval was granted on December 14<sup>th</sup>.

Please note that the fee for ethical approval was submitted to RNEC on October 23<sup>rd</sup>, 2021, as per the original plan of DHCR Evaluation. However, UNICEF requested change in methodology on October 23<sup>rd</sup>, 2021, which was not possible on such a short notice. The Inception Report was finally approved by UNICEF on November 15<sup>th</sup>, 2021.

### **Ethical Approval Checklist and letter**



NHRC\_Checklist\_20  
14.pdf



Approval for  
NKURIKIYINKA Valens

## **Appendix 22: Household Survey Tabulations**

Please see the file attached below for all the Household tabulations.

  
00 DHCR\_  
HHS\_Tables (all comb)

## Appendix 23: Compliance to UNEG Norms and Standards for Evaluation

Norms	Description	Compliance Measures <sup>169</sup>
<b>Norm 1: Internationally agreed principles, goals, and targets</b>	The principles and values to which the United Nations is committed, including the 2030 Agenda for Sustainable Development	The evaluators are aware of and subscribe to the principles and values of the UN. The evaluators are committed to refer to and integrate the international development frameworks such as SDGs, to inform the design, processes, and outputs of the evaluation.
<b>Norm 2: Utility</b>	Utility of an Evaluation is determined through the clear intention to use the resulting analysis, conclusions, or recommendations to inform decisions and actions. Subsequently, the Evaluations can be used to generate knowledge and empowering stakeholders, other than contributing to the work of an Organization.	The evaluators undertook a comprehensive review of the available Programme documents to identify the possible uses of the evaluation for each of the relevant stakeholder. Moreover, during kick-off meeting with UNICEF team the evaluation utility for key stakeholders were explored. The Terms of Reference also provided a deep insight on the possible uses of this evaluation for the Government particularly the MoH, UNICEF, and other IPs. The evaluators have taken due note of the objectives and possible uses (of evaluation) by the key audiences, to plan and implement a practical, specific, and realistic evaluation. Eventually, the resulting appreciation (of the evaluation utility) has informed the formulation of evaluation design and proposed methodology, to enable evaluators to produce analysis, conclusions and recommendations that can be used confidently to improve organizational learning, inform decision-making and create accountability. A national consultative workshop was conducted with selected stakeholders (national & sub-national) to enhance the utility and application of the evaluation.
<b>Norm 3: Credibility</b>	Credibility is based on independence, impartiality, and rigorous methodology	In addition to the steps that are being taken to ensure compliance with the norms of independence and impartiality, the evaluation is being implemented following transparent processes (by making the final report public by putting this on UNICEF Evaluation Database). Moreover, by evolving and implementing ‘inclusive approaches’ as evident in terms of constitution of multi-stakeholder ESC (for oversight) and reaching out to all key stakeholders including service providers, donors, technical partners, media, communities and others. A series of robust and tested quality assurance mechanisms (refer to the main report) are to be put in place for quality implementation and data collection. The evaluators are committed to ensure derivation of evaluation results (or findings) and recommendations by applying the conscientious, explicit, and judicious use of the best available, objective, reliable and valid data and by accurate quantitative and qualitative analysis of evidence. The credibility of the evaluation was achieved through careful use of the available data. To maintain credibility final evaluation report was published in UNICEF evaluation database.
<b>Norm 4: Independence</b>	Independence consists of two key aspects: <ol style="list-style-type: none"> <li>1. Behavioural Independence: the ability to evaluate without undue influence by any party</li> <li>2. Organizational Independence: independence from management functions &amp; availability of adequate resources to conduct its work</li> </ol>	Senior evaluation team lead to hedge against any influence on analysis and findings of the evaluation. Given it reaches to that level, evaluation team lead shall reach out to UNICEF to remind commitment to independence. The potential of conflict (team members have no potential of conflict) has been considered while forming the team for this evaluation to maintain impartiality.  The responsibility to maintain independence lies with the evaluators as much as with commissioning agency (UNICEF) and the lead national partner MoH. The evaluation team brings years of experience and exposure, which is reassuring in terms of their appreciation and capability to address any attempts to influence the evaluation. The evaluators remained vigilant for any factors that could affect or undermined the independence of the evaluation, and took all measures as necessary, including reporting to both UNICEF (as contract holder) and Evaluation Steering Committee (ESC -as an oversight forum).

<sup>169</sup> UNEG Norms and Standards for Evaluation 2017. <http://www.unevaluation.org/document/download/2787>

Norms	Description	Compliance Measures <sup>169</sup>
		The agreement (available in terms of contract) between parties, at implicit level is suggestive of adequacy of resources (by the evaluators) to plan and implement a robust evaluation.
<b>Norm 5: Impartiality</b>	The key elements of impartiality are objectivity, professional integrity, and absence of bias.	Awareness of the need to avoid any sort of bias is built into both the systems and culture of the evaluators. Any potential conflicts of interest and issues around integrity are investigated and addressed both when forming the core team and when training and selecting field team members. The data collection methodology is designed with the need to avoid biased sampling, tools etc. This vigilance extends into the data analysis and report-writing phases, as various pitfalls exist at both points in the evaluation that can undermine the impartiality of the process.
<b>Norm 6: Evaluation Ethics</b> <b>Intentionality:</b> <b>Conflict of interest</b> <b>Interactions with participants</b> <b>Evaluation processes and products:</b>	<p>Ethical principles for evaluation include obligations on the part of the Evaluators to behave ethically in terms of:</p> <ol style="list-style-type: none"> <li>1. <b>Intentionality:</b> considering the utility and necessity of an evaluation at the outset.</li> <li>2. <b>Conflict of interest:</b> exercising the commitment to avoid conflicts of interest in all aspects of their work.</li> <li>3. <b>Interactions with participants:</b> engaging appropriately and respectfully with participants in evaluation processes, upholding the principles of confidentiality and anonymity and their limitations; dignity and diversity; human rights; gender equality; and the avoidance of harm.</li> <li>4. <b>Evaluation processes and products:</b> ensuring accuracy, completeness, and reliability; inclusion and non-discrimination; transparency; and fair and balanced reporting.</li> </ol>	<p>The evaluators fully understand and are committed to ethical behaviour throughout the evaluation, while keeping in view the utility, necessity, and objectives of the evaluation. The evaluation team ensured respect to local culture, values and sensitivities during the KIIs and FGDs and confidentiality of the respondent shall be maintained.</p> <ul style="list-style-type: none"> <li>• <b>Any potential conflicts of interest</b> and issues around integrity are investigated and addressed both when forming the core team and when training and selecting field team members.</li> <li>• <b>The evaluators are committed to engaging respectfully with evaluation participants</b> and ensuring that respect to local culture, values, and sensitivities is maintained throughout, ensuring respect to local culture. The consultants fully understand and commit to exhibit complete confidentiality of the respondents, during fieldwork, data entry and cleaning. Personal information is kept physically separate as much as possible and consolidated data is handled by a single individual to reduce potential points of failure.</li> <li>• The evaluation ensured consistency and compliance with available guidelines to maintain human dignity and diversity, human rights, gender equality, and avoiding from harm both the respondents and evaluation team members.</li> <li>• The evaluators are committed to plan and implement an evaluation that ensures accuracy, completeness, reliability, inclusion and non-discrimination, transparency, and balanced reporting while acknowledging varied perspectives.</li> </ul> <p>Any misconduct noted during the evaluation shall be reported to the ESC, and given need, a discreet reporting to UNICEF Office of Audit and Investigation.</p>
<b>Norm 7: Transparency</b>	Transparency is an essential element of evaluation that establishes trust and builds confidence, enhances stakeholder ownership, and increases public accountability.	The Evaluators are ensuring that all the products should be publicly accessible to the relevant stakeholders and the key beneficiaries.
<b>Norm 8: Human Rights and Gender Equality</b>	The universally recognized values and principles of human rights, and gender equality need to be integrated into all stages of an evaluation.	The Evaluators are ensuring that all relevant human rights, and gender equality codes are integrated in all stages of the Evaluation. The evaluation complied with UN-SWAP, HRBA, and UNEG 2017 guidelines on "Integrating Human Rights and Gender Equality".
<b>Norm 9: National Evaluation Capacities</b>	The effective use of evaluation can make valuable contributions to accountability and learning and thereby justify actions to strengthen national evaluation capacities.	The Evaluators ensured on building capacity for the evaluation of development activities at the country level, national evaluation capacities should be supported upon the request of the Member States.
<b>Norm 10: Professionalism</b>	Key aspects of professionalism include access to knowledge, education, and training; adherence to ethics and these norms, and standards; utilization of evaluation competencies; and	The evaluators have put together a team of experienced experts who bring complementary training backgrounds, evaluation and sector expertise, global and regional exposure, to plan and implement the evaluation. The team members include both international and national experts, which would enable leveraging the local knowledge

Norms	Description	Compliance Measures <sup>169</sup>
	recognition of knowledge, skills, and experience.	and deeper context understanding. By putting together such a team including local partners (for field data collection), the evaluators are confident of the professional conduct of the team deployed. Moreover, AAN employs a series of internal checks and quality assurance mechanisms, which enable compliance to the best industry practices and standards. The evaluation team has extensive experience of working with multiple clients in local and international projects so demonstrate all sorts of professionalism in their work and conduct.

## Compliance to UNEG Standards

Standards	Sub-Standards	Description	Compliance Measures
<b>Standard 1:</b> <b>Institutional Framework</b>	<b>Standard 1.1:</b> Institutional framework for evaluation	The organization should have an adequate institutional framework for the effective management of its evaluation function.	The Evaluators have a comprehensive institutional framework to manage evaluation functions and conducting evaluations to ensure an effective evaluation process.
	<b>Standard 1.2:</b> Evaluation Policy	Organizations should establish an evaluation policy that is periodically reviewed and updated to support the evaluation function's increased adherence to the UNEG Norms and Standards for Evaluation.	Evaluators established an evaluation policy that was inclined with the UNEF Norms and Standards for the evaluation and with the Organization's goals and strategies.
	<b>Standard 1.3:</b> Evaluation plan and reporting	Evaluations should have a mechanism to inform the governing body and/or management on the evaluation plan and on the progress made in plan implementation.	The Evaluators made an evaluation plan based on an explicit evaluation policy and/or strategy, prepared with utility and practicality in mind and developed with a clear purpose, scope, and intended use for each evaluation. The Evaluators planned which should be supported with adequate human and financial resources to ensure the quality of evaluations conducted under the framework.
	<b>Standard 1.4:</b> Management response and follow up	The organization should ensure that appropriate mechanisms are in place to ensure that management responds to evaluation recommendations. The mechanisms should outline concrete actions to be undertaken in the management response and in the follow-up to recommendation implementation.	The Evaluators provided a formal management response to each evaluation. Moreover, the Evaluators should have an oversight mechanism to ensure that there are management responses to evaluation, that the actions contained in management responses are adequate to substantially address agreed recommendations and that the recommendations are appropriately implemented. The Evaluators should have a mechanism to oversee the implementation of actions provided in management responses, such as follow-up reports or tracking systems.
	<b>Standard 1.5:</b> Disclosure policy	The organization should have an explicit disclosure policy for evaluations. To bolster the organization's public accountability, key evaluation products (including annual reports, evaluation plans, terms of reference, evaluation reports and management responses) should be publicly accessible.	The Evaluators should have a disclosure policy that ensured that the public has easy access to evaluation reports. Depending on the nature of the evaluated organization's work, some cases may require an exception to the disclosure rule (e.g. when protection of stakeholders' private information is required).
<b>Standard 2:</b> <b>Management of the Evaluation Function</b>	<b>Standard 2.1:</b> Head of evaluation	The head of evaluation has the primary responsibility for ensuring that UNEG Norms and Standards for Evaluation are upheld, that the evaluation function is fully operational and duly independent, and that evaluation work	The institutional framework should clearly define the responsibilities of the head of evaluation who should ensure that an evaluation policy is implemented that adheres to UNEG Norms and Standards and applies the latest evaluation practices.

Standards	Sub-Standards	Description	Compliance Measures
		is conducted according to the highest professional standards.	He ensured that the evaluation plan is appropriately developed and implemented, the budget is efficiently managed, and all evaluation work is conducted according to the highest professional standards.
	<b>Standard 2.2:</b> Evaluation guidelines	The head of evaluation is responsible for ensuring the provision of appropriate evaluation guidelines.	The head of evaluation ensured the provision of evaluation guidelines within the organization for both central and decentralized evaluation.
	<b>Standard 2.3:</b> Responsiveness of the evaluation function	The head of evaluation should provide global leadership, standard-setting, and oversight of the evaluation function to ensure that it dynamically adapts to new developments and changing internal and external needs.	The head of evaluations from the Evaluators provided global leadership, standard-setting, and oversight of the evaluation function, moreover, the head managed all functions of evaluation, such as Raising awareness & capacity building, managing evaluation networks, design & implement evaluation methodology and system, ensure the maintenance of institutional memory through the user-friendly mechanism and promote systematic compilation of lessons.
<b>Standard 3: Evaluation Competencies</b>	<b>Standard 3.1:</b> Competencies	Individuals engaged in designing, conducting, and managing evaluation activities should possess the core competencies required for their role in the evaluation process.	Evaluators, evaluation managers and evaluation commissioners should continually seek to maintain and improve their competencies to provide the highest level of performance in producing and using evaluations within evolving institutional, national, regional, and global contexts and needs. This may require continuing professional development and capacity building initiatives.
	<b>Standard 3.2:</b> Ethics	All those engaged in designing, conducting, and managing evaluations should conform to agreed ethical standards in order to ensure overall credibility and the responsible use of power and resources.	The Evaluators engaged the members involved in designing, conducting, and managing evaluations to adapt to agreed ethical standards to ensure overall credibility and accountable use of power and resources.
<b>Standard 4: Conduct Evaluations</b>	<b>Standard 4.1:</b> Timeliness and intentionality	Evaluations should be designed to ensure that they provide timely, valid, and reliable information that was relevant to the subject being assessed and should clearly identify the underlying intentionality.	The evaluators designed all the evaluation activities to provide timely, valid, and reliable information relevant to the subject being assessed.
	<b>Standard 4.2:</b> Evaluability assessment	An assessment of evaluability should be undertaken as an initial step to increase the likelihood that an evaluation provided timely and credible information for decision-making.	The Evaluator took measures to address the problems such as the reconstruction of theory of change, readjusting evaluation scope or time or reconsulting commissioners to revise the expectations.
	<b>Standard 4.3:</b> Terms of reference	The terms of reference should provide the evaluation purpose, scope, design, and plan.	The Evaluator briefly go through the terms of reference for the clarity of the purpose and to understand the intentionality of the evaluation. The Terms of Reference provides an appropriate indication of the size and magnitude of the subject to be evaluated.  However, any changes to the terms of reference during the evaluation was reviewed, if agreeable, approved by the commissioning party.
	<b>Standard 4.4:</b> Evaluation scope and objectives	Evaluation scope and objectives should follow from the evaluation purpose and should be realistic and achievable considering resources available and the information that can be collected.	Following from the purpose, the scope and objectives concretely explain what the evaluation is expected to cover and achieve. The evaluation scope determines the boundaries of the evaluation, tailoring its objectives to the given situation. The scope acknowledges the limitations of the evaluation.

Standards	Sub-Standards	Description	Compliance Measures
	<b>Standard 4.5:</b> Methodology	Evaluation methodologies must be sufficiently rigorous such that the evaluation responds to the scope and objectives, is designed to answer evaluation questions, and leads to a complete, fair, and unbiased assessment.	The Evaluation team choose methodologies with a clear intent to provide credible answers to the evaluation questions. The methodology was ensuring that the information collected is valid, reliable, and sufficient to meet the evaluation objectives. The evaluation team applied the triangulation principles to validate the findings.
	<b>Standard 4.6:</b> Stakeholder engagement and reference groups	Inclusive and diverse stakeholder engagement in the planning, design, conduct and follow-up of evaluations is critical to ensure ownership, relevance, credibility, and the use of evaluation. Reference groups and other stakeholder engagement mechanisms should be designed for this purpose.	The Evaluation team consulted all the relevant stakeholders in the planning, design, conduct and follow-up stages of the evaluation. The Evaluators used a variety of mechanisms to consult a broad range of stakeholders, such as consultation meetings, validation workshops, learning workshops etc.
	<b>Standard 4.7:</b> Human rights-based approach and gender mainstreaming strategy	The evaluation design should include considerations of the extent to which the United Nations system's commitment to the human-rights based approach and gender mainstreaming strategy was incorporated in the design of the evaluation subject.	The Evaluation team considered gender equality issues even in the hard-to-reach and vulnerable groups. The Evaluation team indicated both duty bearers and rights holders (particularly women and other groups subject to discrimination) as primary users of the evaluation and specify how they involved in the evaluation process; Specify an evaluation approach and methods of data collection and analysis that are human rights-based and gender-responsive.
	<b>Standard 4.8:</b> Selection and composition of evaluation teams	The evaluation team should be selected through an open and transparent process, considering the required competencies, diversity in perspectives and accessibility to the local population. The core members of the team should be experienced evaluators.	The evaluation team included members having appropriate methodological expertise. External evaluators were selected by avoiding any biases and selecting members with a strong professional opinion on the subject matter. Moreover, the Evaluation team had experts in the advisory roles and their views should be triangulated. The evaluation team made sure to achieve gender balance in the evaluation team and geographical diversity involving different perspectives. Along with this, the evaluation team included national and regional members to enhance the acceptability by local populations.
	<b>Standard 4.9:</b> Evaluation report and products	The final evaluation report should be logically structured and contain evidence-based findings, conclusions, and recommendations. The products emanating from evaluations should be designed to the needs of its intended users.	The evaluation team present the evaluation report in a way to allow intended readers to access relevant information clearly and simply. The Evaluation team manager designed the report to cater to different types of intended readers.
	<b>Standard 4.10:</b> Recommendations	Recommendations should be firmly based on evidence and analysis, clear, results-oriented, and realistic in terms of implementation.	The Evaluation team formulated the recommendations. Depending on the subject of evaluation, the recommendations was indicated strategic directions or be more focused on operational matters. The evaluation team make sure that the recommendations would be clear on who needs to implement them.
	<b>Standard 4.11:</b> Communication and dissemination	Communication and dissemination are integral and essential parts of evaluations. Evaluation functions should have an effective strategy for communication and dissemination that is focused on enhancing evaluation use.	The Evaluation team communicated the key evaluation messages to the relevant stakeholders and any potential users of the information and knowledge generated. The Evaluators conducted effective and proactive communication and dissemination contribute to the use of evaluation not only for public accountability purposes but also for knowledge building and sharing, cross-fertilization of lessons learned and the promotion of good practices.

Standards	Sub-Standards	Description	Compliance Measures
<b>Standard 5: Quality</b>	<b>Standard 5.1:</b> Quality assurance system	The head of evaluation should ensure that there is an appropriate quality assurance system.	The head of evaluation ensured an appropriate quality assurance system which ensured the objectivity of the review. It can be conducted through internal or external experts which provided guidance and oversight through the process of evaluation.
	<b>Standard 5.2:</b> Quality control of the evaluation design	Quality should be controlled during the design stage of evaluation.	The Evaluators control the quality of the evaluation design at the design stage by examining the terms of reference, the scope and methodology, the evaluation processes, evaluation team and other ethical issues.
	<b>Standard 5.3:</b> Quality control at the final stage of evaluation	Quality should be controlled during the final stage of evaluation.	The Evaluators control the quality during the final stages by examining the quality-assured methodologies and processes, moreover, ensure the appropriateness of the data collected and findings, whether the evaluation adequately addresses human rights, and gender equality considerations, whether the report answers all the evaluation questions and is in the appropriate editorial style and structure.

## Appendix 24: Compliance to UNICEF Procedure for Research & Evaluation

Ethical Considerations & Description	Compliance Measures <sup>170</sup>
<b>Conflicts of Interest:</b> Conflict of interest: exercising the commitment to avoid conflicts of interest in all aspects of their work.	Any potential conflicts of interest and issues around integrity are investigated and addressed both when forming the core team and when training and selecting field team members.
<b>Avoidance of Harm:</b> Avoiding harm or injury to participants, both through acts of commission or omission; ensure no harm comes to participants by inappropriate, unskilled or incompetent researchers or enumerators.	The evaluators put in place mechanisms to pre-empt and adequately respond to the security and safety risks associated with the fieldwork. The application of this principle would apply both to the participants of the evaluation and teams to be deployed for field data collection. The field team members shall be trained on the principle of avoidance of harm and informed of security and safety protocols for the fieldwork. Similarly, the quality assurance team was guided to investigate the application of the principle of avoidance of harm.
<b>Informed Consent:</b> The voluntary agreement of an individual to participate in an evidence generating activity based on sufficient knowledge and understanding regarding it.	Potential participants were duly informed about the purpose of the activity and scope of their involvement. They were informed about the voluntary nature of their participation, and that the consent can be withdrawn at any point. The decision whether to participate, including dissent or unwillingness to participate, was respected. Evaluators obtained informed consent for the use of private information from those who provide it. They provided participants with informed consent (IC) form in a format that is consistent with the capabilities (including literacy) of participants.
<b>Privacy of Participants:</b> It refers to the rights of the individuals to limit access of others to aspects of their person that can include their thoughts and identifying information. Measures must be taken to ensure participants' privacy during and after the data collection process.	In all reports produced consequent to findings of research, evaluation or data collection and analysis, the privacy and confidentiality of participants was assured with data de-identified at the individual level, or findings summarized to an appropriate level of aggregation, particularly in the instance of clear negative impacts such as stigma and reprisals. Participants was also given a clear indication of who had access to their private data and in what form.
<b>Storage of Data:</b> Confidential participant information or data that is collected must be securely stored, protected, and disposed of.	Hard copies such as interview notes, prints of photographs, or video or audiotapes to be kept securely locked away; Files, including computer files, that contain personal or identifiable data (such as names) was encrypted or password protected and only accessed by agreed members of the team; and computer files including anonymised data was held securely, and can only be shared according to the terms of your consent from participants.
<b>Protection Protocols for Vulnerable Groups:</b> Protection protocols for vulnerable groups must be in place to provide safe environments for data collection, to safeguard them from abusive or incompetent researchers/evaluators/enumerators, to respond to any safety concerns or grievances, and to refer them to local supports both during and after the evidence generation activity	When there is conclusive proof of definitive negative outcomes for participants or their communities during the evidence generation, protection protocols shall be enacted, and an assessment undertaken by the project managers, whether the project can be modified to prevent further negative outcomes or whether the project must be stopped.

<sup>170</sup> UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection And Analysis (2015). Document Number: CF/PD/DRP/2015-001.  
[https://www.unicef.org/supply/files/ATTACHMENT\\_IV\\_UNICEF\\_Procedure\\_for\\_Ethical\\_Standards.PDF](https://www.unicef.org/supply/files/ATTACHMENT_IV_UNICEF_Procedure_for_Ethical_Standards.PDF)

## Appendix 25: Evaluation Team Organogram, Profile and Role

The evaluation is commissioned to AAN Associates, an international development firm. AAN Associates as prime contractor remains responsible for complete evaluation. For field data collection and coordination, AAN Associates shall work with local partner, Research Hub and deploy team of international and national consultants to complete the assignment.

The evaluation team to be deployed for the evaluation comprises both national and international experts. The team brings together a good balance of maturity, experience, sector understanding, international exposure and context understanding. A considered focus was laid on forming a gender-balanced teams for field data collection and management. The national partner provided additional human resources such as survey manager, field supervisor, moderators, enumerators, note takers, and quality monitors.

Find below the tasks assigned to core team members (refer to Table below).

Position - Name	Responsibilities	LOE (days/months)
<b>International Team</b>		
<b>Evaluation Team Lead</b> Mr. Nadeem Haider	<ul style="list-style-type: none"> <li>Lead the entire evaluation processes at all stages of the evaluation.</li> <li>Develop and provide detailed methodological guidance on each stage of the evaluation.</li> <li>Delegate, monitor and supervise the work of other team members.</li> <li>Lead the field mission and decide upon the division of roles and responsibilities among team members.</li> <li>Train team members for data collection Lead in analysis and reporting ensuring that gender lens is applied in all aspects of evaluation findings and reporting.</li> <li>Lead the reflection and validation workshop.</li> </ul>	53 days
<b>Evaluation Manager</b> Mr. Asher Osman Khan	<ul style="list-style-type: none"> <li>Providing technical inputs in evaluation design, methodology, tools preparation, analysis, and reporting.</li> <li>Provide oversight for logistics, and coordination, and communication with national/international Consultants and partner.</li> <li>Manage and coordinate with other departments for support in field.</li> </ul>	5 months
<b>Quantitative Data Analyst</b> Mr. Zahid Jamal	<ul style="list-style-type: none"> <li>Lead quantitative data analysis.</li> <li>Develop crosstab and frequency tables.</li> <li>Discuss any new and emergent themes from the analysis with team members.</li> </ul>	27 days
<b>Qualitative Data Analyst</b> Ms. Sara Anver	<ul style="list-style-type: none"> <li>Lead qualitative data analysis.</li> <li>Undertake qualitative coding of interviews in MAXQDA.</li> <li>Discuss any new and emergent themes from the analysis with team members.</li> </ul>	27 days
<b>Research Associate</b> Ms. Surraya Mehbub Malik	<ul style="list-style-type: none"> <li>Assist in desk review.</li> <li>Support the team members in quantitative and qualitative data analysis.</li> <li>Assist in report writing and undertake any other research-oriented tasks.</li> </ul>	5 months
<b>National Team</b>		
<b>Child Protection Expert</b> Mr. Valens Nkurikiyinka	<ul style="list-style-type: none"> <li>Provide technical inputs on sector related (child protection) issues specifically for the country of interest.</li> <li>Provide inputs on evaluation design, evaluation matrix, and tools.</li> <li>Conduct/lead KIIs and FGDs.</li> <li>Finalizing field notes and analysis from field findings.</li> <li>Support the team in analysis.</li> <li>Provide support on final report.</li> </ul>	18 days
<b>Evaluation and WASH Expert</b> Mr. Bernard Habimana	<ul style="list-style-type: none"> <li>Provide technical inputs on sector related (WASH) issues specifically for the country of interest.</li> <li>Provide inputs on evaluation design, evaluation matrix, and tools.</li> <li>Conduct/lead KIIs and FGDs.</li> <li>Finalizing field notes and analysis from field findings.</li> <li>Support the team in analysis.</li> <li>Provide support on final report.</li> </ul>	25 days
<b>Health Expert</b> Ms. Francisca	<ul style="list-style-type: none"> <li>Provide technical inputs on sector related (child protection) issues specifically for the country of interest.</li> <li>Provide inputs on evaluation design, evaluation matrix, and tools.</li> <li>Conduct/lead KIIs and FGDs.</li> </ul>	25 days

Position - Name	Responsibilities	LOE (days/ months)
<b>National Coordinator</b>	<ul style="list-style-type: none"> <li>Finalizing field notes and analysis from field findings.</li> <li>Support the team in analysis.</li> <li>Provide support on final report.</li> </ul>	
Patrick Ndayambaje	<ul style="list-style-type: none"> <li>Remain full time available with the team and support in all field logistics and coordination.</li> <li>Organize internal meetings with partner and other stakeholders.</li> <li>Accompany team to the concern government offices.</li> </ul>	24 days
<b>National Survey Manager</b> <b>Research Hub</b> (local Partner) Staff	<ul style="list-style-type: none"> <li>Conduct regular field visits for quality checks.</li> <li>Carry out field monitoring visits to collect data, on predesigned monitoring instruments, through observation, personal interviews and taking photographs (if feasible)</li> </ul>	22 man-days

## Appendix 26: Evaluation Workplan

Key Steps of Phases	Key Activities	Activities Completion Date	Remarks
Kick-off Meeting	Kick-off Meeting	September 10, 2021	
Inception Report	Submit IR to UNICEF	October 3, 2021	
	UNICEF/ESAR partial feedback shared with AAN	October 24, 2021	
	UNICEF/ERG partial feedback shared with AAN	November 4, 2021	
	Consolidated Feedback incorporated to finalize the IR	November 6, 2021	<ul style="list-style-type: none"> <li>After Kick Off Meeting this Phase took <b>9 Weeks</b> due to Finalization of Evaluation Methodology.</li> <li>UNICEF delayed sharing documents with us</li> <li>UNICEF' approval on the IR took more than the estimated time as it was approved in the mid of November (15<sup>th</sup>).</li> </ul>
Pre-field planning	RNEC Application submitted	November 16, 2021	This Phase also took <b>9 Weeks</b> <ul style="list-style-type: none"> <li>Presentation on ERB (29<sup>th</sup> Nov) and ERG (13<sup>th</sup> Dec) was dependent on approval from UNICEF on IR.</li> <li>ERG presentation was dependent on the members who were not available.</li> <li>Due to Christmas break, TOT was scheduled from 10<sup>th</sup> January onwards.</li> </ul>
	Approval from RNEC	December 14, 2021	
Training and Pre-testing	Training of enumerators and national consultants and pre-testing	January 10-18, 2022	
Field Work Execution	Field work completed (HH, Klls, FGDs)	January 19 – February 10, 2022	Field Activities Planned in <b>3 Weeks</b> <ul style="list-style-type: none"> <li>UNICEF delayed sharing the contact list with us</li> </ul>
Data Processing and Management	Transcription, qualitative data processing, extraction of summaries, triangulation, and analysis	February 10- March 25, 2022	Data Analysis Planned in <b>2 Weeks</b>
Draft Final Report	First draft shared with UNICEF	April 15, 2022	Final Report Submission and finalization planned in <b>7 Weeks</b>
Final Report and Project Closure	Client's Consolidated feedback received	April 30, 2022	
	Summary Report and Finalize and revised the final report	May, 2022	
	Knowledge product (to be determined – e.g. Summary Report, Brief, or Poster)		
	Validation workshop with key stakeholders to present the findings and recommendations		
	Handover of all documents		
<b>Total Time Duration of the Project</b>			<b>30 Weeks</b>

## Appendix 27: Relevance Detailed Findings

The matrix below provides detailed findings on alignment of DHCR with UNICEF's regional and global priorities:

Table: Overlaps Between DHCR objectives, and components with GoR ECD and Nutrition Policy

Programme' Impact, outcomes, components, and strategies	National ECD Policy Objectives /Goal (2011)	National Nutrition Policy Objectives /Goal (2014)	Analysis
<b>Impact (I):</b>  <b>I 1:</b> Prevalence of stunting among children under 5 (U5) years reduced  <b>I 2:</b> Young children's holistic development	<b>Goal:</b> To ensure all Rwandan children achieve their potential, and their caretakers become nurturing caregivers through receiving integrated ECD service <b>(I1) (O2) (PC1)</b> .	<b>Mission/Objective:</b>  To improve the household food security and nutritional status. <b>(O1, PC1, PC6)</b>	<ul style="list-style-type: none"> <li>The DHCR design fully corresponds with GoR ECD, and Nutrition Policy.</li> <li>The two impact indicators of DHCR programme and most of the outcomes are in line with <b>ECD policy</b> in term of provision of WASH services, pre-primary education, ECD services, integrated multisectoral interventions, reduction in stunting and holistic development.</li> </ul>
<b>OUTCOMES (O)</b>  <b>O1:</b> Children U5 utilize effective nutrition / health interventions  <b>O2:</b> Young children and families utilize quality ECD services  <b>O3:</b> Families with young children in the targeted districts use improved WASH services  <b>O4:</b> Poorest households with children U5 in 10 districts/sectors have benefitted from child-sensitive public works  <b>O5:</b> Improved and equitable participation in quality pre-primary education  <b>O6:</b> The integrated multi-sectoral programme interventions are effectively planned, managed, and coordinated at national and sub-national level; and key family practices across sectors are promoted  <b>O7:</b> Private sector investment and support to the multi-sectoral Nutrition programme increased  <b>Programme' components (PC)</b>  <b>PC1:</b> Nutrition-specific interventions  <b>PC2:</b> ECD services and education  <b>PC3:</b> WASH services and education  <b>PC4:</b> Social protection  <b>PC5:</b> Equitable pre-primary education  <b>PC6:</b> Planning, management, coordination, and monitoring for integrated programme	<b>Specific Objectives (SO)</b>  <b>SO1:</b> To improve birth outcomes, reduce infant and maternal mortality and high fertility rates. <b>(O1, PC2)</b>  <b>SO2:</b> To improve parents' and legal guardians' knowledge, skills, and resources to support the development of their children <b>(O2, O1, O6, PC1)</b>  <b>SO3:</b> To ensure infants and toddlers receive nurturing care and developmental services, and prepared for success in school and life <b>(O2, O5, PC2, PC5)</b>  <b>SO4:</b> To prevent and reduce stunted growth and improve child development outcomes for the most vulnerable children and children with special needs <b>(O2, PC1)</b>  <b>SO5:</b> To reduce malnutrition and children under-5 child mortality and morbidity through preventive measures and child health care and nutrition services <b>(O1, PC1, PC4)</b>  <b>SO6:</b> To reduce the incidence of childhood illnesses and diseases due to WASH issues <b>(O3, PC3)</b>  <b>SO8:</b> To provide comprehensive ECD services of high quality <b>(O2, O6, PC2, PC5)</b>  <b>SO9:</b> To ensure that all children begin school at the correct age <b>(O5, PC2, PC5)</b>  <b>SO10:</b> To support the coordination, monitoring and evaluation of all processes, programmes and services related to ECD, <b>(O2, O6, PC6)</b>  <b>SO11:</b> To sensitise local authorities, opinion leaders, parents, communities, and journalists about the importance of children's early development, ECD Policy provisions, and their roles in assisting with planning, implementing, and	<b>Strategic Objective (SO)</b>  <b>SO1:</b> Sustain the position of food and nutrition as central priorities of the Government <b>(O1, O7, PC6)</b>  <b>SO2:</b> Prevent stunting in children under two years of age <b>(O1, O2, O3, PC1, PC3)</b>  <b>SO3:</b> Strengthen, expand, and promote services and practices of food security year-round <b>(O1, O4, O6, PC2)</b>  <b>SO4:</b> Prevent and manage all forms of malnutrition <b>(O1, O3, PC1, PC3)</b>  <b>SO5:</b> Strengthen nutrition education in schools and higher learning institutions <b>(O5, PC5)</b>  <b>SO6:</b> Strengthen emergency preparedness and response <b>(O1, O6, PC4)</b>  <b>SO7:</b> Improve governance systems and accountability for nutrition and food security <b>(O6, O7, PC6)</b>	<ul style="list-style-type: none"> <li>Nutrition policy mainly focuses on children U2 years of age whereas the Outcome 1 of DHCR focuses on children U5 years, the general objective of the Policy aligns with the outcome 1 of the DHCR programme emphasizing on the health and nutrition interventions.</li> <li>The nutrition policy focuses to prevent stunting, providing public works, improve WASH services, to prevent malnutrition, provide ECD services to children and caregivers, ensure active participation of private sector and government officials, improve quality of education, and improve household food security. These focuses are aligned with the DHCR.</li> <li>DHCR design also found relevant with goal and programmatic priorities of UNICEF Nutrition Strategy (2020-2030) which aimed that: A world where all children, adolescents and women realize their right to nutrition.</li> <li>DHCR design also found relevant with UNICEF vision for ECD which states that: All children from conception to the age of school entry, especially the most disadvantaged, achieve their developmental potential, including in humanitarian settings.</li> </ul>

	overseeing essential children's services (O2, O6, PC2, PC6)		
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Programme' Goal, outcomes, and outputs	UNICEF goals & Strategy for Health (2016-2030) <sup>171</sup>	UNICEF goals for ECD (Programme Division 2017) <sup>172</sup>	UNICEF Nutrition Strategy 2020-2030 <sup>173</sup>
<p><b>Impact 1:</b> Prevalence of stunting among children under 5 years reduced</p> <p><b>Impact 2:</b> Young children's holistic development improved</p> <p><b>Outcome 1:</b> Children under 5 utilize effective nutrition / health interventions</p> <p><b>Outcome 2:</b> Young children and families utilize quality ECD services, and parents/primary caregivers apply improved childcare and stimulation practices</p> <p><b>Outcome 3:</b> Families with young children in the targeted districts use improved water, sanitation and hygiene services</p> <p><b>Outcome 4:</b> Poorest households with children under 5 in 10 districts/sectors have benefitted from child-sensitive public works</p> <p><b>Outcome 5:</b> Improved and equitable participation in quality pre-primary education</p> <p><b>Outcome 6:</b> The integrated multi-sectoral programme interventions are effectively planned, managed and coordinated at national and sub-national level; and key family practices across sectors are promoted</p> <p><b>Outcome 7:</b> Private sector investment and support to the multi-sectoral Nutrition programme increased</p>	<p><b>Vision</b></p> <p>A world where no child dies from a preventable cause and all children reach their full potential in health and well-being (I2)</p> <p><b>Goal</b></p> <p>Goal 1. End preventable maternal, newborn and child deaths (I2) (O1) (O4) (O6)</p> <p>Goal 2. Promote the health and development of all children (I1) (I2) (O1)</p> <p><b>Strategies</b></p> <p>S 1. addressing inequities in health outcomes (O1)</p> <p>S 2. strengthening health systems, including emergency preparedness, response and resilience (O6)</p> <p>S 3. promoting integrated, multi-sectoral policies and programmes (O2) (O3) (O4) (O5) (O6) (O7)</p>	<p><b>Goal</b></p> <p>All young children, from conception up to the age of school entry, achieve their developmental potential in equitable inclusive care environments, programme and policies, including in humanitarian setting (I2) (O3) (O4) (O6)</p> <p><b>Objectives</b></p> <p>1. Children up to the age of school entry receive essential services Children up to the age of school entry, including children with disabilities and children in fragile contexts, have equitable access to quality childcare, health, nutrition, protection and early learning services to address their developmental needs (I1) (I2) (O1) (O2) (O4) (O5) (O6)</p> <p>2. Parents and caregivers practice nurturing Care Parents engaged in nurturing care and positive parenting and stimulating and learning activities (I2) (O2)</p>	<p><b>Vision</b></p> <p>A world where all children, adolescents and women realize their right to nutrition (O1)</p> <p><b>Goal</b></p> <p>To protect and promote diets, services and practices that support optimal nutrition, growth and development for all children, adolescents and women (I1) (I2) (O1) (O4) (O5) (O7)</p>

The matrix below provides detailed findings on alignment of DHCR goals with Partners' goals:

Table Findings on alignment of DHCR goals with Partners' goals

Programme' Goal, outcomes and outputs	WFP	WHO	FAO
<p><b>Impact 1:</b> Prevalence of stunting among children under 5 years reduced</p> <p><b>Impact 2:</b> Young children's holistic development improved</p> <p><b>Outcome 1:</b> Children under 5 utilize effective nutrition / health interventions</p> <p><b>Outcome 2:</b> Young children and families utilize quality ECD services, and parents/primary caregivers apply improved childcare and stimulation practices</p>	<p><b>Nutrition</b></p> <p><b>Mission</b><sup>174</sup>: The mission is to <b>deliver food assistance in emergencies</b> and work with communities to <b>improve nutrition and build resilience</b> (I1)(I2) (O1) (O2)</p> <p><b>Strategic Goals</b><sup>175</sup></p>	<p><b>WHO ECD Guidelines (2020)</b><sup>176</sup> - provides global, evidence-informed recommendations on improving ECD. The objective is to identify ECD-specific interventions and feasible approaches that are effective in improving developmental outcomes in children.</p> <p><b>Objectives:</b></p> <ul style="list-style-type: none"> <li>To identify ECD-specific interventions that are effective in</li> </ul>	<p><b>Nutrition</b> (I1)(I2) (O1)</p> <ul style="list-style-type: none"> <li>To achieve food security for all and make sure that people have regular access to enough high-quality food to lead active, healthy lives<sup>178</sup></li> <li>Reduce malnutrition</li> </ul>

<sup>171</sup> UNICEF Strategy for Health 2016-2030

<sup>172</sup> ECD UNICEF\_ECD\_Programme\_Guidance,\_September,\_2017

<sup>173</sup> UNICEF Nutrition Strategy 2020-2030

<sup>174</sup> <https://www.wfp.org/overview>

<sup>175</sup> <https://www.wfp.org/corporate-strategy>

<sup>176</sup> <https://www.who.int/publications/item/97892400020986>

<sup>178</sup> <https://www.fao.org/about/en/>

<p><b>Outcome 3:</b> Families with young children in the targeted districts use improved water, sanitation and hygiene services</p> <p><b>Outcome 4:</b> Poorest households with children under 5 in 10 districts/sectors have benefitted from child-sensitive public works</p> <p><b>Outcome 5:</b> Improved and equitable participation in quality pre-primary education</p> <p><b>Outcome 6:</b> The integrated multi-sectoral programme interventions are effectively planned, managed and coordinated at national and sub-national level; and key family practices across sectors are promoted</p> <p><b>Outcome 7:</b> Private sector investment and support to the multi-sectoral Nutrition programme increased</p>	<p><b>Strategic Goal 1:</b> Support countries to achieve zero hunger (SDG 2) (I1)(O2) (O6) SO 1. End hunger by protecting access to food SO 2. Improve nutrition SO 3. Achieve food security</p> <p><b>Strategic Goal 2:</b> Partner to support implementation of the SDGs (SDG 17) (O2) (O7) SO 4: Support SDG implementation SO 5: Partner for SDG results</p>	<ul style="list-style-type: none"> <li>improving developmental outcomes in children</li> <li>Identify effective, feasible approaches to deliver interventions to improve ECD.</li> </ul> <p><b>Nutrition</b><sup>177</sup> (I1)(I2) (O1)</p> <p><b>Objectives:</b></p> <ul style="list-style-type: none"> <li>achieve a 40% reduction in the number of children under-5 who are stunted</li> <li>achieve a 50% reduction of anaemia in women of reproductive age.</li> <li>achieve a 30% reduction in low birth weight</li> <li>ensure that there is no increase in childhood overweight</li> <li>increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%</li> <li>reduce and maintain childhood wasting to less than 5%</li> </ul>	through efficient, inclusive, resilient and sustainable agri-food systems <sup>179</sup>
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## WHO

Existing WHO guidelines related to neonatal care; infant and young child nutrition; environmental health; prevention and treatment of childhood illnesses; violence and injury prevention; mental health; prevention of noncommunicable diseases; and support for children with developmental difficulties or disabilities, refer to the importance of respective interventions for ECD. However, they do not address ECD-specific interventions such as those related to responsive caregiving and early learning.<sup>180</sup>

## FAO

ECD is not in direct goals of FAO but for FAO holistic and coherent school programmes and policies are key to achieve children's human rights to food, education and health. Through complementary interventions such as healthy school meals and food and nutrition education, pupils can improve their diets, develop healthier food practices and extend these to their families and communities. These programmes can also support local agriculture, strengthen and diversify local food systems and help move people out of poverty by sourcing food for school meals from local smallholder farmers. FAO works with governments to leverage schools' potential through programmes and policies, supporting the Sustainable Development Goals of food security, nutrition, education and health for everyone.<sup>181</sup> DHCR lacks alignment with FAO on ECD as it could have helped in utilizing ECD centers for imparting information on healthy school meals and food and nutrition etc.

## WFP

In Rwanda, the school feeding on-site for children corresponds to Early Child Development (ECD) which hasn't started since the beginning of the country strategic plan -CSP (2019)<sup>182</sup>. In 2015, Burundi refugee crisis began as they try to escape violence in their home country, thousands of Burundians have fled and become refugees. These people seek shelter in several different countries, including Rwanda.<sup>183</sup> At the end of 2020, some 65,000 Burundian refugees were registered in Rwanda. Between 27 August and 31 December 2020 weekly convoys were organized, facilitating the return of 7,896 refugees.<sup>184</sup> This affected approximately 35,286 refugee children and host community children attending the same school as refugee children. This included a scale-up of the national school feeding programme to reach all primary schools, from the programme's current target reach of secondary schools and early childhood development centers.<sup>185</sup>

The matrix below provides detailed findings on alignment of DHCR with country's other sectoral policies – Ministry of Economic and Finance, Education, Local Government, Family Promotion, National Strategy for Transformation and vision 2020:

<sup>177</sup> <https://www.who.int/publications/i/item/WHO-NMH-NHD-14.2>

<sup>179</sup><https://www.fao.org/nutrition/en/#:~:text=The%20Vision%20and%20Strategy%20for,sustainable%20agri%2Dfood%20systems%20>

<sup>180</sup> <file:///C:/Users/kkc/Downloads/9789240002098-eng.pdf>

<sup>181</sup> <https://www.fao.org/school-food/en/>

<sup>182</sup> <https://docs.wfp.org/api/documents/WFP-0000125428/download/>

<sup>183</sup> <https://borgenproject.org/burundi-refugee-crisis/>

<sup>184</sup> <https://www.dw.com/en/burundi-rwanda-refugees-pierre-nkurunziza/a-54727122>

<sup>185</sup> <https://docs.wfp.org/api/documents/WFP-0000125428/download/>

Table: Findings on alignment of DHCR with country's other sectoral policies

Programme' Goal, outcomes and outputs	MINECOFIN <sup>186</sup>	MINEDU <sup>187</sup>	MINALOC <sup>188</sup>
<p><b>Impact 1:</b> Prevalence of stunting among children under 5 years reduced</p> <p><b>Impact 2:</b> Young children's holistic development improved</p> <p><b>Outcome 1:</b> Children under 5 utilize effective nutrition / health interventions</p> <p><b>Outcome 2:</b> Young children and families utilize quality ECD services, and parents/primary caregivers apply improved childcare and stimulation practices</p> <p><b>Outcome 3:</b> Families with young children in the targeted districts use improved water, sanitation and hygiene services</p> <p><b>Outcome 4:</b> Poorest households with children under 5 in 10 districts/sectors have benefitted from child-sensitive public works</p> <p><b>Outcome 5:</b> Improved and equitable participation in quality pre-primary education</p> <p><b>Outcome 6:</b> The integrated multi-sectoral programme interventions are effectively planned, managed and coordinated at national and sub-national level; and key family practices across sectors are promoted</p> <p><b>Outcome 7:</b> Private sector investment and support to the multi-sectoral Nutrition programme increased</p>	<p><b>STO:</b> Promotion of macroeconomic stability and wealth creation to reduce aid dependency (O7)</p> <p><b>MTO:</b> Transforming from an agrarian to a knowledge-based economy (O5) (O6)</p> <p><b>LTO:</b> Creating a productive middle class and fostering entrepreneurship (O6) (O7)</p>	<p><b>Core Objectives (CO)</b></p> <p><b>CO 1.</b> To educate a self-resilient citizen who is free from all kinds of discrimination, including gender based discrimination, exclusion and favouritism (O5)</p> <p><b>CO 2.</b> To contribute to the promotion of a culture of peace and to emphasize Rwandan values, and the universal values of justice, peace, tolerance, respect for human rights, gender equality, solidarity and democracy (O4) (O5) (O6)</p> <p><b>CO 3.</b> To dispense a holistic moral, intellectual, social, physical and professional education through the promotion of individual competencies and aptitudes in the service of national reconstruction and the sustainable development of the country (O5) (O6)</p> <p><b>CO 5.</b> To develop in the Rwandese citizen autonomy of thought, patriotic spirit, a sense of civic pride, a love of work well done and global awareness (O6)</p> <p><b>CO 6.</b> To transform the Rwandese population into human capital for development through acquisition of lifelong learning skill (O5) (O6)</p> <p><b>CO 7.</b> To eliminate all the causes and obstacles which can lead to disparity in education be it by gender, disability, geographical or social group (O5)</p>	<p><b>Specific Objectives (SO)</b></p> <p><b>SO 1.</b> To empower citizens in an inclusive way so that their participation and engagement in development, self-reliance, unity and reconciliation keep improving continuously (I2) (O6)</p> <p><b>SO 5.</b> To ensure that all services offered at local level are effectively decentralized and that all stakeholders work in harmony and converge all their contributions towards the transformation agenda (O6)</p> <p>7. To promote innovations through streamlining best practices and homegrown solutions as well as Rwandan core values to ensure sustainability in consideration of the country's unique development context (O6)</p>

Table Findings on alignment of DHCR with country's other sectoral policies

Family Promotion <sup>189</sup>	NST <sup>190</sup>	NCDA <sup>191</sup>	Vision 2020 <sup>192</sup>
<p><b>Mission</b> The main mission of the National Policy for Family Promotion will be to promote the Rwandan family as a natural and cultural basis of our society (O2) (O5)</p> <p><b>Comprehensive Objective</b> National Policy for Family Promotion is aimed at outlining a framework for the implementation and monitoring of programmes to ensure the protection and support of the family in order to enable it to play efficiently its vital role in the</p>	<p><b>Specific Objectives (SO)</b></p> <p><b>SO 1.</b> Create decent jobs for economic development and poverty reduction (O3) (O4) (O6) (O7)</p> <p><b>SO 3.</b> Promote industrial development, export promotion and expansion of trade related infrastructure (O7)</p> <p><b>SO 4.</b> Develop and promote a service-led and knowledge-based economy (O2) (O5) (O6)</p> <p><b>SO 5.</b> Increase agriculture and livestock quality,</p>	<p><b>General Mission:</b> To foster the development of a child, the promotion, and the protection of his or her rights (I2)(O1)(O2)(O4) (O6)</p> <p><b>Mission:</b> To unite civil society and drive action on NCD prevention and care, leaving no one behind (O2) (O6)</p>	<p><b>Major Objectives</b> The Vision seeks to fundamentally transform Rwanda into middle - income country by the year 2020 (O1)</p> <ol style="list-style-type: none"> <li>Macroeconomic stability and wealth creation to reduce aid dependency (O6)(O7)</li> <li>Structural economic transformation (O1) (O5)</li> <li>Creating a productive middle class and fostering entrepreneurship (O7)</li> </ol>

<sup>186</sup> MIn Finance\_Eco Dev-Rwanda Vision 2020<sup>187</sup> Education\_Sector\_Strategic\_Plan\_2018\_2024<sup>188</sup> Governance\_\_Descentralization\_Sector\_Strategic\_Plan<sup>189</sup> NATIONAL\_POLICY\_FOR\_FAMILY\_PROMOTION-2<sup>190</sup> Rwanda National Strategy for Transformation 7YGP\_Final<sup>191</sup> <https://www.ncda.gov.rw/about-ndca><sup>192</sup> Rwanda\_Vision\_2020\_revised\_2012\_

country development. (O2) (O5) (O6)	productivity and production (O6) (O7)		
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Table : Overlaps Between DHCR strategies with GoR and UNICEF ECD and Nutrition Policy

DHCR Strategies	Pillars of ECD Policy (ECD-P) / Strategic Directions of Nutrition Policy (NFNP-SD)	UNICEF ECD strategy (2017) <sup>193</sup> and Nutrition Strategy (2020-2030) <sup>194</sup>	Evaluator's Assessment
Evidence generation and strategic knowledge	<b>NFNP-SD 1.</b> Food and nutrition advocacy to sustain commitment and mobilise resources for policy implementation	<b>ECD-S4.</b> Broadening data- and evidence-gathering Systems <b>Nut-S4:</b> early detection and treatment of wasting in early childhood. <b>Nut-S6:</b> to strengthen partnerships, data, knowledge, advocacy, and financing, the five key pillars of UNICEF's governance work for maternal and child nutrition	<ul style="list-style-type: none"> <li>It is evident from the literature review that the design of DHCR at strategy level is fully aligned with strategies of Rwanda Nutrition and ECD policy.</li> <li>Also, it incorporates major elements of UNICEF's ECD and Nutrition Strategy.</li> </ul>
Capacity and human resource development	<b>ECD-P 2.</b> Human Resource Development and a knowledge-based economy, with improvements in Health and Education services used to build a productive and efficient workforce <b>NFNP-SD 2.</b> Prevent stunting in children under two years of age at national scale <b>NFNP-SD 6.</b> Assuring food and nutrition in emergencies	<b>ECD-S4.</b> Broadening data- and evidence-gathering Systems <b>ECD-S5.</b> Strengthening public financing for ECD <b>Nut-S1:</b> prevention of all forms of malnutrition in children under 5 years of age <b>Nut-S 3:</b> prevention of all forms of malnutrition among women during pregnancy and breastfeeding <b>Nut-S 4:</b> early detection and treatment of wasting in early childhood.	
Policy dialogue and advocacy, including social mobilization	<b>NFNP-SD 1.</b> Food and nutrition advocacy to sustain commitment and mobilise resources for policy implementation <b>NFNP-SD 3.</b> Promote services and practices that result in improved household food security <b>NFNP-SD 4.</b> Prevention and management of all forms of malnutrition <b>NFNP-SD 5.</b> Improving food and nutrition in schools	<b>ECD-S 3.</b> Using advocacy and communications to support programmatic goals <b>Nut-S 6:</b> to strengthen partnerships, data, knowledge, advocacy, and financing, the five key pillars of UNICEF's governance work for maternal and child nutrition	
Partnerships	<b>ECD-P 1.</b> Development of the nation and its social capital anchored on good governance and underpinned by a capable state <b>ECD-P 3.</b> A private sector-led economy characterized by competitiveness and entrepreneurship	<b>Nut-S 6:</b> to strengthen partnerships, data, knowledge, advocacy, and financing, the five key pillars of UNICEF's governance work for maternal and child nutrition	
Innovations and cross-sectoral linkages.	<b>ECD-P 4.</b> Infrastructural development, entailing improved transport links, energy and water supplies and ICT networks <b>ECD-P 5.</b> Productive and market-oriented Agriculture <b>ECD-P 6.</b> Promotion of regional economic integration and cooperation	<b>ECD-S 1.</b> Fostering multisectoral programming for ECD <b>ECD-S 2.</b> Improving the delivery of essential services through system strengthening, Promoting caregiving behaviours, demand for services and social norms for positive parenting	

<sup>193</sup> UNICEF ECD Programme Guidance - September 2017

<sup>194</sup> UNICEF Nutrition Strategy 2020-2030

## Appendix 28: Achievement of DHCR (Outcomes and Outputs)



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### Planned vs. Achieved Results (Outputs level)

Find below the graphic summary for outputs achievements and rating.



## Appendix 29: Effectiveness - Baseline and Endline Comparison Tables

Find below the summary of comparison of baseline and endline values:

Progress Status: refers to comparison with baseline and endline (HHS) results

Total Indicators Improved	28
Total Indicators deteriorated	18
Total Indicators	46

Indicators	Baseline (n=1637)	Endline (n=1352)	Progress (%)
<b>Household assets</b>			
Percentage of children living in households that own land	91.00%	25.80%	-65.20%
Percentage of children living in households with electricity	18.60%	37.5% (n=1350)	18.90%
Percentage of children living in households with radio	35.20%	30.1% (n=1350)	-5.10%
Percentage of children living in households with mobile phone	48.60%	64.60%	16.00%
Percentage of children living in households with bike	7.70%	5.2% (n=1351)	-2.50%
Percentage of children living in households with bed net	87.00%	91%	4.00%
Percentage of children living in households that own cows or small animals	61.90%	41.90%	-20.00%
<b>Early childhood development</b>			
Caregiving practices		...	
Percentage of children experiencing any inadequate care in the past week (left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the last week)	35.30%	11%	24.30%
Support for learning		...	
Primary caregiver engages in four or more activities to promote learning or school readiness in the past week	41.20%	56%	14.80%
Percentage of children who play with toys	23.60%	12.00%	-11.60%
Percentage of children who play with household items	38.70%	18.40%	-20.30%
Percentage of households who reported ever having listened to Itetero	23.30%	48.60%	25.30%
Percentage of households who listen to Itetero that listen every week (n=381)	35.8% (n=381)	44.3% (n=657)	8.50%
Access to ECD and community services			
Percentage of caregivers who have heard of cooking demonstrations by CHWs	50.00%	68% (n=912)	18.00%
<b>Water, sanitation, and hygiene</b>			
Percentage of households with basic water services	49.40%	79%	29.60%
Percentage of households that treat water	29.70%	52%	22.30%
Percentage of households with insufficient water in the past two weeks	19.10%	35.40%	-16.30%
Percentage of households that pay for drinking water	26.30%	35.70%	-9.40%
Percentage of households with basic sanitation services	64.10%	93.40%	29.30%
Percentage of household with basic hygiene facility	36.00%	73%	37.20%
Percentage of caregivers who are unable to wash hand when desired	8.70%	11.50%	-2.80%
Percentage of households in a community with a community hygiene club	26.80%	30.50%	3.70%
<b>Health</b>			
Percentage of children 6-11 months who had diarrhea in the past two weeks	33.6% (n=455)	39% (n=475)	-5.40%
Percentage of caregivers who sought any treatment for diarrhea for children aged 6-11 months	54.2% (n=455)	65% (n=187)	10.80%
Percentage of children 12-23 months who had diarrhea in the past two weeks	31.2% (n=1181)	43% (n=877)	-11.8
Percentage of caregivers who sought any treatment for diarrhea for children aged 12-23 months with diarrhea	65% (n=368)	74% (n=374)	9%
Percentage of children who slept under mosquito net last night	79.60%	87.80%	8.20%
Percentage of children who had fever in the past two weeks	34.60%	46.10%	-11.50%
Percentage of caregivers who sought any treatment for fever in case the child had fever in the past two weeks	66.90%	74.2% (n=623)	7.30%
Percentage of households with any member insured	74.90%	92%	16.60%
<b>Nutrition</b>			
Percentage of children 6-23 months who are stunted	31.3% (n=1,559)	29.70%	1.60%
Percentage of children 6-23 months who are underweight	12.5% (n=1,559)	10.70%	1.80%

Indicators	Baseline (n=1637)	Endline (n=1352)	Progress (%)
Percentage of children 6–23 months who are moderately wasted	2.7% (n=1,559)	4.70%	-2.00%
Percentage of children 6–23 months with moderate acute malnutrition	4.9% (n=1,559)	2.70%	2.20%
Percentage of children aged 12–23 months who are still breastfeeding	93.4% (n=1,162)	96.2% (n=1322)	2.80%
Percentage of children aged 6–8 months who consumed solid, semi-solid or soft food during the previous day or night	90.2% (n=172)	74% (n=245)	-16.20%
Percentage of breastfed children who receive the minimum meal frequency	48.8% (n=1,524)	47% (n=1272)	-1.80%
Percentage of children who consumed iron-rich food	17.70%	20%	2.30%
Percentage of children who consumed MNP in the past seven days	34.70%	30%	-4.70%
Percentage of children who consumed fortified blended food	15.20%	43.60%	28.40%
Percentage of children who received vitamin-A supplementation in previous six months	87.70%	91.10%	3.40%
<b>Social protection</b>			
Percentage of households that participated in VUP in preceding 12 months	19.10%	14.10%	-5.00%
Percentage of VUP households enrolled in classic public works	37.5% (n=312)	91.6% (n=190)	54.10%
Percentage of VUP households that received livestock	34.30%	41.1% (n=124)	6.80%
Percentage of VUP households that participated in VUP savings group	33.70%	21.8% (n=124)	-11.90%
Percentage of VUP households that received skills training	14.10%	16% (n=124)	1.90%

## Appendix 30: Efficiency Calculations

### Reported and Calculated Budget of programme:

Outcomes & Outputs	Rep total BUD	Calc. Total BUD	Rep total EXP	Calc. Total EXP
Outcome 1: Children under 5 utilize effective nutrition / health interventions	11,598,120	11,598,120	8,995,187	8,995,187
Outcome 2: Young children and families utilize quality ECD services, and parents/primary caregivers apply improved childcare and stimulation practices	3,578,000	3,578,000	2,733,889	2,733,889
Outcome 3: Families with young children in the targeted districts use improved water, sanitation and hygiene services	2,136,800	2,675,883	1,983,511	1,983,511
Outcome 4: Poorest households with children under 5 in 10 districts/sectors have benefitted from child-sensitive public works	522,102	874,162	506,662	506,662
Outcome 5: Improved and equitable participation in quality pre-primary education	1,250,450	1,250,450	1,127,862	1,127,862
Outcome 6: The integrated multi-sectoral programme interventions are effectively planned, managed, and coordinated at national and sub-national level; and key family practices across sectors are promoted	3,048,800	3,048,800	1,799,759	1,799,759
Outcome 7: Private sector investment and support to the multi-sectoral Nutrition programme increased	249,830	249,830	219,161	219,161
	22,384,102	23,275,245	17,366,030	17,366,030
<b>Diff. in reported in calculated values</b>	<b>-</b>	<b>-891,143</b>	<b>-</b>	<b>0</b>

### Planned Budget Vs Utilized Budget: (based on reported budget)

Outputs	Total budget (2017-2021)	% Budget Allocation	Total expenditures* (Dec 2020)	% Budget Expenditures
Outcome 1: Nutrition	\$11,598,120	42%	\$8,995,187	33%
Outcome 2: ECD	\$3,578,000	13%	\$2,733,889	10%
Outcome 3: WASH	\$2,136,800	8%	\$1,983,511	7%
Outcome 4: Social protection	\$522,102	2%	\$506,662	2%
Outcome 5: Education	\$1,250,450	5%	\$1,127,862	4%
Outcome 6: M&E	\$3,048,800	11%	\$1,799,759	7%
Outcome 7: Linkages with the Private Sector	\$249,830	1%	\$219,161	1%
Programme support staff	\$2,335,517	9%	\$2,200,824	8%
Operations costs	\$689,546	3%	\$537,086	2%
Harmonized cost recovery	\$2,032,733	7%	\$1,608,315	6%
Grand total	\$27,441,898	100%	\$21,712,256	79%

### Cost per beneficiary Analysis:

The matrix below presents the cost per beneficiary analysis.

Outputs	Total Budget Allocated (\$)	Total Budget utilized (\$)	Total Beneficiaries	Planned Cost per beneficiary (\$)	Actual Cost per beneficiary (\$)
Outcome 1: Nutrition	\$11,598,120	8,995,187	1267815	\$9.15	7.10
Outcome 2: Early Childhood Development	\$3,578,000	\$2,733,889	48967	\$73.07	55.83
Outcome 3: Water, Sanitation and	\$2,136,800	\$1,983,511	24683	\$86.57	80.36

Hygiene (WASH)					
<u>Outcome 4:</u> Social protection	\$522,102	\$506,662	28828	\$18.11	17.58
<u>Outcome 5:</u> Education	\$1,250,450	\$1,127,862	7812	\$160.07	144.38
<u>Outcome 6:</u> Planning, Monitoring and Evaluation of multi-sectoral project interventions and Behavior Change Communication	\$3,048,800	\$1,799,759	7077819	\$0.43	0.25
<u>Outcome 7:</u> Linkages with the Private Sector	\$249,830	\$219,161	4636	\$53.89	47.27
Grand total	\$22,384,102	\$17,366,031.00	8460560	\$2.65	\$2.05
<p><b>*** Important Note:</b> The above calculated number of beneficiaries are liable to "double counting". For example, one child may have received Vitamin A supplementation and MNP. Also, households benefitting from integrated child-sensitive social protection with improved socio-economic indicators may also have screened and who have received one or more livelihood enhancement inputs (livestock / agricultural inputs / loans). It is not possible to calculate unique value of beneficiaries.</p> <p>The Appendix 6 provides disaggregated number of key direct beneficiaries (Children aged 0-11 months; 0-59 months; and no. of Children accessing (ECD, WASH, and Nutrition services); no. of Pregnant and lactating women; Training of CHWs, master trainers, no. of caregivers/ tea pluckers trained on ECD, no. of community volunteers trained - Advocates for ECD and Govt. officials) for all outcomes.</p>					

#### Year wise budget allocation and utilization (Based on calculated budget values)

	Year 1 (2017)	Year 2 (2018-19)	Year 3 (2019-20)	Year 4 (2020-21)	Total
Planned Budget	30%	32%	23%	15%	100%
Budget Utilized	14%	17%	28%	15%	75%

## **Appendix 31: List of Vulnerable Children**



List of Vulnerable  
Children.xlsx

## Appendix 32: Sustainability of DHCR Interventions

World Bank Initiatives	Cost and Year	Districts Covered
Stunting Prevention and Reduction Project	\$55 M, 2018-2023	Nyabihu, Ngororero, Karongi, Rubavu, Rutsiro, Rusizi, Nyamagabe, Huye, Nyaruguru, Ruhango, Gakenke, Kayonza and Bugesera.
Human Capital for Inclusive Growth - Development Policy Financing	\$450 M, 2021-2023	In 26 districts (Names of districts not available)
Strengthening Social Protection Project	\$103 M, 2017-2021	In all 30 districts
Social Protection Transformation Project	Under preparation \$100 M, 2022-2025	In 10 districts (Names of districts not available)
Rwanda Quality Basic Education for Human Capital Development Project	\$209.72 M, 2019-2024	In all 30 districts
Rwanda Priority Skills for Growth	\$270 M, 2017-2023	N/A

## Appendix 33: Compliance with UN-SWAP

No.	Performance Indicators (PI)	Evaluation Team's Commentary & Assessment
<b>Results-based management</b>		
1	PI-1: Strategic planning gender-related SDG results.	The Programme includes no indicator or target that captures gender disaggregation (where it was possible), especially for interventions and results related to the number of boys and girls who were reached, Prevalence of stunting among children U5 in the targeted district; % of severely acute malnourished children 6-59 months receiving appropriate treatment in targeted districts; % of children attending organized early childhood education programmes; pre-primary school net enrolment rate and so on. Hence, the Programme is not meeting this performance target.
2	PI-2: Reporting on gender-related SDG results.	The Programme was reported some gender-related results, despite not setting any targets. Therefore, is assessed as compliant to this indicator.
3	PI-3: Programmatic gender-related SDG results.	Similar to the commentary above, although the reporting is limited, the Programme reports gender-related results (for male and female) where possible. Thus, it is meeting the performance target.
<b>Oversight</b>		
4	PI-4: Evaluation	Not assessed. Assessment of the UNICEF's evaluation functions is beyond the scope of the evaluation.
5	PI-5: Audit	Not assessed. Assessment of the audit systems is beyond the scope of the evaluation.
<b>Accountability</b>		
6	PI-6: Policy	Not assessed. The evaluation team does not have adequate evidence on policy level directors of the Programme or the organization-level policy interventions at RCO to conclude or comment on this indicator.
7	PI-7: Leadership	Not assessed. The evaluation team does not have adequate evidence on senior managers in the Programme internally or publicly championing gender equality.
8	PI-8: Gender-responsive performance management	Not assessed. The evaluation team does not have details related to gender equality and the empowerment of women integrated into core values and/or competencies for all staff, with a particular focus on levels P4 or equivalent and above.
<b>Human and Financial Resources</b>		
9	PI-9: Financial resource tracking	The Programme could not achieve this target, as there is no financial resource-tracking mechanism used by the Programme to quantify disbursement of funds to promote gender equality and women's empowerment.
10	PI-10: Financial resource allocation	The Programme could not achieve this, as there is no financial disbursement or benchmark to promote gender equality and women's empowerment.
11	PI-11: Gender architecture	Not assessed. It is beyond the scope of this evaluation to assess the presence of focal points at HQ, regional or country level.
12	PI-12: Equal representation of women	Not assessed. It is beyond the scope of this evaluation to assess representation of women staff at the country office level.
13	PI-13: Organizational culture	Not assessed. Assessment of the organizational culture, whether it fully supports promotion of GE is beyond the scope of the evaluation.
<b>Capacity</b>		
14	PI-14: Capacity assessment	Not assessed. Assessment of UYCO capacity building initiatives is beyond the scope of the evaluation.
15	PI-15: Capacity development	Not assessed. Assessment of UYCO capacity building initiatives is beyond the scope of the evaluation.
<b>Knowledge, Communication and Coherence</b>		
16	PI-16: Knowledge and communication	The progress reports do not have specified gender and empowerment sections. Therefore, the Programme could not achieve the target for internal production and exchange of information on gender equality and women's empowerment.
17	PI-17: Coherence	Not assessed. Assessment of URCO's coherence structure is beyond the scope of the evaluation.