Project evaluation collection
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Child-centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE) Project

External: Mid-term Evaluation

April 2025

Bronkar (U) Limited
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Acknowledgements

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Acronyms and Abbreviations

AFI	Andre Foods International
ANC	Antenatal Care
CBO	Community Based Organisation
CBR	Community-Based Rehabilitation
CBVs	Community Based Volunteers
CDWC	Child Development and Wellbeing centres
CHANCE	Child-centered Holistic Approach to a Nurturing Care Enabling Environment
CRRF	Comprehensive Refugee Response Framework
CSOs	Civil Society Organisations
DEO	District Education Officer
DHO	District Health Officer
ECD	Early Childhood Development
FGD	Focus Group Discussion
HI	Humanity and Inclusion
ICM	Inclusive Case Management
IDEC	Intervention for Disabilities in Early Childhood
IRC	International Rescue Committee
KII	Key Informant
LC	Local Chairperson
LG	Local Government
MDAT	Malawi Development Assessment Tool
MEAL	Monitoring, evaluation, accountability, and learning
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, newborn and child health
MOU	Memorandum of Understanding
NCF	Naturing Care Framework
NGOs	Non- Government Organisations

NUDIPU	National Union of Disabled Persons of Uganda
NUWODU	National Union of Women with Disabilities in Uganda
OPD	Organisation for Persons with Disabilities
OPM	Office of the Prime Minister
PNC	Prenatal Care
PRSPs	Poverty Reduction Strategy Papers
PWDs	People with Disabilities
RWCs	Refugee Welfare Councils
ScoPeO	Score of Perceived Outcomes
TOC	Theory of Change
USDC	Uganda Society for Disabled Children
VHT	Village Health Team
WHO	World Health Organisation

Executive Summary

Introduction

Refugee and host communities are commonly remote from service centers and have limited access to services. Similarly, host communities and refugee populations in Terego District, West Nile face several issues in accessing quality services like healthcare, nutrition, and education coupled with the difficulty by both the government and NGOs to respond to the needs of the refugee population, as there is limited funding to operationalize the Refugee Response Plan. HI Uganda implemented the Child-Centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE) to improve motor, language and social outcomes and quality of life for children (0-12 years), particularly the most vulnerable including children with disabilities or at risk of developmental delay.

The methodological approach to the mid-term evaluation was a cross-sectional study that utilized both quantitative and qualitative methods of data collection and analysis. Quantitative methods focused primarily on assessing the progress towards achievement of the project's intended outcomes and changes on development milestones, as well as identifying significant changes attributable to the project. The quantitative data were obtained from the project database and were supported by qualitative tools, including key informant interviews and focus group discussions. A sample of thirty-four (34) key informants were interviewed and a total of sixteen (16) focus group discussions were conducted for the qualitative data, while for the quantitative data, one-hundred (117) children were assessed in 2023 and re-assessed in 2024. Over 65 (56%) of the assessed children were male, and a majority, 98 children (84%) were aged 3-7 years old.

Key Findings

Relevance

The CHANCE project demonstrates strong alignment with both the needs of the target populations and national/international frameworks on early childhood development. It has helped address the developmental needs of children with disabilities and those at risk of developmental delay, in alignment with at least three core components of the Nurturing Care Framework: health, nutrition, and responsive caregiving.

In health, the project responds to urgent gaps in early identification, rehabilitation, and assistive technology services in Uganda; particularly in the underserved West Nile region, where infant and under-5 mortality rates remain among the highest nationally. The development of community-based rehabilitation teams aligns with national health priorities and fills critical service delivery gaps in a context where only 7.5% of children aged 5–9 have access to disability-related support.

In nutrition, the project collaborates with key partners like World Food Programme (WFP), International Rescue Committee (IRC) and Andre Foods International (AFI) to improve nurturing care service delivery (e.g. nutrition, health) and integrates parental education and gender-sensitive approaches to promote better nutritional outcomes. On responsive caregiving, the project promotes culturally sensitive psychosocial support and caregiver training. Through fixed service points and caregiver groups, the project has fostered nurturing interactions, promoting father involvement, and supporting families emotionally and socially.

Effectiveness

The project has registered progress in improving developmental outcomes and quality of life for children with disabilities and those at risk of developmental delay. Based on the MDAT data, 78% of the children who received interventions show an improvement (or reduction in delay) in development between the baseline and follow-up assessment, while 16% of the same children who had developmental delays at baseline caught up in terms of development in the 4 areas (gross motor, fine motor, language, and social) between the beginning and the follow-up assessment. Correspondingly, there was an improvement in percentage of children without delays under gross motor and social domains, while fine motor and language domains worsened slightly, with a higher percentage of children showing delays at mid-term in comparison to the baseline. This was backed by qualitative data where parents highlighted noticeable improvements in their children's ability to move, communicate, and attend school following CHANCE project services like therapy, and psychosocial services.

In terms of gender dynamics, qualitative findings show some progress as several fathers reported increased involvement in caregiving roles. However, most caregiving responsibilities still fall on mothers, and overall male engagement remains inconsistent. Some of the challenges reported include access difficulties especially the long distances to fixed service points and lack of transport, and long training sessions without food. A few parents also reported no visible improvement in their child's development despite being the beneficiaries of the project services.

Efficiency

Despite initial setbacks, such as funding delays and reduced staffing, the CHANCE project has demonstrated adaptive management and cost-effective implementation. To mitigate time and resource constraints, CHANCE leveraged key partnerships like with Save the Children to provide therapeutic feeding to children and partnering with BRAC to provide training for parents and caregivers on creating toys. The project also achieved technical efficiencies by selecting and adapting tools like the MDAT-IDEC, ScoPeO, Baby Ubuntu, and

Blue Box for local use, enabling community-based screening, monitoring, and parental support. Cost-saving measures included joint trainings with Rwanda and DRC, utilizing internal expertise instead of external consultants. However, operational inefficiencies were noted, including overcrowded service points, limited home visits by community health workers, and long travel distances to fixed points. Additionally, the absence of income-generating support remains a constraint for caregivers. It was suggested that provision of microfinancing, income generating activities is needed to caregivers who are investing time and effort in the care of their children with disabilities and at risk of developmental delay.

Changes

The Project has invested in training actors from various levels of governance and within various sectors on the Nurturing Care components. It has laid the foundations for improving positive change within the target zones by creating a common and comprehensive discourse on the rights of children with disabilities and developmental delays across beneficiaries, government workers, CBVs and staff from CBOs. Furthermore, the project has promoted a gender-neutral environment, providing access to all beneficiaries and children with disabilities and developmental delays regardless of their gender. This has been achieved through community awareness sessions whereby the project specifically targeted the promotion of male involvement in caregiving by inviting them to attend parenting sessions (Baby Ubuntu). However, evaluation findings also found that the project has not been able to address all the issues for all the children for example accessing school is complicated or not possible for some children with disabilities and developmental delays due to several reasons like physical barriers and the psychological environment.

Empowerment

The project has ensured the empowerment of the project beneficiaries through two main approaches: strengthening of existing community-level health infrastructure and capacity building and behaviour change components within communities. These activities have helped healthcare professionals on prevention, early detection and management of disabilities and development delays in pregnant women and children thus filling the gap that was existing in the community. Furthermore, the Project has reinforced the community's resilience and capacity to respond to current and future challenges, to advocate for their children's rights and to seek support among service providers through implementing activities which aim to give knowledge, skills and capacities to parents and caregivers. However, evidence from project beneficiaries does not support that parents and caregivers feel significantly more empowered to respond to the needs of their children outside of their immediate home environment (in the community), as Caregivers did not indicate that they felt more resilient or more capable in terms of advocating for their child, increasing

community support for children with disabilities or at risk of developmental delay or advocating for changes in their nearby environment.

Partnership/Coherence

The Project has aligned with community engagement, which is a relevant and critical factor of consideration for changing behaviours and attitudes towards children with disabilities and developmental delays. CHANCE's focus on grassroots and community-based organisations to provide a link with the project beneficiaries was relevant and reinforced the programme design at several levels by mobilising families and the children through community meetings, helping to identify children who needed services and making referrals and by engaging community-based organisations such as RIAD and Terego Union of Persons with Disabilities to advocate for inclusion of children with disabilities, promote rights of children with disabilities, discuss the issues around having a child with disabilities at family and community level, and promote male involvement using music, dance and drama. Furthermore, the project has strengthened community structures and contributed to the development of sustained interactions and reinforcement at community level to advance nurturing care through the development of partnerships and collaborations with international and national NGOs (like BRAC and Save the Children) and small grants to organisations for persons with disabilities (OPDs).

Conclusion and Recommendations

The CHANCE Project is a well-targeted initiative addressing critical service gaps for children with disabilities and developmental delays in Terego district. Aligned with the Nurturing Care Framework, it has shown early success for children aged 0–5 years with measurable improvements in development and caregiver engagement despite budget and operational constraints. Strategic partnerships have strengthened service delivery and community outreach, though sustainability and national integration remain challenges. Continued investment in data, targeted interventions, and advocacy is key to maximizing impact and scaling this model for broader systems change in inclusive early childhood development.

The evaluation findings support the following recommendations:

1. Reinforce community-based screening and service delivery for children ages 0 to 6 through refresher trainings and ensure the delivery of health, protection and responsive caregiving pillars, while reinforcing activities related to caregiving and early learning opportunities across the target population groups.
2. Reinforce community-based advocacy for all children with disabilities and developmental delays to foster sustainable results for current and future generations and help reduce the gap that exists between policies and programming at the community level.

3. Foster partnerships which can support advocacy in the humanitarian-development nexus. This can help develop longer-term results and build support among other actors in the humanitarian-development nexus and at the national and district levels.
4. Tap into opportunities for new sources of finance to help sustain current activities, lighten the heavy workload of its staff, build new partnerships and scale quality service delivery across the target zones.
5. Scale-up the use of assessment tools (MDAT and ScoPeO) as well as Baby Ubuntu and Blue Box implementation with clear mapping and tracking system of project beneficiaries.

1 Introduction

1.1 Background Context

Research indicates that in low to middle income countries, 43 percent of children under five years of age are at risk of poverty, poor health, poor nutrition, and other adversities, which threatens their ability to reach their developmental potential. In Uganda, 63 percent of children under five years of age are at risk of poor development based on a composite indicator of stunting, extreme poverty, or both. According to the Early Childhood Development (ECD) Report by the Ministry of Gender, Labour and Social Development, Children from the West Nile and Karamoja regions were notably poorer, with rates 13 percentage points higher than the national average, compared to their counterparts in other regions. The multi-dimensional poverty measure reveals that children are deprived in two or more fundamental rights including nutrition, health, water, education, sanitation, shelter, information, and protection. Among children in Uganda aged 5 and below, malnutrition is the most prevalent form of deprivation with nearly one-third (29%) of children in this age group experiencing stunting, more prevalent among boys (31% than girls (27%). Nutritional deficiencies have long term consequences for children, leading to frequent illness and disability later in life.[1]

Furthermore, despite the government's success in its commitment to disability rights by establishing a comprehensive body of legislation, policies and socio-economic programmes consistent with social justice, societal and cultural negative attitudes and perceptions have been indicated as the greatest obstacle to disability inclusion. Such negative attitudes have been reported to prevent genuine consideration of disability within the national development agenda including the PRSPs. For example, government efforts towards inclusive education have often been criticized and accused of putting children with disabilities amongst children without disabilities without adequate modifications to the teaching and learning environment, and with inadequate specialised teachers.[2]

In the past decade, successive governments and various ministries have developed several policies around early childhood care and education. The 2016 National Integrated Early Childhood Development Policy of Uganda outlines the government's commitment to improving the delivery of services to children from conception to 8 years.[3] This includes

[1] USAID, Nurturing Care to Improve Early Childhood Development: https://www.advancingnutrition.org/sites/default/files/2020-12/landscape-brief_uganda.pdf , last accessed 4th March 25

[2] National Library of Medicine, Uganda's disability journey: Progress and challenges: https://pmc.ncbi.nlm.nih.gov/articles/PMC5443041/#:~:text=The%20implementation%20gap%20is%20about,information%20and%20assistive%20mobility%20devices last accessed 4th March 25

[3] Ministry of Gender, Labour and Social Development (2016 policy): https://health.go.ug/sites/default/files/FINAL%20NIECD%20Popular%20Version%20Approved%20by%20Acting%20P.S%20%20%20%20%20%20%20Mpagi.pdf | article on new policy : https://www.newvision.co.ug/category/education/govt-passes-early-childhood-development-polic-NV_188314

adopting similar components to the Nurturing Care Framework, notably "to provide basic health care, adequate nutrition, nurturing and stimulation within a caring, safe and clean environment for children and their families.[4] " The Policy also states the partnership and collaboration across government sectors to improve the effectiveness and efficiency of delivering integrated services to the children and their families to improve their development outcomes. The Ministry of Education in Sports in 2018 delivered an Early Childhood Care and Education Policy with an additional emphasis on community participation and financing, and a new ECD policy was announced in 2024.[5]

According to the early child development index, 63% of youngest children age 36-59 months living with their mother are developmentally on track. In 2022, 29% of children ages 3 and 4 were attending early childhood education (ECE), with significant disparities in access per place of residence (urban/rural), region, mother's education and family wealth[6]. Following the introduction of Universal Primary Education in 1997, Uganda has made tremendous progress in enrolment of children at primary level. However, hidden costs of education, violence, lack of parental and community engagement in education programmes and low investment translating into low quality education has kept many children out of school or motivated drop-outs (62% only completed the last year of primary). In pre-primary and post-primary, the level of enrolment is lower and access to those levels of education is strongly constrained in many areas of the country. Children with disabilities are especially excluded, as only 9% finish primary school.

In regards to health, maternal, newborn and child health, antenatal care is widely spread (97% of women), with 60% completing 4 visits. 73% of deliveries are done in health facilities and 74% with a skilled birth attendant. However, only 54% of women and 56% of newborns received postnatal check within two days after delivery. In addition, between 2016 and 2022, under-5 mortality rate decreased from 64 deaths to 52 deaths per 1000 (‰) births, and is slightly lower for the refugee population (45‰). Similarly, during this same period, infant mortality (probability of dying during the first year after birth) dropped across Uganda from 43‰ to 36‰, and neonatal mortality (probability of dying within the first month following birth) decreased from 27‰ to 22‰. The West Nile region had the highest infant mortality and the under 5 mortality rates, 55‰ and 80‰, respectively, in the country.[7]

[4] Nurturing Care Framework 2018 (pg.3): https://www.education.go.ug/utsep/wp-content/uploads/2020/03/4.-Reviewed-Draft-Early-Child-Care-Education-Policy-Approved-by-ME-WG-Dec-2018.pdf

[5] The evaluation team has not reviewed this policy.

[6] Uganda Bureau of Statistics (2023). Uganda Demographic and Health Survey (UDHS) 2022. November. https://www.ubos.org/wp-content/uploads/publications/UDHS-2022-Report.pdf.

[7] Data for the paragraph are from UDHS 2022.

When it comes to child safety, most children in Uganda have experienced physical violence that threatens and halts their holistic and positive development; 59 per cent of girls and 68 per cent of boys. Gender-based violence and sexual violence are also pervasive, with 35 per cent of girls and 17 per cent of boys having experienced sexual violence during childhood. Girls are especially at risk of child marriage, teenage pregnancy, and female genital mutilation. In addition, child labour is pervasive, with children mainly working in the informal sector. In rural areas, 93 per cent of children are engaged in agriculture and fishing.[8]

Refugee and host communities are commonly remote from service centres and have low access to services. Similarly, host communities and refugee populations in West Nile face several issues in accessing quality services like healthcare, nutrition, and education services coupled with the difficulty by both the government and NGOs to answer the needs of the refugee population, as there is limited funding to operationalize the Refugee Response Plan. Additionally, funding is limited to deploy similar services to host communities, as outlined in the Comprehensive Refugee Response Framework (CRRF) and the Refugee and Host communities Empowerment Strategy. The Case study on Uganda CRRF done by UNHCR promotes the NEXUS approach, while also highlighting the need for a paradigm shift from care and maintenance to self-reliance and resilience.

Government-run rehabilitation centres are available in 5 national and 15 regional referral hospitals around Uganda (including a regional referral hospital in Arua, which serves 8 districts)[9][10][11]. Other specialized hospitals and rehabilitation centres, privately run, NGO funded, are also available. Rehabilitation services provided in hospitals are either free of charge or at a subsidized cost. Users must pay for rehabilitation at private centres, while they are provided for free in NGO-supported facilities. Inpatient and outpatient physiotherapy services are available, and national hospitals may have additional occupational therapy and speech and language therapy services. Government-run rehabilitation centres are linked to an orthopaedic workshop producing assistive devices, including braces, prostheses, and wheelchairs. However, not all orthopaedic workshops are operational due to a lack of funding for raw materials and human resources, and users' difficulty to pay for their devices. Studies show low use of rehabilitation services.[12]

[8] UNICEF, Child protection: https://www.unicef.org/uganda/what-we-do/child-protection (last accessed 3 March 25
[9] https://www.radiopacis.org/en/news/terego-district-approves-12-health-facilities-for-upgrade
[10] https://www.teregodlg.go.ug/sites/default/files/Health%20Department.pdf
[11] https://doctorswithafrica.org/en/whats-new/news/homenews/uganda-towards-more-equitable-and-inclusive-healthcare/
[12] Project document : Adaptation_HI_DGD 22-26_Ouganda - Annexe O6.2_TOC)

1.2 About the Program

Humanity & Inclusion (HI) has a long track record in maternal and child health, pediatric rehabilitation and inclusive education programs. For the past 10 years, HI has been working to integrate these interventions to create cross-sectoral early childhood development (ECD) programmes in Southeast Asia the Middle East and North Africa. Since 2019, HI's ECD projects have respected the principles of nurturing care for children.

Between 2009 and 2013, HI was present in Uganda to support survivors of landmines and other explosive remnants of war and focused on services related to physical rehabilitation, psychological support and job training. As of 2017, HI launched its commitment to support Uganda's large influx of refugees from neighboring countries, especially in the areas of psychological support, rehabilitation services and inclusive education.[13]

HI signed a framework agreement with the Belgian government in 2022. Rwanda, DRC and Uganda are three of the eight targeted countries of this 5-year multi-year programme. In these three countries, the projects implemented follow the Nurturing Care Framework for Early Childhood Development developed by the WHO, the World Bank and UNICEF.[14]

The Nurturing Care Framework (NCF) for Early Childhood Development (ECD) was launched in 2018 by the World Health Organization (WHO), UNICEF, and the World Bank Group. It provides a roadmap for supporting children from pregnancy to age 5 by ensuring that they grow up in an environment that fosters optimal development.

The Nurturing Care Framework outlines the five essential components required for the young child's holistic development and well-being: good health, adequate nutrition, safety and security, opportunities for early learning and responsive caregiving. The Framework emphasizes the interrelated nature of these components to support the development of children from pregnancy to age 3. Multisectoral coordination across agencies responsible for education, health, child protection and social protection are is recommended to create an enabling environment for the Nurturing Care Framework.[15]

[13] HI (2024). Humanity & Inclusion Uganda: Who are we?.

[14] WHO, UNICEF and World Bank (2018), The Nurturing Care Framework for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential, https://nurturing-care.org/ncf-for-ecd.

[15] WHO, UNICEF and World Bank (2018), The Nurturing Care Framework for Early Childhood Development: A framework for helping children survive and thrive to transform health and human potential, https://nurturing-care.org/ncf-for-ecd.

Figure 1: The Components of Nurturing Care

In Uganda, the Child-Centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE) project is led by using a nurturing care approach to all interventions in health and education. The main elements of the project are summarized in the table below.

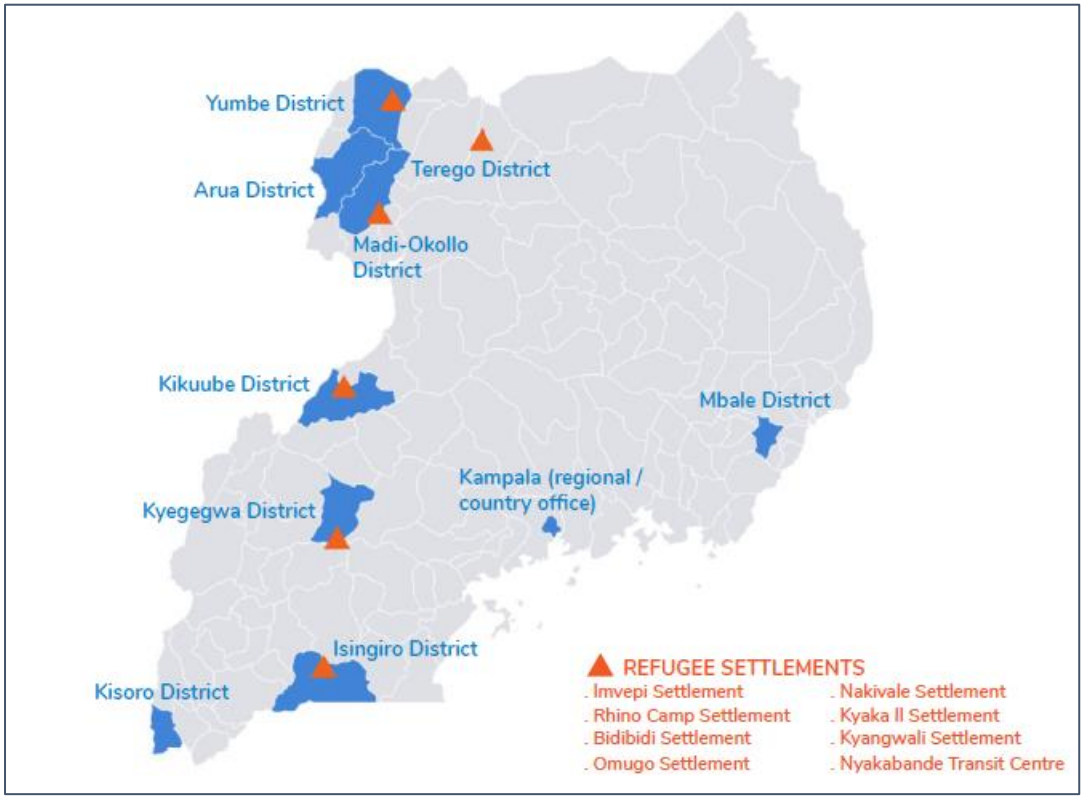
Table 1: A Summary of the Project Details

Project title	Child-Centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE)
Country	Uganda
District/Region	Terego District, West Nile Region-Uganda
Donors	Directorate General for Development Cooperation of the Kingdom of Belgium (DGD)
Budget	2,464,290 EURs
Duration	January 2022 – December 2026
Overall objective/goal	Improve motor, language and social outcomes and quality of life for children (0-12), particularly the most vulnerable including children with disabilities or at risk of developmental delay.
Intermediate changes (IC)	1. Children (0-12) have access to adequate early stimulation, learning, and development opportunities 2. Caregivers have improved capacity to provide nurturing care and support to their children's learning and development

	3. Communities support children's development (0-5) and quality of life (6-12) 4. Health and education services are high-quality, inclusive, and monitored, in order to address the needs of children 0-12, particularly those with disabilities and at risk of developmental delay 5. National policies promote nurturing care, early childhood development, and the quality of life for youth and adolescents
Expected target reach	• Children from 0 to 12, especially those with disabilities and at risk of developmental delay within the host and refugee communities • Parents and caregivers • Community-based structures (including VHT, Protection and Child Protection Committees), • Health and education service providers, and other relevant stakeholders • Local authorities (local councils, district authorities, Refugee Welfare Committees, OPM).
Partners (institutional and operational)	• National Union of Disabled Persons of Uganda (NUDIPU) • Local Government of Terego District • Rural Initiative Alliance for Development (RIAD) Foundation Uganda • Reach A Hand Uganda (RAHU) • Humanitarian and development partners • Community-based structures like the VHT • Beneficiaries
Collaboration	• NUDIPU • RIAD Foundation Uganda • RAHU

The Project is operationalized principally in the Imvepi and Rhino settlements and extended to reach host and refugee communities of Terego district.

Figure 2. Map of HI Interventions in Uganda in 2024.



Source: HI (2024). Humanity & Inclusion Uganda: Who are we?

1.3 Project goal

The ultimate long-term change as stated in the TOC (Annex A) is "Optimising the development and quality of life for children (0-12), particularly those with disabilities or at risk of developmental delay.

The development and quality of life are defined in a holistic manner, whereby the child's physical, social and mental well-being are considered in light of children's interactions with their physical and social environment. Per the TOC, "development" refers to "growth, learning and health outcomes" and "quality of life" to "physical, social and emotional well-being.

The project has two main domains of change based on the age groups of children:

- Improving gross motor, fine motor, language, and social development for children 0 to 5;
- Improving the quality of life for children 6 to 12.

These objectives are translated through the five intermediate changes:

1. Children (0-12) have access to adequate early stimulation, learning, and development opportunities.
2. Caregivers have improved capacity to provide nurturing care and support to their children's learning and development.

3. Communities support children's development (0-5) and quality of life (6-12).
4. Health and education services are high-quality, inclusive, and monitored, in order to address the needs of children 0-12, particularly those with disabilities and at risk of developmental delay.
5. National policies promote nurturing care, early childhood development, and the quality of life for youth and adolescents.

1.4 Evaluation Purpose and Specific objectives

The general objective of the mid-term evaluation was to assess the effectiveness and sustainability of the Child-Centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE) Project. This evaluation aimed to provide stakeholders with a comprehensive understanding of the project's performance, identify strengths and weaknesses, and generate recommendations for improvement.

The mid-term evaluation was driven by the need to ensure that the CHANCE Project is achieving its intended outcomes on nurturing care for children across all project interventions. This means that the evaluation paid considerable attention to the role of holistic child development in the project design and implementation, namely through the Nurturing Care Framework and its five interrelated components. This evaluation aimed to identify factors that may be hindering or facilitating the project's success, allowing stakeholders to make informed decisions about future programming and resource allocation. The evaluation focused on some parts of the program, namely:

- the application of the Nurturing Care Framework approach;
- the rehabilitation service provision activities;
- the sustainability of the program within a development-humanitarian nexus context; and
- the consideration of gender within the Project.

Based on its findings, the mid-term evaluation will give concrete and realistic recommendations on how the intervention should be adapted until the end of the current Project period to better reach its objectives and targets. It will also propose ideas and suggestions for a future nurturing care project (after 2026).

The mid-term evaluation answers the evaluation needs using both primary data (survey data i.e., key informant interview data, focus group interview data, and the MDAT, Baby Ubuntu & Blue Box data from the project database) and secondary data from project documents and other documents. This data will be used to provide actionable recommendations for future programming.

1.5 Key project achievements

The Child-Centered Holistic Approach to a Nurturing Care Enabling Environment (CHANCE) project has been implemented in Uganda, Terego district, for 2022 with its main objective being to improve motor, language and social outcomes and quality of life for children (0-12), particularly the most vulnerable including children with disabilities or at risk of developmental delay. Below are some of the project key achievements as identified in the TOR as of 2023:

- Four (4) Child Development Well-being Centres (CDWC) (Fixed Points) have been established whereby 3 already existing have been rehabilitated and one has been constructed within the host and refugee communities to bring physical and functional rehabilitation (Physiotherapist, Occupational Therapist, Speech and language Therapy and mental health) services closer to beneficiaries.
- Over 300 children with disabilities and developmental delays have been identified and 150 are receiving targeted and indicated support.
- Thirty-five (35) Village Health Teams (VHTs) and Community Based Volunteers (CBVs) trained on early identification of and early childhood intervention for children with disabilities and developmental delays (MDAT-IDEC) and specific approaches for activities with children and parents (Blue Box, Baby Ubuntu).
- CHANCE project team and CBVs have been trained on parenting using baby ubuntu model with an aim of empowering caregivers within groups so that they can provide appropriate care for their children with disabilities and developmental delays.
- 4 caregiver groups have been trained, one in each fixed point. Each group has 12 members (48 caregivers attending Baby Ubuntu sessions). 2 of the caregivers were male thus promoting male involvement in the care for children within the community. All groups completed four sessions by December 2023.
- 4 Baby Ubuntu parent support group are running since November 2023 and 8 new groups were in setting stage end of 2024.
- Blue Box training for project staff and CBVs have been conducted from 2nd to 7th October 2023 at the HI Omugo Office.[16] The aim of the training was to equip the project team with the knowledge and skills to identify the individual developmental challenges of each child, support caregivers to identify specific activities to address the delays identified and integrate them into the home routines.
- 119 Blue Box beneficiaries have been enrolled, 212 Caregivers have been enrolled for Baby Ubuntu, and 86 have been discharged and 14 parenting groups have been formed.

[16] Blue Box is described in Annex E.

2 Methodology

2.1 Approach to the evaluation

The mid-term evaluation was conducted using a non-experimental design, and theory-driven and participatory approaches. The methods involved the direct engagement of rights-holders and duty-bearers based on the core tenet of a human rights-based approach. The participatory approach informed the selection of interviewees, how rights-holders and duty-bearers were engaged, and how information was triangulated. Using a participatory approach, the evaluation ensured that state and non-state actors' priorities, interests, and intentions were properly considered, also helping amplify various rights-holders' voices to influence an understanding of delivery to date and desired directions for future programming.

The mid-term evaluation was a cross-sectional study that utilized both quantitative and qualitative methods of data collection and analysis. Quantitative methods focused primarily on assessing the progress towards achievement of the project's intended outcomes and changes on development milestones, as well as identifying significant changes attributable to the project. The quantitative data were obtained from the project database and were supported by qualitative tools, including key informant interviews and focus group discussions.

The qualitative evaluation was conducted using tools such as key informant interviews, focus group discussions, and a review of secondary data from documents such as national policies and district-level policies across all involved sectors/thematic areas in early childhood development (e.g., education, health, nutrition, gender). Both key informant interviews and focus group discussions were conducted using open-ended questions. The mid-term evaluation began with a meeting that brought together the Bronkar team, project staff, and enumerators to discuss the survey objectives, fieldwork plan, and survey tools. A pre-test of the qualitative tools was conducted thereafter to enable the survey tools to be fine-tuned ahead of the actual field data collection.

Documents reviewed included: the project proposal documents, Mission reports, ISPR reports and other relevant project reports. Quantitative data analysis from the MDAT assessments, KIIs and FGDs aided in measuring changes in the project outcomes. The ISPR monitoring reports were also useful references for this evaluation, especially in regarding establishing project achievements, successes and challenges. Global and national policy documents related to women and children health and well-being, nurturing care, education in emergencies, humanitarian approaches to child protection complemented the documentation received from HI. Field observations were conducted throughout the data

collection process to further enable verification and provide a qualitative illustration of the quantitative information collected.

2.2 Sampling strategy

The mid-term evaluation employed a purposive sampling approach in the field, using qualitative methods based on both primary and secondary sources of project information. The review process was structured around the project's results framework, a set of evaluation questions, corresponding data collection methods or tools, data sources, and a data analysis plan.

Table 2: Primary Data Collection Sample

Sample category	Sample size
1. Key Informant interviews:	**34**
• Project staff (Technical specialist, Manager programs, MEAL, psychologist)	6
• Project Partners (Operational partners (NUDIPU), RAID, RAHU	3
• Government Officials and district officials (DHO, DEO, Special Needs officers, Child protection officers) at Terego district level	2
• CSOs and NGOs (Disabled Peoples Organizations among others, Save the Children, Aga Khan Foundation, Plan International, BRAC)	1
• Health Care Providers, (Health officials {maternal and child health – nutrition}, VHTs etc.)	6
• Local Leaders (LC1, representatives of PWDs, RWCs)	2
• Caregivers Parents	14
2. Focus Group Discussions:	**158**
• Female Caregivers of children living with disabilities and development delays (13)	122
• Male Caregivers of children living with disabilities and development delays (3)	27
• Village Health workers and community-based volunteers (1)	9
Total number of respondents	**192**

2.3 Organization

A team of 5 enumerators (both selected males and females to ensure gender equality) conducted qualitative data collection and administer the questionnaires in the targeted settlements. The Enumerators were recruited based on fluency of local language spoken in the respective settlements and had at least a post – secondary school qualification (e.g., certificate or diploma holders and above). Strong screening questions were therefore used during the process of recruiting data collectors to ensure that the desired quality of data

collection was met. The enumerators were trained by the Bronkar team on the ethical considerations, thematic information on nurturing care and early childhood development as well as on the qualitative data collection tools.

The field data collection took a period of 6 days from 14th April to 19th April 2025 and during this exercise, all data collection at community level was supervised by two (2) Bronkar research associates, who guided enumerators during respondent household selection, conducted face-to-face interviews and capture of field observations. The Bronkar consulting team led by the Team Leader conducted the qualitative data collection using structured interview guides, specifically the key informant and focus group discussions. Where appropriate, enumerators who supported the Bronkar evaluation team during translation of local languages to English, especially during the conducted focus group discussions. The field data collection was conducted by a team of Bronkar staff consisting of a Team leader, Assistant team leader and Research associates who have experience in research methods and had a deeper understanding of the project objectives. The Bronkar team fully participated in qualitative data collection activities using FGDs and KIIs.

2.4 Ethical consideration

Pursuant to the ethical principles guiding research involving humans as participants, protection of child rights, human rights and dignity of participants and compliance with HI's Safeguarding Policy, consent documentation was evidenced either through a signed form from all survey respondents, including Caregivers, VHT's, Project staff, other key informants, and people involved in focus group discussions. The study's purpose, procedures, benefits, privacy and confidentiality provisions, contact persons for those who can answer research and subject's rights and dissemination of findings were clearly articulated to the respondents before the interviews. Privacy was ensured as much as possible during data collection, analysis and storage. Under the principle of beneficence, procedures were implemented to ensure that risks to participants are minimized while maximizing benefits

2.5 Data collection, quality assurance, and analysis

The field data collection exercise was conducted over six (6) days period from 14th April to 19th April 2025. A team of 5 enumerators experienced in collecting data for evaluations of a similar nature, with at least a post-secondary qualification, and knowledge of the local culture and languages spoken in the project areas were identified by the consultant and trained to administer the evaluation tools. The training covered interviewing techniques, followed by a detailed review of the project objectives, key informant guides and FGD guides, mock interviews and role plays in order to understand the survey questions. A field pretest was conducted prior to the actual field data collection to test the length of the questionnaire,

logical sequence, whether the questions are understandable, and the relevance/validity and ease of translation into local languages.

2.6 Analytical Approach

Quantitative data was analyzed using descriptive statistics and cross tabulations to create frequencies, percentages and graphics. Excel was used for data analysis, visualization and descriptive statistics. We used a multiple linear regression analysis to assess change in gross motor, fine motor, language development, social skills based on changes in MDAT z-scores between the baseline (May 2023 – June 2024) and follow-up (October 2024 – February 2025) assessments. Age and gender were used as the dependent variables in the model whose results are summarized in Table 8.

2.7 Challenges during the study

- Long distances from Arua to the refugee camps, as well as between different refugee settlements, led to delays and prolonged waiting times for mobilized respondents, resulting in some individuals refusing to participate in the interviews. This was resolved by scheduling the interviews for the following day.
- Low turnout of respondents, which was partially addressed by scheduling appointments for those who were unavailable to participate on the initial day.
- Language barriers also posed a challenge, as some enumerators could not speak the refugees' languages, necessitating the hiring of translators. The enumerators were fluent in the main local languages, such as Arabic and Lugbara. However, some refugees spoke other languages that the enumerators did not understand.
- Furthermore, the timing of the fieldwork during the Easter festive season contributed to the low turnout of the respondents, as many individuals were engaged in holiday activities. This was resolved by scheduling online interviews.

3 Study Demographics

3.1 Demographic and social characteristics of study respondents

Out of 117 children screened for developmental delay using the gross motor, fine motor, language and social domains of the MDAT tool, 65 (56%) were male and majority were 3-7 years old 98 (84%). The number of cases assessed using Blue Box and Baby Ubuntu were 17 and 45 respectively while 149 individuals participated in focus groups.

Table 3: Demographic and social characteristics of study respondents.

Characteristics	Frequency (117)	Percentage (100%)
MDAT Assessment (n=117)		
Gender		
Male	65	56%
Female	52	44%
Age		
0-24 Months	19	16%
3-7 years	98	84%
Blue Box Assessment (n=17)		
Gender		
Male	4	25%
Female	12	75%
Age		
0-24 Months	11	69%
2-3 years	5	31%
Baby Ubuntu Assessment (n=45)		
Gender		
Male	4	9%
Female	41	91%
Focus groups (n=149)		
Gender		
Male	27	18%
Female	122	82%

4 EVALUATION FINDINGS

4.1 Relevance

The project meets the identified needs and is adapted to the context of intervention.

Needs

Does the project address the needs of the beneficiaries from at least 3 (good health, nutrition and responsive caregiving) components of the Nurturing Care Framework?

The CHANCE project in Uganda was designed in alignment with the Nurturing Care Framework, which identifies strategic actions and the roles and responsibilities of education, health, nutrition and child protection stakeholders for effective early childhood services in low-income countries (WHO et al., 2018). The Framework reflects the holistic developmental needs of the Project's intended beneficiaries - children with disabilities or at risk of developmental delay – and provides a reference against which to assess the programming of the Project's activities.

The CHANCE Project was created following a robust needs and context analysis, according to reviewed documents and key informants with Terego district officials. According to KIIs with government officials, HI worked with them during the Project inception phase to map existing service providers at the local levels, including Village Health Teams (VHTs) and Community Development Officers (CDOs), to determine the local needs for Project emphasis.

In addition, a gap analysis conducted in 2024 for the Project reported on the quality of the existing legal and policy framework in Uganda to support the rights and integration of children with disabilities and at risk of developmental delay in relation to nurturing care. Its recommendations included suggestions for improving health service delivery for children with disabilities or at risk of developmental delay, thereby confirming the relevance of the Project design. As summarised by one community leader: "When the CHANCE project came in, it fit the [service delivery] gap."

The following sections examine the evaluation question for each component of the Nurturing Care Framework.

4.1.1 Health

The CHANCE project responds directly to the need for greater support to caregivers and children with disabilities or at risk of developmental delay. The provision of maternal, neonatal and child health (MNCH) has improved in recent years, with infant mortality rates more than halved between 2000 and 2022, but this progress is uneven across Uganda. The West Nile region has the highest rate of infant and under-5 mortality rates in the country, at

55‰ and 80‰, respectively.[17] The health care system remains fragile as the Covid-19 pandemic threatened to reverse gains in health service delivery and health outcomes for this population.[18] Moreover, Uganda has experienced several recent public health emergencies, including cholera, measles, Marburg, Monkey pox and Ebola, which have strained finances.

This mid-term evaluation found that the Project's focus on providing rehabilitation services at primary health centres and building capacity at the community level is strongly aligned with the national health policy. Access to high-quality health services can reduce the prevalence of disability, which can be costly to support with rehabilitative services and assistive technology.[19] In Uganda, rehabilitation and assistive technology services remain heavily underfunded by the public system and are largely missing at the community level. As such, the provision of rehabilitation services takes place across a combination of government and non-governmental organisations (NGOs), creating gaps in access and delivery and competing funding priorities. Until recently, there was no clear guiding policy on the improvement of rehabilitation services in Uganda.[20]

The Project is also highly relevant to the needs of beneficiaries. An estimated 17.5% of persons ages 15 and older have a functional difficulty in Uganda; in younger populations (which excludes functional difficulties linked to ageing) the rate is much lower at 7.5% of persons ages 5-9 years old.[21] A systematic assessment of rehabilitation services in Uganda identified the following findings and needs in relation to children with disabilities and developmental delays, which are relevant to the Project's approach to provide services closer to host and refugee communities:

- Children with complex long-term or neuro-developmental conditions such as cerebral palsy can benefit from "timely and on-going or intermittent rehabilitation services" which are unavailable within primary health care facilities or at community levels;

[17] Uganda Bureau of Statistics (2022). The 2022 Uganda Demographic and Health Survey (UDHS), main report powerpoint presentation, https://www.ubos.org/wp-content/uploads/2024/03/UDHS-2022-Main-Report-Powerpoint-Presentations-1.pdf.
[18] Burt, J.F.; Ouma, J.; Lubyayi, L.; Amone, A.; Aol, L.; Sekikubo, M.; Nakimuli, A.; Nakabembe, E.; Mboizi, R.; Musoke, P.; and Kyohere, M. 2021. "Indirect Effects of COVID-19 on Maternal, Neonatal, Child, Sexual and Reproductive Health Services in Kampala, Uganda." BMJ Global Health, 6(8), p.e006102.
[19] The organisation of health care service delivery in Uganda puts the burden on local governments to provide primary healthcare services, while strategic direction, policy and planning are developed at the national level.
[20] The 2024/2025 Uganda Rehabilitation Strategic Plan fills the policy gap by addressing the rehabilitation needs, including assistive technology, of the Ugandan people. John Hopkins School of Public Health and USAID (2023). Rehabilitation in Uganda: A Call to Action Policy Brief – August 2023, https://publichealth.jhu.edu/sites/default/files/2025-04/Policy-brief_policy-prioritization-Uganda-Final-1.pdf; Zziwa, S., Babikako, H., Kwesiga, D. et al. Prevalence and factors associated with utilization of rehabilitation services among people with physical disabilities in Kampala, Uganda. A descriptive cross-sectional study. BMC Public Health 19, 1742 (2019).
[21] Uganda DHS 2022.

- Children with disabilities, especially from the rural areas have limited opportunities for education and other important services;
- Currently, Uganda does not have outreach capacity for children with disabilities and developmental delay and has not integrated government-supported rehabilitation services in early childhood intervention programs or other early child development services.[22]

Moreover, in 2022, the High Court in Uganda found the Government to be in violation of the human rights of children with autism, because it was not providing them with necessary early detection, case management and rehabilitation services.[23] The Project activities respond directly to these needs by enhancing early identification, access and quality of life of children with disabilities or at risk of developmental delay at the community level.

4.1.2 Nutrition

Malnutrition is an ongoing challenge in Uganda and humanitarian risks, disease outbreaks and climate shocks act as a multiplicator effect. The Project is highly relevant to malnutrition needs, which are particularly severe in the Terego district, where acute food insecurity affects an estimated 17% of the population who are at risk of malnourishment in 2025. Of those, 54,000 children under age 5 are acutely malnourished and at risk of poor child development.[24] At a national level, the stunting rate (low height for age, a proxy for malnutrition) is also high at 24%, with children from poorer families and living in rural areas fairing worse, highlighting the needs of the Project's beneficiaries.

The Project was designed to "work with the different food and nutrition partners in the area such as World Food Programme (WFP), International Rescue Committee (IRC) and Andre Foods International (AFI) to improve nurturing care service delivery (e.g. nutrition, food supplements) and integrates parental education and gender-sensitive approaches to promote better nutritional outcomes. These partnerships help to ensure proper and efficient referral pathways, allowing relevant interventions for identified households and children who are at-risk of acute malnutrition.[25] Working with partner organisations such as AFI also provided opportunities for complementary support, including therapeutic feeding and follow-up referrals to CHANCE for rehabilitation services (e.g. physiotherapy, language

[22] Ministry of Health (2023), Systematic Assessment of Rehabilitation Situation (STARS) in Uganda, September 2022, p.62, https://library.health.go.ug/sites/default/files/resources/UGANDA%20STARS%20REPORT%202023.pdf.
[23] https://validity.ngo/2022/03/25/uganda-high-court-orders-government-to-ensure-community-services-for-children-with-autism/.
[24] IPC acute food insecurity and acute malnutrition situation for the refugees host districts, https://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Uganda_Acute_Food%20_Insecurity_Acute_Malnutrition_Jul2024_June2025_Report.pdf.
[25] 0_HI_DGD 22-26_OUTCOME 6_OUGANDA_Version narrative Privée.docx

therapy, stimulation therapy). The partnership arrangements are informal, however; without a Memorandum of Understanding (MOU), for example, the sustainability of nutrition service delivery remains at risk and dependent on other organisations.

Similarly, the role of parents in improving nutrition for young children was emphasized through parental interventions and community awareness focus of the Project's activities. Notably the promotion of gender equality, the involvement of fathers, gender empowerment in community-awareness events and caregiver support groups can improve positive parenting and ECD outcomes, including nutrition. The body of evidence around nutrition interventions finds that positive outcomes are linked to a holistic approach for child development, programmes involving both parents and bundled interventions (i.e. including nutrition with other interventions). Providing nutritional supplementation alone may not be sufficient to improve young children's cognitive outcomes.[26]

4.1.3 Responsive caregiving

The need for psychosocial support in host and refugee communities has been reported in Uganda.[27] In the general population, violence is a prevalent component of children's environments, with 3 in 4 children having experienced any violent form of discipline (psychological or physical).[28] The Project has paid particular attention to the provision of specialised services (including psychosocial support) in the four fixed points and has designed caregiver groups to support and train parents around the provision of appropriate care and stimulation activities for their children with disabilities and at risk of developmental delay.

Moreover, the Project was designed to include psychosocial supports for parents and to involve fathers in responsive caregiving activities. Providing emotionally supportive and contingent responses, enabling responsive interactions, singing, talking, playing and other positive interactions with infants and children are important components to support children's development. Yet, caregiving patterns vary by cultures and households, and women are largely responsible for caretaking activities. Including men's participation in

[26] UNICEF (2014). A systematic review of parenting programmes for young children in low and middle income countries. https://www.unicef.org/sites/default/files/press-releases/media-P_Shanker_final__Systematic_Review_of_Parenting_ECD_Dec_15_copy.pdf.
[27] Uganda Country Refugee Response Plan Detailed planning 2024-2025.
[28] Uganda DHS 2022.

caregiving is supported by research and can contribute to improved child development outcomes.[29]

4.1.4 Child protection (safety and security)

Child protection is a key element in the project, with the several intermediate changes linked to the improvement of children's quality of life. Under Ugandan law, children with disabilities or at risk of developmental delay are provided enhanced protection against abuse and neglect, with an emphasis on comprehensive support, strong protection mechanisms and a rights-based approach. National Parenting Guidelines provide a framework for empowering parents and families to provide nurturing environments to their children.

Through the design of Project CHANCE, the objectives focus on implementation gaps and collaboration needed to provide stronger health and education systems for the protection of children with disabilities or at risk of developmental delay with disabilities. Caregivers are also targeted to be empowered by the project activities, resulting in better knowledge and understanding of children's rights to improve their well-being. The Project also focused on including male caregivers, whose involvement in providing children with nurturing care has been linked to improved positive outcomes for women and children in the areas of maternal, newborn and child health (MNCH), nutrition, mental health and early learning.[30]

4.1.5 Early learning opportunities

The Project is also aligned with international, regional and national commitments to children's rights, including the right to inclusive education. Ugandan is a signatory to the main international conventions and declarations on human rights, education, disability and refugees, such as the UN Convention on the Rights of the Child (CRC, 1989). The African Union Social Policy Framework for Africa (2008), the African Union (AU) Agenda 2063 and the Eastern African Conference Vision 2050 also outline objectives for the development of social protection systems for vulnerable groups, including people with disabilities.

The Government of Uganda's has marked commitment to a more inclusive education system through the Draft National Inclusive Education Policy, which focuses on creating a responsive education system for all learners, beginning in pre-primary education, with early detection of children's special learning needs and inclusive infrastructure.[31]

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[29] Black, Maureen M, France Aboud, SK Masum Billah, Ilan Cerna-Turoff, Rahki Dandona, Sayaka Horiuchi et al. (2024). "Responsive caregiving: conceptual clarity and the need for indicators", The Lancet Child & Adolescent Health, Volume 8, Issue 10, 713 – 715; WHO and UNICEF (2022). Nurturing care and men's engagement: thematic brief, https://nurturing-care.org/wp-content/uploads/2023/09/Nurturing-care-and-mens-engagement.pdf.

[30] WHO and UNICEF (2022). Nurturing care and men's engagement: thematic brief. https://nurturing-care.org/engaging-men-in-nurturing-care/.

[31] Ministry of Education and Sports (2022).

Several KIIs and FGDs conducted for this mid-term evaluation confirmed that the inclusion of children with disabilities and at risk of developmental delay in education and health services (IC 4) addresses a critical need raised by CHANCE. Reducing barriers to participation is targeted by the project across multiple dimensions of the education and health sectors. As reported by key informants, having a disability is considered a curse, an omen or a taboo generally in the Terego district, with some informants even reporting that certain parents lock up children with disabilities and at risk of developmental delay, discriminate against them or deny them their human rights. In addition to sociocultural norms, other demand- and supply-driven barriers can limit their participation in education.

Table 4. Main barriers to education for children with disabilities and at risk of developmental delay

Type of barrier	Examples of barriers
Demand for education	• **Sociocultural:** stigmatization; discrimination by parents, peers and community members; negative attitudes; misperceptions of learners' abilities; risk of violence and gender-based violence • **Economic:** difficulty for families to cover costly informal fees; lack of transportation; lack of assistive devices
Education supply	• **Education delivery:** lack of trained teachers; inaccessible teaching materials; inaccessible school infrastructure • **Policy and planning:** weak political will; lack of data for planning; poor inter-ministerial coordination

Source: Kerr et Kurzawa (2022); [32]Uganda Country Refugee Response Plan Detailed planning 2024-2025.

Once children with disabilities and at risk of developmental delay are attending school, building inclusive environments helps to promote their educational outcomes.[33] CHANCE project design includes activities which go beyond the physical environment, training and supporting directors (head teachers) and teachers on promoting inclusion in the school environment (IC 4). The need for behavioural change is important for inclusion: one Ugandan study found that 84% of children with disabilities had experienced bullying and violence in

[32] Kerr, Kimberley et Zuzanna Kurzawa (2022). Financing Disability-Inclusive Education. United States Agency for International Development, Center for Education, 2022.
[33] UNESCO (2020). Global Education Monitoring Report 2020: Inclusion and education: All means all. Paris, UNESCO.

schools by their peers or staff, compared to 53% of those without disabilities.[34] Negative attitudes are also compounded when facing additional vulnerabilities, including being a refugee (with additional language barriers).[35]

Does the project address the priorities of other stakeholders? Does it integrate coherently with other ongoing interventions in the area to ensure a comprehensive response to the multiple and evolving needs of children aged 0-12 years and their parents?

Refugee populations are at risk of exclusion from education and health services in their host country. In Uganda, the gross enrolment rate in pre-primary schools stands at 45% for refugee and host populations.[36] While specialized healthcare services like early detection and intervention exist for children with disabilities and at risk of development delay exist in Uganda, healthcare access is still a challenge for them especially in rural areas because they are often understaffed healthcare facilities, expensive, and inaccessible to those with severe disabilities or in remote communities. Furthermore, specialized services like occupational therapy, physiotherapy, and neuro-developmental clinics are primarily found in regional referral hospitals, often located far from communities, making them inaccessible to those with severe disabilities.[37]

In Uganda, the Comprehensive Refugee Response Framework aims to increase access to high-quality and integrated ECD programmes by increasing the number of certified caregivers and centres.[38] Recently in 2024, the Ministry of Education and Sports strengthened the ECD system with the development of a new national Early Childhood Care and Education policy. It emphasizes a higher quality for the provision of ECD services, including the professionalisation of caregiver training with its inclusion in Primary Teacher Colleges (diploma level) and the commitment to enforcing higher quality standards in the regulatory framework.[39]

Does the project **consider sufficiently the cultural beliefs and practices of its beneficiaries, especially in terms of child care and gender role?**

[34] Devries K, Kuper H, Knight L, Allen E, Kyegombe N, Banks LM, Kelly S, Naker D. Reducing Physical Violence Toward Primary School Students With Disabilities. J Adolesc Health. 2018 Mar;62(3):303-310. doi: 10.1016/j.jadohealth.2017.09.004. Epub 2017 Dec 6. PMID: 29217214; PMCID: PMC5817160.
[35] Ministry of Education and Sports (2022). Education Partnership Compact: Transforming the Education System in Uganda. https://www.globalpartnership.org/content/uganda-partnership-compact-2022.
[36] UNHCR (2024). Uganda Refugee Response: Education dashboard Quarter 4 2024.
[37] Namukasa, L. (2010) Report on accessibility of health care services to persons with disabilities in Isingiro, Mubende, Mbale and Gulu Districts. Kampala: National Council for Persons with Disabilities. Available at: https://www.ncpd.go.ug/sites/default/files/2022-03/PWDs.pdf (Accessed: 10 June 2025).
[38] Uganda Country Refugee Response Plan Detailed planning 2024-2025.
[39] https://allafrica.com/stories/202412060026.html.

Although the project was designed with little implication from community level actors, it is generally regarded by key informants as respectful of cultural traditions in host and refugee communities. This is explained by the high level of community implication and awareness-building observed by the CHANCE staff in implementation. For example, CHANCE supported community members in creating their own self-help groups which can continue after Baby Ubuntu sessions are completed. KIIs conducted for this mid-term evaluation also noted that communities have increased awareness of child care needs for development. One statement summarises this point well : "Maybe there are those [children] who were not doing [well] at all, but they are now trying to [and] that feels like an improvement. It comes across so significantly, that children's general development has improved."

The use of locally available materials for the development of toys and play materials was also considered by beneficiaries and professional staff as a culturally respectful approach used by CHANCE.

Also, community outreach has included partnering with local NGOs as well as discussions with clan leaders and other cultural leaders in the community to discuss the rights of children with disabilities and at risk of developmental delay.

> *"This project involves people from both host and refugee communities and all these are people from various cultures and beliefs." – A government official*

Moreover, beneficiaries stated that the Project is respectful of traditional gender roles. Women are encouraged to ask for husband's assistance with the child's well-being, and this was considered acceptable while maintaining respect within the couple.

4.2 Effectiveness

4.2.1 Achievement of project results

To what extent are the project interventions contributing to the achievement of the project results?

The overall objective of the Project is measured by two indicators:

- % of children ages 0-5 years in the intervention area who have improved in their level of development, as measured by the Malawi Development Assessment Tool (MDAT)
- % of children ages 6-12 years who have improved in their quality of life, as measured by the Score of Perceived Outcomes (ScoPeO).

Table 5 provides an overview of specific activities which were developed in the project design and organised per Intermediate Change (IC) linked to the TOC (see Table 1). The table below summarises information collected during both qualitative and quantitative data

collection. Specific results linked to the logframe indicators are reported below, when available.

Table 5. Overview of findings related to Project activities and Intermediate Changes

Activity / Intermediate change (IC)	Description	Evaluation/Observation
Child Development and Well-Being Centres (IC 1)	Four (CDWC) are established in target areas to provide direct services to children and families at community level. Baby Baby Ubuntu and Blue Box are delivered in all four CDWCs (see rows below).	Four (CDWC) are established in target areas to provide direct services to children and families at community level3 CDWC ("fixed points") are renovated and 1 newly constructed. The 4 centres were operational by August 2023 (ISPR), with the 4th operating out of a tent until the new construction was finalised in 2024. Location for new centre in host community was selected with local partners and district officials. [40]
Access adequate early stimulation, learning and development opportunities (IC 1)	Access to early learning opportunities is designed through Baby Ubuntu and Blue Box primarily (see rows below) and through play materials developed with locally available materials and available at the CDWCs.	See Sections 4.2.1.1 and 4.2.1.2 for additional observations. Linkages or referrals with ECD centres has not been monitored or established by this evaluation.
Baby Ubuntu parental groups (IC 2)	4 caregiver groups formed in 2023, one in each fixed point, and 8 in 2024. Each group has 12 members (48 caregivers attending Baby Ubuntu sessions). 2 of the caregivers were male thus promoting male involvement in the care for children within the community. All groups completed four sessions by December 2023. 212 Caregivers have been enrolled in Baby Ubuntu, and 86 have been	Parents with children with developmental delays are invited to weekly sessions of the Baby Ubuntu parenting group, whereby caregivers learn how to care for their children and provide mutual support. The sessions occur in family homes, which has the added benefit of involving other family members to support. Stigma reduced in the community and within families with children

Activity / Intermediate change (IC)	Description	Evaluation/Observation
	discharged and 14 parenting groups have been formed.	with disabilities or at risk of developmental delay. Parents report feeling increased sense of belonging to the community and receive support from other parents.
Blue Box (IC 2)[41]	119 Blue Box beneficiaries have been enrolled.	Parents learned how to care for their children, which empowers them to provide quality of life improvement for their child. Not all professional staff at fixed points have been trained.
Rehabilitation team in fixed points (IC 3)	Professionals hired at fixed points to provide rehabilitation services at the community level., undertake community mobilization, inclusive case management, parenting sessions, and supervise CBVs in leading Blue Box activities.	Social workers were recruited and trained to undertake community mobilization, inclusive case management, parenting sessions, and supervise CBVs in leading Blue Box activities. They also provide guidance on social protection and risks of GBV.
Community-based health with VHTs and CBVs (IC 3)	VHTs and CBVs trained on Intervention for Disabilities in Early Childhood (IDEC) for early identification and other specific approach. CBVs also conduct parental supervision and mobilisation for Blue Box and Baby Ubuntu.	35 VHTs and CBVs trained on Intervention for Disabilities in Early Childhood (MDAT-IDEC) for early identification and other specific approaches to activities with parents and children (Blue Box, Baby Ubuntu)
Quality of life services and referrals (IC 3)*	384 children ages 0-6 were identified with at least one developmental delay (MDAT). Of these, 313 children in the project are receiving project services. More specifically, 119 have had	Multiple parents and other key informants report on improved quality of life for children following referral for rehabilitation, assistive devices or surgeries.

[41] The Blue Box is not a detection or diagnostic tool, but it can be used to recommend an appropriate activity to encourage stimulation in one or more aspects of development based on the child's level of developmental delay. A brief description of the Blue Box is in Annex E.

Activity / Intermediate change (IC)	Description	Evaluation/Observation
	physical therapy, 168 occupational therapy, 141 speech and language therapy and 89 Mental Health and Psychosocial Support (MHPSS). Per ScoPeO (usually 6-12 years old), 197 children have received project services (unspecified).	
Primary schools (IC 4)	Project design included the training of teachers and school supervisors to improve the inclusion of children with disabilities in primary schools and local coordination with health centres.	Training has not been conducted as expected; referrals of children with disabilities and developmental delays to schools has not been monitored, so this evaluation was not able to obtain additional information on this point.
Health centres (IC 1 and 4)	Coordination of health services in ante-natal care and post-natal care and newborn screening.	Technical support was provided to health care workers through trainings and engagements by CHANCE. No information on whether routine monitoring is now occurring.
Partnerships for nutrition services (IC 4)	The Project was designed to work with the different food and nutrition partners in the host and refugee communities.	This evaluation was not able to determine whether partnerships supported all project beneficiaries. WFP provides food to all refugees including parents and caregivers under the CHANCE project. No formal MOUs are in place.

Note: * Data from MDAT and ScoPeO databases. For data collected with ScoPeO, ages range from 9 months to 19 years old.

During the FGDs and KIIs conducted for this mid-term evaluation, beneficiaries reported specific components of effectiveness from CHANCE activities, which are summarised below:

- During Baby Ubuntu groups, parents gain confidence in ability to take care and meet basic needs of children with disabilities and at risk of developmental delay (e.g. learning to feed and bathe their child).

- During project interventions (which ones were not specified), children with disabilities and at risk of developmental delay have a better quality of life, can do more things independently, and want to learn.[42]
- Child enrolled in school following a surgery referral (and transport costs) provided by CHANCE.
- Specific physiotherapy sessions and surgeries provided better quality of life for children with disabilities, who can move (with or without assistive devices), talk or use limbs which were not functional before the CHANCE support.
- Hearing aids and other assistive technologies provided by the Project for children with disabilities or at risk of developmental delay enabled these children to leave their home, play with other children and enrol or return to school.

"My boy used not to talk, playing and eating was difficult; he used to not go to school, but through the therapy, he has been able to do all these things, even go to school." – Parent

"Before this project we used to abandon them [children with disabilities or at risk of developmental delay] and didn't care about them. But since this project, we now know how to care them." – Parent

"Due to teaching materials, they [the children] got the interest to learn faster." – Parent

With regards to the evidence around parental take-up of the Nurturing Care Framework (IC 2), this mid-term evaluation found that parents have received information and understand the multidimensional components of child development. Parents report understanding the benefits of good nutrition, sanitation and housing as boosting child's growth and development, as confirmed by health workers. Parents self-identified their pre-intervention neglect of children with disabilities and at risk of developmental delay, especially with regards to nutrition and education. As stated by parents, CHANCE provided them with knowledge about children's rights and techniques to support their development. From the Project, they received practical information on how to care, feed and clean children with disabilities or at risk of developmental delay and how to interact with them and playful techniques to support child development (see also Section 4.2.1.2 on effectiveness of Baby Ubuntu and Blue Box).

This evidence is reinforced by interviews from VHTs and health workers who identify benefits beyond the physical and physiotherapy activities of the Project. Namely, they report that parents are more nurturing with their children with disabilities or developmental delays, because the Project has provided them with knowledge on children's rights and hope for children's improved well-being, health and quality of life. Parents have learned to play and communicate with their children, understanding the benefits of responsive caregiving. The success stories of children who have benefited from speech, language and physiotherapy

[42] This is qualitative assessment provided by beneficiaries and others interviewed during this mid-term evaluation.

services have helped change the community attitudes to accept children with their disabilities and developmental delays.

The provision of Mental Health and Psychosocial Support (MHPSS) in the CWBCs has been beneficial to children and parents by providing them with socioemotional development tools and support. Beneficiaries note that both children and parents have learned coping mechanisms to manage socioemotional distress, such as anger management, reduction in physical confrontations and increased happiness. Beneficiaries discussed that children were previously considered "useless" and that, before the CHANCE project, they did not have information or techniques to care for their children.

"Through the psychosocial support, I am able to prioritize my child and take whatever comes from people with ease." – Parent

"The noticeable changes I have seen is the happiness of these children because they now believe that they are loved, been identified in the community and owned." – Parent

FGDs and KIIs also highlighted the Project's role in reducing stigma and negative attitudes around children with disabilities and developmental delays among parents and community members. The Baby Ubuntu groups are reported as providing support within the community, improving parents' capacities to support each other and feel supported together.

Only a few parents expressed mild to severe challenges with regards to the service delivery provided by CHANCE. The most severe challenges were cases of children with specific disabilities where the Project could not provide daily support for improving the life of the child (e.g. operation and regularly attending hospitals, but child autonomy not improved), but these were balanced with reports of increased attentive caregiving and positive attitudes by the parents. Mild difficulties reported included the reporting of long parenting ("training") sessions where no food is provided for the children, making parents less attentive to the information. Other reports of ineffectiveness in the project regard the distance between the Fixed points and homes (no means of transportation and carrying child) as well as the lack of transportation funds to support parents attending Baby Ubuntu sessions in the CDWCs. One parent also noted that their child did not improve after receiving training and doing exercises.

4.2.1.1 Prevalence of developmental delay

The project conducted a baseline assessment for MDAT in May 2023 for 179 children and mid-term in 2024 for 117 children. The age distribution of children assessment is in table 6 and shows a gap (missing values) in the baseline and mid-term data collection.

Table 6. Age distribution of children assessed with MDAT at baseline (2023) and follow-up (2025)

Age range	Number of children (% total)	
	Baseline	**Mid-term**
0-12 months	26 (15%)	19 (16%)
13 – 24 months	33 (18%)	
25-36 months	42 (23%)	98 (84%)
37 – 48 months	33 (18%)	
49-60 months	28 (16%)	
61-72 months	17 (9%)	
TOTAL	**179**	**117**

The follow-up assessment only included those children with developmental delays and receiving services from the Project. Those children included in the Project had an average of 34 months at baseline and 48 months during the follow-up assessment, which is quite short relative to measure changes in children's development.

- % of children ages 0-5 years in the intervention area who have improved in their level of development, as measured by the Malawi Development Assessment Tool (MDAT)

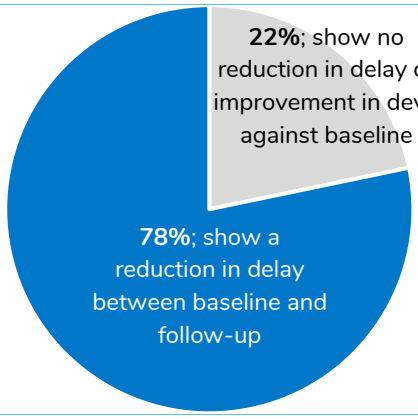
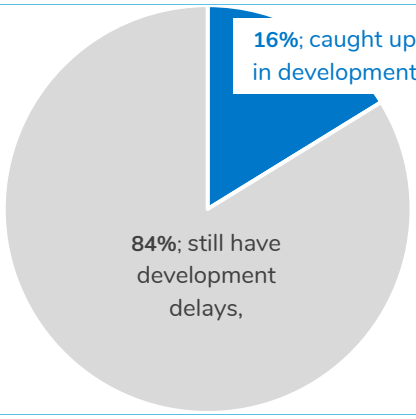
The aim of conducting MDAT assessments was to determine whether the activities implemented by HI and its partners have contributed to an overall improvement in children's development as shown in three indicators;

1. Helping children to reduce their developmental delay: % of children who show an improvement in terms of development between the beginning and the end of the project (in all 4 domains or at least one of the 4 domains)
2. Helping children catch up in their development: % of children who caught up in terms of development in the 4 areas between the beginning and the end of the project

Results of the MDAT assessments in table 7 indicate that 78% of the children who received interventions show an improvement (or reduction in delay) in development between the baseline and follow-up assessment, while 16% of the same children who had developmental delays at baseline caught up in terms of development (i.e., scored 0 in all domains) in the 4 areas between the beginning and the follow-up assessment. Amongst the 72 cases (78%) that showed an improvement in development between follow-up and baseline. 69% received Occupational therapy (OT), 54% received Speech and Language Therapy (SLT), 43% received Physio Therapy (PT), while 38% received Mental Health and Psychosocial

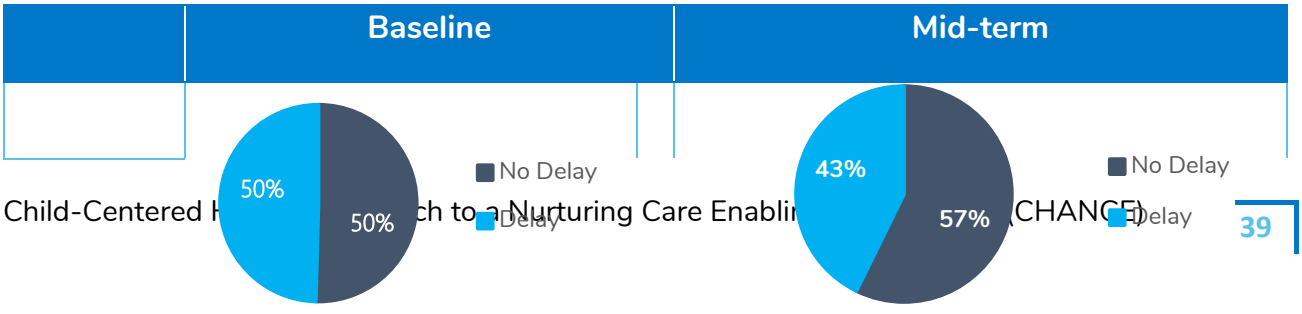
Support (MHPSS). This demonstrating that activities implemented by HI and its partners contributed to overall improvement in children's development.

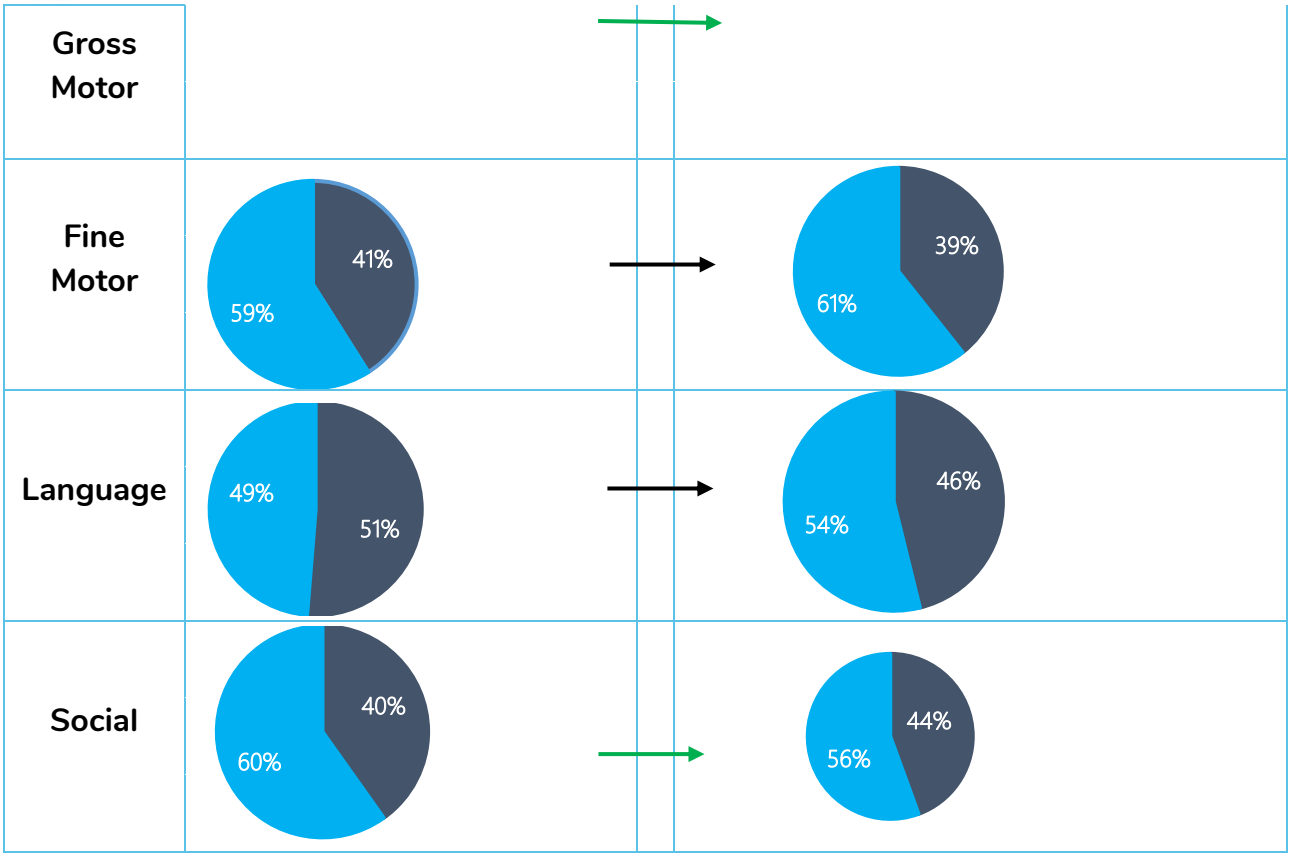
Table 7. Status of project outcome indicators based on MDAT assessments (n=92)

Indicators	% of children who show an improvement in terms of development between the beginning and the end of the project (in all 4 domains or at least one of the 4 domains)	% of children who caught up in terms of development in the 4 areas between the beginning and the end of the project
		
Number of cases/ **Interventions**	72 out of 92 cases showed an improvement (or reduction in delay) in terms of development between the baseline and follow-up assessments.	12 out of 74 cases with a development delay in one or more domains at baseline have age appropriate development during the follow-up assessment.
PT	43%	47%
OT	69%	76%
SLT	54%	64%
MHPSS	38%	35%

Analysis across each domain in figure 3 revealed that there was an improvement in percentage of children without delays under Gross Motor and Social domains. Fine Motor and Language domains worsened slightly against baseline, with a higher percentage of children showing delays at mid-term because some areas are not always expected to develop at certain ages and also the intervention may not be helping the child improve. This mixed pattern suggests that others may require more focused support particularly in fine motor and language development, which is foundational for school readiness.

Figure 3: Proportion of children experiencing deployment delays across each domain (n=117) between baseline and mid-term





Source: MDAT baseline and follow-up data from the CHANCE Project

A total of 117 children experiencing development delay or disability received interventions, with 63 (54%) receiving Occupational therapy (OT), 55 (47%) receiving Speech and Language Therapy (SLT), 38 (32%) receiving Physio Therapy (PT), while 33 (28%) received Mental Health and Psychosocial Support (MHPSS).

Multiple linear regression analysis using the Malawi Development Assessment Tool (MDAT) changes in z-scores (development-for-age Z scores) was observed across the 4 domains (gross motor, fine motor, language, and social) and against baseline, reflecting no significant developmental progress or regression. Total MDAT z-scores also showed no significant development progress with p-values at 0.05 level obtained by t tests. Therefore, there are no statistically significant effects of the four (4) interventions on MDAT z-score changes thus the need to further investigate the potential for PT, OT, SLT and MHPSS to improve development outcomes over the remaining project duration.

Table 8. Change in MDAT z-scores among children experiencing development delay or disabilities between baseline and follow up assessments[43]

Characteristics	Baseline		Follow-up				
	n	Mean ±SD	n	Mean ±SD	n	Difference (95% CI)	P-value[44]

[43] Data are number, mean ±SD, difference (endline-baseline) with 95% CI and p value.
[44] P-value obtained by t test.

Gross motor	92	-3.69±3.72	92	-3.88±6.53	92	0.19 (-1.35; 1.74)	0.403
Fine motor	92	-3.94±4.66	92	-4.65±5.85	92	0.71 (-0.83; 2.25)	0.182
Language	92	-3.26±2.63	92	-3.62±3.64	92	0.36 (-0.57; 1.28)	0.224
Social skills	92	-4.33±5.39	92	-4.52±6.26	92	0.19 (-1.51; 1.89)	0.414
Total score	**92**	**-3.81±4.23**	**92**	**-4.17±5.36**	**92**	**0.36 (-0.36; 1.09)**	**0.164**

4.2.1.2 Effectiveness of Baby Ubuntu and Blue Box models

The evaluation established that the Baby Ubuntu and Blue Box models have so far been effective in improving development outcomes and quality of life for children with disabilities and or development delays. The training of the project team and CBVs on parenting using Baby Ubuntu model has improved parents' or caregivers' knowledge (**Figure 5Erreur ! Source du renvoi introuvable.**), attitudes (**Figure 5**) and confidence (**Figure 6**) in supporting the development of their children with development delay or disability, as shown by their level of satisfaction during the pre- and post- Baby Ubuntu knowledge and skills assessment demonstrated below.

Figure 4: Pre- and Post- Baby Ubuntu caregiver knowledge of developmental delay or disability among children

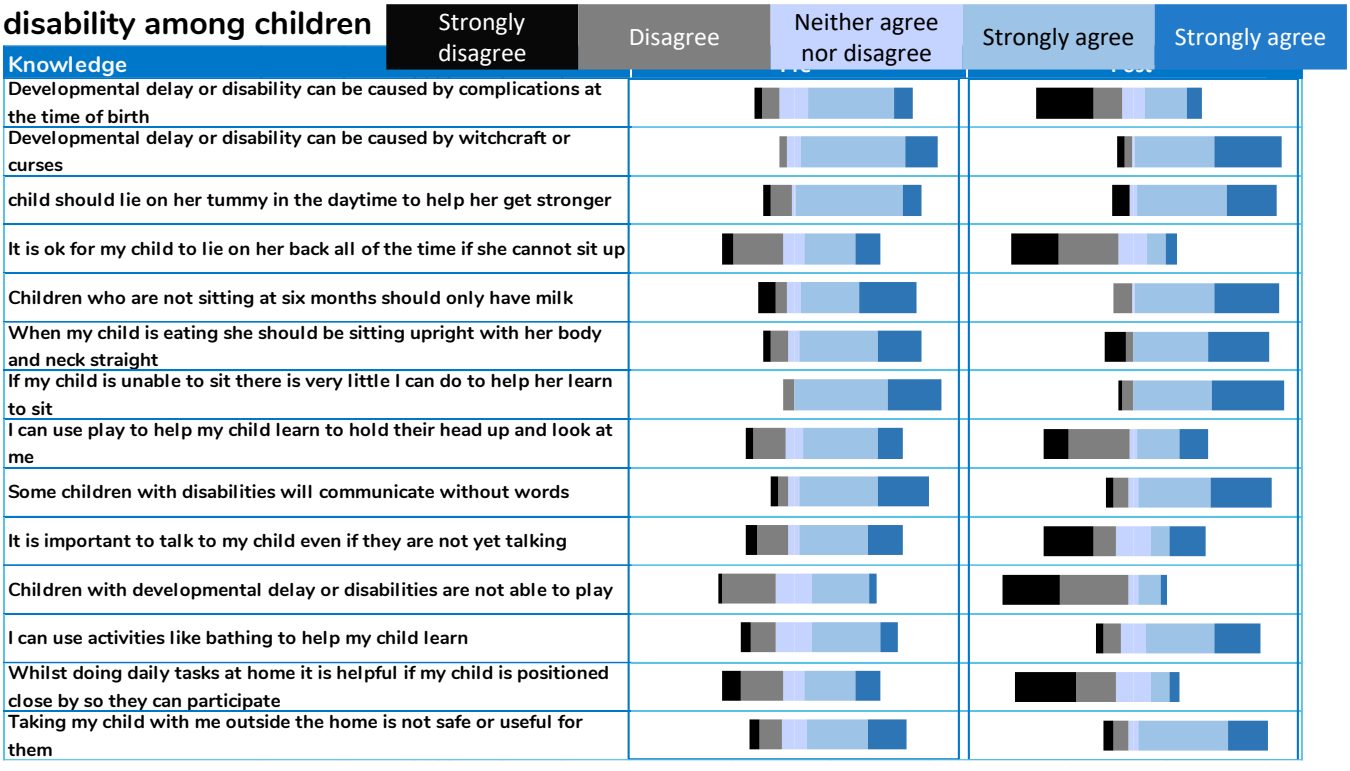


Figure 5: Pre- and Post- Baby Ubuntu caregiver attitudes towards children with developmental delay or disability

Attitudes	Pre-	Post-
My child has developmental delay or disability because Im being punished for doing something bad		
children with developmental delay or disability cannot learn new skills		
Children with developmental delay or disabilities can benefit from attending routine child health services like other		
It is better for me to spend time with my other children who can learn faster		
children with developmental delay or disabilities cannot participate in family life		
children with developmental delay or disability can attend school		
I feel hopeful about your childs health and development		

Figure 6: Pre- and Post- Baby Ubuntu caregiver confidence towards children with developmental delay or disability

Knowledge - "I feel confident ..."	Pre-	Post-
explaining what a developmental delay or disability is to a close friend or family member		
positioning my child while I am working to help their body get stronger		
feeding my child safely		
helping my child learn to hold their head up		
helping my child learn to sit		
helping my child learn to reach and hold toys		
helping my child learn to communicate		
helping other children and family members play with my child		
taking my child outside		
using everyday activities like bathing to help my child develop strength and skills		
seeking help from others		
I feel confident that I can cope with stress		

Secondary data collected using the Blue Box monitoring tool from sixteen (16) children (4 males, 12 females) with development delays due to biological conditions (5), medical health conditions (5), child risk factors (3), parental risk factors (1) and unknown factors(2) showed improvement during first follow-up visit where none of the children's condition had remained the same but eleven (11) showed strong improvement while five (5) had slightly improved. Children observed to have strong improvement since the first visit could now either sit without support, communicate better, play with fellow children, name objects or express their feelings; while those with slight improvement could now either say some words, sit with support, see objects clearly, could take five steps while walking or could bring hands together at midline.

Table 9: Cause of delayed development against child's improvement since first visit

The main estimated cause of Delayed Development	N	%	Strongly improved	Slightly improved	Remained the same
Biological condition	5	31%	2	3	-
Medical health condition	5	31%	5	1	-
Child risk factors	3	19%	2	1	-
Parental risk factors	1	6%	-	-	-
Unknown	2	13%	2	-	-
Total	**16**	**100%**	**11**	**5**	**-**

Secondary data further shows improvement in parent's knowledge of the importance of stimulating their children with development delay or disability.

Table 10: Blue Box assessment of parent's knowledge and community participation

Area of self assessment	First session	1st Follow-up session
Parent's knowledge		
Parents/ Caretaker cannot explain the importance of stimulating their child	44%	↓ 6%
Parents/ Caretaker can partially explain the importance of stimulating their child	44%	↑ 44%
Parents/Caretaker can explain and able to convince others in the community on the importance of child stimulation	13%	↑ 50%
Community participation		
Does your child play with surrounding children (brothers, sisters, neighbours..)		
Never	13%	↓ 6%
Sometimes	50%	↓ 25%
Regularly	38%	↑ 69%
Does your child participate in organized collective activities :		
Never	31%	↓ 13%
Sometimes	50%	→ 31%
Regularly	19%	↑ 56%

4.2.2 Gender transformation

Do the project activities tend to be gender transformative?

Mothers of children with disabilities and at risk of developmental delay are often treated as though they are solely responsible for the child's health and well-being. They can be rejected by their family and live in isolation due to traditional negative beliefs about disabilities. As such, the Project aims to improve community awareness, provide support to improve the well-being of mothers, involve male caregivers, address issues of stigma, and thereby improve the situation with gender dynamics in the household.

Overall, there are sufficient number of positive attributions by various types of stakeholders and beneficiaries to the Project which provide the confidence to state that the Project has made some stride in creating positive changes in traditional gender roles. Qualitative results revealed that there are noticeable shifts in traditional gender roles, specifically in caregiving. For example, men are increasingly participating in caregiving tasks that were once traditionally reserved for women, such as taking children to healthcare appointments or playing with children, although their involvement is not considered very regular by health care workers. This change was attributed to the community awareness campaigns, training and sensitization sessions by the CHANCE project. Specifically, the Project activities engaged both men and women and used community-led approaches to challenge traditional gender norms. Also, the Project has delivered targeted training that includes gender-based violence and gender-sensitive caregiving.

"After awareness creation and needs identification, men now support their wives in caregiving." – Parent

"A lot has changed. Due to the massive sensitization, men now help in childcare, which was not common before." – Health Worker

In the FGDs conducted for this mid-term-evaluation, however, the initial results seem mitigated thus far. Some mothers have reported the improvement in male involvement in child-rearing due to the CHANCE project, including their increased responsibility in caregiving, cooking, cleaning and taking children to health centre appointments. Other respondents, however, noted that fathers have not been involved, have disowned their children and are not sharing the responsibility in caregiving.

From the point of view of fathers interviewed for this evaluation, they feel they are more implicated with the child-rearing and caretaking with their children with disabilities or at risk of developmental delay. The following quotes from fathers underscore the role of the CHANCE project in their behaviour changes:

- "I used not to stay with my daughter but since she started her recovery from the CHANCE project, I've been around more and I love seeing my child happy when I'm playing with her."
- "We were taught with 11 sessions, and there was a component of livelihood, that we are supposed to grow vegetables for us near the home so that we can cook some for these our children and also sell some to get money with."
- "CHANCE project has taught us different activities and exercises to do together with our children suffering from disabilities and this alone has made me confident as a parent."
- "Since I came to this training everything has changed and it has reduced my stress."

In short, it is too early to clearly state whether the Project has had any sustainable, transformative effect on gender roles in the target populations. Additional information would be required to understand the discrepancies between female and male perceptions on their relative contributions to the well-being of children with disabilities or at risk of developmental delay.

4.3 Efficiency

To what extent have the resources (human, logistical, financial, technical) available enabled the project to achieve its objectives?

The CHANCE project faced budget cuts initially, which reduced the size of the project, but not the scope of activities. The focus was on delivering rehabilitation and psychosocial services to reach the 2000-children objective. As a result, the CHANCE team does not include an early childhood education specialist at the national level, but rather a part-time regional technical specialist.

Delays in project implementation lasted nearly 1.5 years. About 9 months passed between project start date (January 2022) and before funding was disbursed for activities (September 2022), which created further delays related to recruitment and commencement of project activities. Recruitment was finalised by February 2023, which was followed by a period of on-boarding and CHANCE-related trainings (e.g. MDAT, ScoPeO, Inclusive Case Management). Therapy, for example, began in June 2023. As such, the project implementation timeline is shortened by about a year. External delays in the construction of the Omugo HCIV led to the procurement and installation of a tent to avoid further delays in implementation. By August 2023, CHANCE had four functioning service points in host and settlement communities: Omugo HCIV (host), Omugo HCIII (settlement); Ofua (settlement) and Imvepi (settlement).

Several partnerships were key to increase efficiencies to meet project objectives:

- The CHANCE project hired two social workers to cover Inclusive Case Management, which had originally been assigned in partnership to National Union of Women with

Disabilities in Uganda (NUWODU), which faced internal challenges). This enabled CHANCE to cover that activity while waiting to finalise a new partnership with National Union of Disabled Persons in Uganda (NUDIPU) for the community awareness and sensitization components.

- CHANCE partnered with Save the Children to provide therapeutic feeding to children, while CHANCE focused on developmental rehabilitation.
- CHANCE partnered with BRAC to provide training for parents and caregivers on creating safe toys and learning materials with locally-available materials.[45]

Technical efficiencies have been made across several activities:

- The selection of the MDAT-IDEC (simplified version of the MDAT) enabled it to be used by Village Health Teams in host and refugee communities. This led to the ability to have on-going identification and screening of children, as well as increase the overall number of children screened for disabilities and developmental delays.
- Community-based volunteers were trained on the ScoPeO assessment, which allows for local tracking of children with disabilities and at risk of developmental delay.
- Existing technical tools (Baby Ubuntu and Blue Box) were adapted for use in Uganda with parents of children with disabilities and at risk of developmental delay.
- Cost-savings were achieved by combining trainings with the other countries in the project (Rwanda and the DRC) and utilizing HI technical experts rather than external consultants. For example, Trainings for Baby Ubuntu were done in partnership and in synergy with Rwanda (refresher and Training of Trainers) and ICM trainings were conducted in Uganda for all three countries.

Some important inadequacies were reported with regards to the operations:

- The Ofua space was considered inadequate by several parents, reporting that the space was too small and too many children were enrolled relative to the staff (child to staff ratio too high).
- The majority of parents interviewed with children with disabilities and at risk of developmental delay stated that CBVs do not visit their homes regularly.
- Beneficiaries report distance to fixed points as difficult creating a barrier in access to services for some families: this was confirmed by HI staff.
- Provision of microfinancing, income-generation activities is needed to support mothers and caregivers who are investing time and effort in the care of their child with disabilities and at risk of developmental delay.

[45] BRAC has worked across several countries through Play Labs to deliver play-based learning materials for ECD, adapting to the local education and humanitarian challenges.

- Professionals note that there are not enough staff or qualified workers at the health centres.

4.4 Changes

EFFECTS:

Is the project likely to contribute to the achievement of positive and measurable changes for the targeted beneficiaries in at least 3 (good health, nutrition and responsive caregiving) components of the Nurturing Care Framework through direct or coordinated actions with other actors?

The CHANCE project provides support and training for caregivers to understand nurturing care. In particular, the Project facilitates good health and responsive caregiving directly through trainings, Baby Ubuntu, Blue Box and enhanced referrals to rehabilitative services. Through the qualitative data collected, positive changes in comprehensive health care service provision are noted by beneficiaries and professionals from the health care system.

The nutrition component of Project CHANCE is much weaker, as some poor households are unable to provide financially for their children and the project partners with NGOs for direct nutrition provision. Nonetheless, the reporting for the partnerships remains uneven and does not provide sufficient information on implementation and results. With regards to the livelihood component, CHANCE also partnered with CBOs for which the monitoring is not available to the evaluation team. and is not reported regularly by the informants, so the scope of this activity and its impact on families remains unclear to the evaluation team.

The Project has invested in training actors from various levels of governance and within various sectors on the Nurturing Care components. By creating a common and comprehensive discourse on the rights of children with disabilities and developmental delays across beneficiaries, government workers, CBVs and staff from CBOs, Project CHANCE has laid the foundations for improving positive change within the target zones. Measurable changes in this regard were not identified, as baseline reporting is not available. Nonetheless, the responses from the interviews conducted for this mid-term evaluation were highly positive with regards to the training and the understanding of the Nurturing Care Framework.

Are changes as a result of the project benefiting girls and boys; women and men fairly/with equity?

The Project has promoted a gender-neutral environment, providing access to all beneficiaries and children with disabilities and developmental delays, regardless of gender. In fact, Project targets state that at least 40% of children are female. Data reported in this mid-term evaluation (Table 3) show that females represent 44% of MDAT

assessments, 75% of Blue Box assessments (12 of 17) and 91% of Baby Ubuntu assessments. The SCOPEO baseline data included 44% of females (191 out of 430).

Community awareness sessions reinforce the need to address traditional gender roles in caregiving, as well as access to Project activities and services. In 2023, CHANCE specifically targeted the promotion of male involvement in caregiving by inviting them to attend parenting sessions (Baby Ubuntu). Of the 318 caregivers, 13% were men. Of those who completed the first phase of parenting sessions, 19% were men.[46] In early 2024, there were only 2 males out of 48 (4%) caregivers in Baby Ubuntu groups.[47] While there is no comparative baseline for pre-project male involvement, the baseline pre-test for Baby Ubuntu only had 7% male respondents (7 of 110). Qualitative assessments suggest that there is undergoing change and increased participation of fathers (see 4.2.2).[48]

However, during the qualitative research and document review conducted for this evaluation, it does not appear that the Project's emphasis is on the promotion of male inclusion. For example, Blue Box training reports do not mention gender roles or father involvement and do not provide trainees with any specific tools to increase male presence in Project activities. Individual Blue Box monitoring tools do not include the gender of the involved parent, or even allow for a differentiated reporting of both parents' caretaking activities with the child.

With regards to the CHANCE staff, recruitment was open for both genders, although females are the minority among staff members (3 out of 8) and CBVs (3 out of 9) involved with the Project.[49]

Are there potential negative effects of the project on beneficiaries that need to be mitigated?

Overall, there have been few negative effects of the Project reported in the data collection for this mid-term evaluation. One of the greatest barriers noted earlier in this report was the distance of the fixed points to the beneficiaries' homes, meaning that all parents were not able to bring their children to the centres. As such, this exclusion factor needs to be addressed, as the concerned parents were not interviewed for this mid-term evaluation.

The Project has not been able to address all the issues for all the children. Parents report that accessing school is complicated or not possible for some children with disabilities and

[46] HI Uganda Donor Report (2024).
[47] HI Uganda. Baby Ubuntu update, January 2024.
[48] CHANCE pretest Baby Ubuntu Caregiver Knowledge and Skills Questionnaire (no date).
[49] HI Uganda Donor Report (2024).

developmental delays. VHTs and parents report that the schools are not inclusive, and do not provide for a welcoming environment for children with disabilities. This ranges from physical barriers (e.g., uneven grounds, steps) as well as the psychological environment (e.g., name-calling). Some parents mentioned that financial barriers also limit school participation. Others mention distance and difficulty in transportation to accessing health or education services. Finally, one beneficiary noted that children are sensitive to the stigma associated with accessing CHANCE project services.

"Some children fear to come here because they fear to be rated as ugly since this place and the services are accessed [only] by children with disabilities." - Parent

Several parents mentioned on-going difficulties with relatives and other community members who mock them and are not supportive of their efforts to provide improved developmental opportunities for their children. These unexpected negative attitudes are added on top of existing tensions around children with disabilities and at risk of developmental delay and do not respect the Do-No-Harm approach of service delivery, especially relevant in conflict situations.

As noted by the key informants, the demand for education for children with disabilities and at risk of developmental delay increased as a result of the Project. The downside is that parents do not consider that government/public schools are well-equipped to handle the learners' needs and request access to improved schools.

4.5 Empowerment

How does the project intervene to strengthen local and national actors on the Nurturing Care Framework and ensure that the nurturing care approach continues after the end of the project?

The Project has two main approaches through which it has focused activities to achieving the overall outcome in the TOC. The focus on local capacity building has been prioritised in these approaches. Nonetheless, the extent to which the Nurturing Care Framework has been fully integrated at these levels was not able to be determined at this early implementation stage.

The first approach is through the strengthening of existing community-level health infrastructure. The activities focused on capacity building of healthcare professionals on prevention, early detection and management of disabilities and developmental delays in children. These were not available locally, and there were no specific solutions to support parents with children with disabilities or at risk of developmental delay. The community-level solutions developed through the project include early detection (through MDAT-IDEC), rehabilitation services and therapeutic support, parental guidance and support

networks (Baby Ubuntu). CHANCE is filling the void in the catchment areas which it serves and works in coordination with district level officials and stakeholders to coordinate service delivery. Fixed points, however, remain inaccessible for some families living in remote areas.

The second is through the capacity building and behaviour change components within communities. By implementing activities which aim to give knowledge, skills and capacities to parents and caregivers, as well as VHTs and CHWs, the Project reinforces the community's resilience and capacity to respond to current and future challenges, to advocate for their children's rights and to seek support among service providers. It remains uncertain at this point whether the numbers or status of persons impacted by the Project will reach a sufficient threshold to build a strong community voice to sustain the Nurturing Care approach for children with disabilities and developmental delays at the end of the Project period. Nonetheless, the initial returns have been positive and project beneficiaries support continuation and scaling of the Project implementation.

The sustainability of the Project's activities and outcomes at the end of the project period is weakened given the Project's reliance on its staff for the therapeutic activities. The CHANCE team is composed of the technical health specialists which are not available in the community.[50] In addition, Project CHANCE relies on the local availability of service providers for the education and nutrition component of the Nurturing Care Framework. The ECD centres are run by international NGOs (e.g. BRAC) and nutrition is provided by Save the Children. While these partnerships are effective for reinforcing the capacity building of parents and caregivers, they also underscore the gaps in national service provision. The exit strategy for the Project is unclear, and interviews with healthcare professionals underscore this concern.

How does the project empower parents/caregivers and the community to respond to the needs of their children in terms of nurturing care?

The positive benefits to parents reported under Effectiveness would be considered empowerment if they consider that through the CHANCE project, they have gained in the capacity and ability to support themselves, their children and other parents with children with disabilities or at risk of developmental delay in their communities. Empowered parents are able to provide better advocacy and services for their children, especially for those with disabilities.

[50] These are: Pediatric Physiotherapist, Pediatric Occupational Therapist, Speech and Language Therapist, Child Psychologist and two Social workers.

From the FGDs and KIIs of beneficiaries, the evidence does not support that parents and caregivers feel significantly more empowered to respond to the needs of their children outside of their immediate home environment. That is, as noted in Effectiveness, they are able to provide better nurturing care for their children, access health and rehabilitation services and not hide their children from their communities. However, those benefits remain at the individual child- and family levels. Caregivers did not indicate that they felt more resilient or more capable in terms of advocating for their child, increasing community support for children with disabilities or at risk of developmental delay or advocating for changes in their nearby environment. For example, among the caregivers interviewed, they did not indicate any involvement in community meetings to discuss child development issues. Some parents did identify gaining executive functioning skills (stress management and problem-solving skills) which can be used more generally to improve their well-being and that of their community.

The Baby Ubuntu groups are designed to provide support within the community, with "lead parents" who act as advocates and knowledge management for issues related to child development. The benefits of having "lead parents", however, was not reported in the interviews by beneficiaries. The service providers, however, had a more positive view of the Baby Ubuntu group's snowballing effects. That is, they observe significant change in the graduated members due to their increased knowledge.

4.6 Partnership/ Coherence

Does the project collaboratively develop operational partnerships that are thoughtful, relevant, and effective for the implementation of interventions to advance nurturing care and the adoption of the nurturing framework at the provincial and national levels?

Through small operational grants with well-established organisations in the target communities, CHANCE selected operational partners to help support the implementation across the host and refugee communities. Rural Initiative Alliance for Development (RIAD) Foundation Uganda was selected to implement activities in the settlements of Omugo, Ofua and Imvep, while Terego Union of Persons with Disabilities (a member organisation of NUDIPU) implements activities in the host community. Reach a Hand Uganda, a youth-led NGO, also provided support to CHANCE with BRAC International to assess health care access for children with disabilities.[51]

CHANCE's focus on grassroots and community-based organisations to provide a link with the project beneficiaries was relevant and reinforced the programme design at several

[51] Reach a Hand Uganda, facebook post, May 15 2025. In Omugo Health Center IV and BRAC Child Friendly Space in Odupi Sub County, Terego District.

levels. At a direct level of engagement, the partnership with NUDIPU assisted CHANCE by mobilising families and the children through community meetings, helping to identify children who needed services and making referrals.[52] At an indirect level, CHANCE broadened the scope of knowledge around children's rights, by engaging community-based organisations such as RIAD and Terego Union of Persons with Disabilities to conduct the following activities using music, dance and drama:

- Advocate for inclusion of children with disabilities so that they can fully participate in the activities and services offered in their communities;
- Promote Rights of children with disabilities in the communities;
- Discuss the issues around having a child with disabilities at family and community level and promote non-judgmental and non-discriminative behaviours and acceptance and support; and
- Promote male involvement in the care for Children in general and CWDs in particular through responsibility sharing between men and women in the families.

The Project has aligned with community engagement, which is a relevant and critical factor of consideration for changing behaviours and attitudes towards children with disabilities and developmental delays. Increasing community involvement and support for these children by broadening the scope of knowledge on children's rights lays the foundation for greater advocacy capacity at the community level. In the end, the project expects that this bottom-up approach hopes to advance nurturing care and the adoption of the Nurturing Care Framework (sphere of influence for IC 5).

The Project also seeks to develop strategic partnerships across the humanitarian-development nexus to improve outcomes for refugee and host communities.[53] Uganda, which hosts the largest refugee population in the world, is committed to the improvement of human rights, and the inclusion of refugee populations. The implementation of refugee policies tend to rely on non-governmental organisations and other partners to provide services for these groups. The Project has reinforced the activities of existing service providers. Through the development of partnerships with international and national NGOs (BRAC and Save the Children) and small grants to organisations for persons with disabilities (OPDs), the CHANCE Project has strengthened community structures and contributed to the development of sustained interactions and reinforcement at community level to advance nurturing care. These partnerships were enacted in both host and

[52] The beginning of the partnership with NUDIPU started in early 2024, as they were not the initial partner organisation (which faced internal challenges).
[53] Adaptation_HI_DGD 22-26_Ouganda – Annexe.

settlement communities, where collaborative efforts targeting beneficiaries and their children with disabilities and at risk of developmental delay were in need.

While commitment to the Nurturing Care Framework has been established by this evaluation at the district level, it is unclear how the Project activities have affected the higher government levels. Activities related to the adoption of the Nurturing Care Framework were less marked throughout the Project implementation period at the provincial and national levels.

Has the project developed the good partnerships to ensure the sustainability of the project?

CHANCE has worked with the pertinent partnership entities and structures to build the foundations for sustainability at the district and community levels. By focusing on the specificities of the context during the design and implementation phases, CHANCE engaged with the Terego district level authorities for their support and cooperation.

At lower levels, closer to the community and at the fixed points, CHANCE engaged with reinforcing the capacity of the existing health structures so that they can be more effective and inclusive when working with families and children in need, especially those with disabilities or developmental delays. Introducing free rehabilitation services in the four fixed points has filled a noticeable gap and partnering with community-level workers to ensure referrals to the fixed points has been particularly effective.

Bringing on board advocacy organisations (i.e., NUDIPU) and grassroots CBOs (e.g. RIAD) has been essential in laying the foundation for sustainability in a general manner. Before Project CHANCE, children with disabilities and developmental delays were not receiving specific, targeted attention from these and other local organisations. As stated by one actor, the challenge was overwhelming for the CBOs to work on this issue: “Disability inclusion is one of the main things that a lot of NGOs don’t look at because of its technical nature”. CHANCE has shared with these partner organisations training and information on nurturing care and children with disabilities and developmental delays, for which they can effectively advocate with other partners: “We request partners like Windle, Brac and others to know about the project and include children with disabilities in their programs.”

CHANCE has been sensitive to the context and selected local partners which work with host and refugee communities, which helps to reinforce sustainability and following the Do No Harm approach of the development-humanitarian nexus. The Partnership strategy had initially expected to limit bias across host and refugee communities by avoiding to identify partners who are identified as part of one community or another: “choosing two different organisations to target the two communities separately would have been contradictory

with the project itself."[54] The change in partnership strategy was not explained in the context of this mid-term evaluation.

It is important to note the limitations of a mid-term evaluation in terms of clearly establishing the Project's contributions to long-term change and sustainability of project outcomes. Nonetheless, it is important to note that within the short timeframe of operations, the Project has fostered noticeable behavioural changes among key beneficiaries in the host and refugee communities. These observations are positive laying the foundations for transformative practices in the inclusion of children with disabilities or at risk of developmental delay.

How does the project strengthen the capacity of its partners as key actors within the ECD/nurturing care sector? Actors which can advocate for a better inclusion of children with disabilities and developmental delays?

The partnerships developed within the framework of the Project included capacity building components, which can support to a limited extent the sustainability of the Project. For example, training CBVs and VHTs to be involved in the identification of children with disabilities and developmental delays, as well as supporting activities to the benefit of these children and their parents helps to build a foundation upon which the health system can evolve for delivery of inclusive services. All in all, advocacy requires multiple levels of effort, of which the national component appears to be weakest at this point in the project implementation.

4.7 Lessons learnt

The CHANCE project underscored the importance of community and local engagement and meaningful stakeholder engagement during the needs assessments. This participatory foundation ensured alignment with community priorities and systemic gaps, fostering local ownership and enhancing program relevance and sustainability.

Integrating the Nurturing Care Framework enabled a comprehensive, multidimensional approach to child development that helped in addressing health, nutrition, responsive caregiving, early learning, and protection especially benefiting children with disabilities and those at developmental risk. Complementing this, the establishment of rehabilitation services in primary health care facilities filled critical public health gaps, increasing access to care in underserved and remote areas like Terego district in West Nile, Uganda.

Parental involvement, including active engagement of both mothers and fathers, emerged as a transformative driver of child development and gender norm shifts in this Project. The fixed points' staff and CBVs, with messaging reinforced by community-based organisations, underscored that parenting children with disabilities and developmental

[54] HI Project Document, Optimisation of the Development and Quality of Life for Children (0-12 years), Description of the Partnership Strategy, p. 22.

delay requires the responsibility and dedication of both parents to ensure their child receives basic needs. For example, several fathers reported their increased involvement in caregiving roles, a point which was repeated in KIIs held with district and local officials as well as HI staff.

The use of technical innovations, such as simplified developmental screening tools like MDAT-IDEC, and the training of community volunteers expanded the project's reach and fostered local empowerment. However, persistent infrastructure, transport, and human resource constraints, including limited home-based follow-up and insufficient staff still remain significant barriers to service accessibility and continuity of care.

Formal and informal partnerships with other NGOs and CSOs (e.g. BRAC, Save the Children IRC, AFI) effectively extended inclusive service delivery, strengthened community structures and contributed to the development of sustained interactions and reinforcement at community level.

5 Conclusions and Recommendations

5.1 Conclusions

Overall, this mid-term evaluation of the CHANCE project highlights the current status and results of the Initiative, while identifying critical areas for reinforcement or improvement for the achievement of outcomes. The conclusions are drawn from a synthesis of the results obtained during the data collection and its ensuing analysis.

The CHANCE Project is highly relevant to the target community that addresses critical service gaps for children with disabilities and those at risk of developmental delay. Its alignment with the Nurturing Care Framework and responsiveness to the complex needs of both host and refugee communities in Terego demonstrate strong value for investment. The Project addresses national priorities, such as the Comprehensive Refugee Response Framework, in the promotion of a comprehensive response for children ages 0 to 12 and their parents.

Early evidence indicates that CHANCE is making meaningful progress in identifying children with disabilities and developmental delays, improving developmental outcomes inline with the Nurturing Care Framework, enhancing caregiver engagement, and reducing stigma around disability as mid-term findings demonstrate moderate but measurable improvements in child development outcomes, particularly among children aged 0–5 years. The percentage of children with no developmental delays rose from 19% to 25%, and those with delays in only one domain fell from 21% to 13%, indicating a positive trend. Improvements were most notable in gross motor and social development, while fine motor and language domains showed little to no improvement suggesting these areas may require more targeted intervention.

The project's ability to deliver measurable results despite budget constraints and operational challenges reflects its strategic use of partnerships and resourcefulness in implementation. Nutrition and education services are dependent on these partnerships, which are often informal arrangements with CSOs. Referrals to nutrition and education services are not currently monitored by the Project. Nonetheless, CHANCE has built valuable partnerships that have strengthened local systems and expanded access to inclusive services. However, sustainability remains a concern, particularly in relation to service continuity and systemic integration at national levels.

To fully realize its potential, the CHANCE Project should continue investing in capacity-building of CBOs, health care providers and CBVs on the identification of children with disabilities and developmental delays. Given the specialised needs of these children, the Baby Ubuntu and Blue Box are specific tools which have enabled parents and

community members in both host and refugee communities to see the possibilities of changes and development in their children (improved parents' or caregivers' knowledge, attitudes and confidence). While it is too early to assess the Project's transformative effect on gender roles in the target populations, improving the involvement of fathers as carers for their children with disabilities and developmental delays has been considered in the design of the programme and implemented during this first phase of activities. Relevant data systems, targeted community interventions, and national-level advocacy will reinforce the delivery of evidence-based results, which help to build the foundations for fulfilling the rights of children with disabilities and developmental delays. With these enhancements, the project is well-positioned not only to achieve its immediate objectives but also to inform broader policy and programmatic shifts in inclusive early childhood development.

5.2 Recommendations

In light of the evaluation findings and conclusions, the following recommendations have been formulated with a vision for the final years of the Project and possible next phase and are explicitly addressed to HI as the project manager. As emerged from the conversations held during the inception phase, the HI Uganda team expects this evaluation to provide a set of operational recommendations that can inform the implementation of the remaining phase of the project.

The mid-term evaluation findings therefore support the following recommendations:

1. **Reinforce community-based screening and service delivery for children ages 0 to 6.**

The mid-term evaluation has highlighted improvement in the delivery of inclusive health care services, coupled with the comprehensive partnering of community-based health care facilities. Responsive caregiving and protection domains have shown initial take-up by parents, although the extent to which parents are taking up nurturing activities in the home is difficult to assess. Benefits to the children identified with disabilities and developmental delays have been positive, notably in terms of receiving referrals to appropriate health care and rehabilitation services. In addition, some children have also had a reduction in the number of developmental delays identified during follow-up assessment.

The training received by VHTs and CHWs, which has helped to promote the nurturing care approach in the community, has been well-received and could be reinforced through refresher trainings. The Project (in preparation for the next phase) could reflect on factors to support the essential role of VHTs and CHWs in light of the approach's sustainability.

Given these findings on effectiveness, the remainder of the project should continue to ensure the delivery of health, protection and responsive caregiving pillars, while reinforcing

activities related to caregiving and early learning opportunities across the target population groups, especially for the younger population. In particular, the Project has been weaker in terms of creating early learning opportunities in structured education settings (i.e., ECD centers and schools) for its target population. As an essential pillar in the Nurturing Care Framework, early learning opportunities need to be available, accessible and inclusive for all children in the Project. The Project should reinforce mechanisms to enable inclusive education for children with disabilities and developmental delays in this phase through referrals to partnering ECD centers and providing technical training for ECD carers on the specific needs of children. In the next phase, the Project could reinforce its activities to develop early learning opportunities in formal or informal ECD centers.

The support received by CHANCE staff in children's homes has yielded positive benefits, which need to be sustained. In particular, parents and caregivers require frequent reminders of the benefits of early stimulation, as well as support in implementing Baby Ubuntu and Blue Box activities to improve the well-being of their children. Given that parents might also have immediate basic needs (e.g., food, clothing, shelter) which might crowd out the Nurturing Care messaging, the Project needs to provide a holistic approach to social work and case monitoring. As such, the Project should reinforce attention and support to the neediest families and provide technical and financial support to instill income-generating opportunities as needed. Those families who have young children who have been detected as having a disability or at risk of developmental delay require ICM to ensure that all nurturing care needs are addressed and met.

Improving the inclusion of male parents should also be a renewed focus during the last months of implementation. In particular, it would be enriching for the Project to understand the different perceptions on fathers' involvement observed during this mid-term evaluation. Evidence from other ECD projects have shown that the when fathers are engaged in caregiving responsibilities, the community benefits from other positive externalities, such as GBV reduction and increased gender equity attitudes. The Project could benefit from considering evidence-based experiences on the inclusion of fathers in early childhood and adapt for the Ugandan and refugee context. While only small modifications are expected at this phase (which can be tested), this subject could be a project focus for the next phase.

Finally, with regards to the nutrition domain of the Nurturing Care Framework, this mid-term evaluation was not able to ascertain how well the Project has guaranteed the delivery of this pillar. While it has partnered with CSOs operating in the same target zones, these referrals are not integrated within CHANCE's case management or monitoring system. As an essential component for child development, nutrition referrals to partner organisations fills the critical gap left as outlined CHANCE's project design. Reinforcing these

2. **Reinforce community-based advocacy for all children with disabilities and developmental delays.**

The Project has filled a need identified in the communities, especially with regards to the promotion of children's rights for children with disabilities and developmental delays. Parents and community-based workers have improved their capacities to care for their children, to provide nurturing care and to promote a better quality of life. Developing community awareness against stigma and discrimination has a limited scope in the project, however, and remains essentially limited to parents and some professionals involved with CHANCE. Reinforcing community awareness on a broader scale places the responsibility at the community level. Training community members to become community champions on children's rights and inclusive education can garner community, local and district-level attention around these issues. Using the data and evidence provided by CHANCE could help further the understanding of the implementation of children's rights, reduce stigma and discrimination against children with disabilities and developmental delays and promote inclusive approaches to community projects. Increased community demand in advocacy and lobbying for enabling the public policy environment to support children's rights and needs will foster sustainable results for current and future generations. CHANCE's role in promoting community awareness and/or advocacy campaigns could help reduce the gap that exists between policies and programming at the community level.

3. **Foster partnerships which can support advocacy in the humanitarian-development nexus.**

CHANCE Project has partnered with UNHCR in support of the refugee population; as such, H&I senior technical staff should participate actively in the Ugandan refugee education sector policy dialogue. Advocacy at the national level has not been a dedicated activity for the Project, yet the sustainability of the TOC's ultimate change requires attention to national policies. The Uganda Education Consortium provides an opportunity for HI to engage actively in an effective venue where all development partners in education in emergencies can collaborate and share in the provision of inclusive education services in refugee communities. Tapping into these existing opportunities and formalizing relevant links across programme operators can help develop longer-term results and build support among other actors in the humanitarian-development nexus, at the national level, with positive benefits for implementation at the district levels.

4. **Tap into opportunities for new sources of financing.**

The success of a nurturing care strategy in host and refugee communities will depend on the implication of national investments in multiple sectors (health, education, nutrition, child

protection). Given the immediate action required with the arrival of new refugee populations, financing to close the gap in service delivery is often stretched thin in government budgets. As such, the Project should consider new sources of financing to help sustain current activities, lighten the heavy workload of its staff, build new partnerships and scale quality service delivery across the target zones. Indicative options to help secure additional financing should focus on ECD investments with active partnerships with the Government of Uganda, namely the Global Partnership for Education (GPE), the World Bank, the European Union and Education Cannot Wait (ECW). Save the Children and UNHCR are active in the implementation of these investments and can provide a bridge for CHANCE to support inclusion throughout these organisation's projects. ECW has already invested with HI and other organisations in interventions to increase access to primary school for children with disabilities and include mental health and psychosocial support for children.[55] Financing partnerships could reinforce the weaker components of the Nurturing Care Framework, namely early education and nutrition.

5. **Scale-up the use of assessment tools (MDAT and ScoPeO) as well as Baby Ubuntu and Blue Box implementation.**

In the target zones, as in many parts of the country, programmes and policies focusing on children with disabilities and developmental delays are very weak. The CHANCE project provided an opportunity to focus on the identification of need through assessment tools, identification of children with needs, and implementing the support through referral and rehabilitation services. Furthermore, the use of community-enhancing mechanisms which empower parents and communities to provide Nurturing Care to their children (i.e..Baby Ubuntu and Blue Box) should be further supported and scaled-up. In particular, the groups require funds to continue functioning (e.g., for transport), need support for improving access to adequate nutrition, and repeated technical assistance from health care professionals and other trained workers to provide adequate supervision of children's development and well-being.

Insofar as possible, the Project should ensure that sufficient cases are covered during follow-up visits to better understand the effect of these community-based models in improving development outcomes and quality of life for the target children. During the remainder of the Project, a stronger monitoring and learning component can be achieved through clear mapping and establishment of a tracking system centered around Project beneficiaries, linking Project activities to expected intermediate changes at the individual level. Child development and well-being indicators might not provide sufficient evidence in Project-related improvement, given that they are not highly sensitive to children with

[55] For example, within pre-primary education, ECW has reached more than 1400 children with disabilities. https://www.educationcannotwait.org/our-investments/where-we-work/uganda.

disabilities and developmental delays. Improving the collection of qualitative evidence in monitoring the Project beneficiaries, through case studies and other qualitative data collection methods can provide further evidence on the positive impact of the CHANCE Project. For example, existing quality of life instruments for caregivers of children with developmental delays and disabilities used in developing countries could be adapted to the Project context. The next phase of the Project could provide an opportunity to assess parental well-being.

Appendix 1 – Status of key Project Outcome Indicators

Table 11: Outcome Indicator Comparison Table (Baseline, MTR and Target Values)

Indicators	Baseline	MTR	Final target
% of children aged 0-5 years in the intervention area who have improved in their level of development.	0	TBD	75%
% of children (ages 6-12) who have improved in their quality of life.	0	TBD	75%
Number of children (0-12 years) who have received care services through the Child Development and Well-Being Centers.	0	TBD	2,000
Number of children (0-12 years) identified to need services.	0	TBD	2,000
Number of cases closed for children (0-12 years) who received care services through the CDWCs.	0	TBD	2,000
Number of functional Child Development and Well-Being Centers (CDWCs) open and functional	0	TBD	2
% of successful referrals between CDWC and health services or related service providers (Protection, Education, Nutrition)	0	TBD	60%
Number of cases receiving services, which have been identified by community-based structures.	0	TBD	1,000
Number of caregivers supported and trained on positive parenting (Baby Ubuntu) and childcare.	0	TBD	2,000
Percentage of caregivers demonstrating improved knowledge, attitudes, and practices related to childcare and positive parenting.	0	TBD	85%
Percentage of caregivers satisfied with the services provided at community and service provider's levels.	0	TBD	90%
Number of identified community members who are better equipped to respond to child and households needs to support development and quality of life of children.	0	TBD	200
Number of community members identified by HI who are better equipped to respond to child and households needs to support development and quality of life of children.	0	TBD	50

Indicators	Baseline	MTR	Final target
Number of community members identified by NUDIPU who are better equipped to respond to child and households needs to support development and quality of life of children.	0	TBD	150
Number of cases receiving services, which have been identified by community-based structures.	0	TBD	1000
Number of cases referred for services by community-based structures.	0	TBD	1000
Percentage of cases directly supported through community-based structures supported by the project.	0	TBD	50%
Number of health officers and community-based volunteers trained in Nurturing Care based on National Policies.	0	TBD	48
Percentage of health officers and community-based volunteers who show increased knowledge in Nurturing Care.	0	TBD	75%
Number of health services identified to have improved service delivery based on the Quality Service Delivery Index.	0	TBD	4
Number of locally developed innovation solutions implemented and evaluated.	0	TBD	4
# of actions related to Nurturing Care included within Local Development plans	1	TBD	--
# of Locally developed innovation solutions implemented and evaluated	0	TBD	--

Appendix 2 – Indicators

Outcome Indicator	Result	Indicator no.	Indicators	Baseline	MTR	Final target
SPECIFIC(S) OBJECTIVES: Improve motor, language and social outcomes and quality of life for children (0-12)		1:	% of children aged 0-5 years in the intervention area who have improved in their level of development.	0	TBD	75%
		2:	% of children (ages 6-12) who have improved in their quality of life.	0	TBD	75%
	1: Child Health and Development (0-12) is improved through improved access to quality and comprehensive services	1.1	Number of children (0-12 years) who have received care services through the Child Development and Well-Being Centers.	0	TBD	2,000
		1.1.1:	Number of children (0-12 years) identified to need services.	0	TBD	2,000
		1.1.2:	Number of cases closed for children (0-12 years) who received care services through the CDWCs.	0	TBD	2,000
		1.2:	Number of functional Child Development and Well-Being Centers (CDWCs) open and functional	0	TBD	2

Outcome Indicator	Result	Indicator no.	Indicators	Baseline	MTR	Final target
		1.3:	% of successful referrals between CDWC and health services or related service providers (Protection, Education, Nutrition)	0	TBD	60%
		1.4:	Number of cases receiving services, which have been identified by community-based structures.	0	TBD	1,000
	2: Caregivers are empowered and provide adequate care to children while improving their quality of life	2.1:	Number of caregivers supported and trained on positive parenting (Baby Ubuntu) and childcare.	0	TBD	2,000
		2.2:	Percentage of caregivers demonstrating improved knowledge, attitudes, and practices related to childcare and positive parenting.	0	TBD	85%
		2.3:	Percentage of caregivers satisfied with the services provided at community and service provider's levels.	0	TBD	90%
	3: Communities support children's development (0-5 years) and	3.1:	Number of identified community members who are better equipped to respond to child and households needs to support development and quality of life of children.	0	TBD	200
		3.1.1:	Number of community members identified by HI who are better equipped to respond to child and	0	TBD	50

Outcome Indicator	Result	Indicator no.	Indicators	Baseline	MTR	Final target
	quality of life (6-12 years)		households needs to support development and quality of life of children.			
		3.1.2:	Number of community members identified by NUDIPU who are better equipped to respond to child and households needs to support development and quality of life of children.	0	TBD	150
		3.2:	Number of cases receiving services, which have been identified by community-based structures.	0	TBD	1,000
		3.2.1:	Number of cases referred for services by community-based structures.	0	TBD	1,000
		3.3:	Percentage of cases directly supported through community-based structures supported by the project.	0	TBD	50%
	4: Quality delivery and monitoring of	4.1:	Number of health officers and community-based volunteers trained in Nurturing Care based on National Policies.	0	TBD	48

Outcome Indicator	Result	Indicator no.	Indicators	Baseline	MTR	Final target
	inclusive health and education services are improved	4.1.1:	Percentage of health officers and community-based volunteers who show increased knowledge in Nurturing Care.	0	TBD	75%
		4.2:	Number of health services identified to have improved service delivery based on the Quality Service Delivery Index.	0	TBD	4
		4.3:	Number of locally developed innovation solutions implemented and evaluated.	0	TBD	4
	5: Support the implementation of enabling policies for nurturing care in Uganda	5.1:	# of actions related to Nurturing Care included within Local Development plans	1	TBD	
		5.2:	# of Locally developed innovation solutions implemented and evaluated	0	TBD	

Appendix 3 – List of Key Informants

#	Name	Locality	Organization	Role	Email
1	Leonard Taremwa	-	Humanity and Inclusion	Occupational therapist	--
2	Busiku Silagi	-	Humanities and Inclusion	Speech therapist	--
3	Emily	-	Humanities and Inclusion	Social worker	--
4	Aziku Sharon	-	Humanities and Inclusion	Social worker	--
5	Kibo Augutino	-	Zone III health center III	Health worker	--
6	Asuba Justine	-	Humanity and Inclusion	-	asubaamulesss@gmail.com
7	Juma Emmanuel	Village 9		Caregiver	--
8	Amaniyo Scovia	Omugo HC IV	Humanities and Inclusion	Facilitator	--
9	Joel Bayuga	-	-	Facilitator	bayugajoel@gmail.com
10	Amandi Simon	Terego	DLG	District Health Officer	--
11	Juma Innocent	-	Uriama HC III	Feeding	--
12	Faiza Ayiba	Ofua 3 Block B	-	-	--
13	Draku Paul	Drimven	-	-	--
14	Alima Fred	Inia village	-	-	--
15	Bayu Innocent	Wenduku	-	-	--
16	Aringa J William	Wenende	-	LC1	--
17	Enima Eunjenious	Yamani village	-	-	--
18	VHT	-	Omugo health center III	-	-

#	Name	Locality	Organization	Role	Email
19	Santino	Mvepi settlement		Chairperson people with disability	-
20	Sam	Terego district headquarters		Probation officer	-
21	Mercy Agaba	-	Reach a hand Uganda	-	-
22	Emmanuel	-	NUDIPU-Terego	Program assistant	-
23	Dusman	Mvepi	Refugee welfare	Chairperson	-
24	Care giver	Omugo settlement	-	-	-
25	Caregiver	Ofua	-	-	-
26	Caregiver	Imvepi	-	-	-
27	Caregiver	-	-	-	-
28	Caregiver	-	-	-	-
29	Caregiver	-	-	-	-
30	caregiver	-	-	-	-
31	Caregiver	-	-	-	-
32	Aline	Rwanda	HI	Nurturing Care TS	a.villette@hi.org
33	Umar	Kampala	HI	Head of Program	u.tumwine@hi.org

Appendix 4 – List of Focus Group Discussion Participants

#	District	Locality	Village	Group interviewed	Number of attendees
1	Terego	Ofua		Women	12
2	Terego	Ofua		Women	9
3	Terego	Imvepi		women	12
4	Terego	Omugo	Health center III	Women	12
5	Terego	Omugo	Health center III	Women	10
6	Terego	Omugo		Men	8
7	Terego	Omugo		VHT	8
8	Terego	Omugo		Women	10
9	Terego	Ofua		Women	9
10	Terego	Imvepi		Men	11
11	Terego	Omugo		Women	8
12	Terego	Ofua		Women	9
13	Terego	Ofua		Women	9
14	Terego	Ofua		Males	8
15	Terego	Ofua		Women	12
16	Terego	Omugo		Women	10

Appendix 5 – Annexes

Annex A - Terms of Reference

Mid-term evaluation of CHANCE Project.dc

Annex C - Qualitative Interview Guides

Appendix I – Key Informant Interview Guide (Introduction)

Consent form

Consent Form HI.docx

This part will apply to all key informant interviews

Hi, my name is [***Name of Research Associate/Enumerator***] and I am working with Bronkar (U) Limited on behalf of Humanity and Inclusion (HI). We are conducting Mid-Term Evaluation of CHANCE Project, trying to understand health, nutrition and responsive caregiving; components of the nurturing care Framework, in children aged 0-12 in your community. In order to understand this better, we would like to ask you some questions. You should know that this assessment might not directly lead to any assistance. The interview will take between 30 and 45 minutes to complete.

Any information provided is strictly confidential and responses will be fully anonymized. Your participation is voluntary, and you may choose not to answer all or some of the questions, and you can stop the assessment at any time for any reason. However, we hope that you will participate since your views are important. Your participation is not linked to any direct benefits or remuneration and refusal will not affect your relationship with HI or any other organization providing aid or assistance. You are encouraged to ask questions at any time about the study and the methods we are using. We will use the information from this study to write a report, which will be a public document, but which will not contain any details of respondents.

Before we begin, we need your consent to participate. Can you confirm:

You are 18 years or older: Yes/No

You agree to take part in the study: Yes/No

Do you agree to proceed? Yes/No

Name of interviewer	
Name of key informant	
Occupation/Role	
Location	
Telephone number	
Email address	

INTRODUCTION

Annex D – Case Study Guide

Case Study Guide.docx

Annex E – Brief Description of Blue Box

The Blue Box tool is a key tool to be used by professionals to provide support to parents of children who have been identified as having a disability or who are at risk of developmental delay. The Blue Box consists of the following elements:

- Play materials to guide the child's development;
- A chart reflecting the different stages of a child's development between the ages of 3 months and 5 years (Figure 7);
- Activity cards (one set for 0–3-year-olds and another for 4–6-year-olds) organised according to developmental domains (cognitive, communication, fine and gross motor skills). Activities are adapted for children with disabilities or functional difficulties;
- A development diary that provides an assessment of the child's level of development based on the observations of a person trained in the tool.

Based on a during the Chance project in Uganda The Blue Box is used in the home and delivered by CBVs and supervised by rehabilitation staff.

Figure 7: Guideline chart to summarise the developmental milestones for a child from 3 months to 5 years

Source : Anaïs Loizillon, Rwanda data collection.

Annex F – Data Collection Plan

Data Collection Plan.docx

Annex G – Enumerators Training Schedule

Enumeratos Training Schedule.docx


humanity
&inclusion