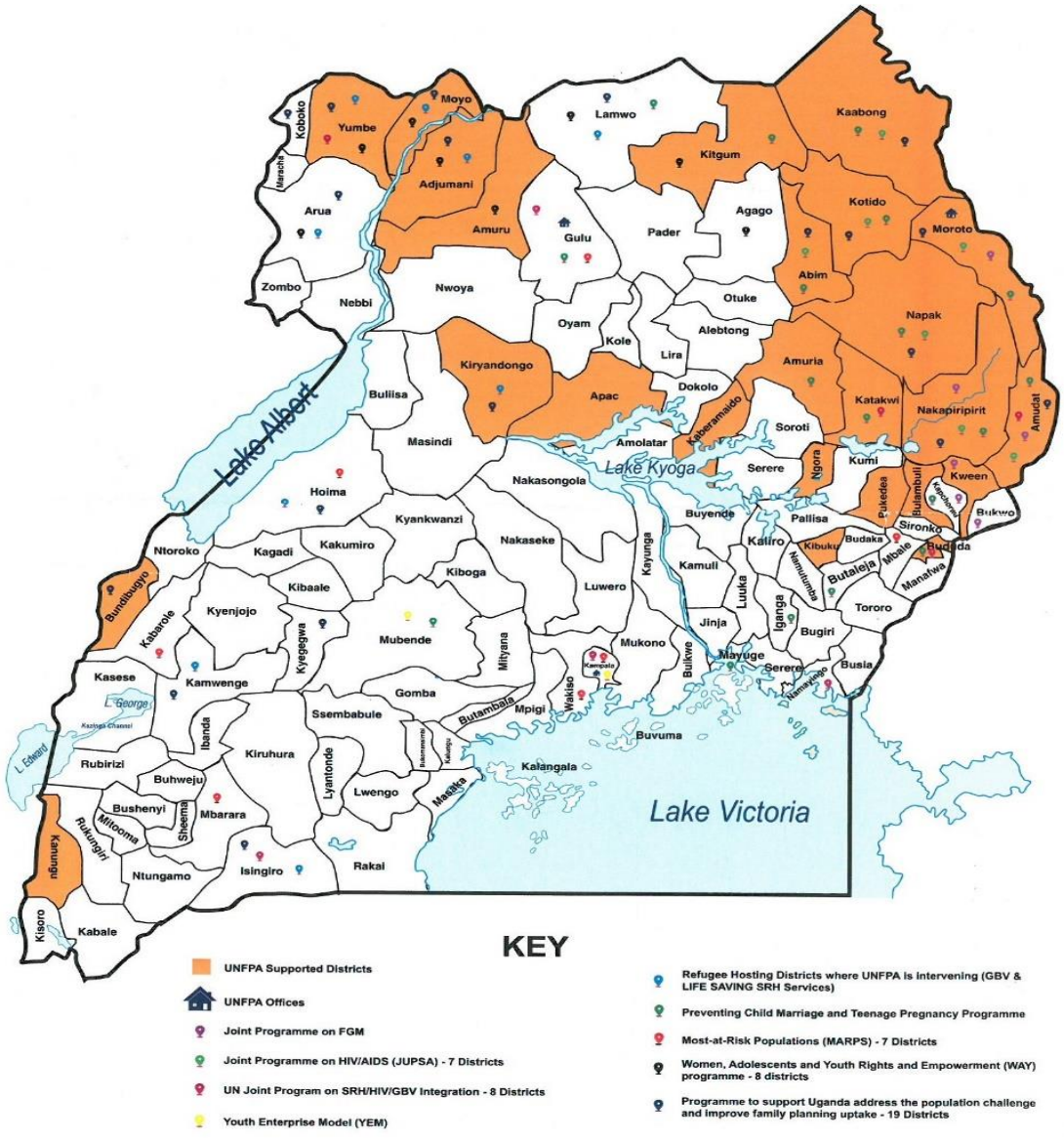
GOVERNMENT OF UGANDA / UNFPA 8TH COUNTRY PROGRAMME 2016 – 2020

EVALUATION REPORT

January 2020

MAP OF UGANDA SHOWING UNFPA INTERVENTION DISTRICTS



Country Programme Evaluation Team

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Abbreviations and Acronyms

ADB	African Development Bank
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
AWP	Annual Work Plan
BEmONC	Basic Emergency Obstetric Newborn Care
BOU	Bank of Uganda
BRICS	Brazil, Russia, India, China and South Africa
CEmONC	Comprehensive Emergency Obstetric Newborn Care
CERF	Central Emergency Response Fund
CIP	Costed Implementation Plan
CO UNFPA	Country Office
COARs	Country Office Annual Reports
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPMEP	Country Programme Monitoring and Evaluation Plan
CPR	Contraceptive Prevalence Rate
CRRF	Comprehensive Refugee Response Framework
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DANIDA	Danish International Development Agency
DaO	Delivering as One
DD	Demographic Dividend
DHIS	District Health Information System
DHS	Demographic and Health Survey
DLG	District Local Government
DO	Decentralised Office
ELA	Empowerment and Livelihoods for Adolescents
EPRC	Economic Policy Research Centre
EQA	Evaluation Quality Assessment
ERG	Evaluation Reference Group
ESARO	Eastern and Southern Africa Regional Office
ET	Evaluation Team
EU	European Union
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GII	Gender Inequality Index
HC	Health Centre
HCD	Human Capital Development
HDI	Human Development Index
HSDP	Health Sector Development Plan
IDA	International Development Association
IP	Implementing Partner
JLOS	Justice, Law and Order Sector
JP	Joint Programme
KII	Key Informant Interview
LDCs	Least Developed Countries
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LNOB	Leaving No One Behind
M&E	Monitoring and Evaluation

MAAIF	Ministry of Agriculture, Animal Industries and Fisheries
MAG	Male Action Group
MARPs	Most at Risk Populations
MDAs	Ministries, Departments and Agencies
MGLSD	Ministry of Gender, Labour and Social Development
MIC	Middle Income Country
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MoES	Ministry of Education and Sports
MoEMR	Ministry of Energy and Mineral Resources
MoH	Ministry of Health
MoJCA	Ministry of Justice and Constitutional Affairs
MoLG	Ministry of Local Government
MPDSR	Maternal and Perinatal Death Surveillance Response
MTR	Mid-Term Review
MWE	Ministry of Water and Environment
NAADS	National Agricultural Advisory Services
NDP	National Development Plan
NEMA	National Environmental Management Authority
NEX	National Execution
NGBVD	National Gender Based Violence Database
NGO	Non-Governmental Organization
NGP	National Gender Policy
NPC	National Population Council
NPP	National Population Policy
ODA	Official Development Assistance
OECD/DAC	Organisation of European Cooperation and Development/Development Assistance Committee
PEPFAR	President's Emergency Plan For AIDS Relief
PLWD	Persons Living with Disabilities
PMTCT	Prevention of Mother to Child Transmission
RCO	Resident Coordinator's Office
RMNCH	Reproductive Maternal Neonatal and Child Health
SASA	Start Awareness Support and Action
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SIED	Sustainable Inclusive Economic Development
SPI	Social Progress Index
SRHR	Sexual and Reproductive Health and Rights
TFR	Total Fertility Rate
UBOS	Uganda Bureau of Statistics
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNHS	Uganda National Household Survey
UNICEF	United Nations Children's Fund
UNSDF	United Nations Sustainable Development Framework
UNSDG	United Nations Sustainable Development Group
UPHIA	Uganda Population-Based HIV Impact Assessment
WHO	World Health Organisation

Key Facts Table - Uganda

Land	
Geographical location	East Africa, West of Kenya, East of the DRC, North of Tanzania, South of South Sudan
Land area	241 5507 square kilometres
	Open water bodies cover 36 864 01 square kilometres
Terrain	Mostly Plateau with rim of mountains
People	
Population[1,2]	Total Population 40 299 300; Male=49%; Female=51% (UBOS, 2012); Urban Population: 6624 050 (21.4%); Rural Population: 31 675 250 (78.6%)
	Population growth rate 3.0 % (2014/15)
Government	Republic per 1995 Constitution, amended in 2005
	1962: Independence from British colonial rule;
	1971 – 1979: Military takeover/government characterised by dictatorship and economic decline;
	1980 – return of democratically elected government
	1981 – 1986: Civil war
	1986: National Resistance Movement Unitary Government
	1986-2006: Civil war in Northern Uganda
	2001 – to-date: Current National Resistance Government under multiparty dispensation.
Economy	
GDP Per Capita (US$), Current Prices[3]	724 (2017/18)
GDP Growth Rate (%)[4]	6.1% (2017/18)
Proportion of Population below the National Poverty Line (%)[5]	21.4 (2016/2017)
Income Distribution (GINI Coefficient) [6]	0.42 (2016/2017)
US$ Labour Productivity Per Worker – Total[7]	2.786 (2014/15)
Working-Age Population Employed	47.5 (2016/17)
Social and Health Indicators	
Human Development Index Rank[8]	0.516
Unemployment Rate (overall)[9]	9.2
Per capita Public Health Expenditure, Uganda shillings[10]	49 637 (2016/17)
Literacy Rate (10 Yrs.+) - Total[11]	73.5 (2017/2018)
Total Fertility Rate[12]	5.4 (2015/16)
Infant Mortality Rate per 1000 live births[13]	43 (2015/16)

Sustainable Development Goals Status		
Goal	**Indicator and Source**	**Status**
SDG1	Poverty Headcount ratio at $1.90 a day (% of population) (2011 PPP[14]	19.2% (2012-2013)

[1] National Mid-year Population Projections 2015-2050 (UBOS, 2018)
[2] UNHS 2012/13, UBOS
[3] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[4] Annual Statistical Abstract Statistical Abstract (UBOS, 2018,
[5] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[6] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[7] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[8] Uganda UNDP Human Development Report, 2018
[9] UNHS 2012/13 & UNHS 2016/17, UBOS
[10] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[11] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
[12] UDHS 2016, UBOS
[13] UDHS 2016, UBOS
[14] UNHS 2012/13, UBOS

Sustainable Development Goals Status		
SDG2	Prevalence of Stunting (Low height-for-age) in children under 5 years of age (%)	29% (2016)
	Prevalence of Wasting in Children under 5 years of age (%)[15]	4.7% (2014/2016)
	Prevalence of Obesity. BMI ≥ 30 (% adult population)[16]	4.2 (women); 0.6 (men) (2011)
SDG3	Maternal Mortality Ratio per 100 000 live births[17]	336 (2016)
	Neonatal Mortality Rate (per 1 000 live births)[18]	43 (2016)
	Mortality Rate for under-5 (per 1 000 live births)[19]	64 (2016)
	Incidence of Tuberculosis (per 100 000 people)[20]	202 (2015)
	HIV Prevalence (per 1 000)[21]	7.6 (2011)
	Healthy Life Expectancy at Birth (years)[22]*	63.6 years (2014)
	Adolescent Fertility Rate (births per 1 000 women ages 15-19)[23]	132 (2016)
	Proportion of Births Attended by Skilled Health Personnel (%)[24]	74.2 % (2016)
SDG4	Net Primary Enrolment Rate (%)[25]	97 % (2014)
	Expected Years of Schooling (years)[26]	11.1 (2012)
	Literacy Rate of 15-24 year olds, both sexes (%)[27] *	72.2 % (2014)
	Primary Completion Rate[28]	61% (2015)
SDG5	Estimated Demand for Contraception that is Unmet (% women married or in union. ages 15-49)[29]	28 % (2016)
	Proportion of Seats held by Women in National Parliaments (%)[30]	35% (2016)
SDG6	Improved Water Source (% of population with access)	73 % (2012-2013)
	Access to Improved Sanitation Facilities (% population) *	91.2 % (2012-2013)
	Imported Groundwater Depletion (m3/year/capita)[31]	29 billion (2013)
SDG7	Access to Electricity (% population)[32] *	872 836 customers (2015)
	Access to Non-solid fuels (% population)[33]*	4.2 % (012-2013)
SDG8	Proportion of the Population using the Internet (%)[34] *	39.7 % (2015)
	Mobile Broadband Subscriptions (per 100 inhabitants)[35]	10.267 (2014)
	Logistics Performance Index: Quality of trade and transport-related infrastructure (1=low to 5=high)[36]	2.74 (2016)
	Number of Scientific and Technical Journal Articles (per capita)[37]	474 (2013)
SDG10	Gini Index (0-100)[38]	0.395 (2012-2013)
SDG11	Improved Water Source piped (% urban population with access)[39]	87.3 % (2012-2013)
	Urban Population (% of total)[40]	21.4 % (2017)

[15] UDHS 2016, UBOS
[16] UDHS 2016, UBOS
[17] UDHS 2016, UBOS
[18] UDHS 2016, UBOS
[19] UDHS 2016, UBOS
[20] https://data.worldbank.org/indicator/IP.JRN.ARTC.SC
[21] Sero Survey 2014
[22] UPHC 2014, UBOS
[23] UDHS. 2016, UBOS
[24] UDHS 2016, UBOS
[25] MoES
[26] Human Development Report (2013). UNHS 2012/13, UBOS
[27] UNHS 2012/13. UDHS 2016. NPHC 2014, UBOS
[28] MoES. Education Statistical Abstract. UNHS. 2012/13, UBOS
[29] UDHS 2016, UBOS
[30] The Uganda Parliament, 2016
[31] National Water Resource Assessment
[32] UNHS 2012/13, UBOS
[33] UNHS 2012/13. UBOS
[34] UNHS 2012/13, UBOS; UCC
[35] https://data.worldbank.org/indicator/IT.NET.BBND.P2
[36] https://data.worldbank.org/indicator/IP.JRN.ARTC.SC
[37] https://data.worldbank.org/indicator/IP.JRN.ARTC.SC
[38] UNHS 2012/13, UBOS
[39] UNHS 2012/13, UBOS
[40] NPHC 2014, UBOS

Sustainable Development Goals Status		
	Population Living in Slums (% of urban population)[41]	*54 (2014)
SDG12	Municipal Solid Waste (kg/year/capita)[42]	0.56 (2014)
	Production-based SO2 Emissions (kg/capita)[43]	0.2 (2014)
SDG13	Energy-related Carbon Dioxide Emissions per capita (tCO2/capita)[44]	0.033 (2014)
SDG14	Total Fisheries Production (Metric Tons)[45]	454 860 tonnes (2015)
SDG15	Terrestrial Protected areas (% of total land area)[46]	16% (2014)
	Annual Change in Forest Area (%)[47]	-2.2% (2015)
SDG16[48]	Prison Population (per 100,000 people)[49]	115 per 100,000 people (2014-2015)
	Proportion of the Population who feel safe walking alone at night in the city or area where they live (%)[50]	60 % (2010-2015)
	Slavery Score (0-100)[51]	50 (2016)
	Transfers of Major Conventional Weapons (Exports) (constant 1990 US$ million per 100 000 people)[52]	per 100 000 people (2014)
	Bribery Incidence (% of firms experiencing at least one bribe payment request)	22 %
SDG17	Tax Revenue (% GDP)[53] *	14.0 % (Q1 FY 2016/2017)

* The national indicator varies slightly from the international indicator.

[41] https://data.worldbank.org/indicator/EN.POP.SLUM.UR.ZS
[42] National Environment Management Authority (NEMA) and UBOS
[43] 2nd National Communication on Green House Gas(GHG) Emission 2014
[44] 2nd National Communication on GHG 2014
[45] MAAIF
[46] State of Environment Report, NEMA
[47] National Forest Authority (NFA)
[48] World Bank (2017). The Atlas of Sustainable Development Goals 2017: From World Development Indicators.
[49] ICPR (2016)
[50] UNICEF (2016)
[51] Walk Free Foundation (2016)
[52] Stockholm International Peace Research Institute (2017)
[53] State of the Economy, BOU

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

The Evaluation Report is structured according to the UNFPA Evaluation Handbook. The first chapter is the introduction. This chapter provides the purpose and objectives of the 8th GoU/ UNFPA Country Programme; the scope of the evaluation as well as the methodology and process. The second chapter showcases the country context, specifically outlining the main development challenges and national strategies, followed by the role of external assistance (both overseas development aid and the United Nations Development Assistance Framework).

The third chapter covers the UN and UNFPA strategic response as well as the UNFPA response through the current CP8 and previous CP7 country programmes. The fourth chapter provides the findings of the evaluation covering all the evaluation questions with respect to relevance, effectiveness, efficiency, sustainability and coordination. The conclusions to the report are provided in the fifth chapter and these are given at strategic and programmatic levels. The sixth chapter provides the recommendations and these are also given at strategic and programmatic levels. Finally, the report provides the following annexes: terms of reference, list of persons/ institutions visited and interviewed, documents reviewed, evaluation matrix, stakeholders map, the CPE agenda and the FGD analysis summary.

Acknowledgements

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Special gratitude goes to the Ministries, Departments and Agencies (MDAs) that were consulted during the CPE that included: Office of the Prime Minister (OPM); Ministry of Education and Sports (MoES); Ministry of Gender, Labour, and Social Development (MGLSD); Ministry of Health (MoH); Justice Law and Order Sector (JLOS) of Ministry of Justice and Constitutional Affairs (MoJCA); National Population Council (NPC), National Planning Authority (NPA) and Uganda Bureau of Statistics (UBOS). We would like to particularly appreciate the following institutions and their staff which provided responses to the evaluation: UN Agencies which included UNDP, UNICEF, WHO, UNAIDS, UNHCR, UN Women and UNFPA; Makerere School of Public Health, Inter-Religious Council of Uganda, ACORD, AIDS Information Centre (AIC), BRAC, CARE International, International Rescue Committee (IRC), Lutheran World Federation (LWF), OUTBOX, Reach A Hand Uganda (RAHU) and Reproductive Health Uganda (RHU).

We also thank the Local Government departments (Chief Administrative Offices, District Health Offices, District Community Development Offices, and District Planning Offices) as well as the communities for their contribution to this evaluation from the following districts: Adjumani, Amudat, Arua, Iganga, Kampala, Kitgum, Moroto and Kyegegwa.

We would like to appreciate the strategic guidance of Mr. Alain Sibenaler, UNFPA Representative, UNFPA Deputy Representative and the supervisory support by the Evaluation Manager, who provided technical oversight to the CPE.

Finally, we thank the CPE team of consultants for executing the evaluation.

Executive Summary

Background: The 8th Country Programme, 2016 - 2020 (CP8) with UNFPA's support to the Government of Uganda (GoU) responded to national priorities as articulated in the 30 year national strategic Vision 2040, the National Development Plan (NDP) II (2015/16 - 2019/20), the United Nations Development Assistance Framework (UNDAF) 2016-2020 and the UNFPA Strategic Plans (2014-2017; 2018-2021). The CP8 was operationalized through a Country Programme Business Plan which was signed in 2015 between the GoU and UNFPA, and is the instrument for joint accountability between GoU and UNFPA.

Purpose of Evaluation: The purpose of the 8th Country Programme Evaluation (CPE) was to demonstrate accountability to stakeholders on the performance achieved; to support evidence-based decision-making; to contribute important lessons learned to the knowledge base of the organisation; and, in turn, to provide independent inputs to the next UNFPA country programme cycle and the strategic direction of the continued role for UNFPA support to the GoU. The **audience** of this CPE was the UNFPA Country Office (CO), Regional Office, UNFPA HQ and the Executive Board; relevant government agencies, national partners, development partners including the donors and UN agencies in the country.

The **Specific Objectives** of the CPE were to: (a) provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the CP8; (b) provide an assessment of the country office positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results; (c) provide an assessment of the extent to which CP8 implementation frameworks and modalities have enabled or hindered achievement of outputs; and (d) draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming design. The **scope** was to evaluate the thematic components of CP8 which are Sexual and Reproductive Health (SRH), Adolescents and Youth (AY), Gender Equality and Women's Empowerment (GEWE) and Population Dynamics (PD). The evaluation criteria applied were comprised of Relevance, Effectiveness, Efficiency, Sustainability and Coordination.

Programme: The CP8 contributed to the UNFPA Global goal of the Strategic Plan, 2018-2021, which was to "achieve universal access to SRH, realise reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population Dynamics. This was to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality". The CP8 pursued four programme outcomes in the areas of SRH, AY, GEWE and PD. The SRH component had three outputs namely: (Output 1): national and District Local Governments (DLGs) have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings, (Output 2): national and district governments have the capacity to increase the demand for and the supply of modern contraceptives; and (Output 3): increased national capacity to deliver integrated SRH and HIV/AIDS prevention programmes that are free of stigma and discrimination. The AY component had one output which was about increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth SRH needs in national laws, policies and programmes, including humanitarian settings. The GEWE component was expected to strengthen the capacity of national and DLGs for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence (GBV) prevention and response services, including in humanitarian settings. The output of the PD component focused on increasing the capacity of national institutions and district governments for the production and use of disaggregated data on population, SRH and GBV for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings.

Methodology: The **CPE had five phases** namely preparatory during which UNFPA CO engaged the Evaluation Reference Group (ERG) to finalise the terms of reference (ToR) and recruit an Evaluation Team (ET) of three experts. The next three phases were design, data collection, analysis and reporting. The design phase started on 3rd October 2019. The fifth and final phase was evaluation quality assessment (EQA), management response and dissemination of the CPE report. The CPE was based on **a set of 10 questions corresponding to the evaluation criteria** afore-mentioned. Using a purposive sampling method, a sample of 7 districts comprising of 4 districts (Adjumani, Amudat, Kitgum and Moroto) where UNFPA had ongoing programme implementation of

all/most of the four thematic interventions and 3 other districts where UNFPA had previous presence (Arua, Iganga and Kyegegwa) was visited during data collection. The selection process took into account the context, region and whether the district was a refugee hosting or not. Other factors which were considered and used in the selection of the interventions were the number of interventions in each district as well as exposure, that is, the duration of implementation of the project. The districts with relatively larger numbers of interventions and projects with a duration of implementation of more than a year were selected. In addition, Kampala District was covered for key interviews of national level Implementing Partners (IPs), UNFPA Country Office (CO) and UN agencies. The CPE triangulated a number of data collection methods, including document review, Key Informant Interviews (KIIs) Focus Group Discussions (FGDs), and observations. Stakeholders for KIIs were selected for participation in the evaluation using purposive sampling and in this regard the stakeholders map was used for stakeholder sampling for data collection. The participants for the FGDs were selected also using purposive sampling in order to ensure that they had the relevant characteristics and experiences required to answer the evaluation questions. The CPE adopted an inclusive and participatory approach, involving a broad range of IPs and stakeholders [including persons living with disability (PLWD) and most at risk populations (MARPs] and ensuring gender balance. Ethics and quality control requirements were adhered to by the ET and assured by the Evaluation Manager. To validate the design of the CPE, preliminary findings and the CPE report, meetings and workshops were held with the ERG and UNFPA CO and IPs respectively.

Key Findings: The CP8 was aligned with national and international development priorities, as outlined in Uganda Vision 2040, NDP II (2015/2016-2019/2020), the UNDAF 2016-2020 and the UNFPA Strategic Plans (2014-2017; 2018-2022) and was contributing to the Sustainable Development Goals (SDGs). The CP8 addressed the needs of beneficiary communities as they were initially consulted about their priorities before the start of CP8. However, during the implementation of CP8 activities, there was limited regular downstream consultations with communities about their emerging needs. On the humanitarian situation, UNFPA CO particularly responded rapidly, effectively and efficiently to the increasing refugee influx over the years, enabled by their strong partnership with other government and UN partners. The development of CP8 programmatic interventions was based on validated baseline data from the areas covered. The targets for output indicators for the four outcomes were largely met. In **SRH**, the functionality of Health Centre (HC) IVs and trends in health facility deliveries significantly improved over the years in the UNFPA supported districts, but those HCs with the capacity to carry out Emergency Obstetric and Neonatal Care (EmONC) was inadequate. For instance, only 8 percent of HC IIIs were able to perform all the 7 signal functions for EmONC (below target by 72 percent); whereas only 7 percent of HC IVs and hospitals were able to perform all the 9 signal functions for EmONC (below target by 53 percent). This implied that the quality of EmONC services in most UNFPA supported facilities is below the required standard. All of the planned target results under family planning (FP) were largely achieved: in that by the time of the CPE, 74 percent of health facilities registered no stock-outs of at least 3 FP common methods (126 percent above target in 2018; and 106 percent compared to a target of 70 percent set for 2019). There was inadequate capacity at heath facility level to manage the logistics management information system. The success of UNFPA in the supply side of FP contributed to a continuous improvement in the couple years of protection, from the time when the programme started in 2016 up to 2019. All targets relating to adequacy of FP commodities, of human resource capacity and a functional supply chain system were met as well as targets for demand creation into the community. UNFPA supported MoH in the development of a number of policies and strategies namely: the Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2016/17-2019/20); the 2nd National Health Policy (2010/11-2019/20): National SRHR and HIV Integration Strategic Plan, a costed FP Investment Plan (2015-2020) and the Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14).

For the **Adolescents and Youth**, the CP strengthened efforts towards provision of life skills for adolescent girls, sexuality education (SE) and youth participation in decision making; empowerment of young people through asset building including social, educational, health and economic assets especially for vulnerable adolescent girls. On the policy front, UNFPA supported government through the Ministry of Health (MoH) and Ministry of Gender, Labour and Social Development (MGLSD) on the development of National SE Framework 2018; National Strategy on Child Marriage and Teenage Pregnancy, 2014/2015-2019/2020; and the SRHR Youth Engagement Strategy, which was validated by the MGLSD TWG pending approval by top management. Provision of adolescent SRH through youth friendly services in health facilities was lagging below the set targets for 2019. Overall, three out of the four (75 percent) output indicators met the defined targets while 1 (25 percent)

did not. In **GEWE**, the CP made significant contributions towards the strengthening of policy, legal, and accountability frameworks on GEWE as well as the transformation of attitudes, values, norms that perpetuate GBV, female genital mutilation (FGM), and, child and forced marriage. UNFPA in partnership with other UN agencies and other development partners was at the helm and provided strategic technical leadership in the development of most of the policy frameworks and plans aimed at GEWE. These included: the Revised National Policy on Elimination of Gender Based Violence (GBV) in Uganda (2019); National Male Involvement Strategy for Prevention and Response to GBV in Uganda (2017); and the National Strategy to End Child Marriage and Teenage Pregnancy (2014/2015 - 2019/2020) which all had strategic actions aimed at reducing gender inequality, promoting women empowerment, and eliminating harmful practices. Under **PD**, significant achievements were realised in the provision of evidence for harnessing the demographic dividend (DD) and the use of compliance tools facilitated the compliance of sectors and districts in integrating DD indicators in planning and budgeting frameworks. As for **leaving no one behind**, UNFPA CO uses a composite index to identify regions and districts with the worst indicators. The CO made good attempts to provide services for the hard-to-reach groups using a number of approaches such as the integrated package of SRHR services for hard-to-reach groups, peer education, Start Awareness Support and Action (SASA) among others. However, there was limited service delivery to special groups such as people with different forms of disabilities, most-at-risk populations (MARPs)/key populations who needed client-centred approaches and differentiated service delivery.

Under **efficiency**, there was efficient use of human, financial, logistics and technical resources at the UNFPA CO level. The CO had adequate and skilled staff in all the programme and administrative areas. UNFPA CO followed the laid down guidelines in procurement of services and materials. Financial resources were well managed, guided by UNFPA checks and balances, using the Global Programming System (GPS) which was helpful in tracking the alignment of IP work plans with the results matrix. The structure of human resources was aligned to the Strategic outcomes and outputs but efficiency was compromised mostly at the implementation level through delayed disbursement of funds for the quarters that reduced the time available for implementation. There was significant progress in the utilisation of funds which increased over the years of CP8 implementation and stood at an average of 98 percent. The geographical expansion to more than 40 districts constrained the consolidation and intensity of programming in the original 25 districts. Similarly, the expansion was done without a commensurate increase of the Decentralised Offices (DOs), which stretched the capacity of the existing two DOs to provide oversight and quality assurance effectively and efficiently. Each DO had one staff each covering more than five districts. Through the Integrated Field Support (IFS) and the Women, Adolescents and Youth (WAY) programme, UNFPA managed to register and expand its field presence. The previous modality of transfer of funds direct to district local governments (DLGs) during CP7 was changed to transferring funds through ministries, departments and agencies (MDAs) and civil society organisations (CSOs) at the start of CP8. The downward side of it was that these efforts focused more on sectoral functions and less on cross-cutting functions critical for effective and efficient multi-sectoral coordination and accountability. In addition, financial accountability and monitoring the implementation of DLGs was a challenge since the DLGs were not legally required to directly report to MDAs through which support was given to them. The problem was of delays by DLGs in the submission of their financial and programme accountabilities to MDAs which constrained quarterly releases and subsequently the implementation of programme activities. The government's financial year (1st July - 30th June) is different from that for UNFPA (1st January - 31st December) and this mismatch further complicated the synchronisation of quarterly fund transfers. However, despite the challenges above, gender and human rights dimensions were clearly visible and reflected in the planning and operational modalities of CP8 programmes and strategies both at the national and DLG levels.

As for the **coordination** within and outside United Nations Country Team (UNCT), UNFPA CO contributed positively to the UNCT and applied its comparative advantage for the effective and efficient running of the UN coordination mechanisms. UNFPA was an influential key player and since 2016, it held key responsible positions in various committees and technical working groups (TWGs) contributing to the country's development agenda. For example, UNFPA was an active member of the Health Development Partners group; MoH SRH/HIV/GBV integration TWG; MGLSD GBV TWG; MoH MCH cluster group; MoH Planning TWG, MoH Supervision, Monitoring, Evaluation and Research TWG (SMEAR). UNFPA was a co-lead (with UNHCR) of the GBV working group in refugee settlements. UNFPA was a co-lead with UNICEF on the strategic intent pillar (SIP) on human capital development as well as being one of UNCT leads (WHO, UNFPA) on the Outcome Result Group (ORG) 2.2 for health under UNDAF. Both UN agencies and GoU MDAs have appreciated the important role UNFPA

played in bringing multi-disciplinary strategic partners together to increase the efficiency and effectiveness of the country's development agenda. The active support by UNFPA to facilitate the coordination of the CP8 by NPC was appreciated by many key informants. However, the inadequate funding for NPC to some extent constrained the technical oversight by NPC over the outcome managers (MoH, MGLSD and NPC) as the quarterly meetings were not held as expected. The evaluation did not observe or establish any **unintended results** during the implementation of this evaluation.

Main Conclusions

At the **Strategic Level**: The wide stakeholder engagement during the design of the CP8 facilitated the alignment to national priorities and needs. However, the intensity of downstream stakeholder consultations particularly of beneficiaries during implementation of the CP8 was perceived to be relatively low compared to that witnessed during the design phase. UNFPA's ability to forge strategic partnerships with multi-national, bilateral development agencies and national government MDAs was impressive and resultantly enhanced the relevance of its programmes. UNFPA provided strategic leadership and advocacy for integrated programming with a focus on **gender, human rights based approaches** and **leaving no one behind**. Integrated programming was strong particularly at national level but required further strengthening at the sub-national level. The IFS facilitated increased interaction and timely feedback between UNFPA and the IPs in the field. The intervention logic in the results framework was quite robust but some areas needed strengthening especially all the outcomes being time bound. The CP8 was responsive to the changing national priorities both in the humanitarian and development fields especially in relation to the DD and integration of Sexual and Gender Based Violence (SGBV) and SRHR/HIV in programmes targeting young people. UNFPA CO had a clear strategic direction in relation to the implementation of the **humanitarian-development-peace nexus** and integrated it in its programmes in humanitarian settings. The goal was to foster strengthening the self-reliance of refugees by increasing their contribution to local development, decrease the need for long-term care and maintenance programmes, and reduce the potential for conflict between the hosts and refugees. The two DOs are insufficient to cover Karamoja, eastern, northern and West Nile regions.

Programmatic Level: With regard to **effectiveness,** significant progress was recorded in achieving most of the outputs and outcomes. There were important achievements in policies, guidelines, strategies, advocacy and strengthening service delivery. In the case of **SRH**, the policies developed were the Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda; the 2nd National Health Policy: National SRHR; Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14); and HIV Integration Strategic Plan and the costed FP Investment Plan. Nine out of eleven (82 percent) output indicators recorded great achievement. Some of the achievements included establishment of functional Maternal and Perinatal Death Surveillance and Response (MPDSR) systems at national and sub-national levels. Despite the investment in FP/RH commodities, teenage pregnancy remained high at 25 percent according to the Uganda Demographic Health Survey (2016). The main challenges encountered included the inadequate supply chain for condoms which continues to be a barrier to access and to meet the demand that has been created.

In the **Adolescents and Youth** area, the key policies developed were the National SE Framework 2018; National Strategy on Child Marriage and Teenage Pregnancy and the SRHR Youth Engagement Strategy. Four output indicators largely met the defined targets, with demonstrated strong accomplishments in provision of life skills for adolescent girls, development of training curriculum for sexuality education (SE) and the provision of adolescent sexual and reproductive health rights (ASRHR) through youth friendly services in health facilities. The SE for in- and out-school children and the use of youth friendly services boosted the SRH services for adolescents and youth. However, the resistance from some cultural and religious leaders on the promotion of SE among the youth was a challenge that required addressing.

For the **Gender Equality and Women Empowerment** (GEWE) component, the main policies that were developed included the Revised National Policy on Elimination of Gender Based Violence in Uganda; National Male Involvement Strategy for Prevention and Response to Gender Based Violence in Uganda; and the National Strategy to End Child Marriage and Teenage Pregnancy. Overall most of the set output indicators and targets under GEWE were met except one on the number of communities making declarations against FGM. Significant progress was registered in supporting the implementation of innovative and effective strategies to foster

behavioural and social norm change such as the involvement of cultural and religious leaders and the use of effective community mobilisation strategies - SASA and strengthening male engagement. However, the ET identified some gaps. Despite the progress that was made in the development of policies and legislation, implementation of the same was weak. There was inconsistent funding and this affected consistent and sustained engagement for behavioral and social norm change interventions yet shifting harmful social norms and sustaining behavior change required consistent and sustained investment.

Strategies that integrate SRHR, GBV and girl's economic empowerment were effective in reducing the risk and vulnerability to GBV and harmful practices. However, the package provided was not standardised and there were no systematic strategic linkages to market opportunities, value chain and existing extension services. The focus of these strategies on gender transformative programming was limited.

Effectiveness of UNFPA interventions was also manifested in bringing **PD** issues into the development discourse in the country. In this regard, UNFPA is a leader in PD and is actively supporting the GoU to provide evidence on required investments for harnessing the DD. The National Demographic Dividend Roadmap was useful in guiding implementation of activities related to DD. However, funding for PD is sub-optimal yet it is central to the realisation of DD in the context of the population structure of Uganda with a huge population of young people.

As for **efficiency**, UNFPA had a robust financial management and tracking system that facilitated programmatic and financial accountability. However, there were delays between requisition of funds by IPs and disbursement by UNFPA and this affected the timely and quality implementation of interventions. The different planning/ financial years for government (July - June) and UNFPA (January - December) posed a challenge to both parties, which calls for serious dialogue between government and UNFPA to resolve the issues. In addition, UNFPA CO should review the length of time between requisition and disbursement of funds to enhance efficiency. Modalities of transfer of funds to districts and holding them accountable have posed a challenge. Apart from the Ministry of Gender, Labour and Social Development (MGLSD) that signed Memoranda of Understanding (MoU) with District Local Governments (DLGs) to enable the transfer of funds, other critical MDAs have not yet done so.

With respect to **sustainability,** the CP8 being aligned to the national Vision 2040 and policy priorities is a strong predictor of sustainability. The CP8's contribution to the enactment and implementation of policies, laws and strategies in different components enhances opportunities for institutionalisation and sustainability. The high level of participation and engagement of key ministries and DLG departments with mandates for the core components in the CP8 has enhanced capacity building and ownership of the CP8 at national and sub-national levels. UNFPA's strategic niche of providing data and supporting other UN agencies with their data needs and its strong leadership in policy advocacy in SRHR, AY, GEWE, PD and promoting gender and human rights integrated programming places UNFPA in a strategic position to influence the strategic decisions within United Nations Country team (UNCT) and during the implementation of the next United Nations Sustainable Cooperation Framework (UNSCF).

With regard to **coordination**, the UNFPA CO contributed positively to the UNCT and applied its comparative advantage for the effective and efficient running of the UN coordination mechanisms. UNFPA has actively participated in the United Nations Development Coordination mechanisms such as UNCT, United Nations Area Coordination (UNAC), United Nations Monitoring and Evaluation Group and United Nations Communication Group (UNCG). The Joint UN Monitoring and Evaluation Group has a well-articulated coordination framework for the implementation of the CP8 at national and sub-national levels. The overall GoU coordinator for CP8 is the National Population Council (NPC) and is the Chair of the Evaluation Reference Group. Through the provision of funds and technical support, UNFPA has facilitated the coordination role of NPC whereby the latter is supposed to have quarterly meetings with the Outcome Managers (MoH, MGLSD and NPC). However, due to limited funds for coordination, fidelity to the coordination framework is not consistently followed particularly at the sub-national level where multi-sectoral coordination in the implementation of programmes is critical.

With respect to **cross cutting issues,** UNFPA is mandated to adopt the human rights approach and gender mainstreaming in all programming. The human rights approach focuses on addressing the needs of the marginalised, stigmatised and vulnerable groups in Uganda. This was demonstrated by interventions to address

the needs of adolescents and young people, SGBV survivors, MARPS/key populations and people with disabilities. The UNFPA CO also uses the composite index to identify and support programming in locations with the worst indicators. However, focus on reaching the most hard-to-reach population groups within these areas needs further strengthening by using the client centred approach or the differentiated service delivery model sensitive to the peculiar needs and contexts of these populations.

Lessons Learnt: The key lessons learnt include that collaboration and coordination between the UNFPA CO, GoU and other cooperating partners is very critical. The implementation modality of GoU/UNFPA CP being known by the DLGs right at the beginning is key to success. The presence of UNFPA staff within districts enhanced the visibility of UNFPA and improved coordination, sub-national level partnerships and quality assurance. Strategic engagement with key sectors at senior management level produces quick results.

Recommendations

At the **Strategic level:** UNFPA CO should use its strong strategic leadership and capacity building to support integrated joint programming and work closely with other UN agencies to increase effectiveness and efficiency gains. Given the new way of working and the repositioning of the United Nations development system, UNFPA CO should actively portray its strategic niche in data especially generation of quality data and being able to support other UN agencies on their data needs. The CO should continue its strong leadership in multi-sectoral coordination and advocate for streamlining coordination to eliminate any possibilities of parallel coordination frameworks that have the potential to undermine the multi-sectoral coordination structures at national and sub-national levels. The current wide geographical expansion requires the CO to make strategic decisions about consolidation versus expansion. The CO should strengthen the financial management system to facilitate programmatic and financial accountability by paying particular attention to innovative strategies aimed at reducing time between requisition and disbursement of funds to IPs. UNFPA CO should have dialogue with MDAs on strategies of strengthening financial and programme accountability of DLGs. The CO should also review the current financial disbursement mechanisms to DLGs particularly to facilitate supervision, coordination and holding IPs accountable for results and deliverables. UNFPA CO should review and consider consolidation by intensifying intra-district and sub-county coverage in existing districts rather than scattering interventions and therefore spreading thinly. The CO should establish two offices for eastern and West Nile regions and add one additional staff in each of the existing DOs. The CO should further strengthen the intervention logic in the results framework to ensure that it includes all the relevant outcome and output indicators as well as a stronger alignment of interventions to the outcomes and outputs. Assumptions should also be explicitly factored into the intervention logic and documented. (Short-term).

Programmatic level: UNFPA should continue to align the Country Programme to national and international goals and objectives with regards to SRHR, AY, GEWE and PD with greater emphasis on the needs of the communities that UNFPA supports. Although it is important to ensure that the next Country Programme is in line with the ICPD PoA, SDGs and Agenda 2063, it is even more important to ensure that the support provided to communities and beneficiaries on the ground addresses the specific needs of those communities. (Short-term).

UNFPA should actively engage MoH to functionalise HC IVs in order to ensure high quality of obstetric care as well as supporting the MoH to improve the robustness of the MPDSR system. Fistula repair should be integrated into other routine health services and attention should be given to the re-integration of fistula survivors in the general community. The CO should advocate for the scale up of interventions /mechanisms to address the persistent FP commodity stock-outs by addressing the gaps in the supply chain. (short-term).

UNFPA in liaison with MoES should develop an advocacy and stakeholder engagement plan to address SE as well as building further the capacity for integration of the youth and gender friendly services within health facilities and communities. (Medium-term).

In the next Country Programme, UNFPA should support implementation of key policies and laws for the prevention and response to GBV, harmful practices and gender inequality as well as making significant investment and systems strengthening to foster consistent and sustained social norm change targeting service providers, leaders and local communities. The CO should advocate for and support the development of a clear,

realistic and feasible scale up strategy and plan for effective GBV prevention and response interventions country-wide in order to create a strong impact in the reduction of GBV and harmful practices. (Medium-term).

The next Country Programme should focus on the momentum built on the DD as this a vehicle for the realisation of Uganda as a middle-income country by 2040 by increasing and ensuring adequate resource mobilisation for PD to match the current needs. The UNFPA CO in liaison with relevant MDAs should strengthen the current efforts to streamline and harmonise the different databases on GBV and violence against children (VAC) at national and sub-national levels. (Medium-term).

CHAPTER 1: Introduction

1.1 Purpose and Objectives of the Country Programme Evaluation

The UNFPA Country Office (CO) commissioned the Government of Uganda (GoU)/UNFPA Country Programme Evaluation (CPE) in order to enhance UNFPA's accountability for results and analyse the relevance and performance of the 8th GoU/UNFPA Country Programme (CP8) for Uganda - 2016-2020. In addition, it was anticipated that the evaluation would improve on the strategic positioning of the UNFPA CO in Uganda, facilitate organisational learning, support evidence-based programming and contribute to the evidence-base for the next Country Programme. The **target audience** of this CPE were the UNFPA Country Office (CO), Regional Office, UNFPA HQ and the Executive Board; relevant government agencies, national partners, development partners including the donors and UN agencies in the country.

The **overall objectives** of the evaluation were:[54] (a) Enhanced accountability of UNFPA to its donors, partners and other stakeholders for the relevance and performance of the country programme; and (b) Broadened evidence base, including lessons learned and practical recommendations, for input into the ninth (9th) programme cycle (2021-2025).

The **specific objectives** of the CPE were to:

- Provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme;
- Provide an assessment of the country office positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;
- Provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs; and,
- Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming design.

1.2 Scope of the Evaluation

With regard to the geographic focus, the evaluation sampled the districts to be visited from the 25 districts in Uganda where most of the resources of the CP8 were invested. As per the evaluation ToR, which were provided to the evaluation team, these 25 districts comprised of Abim, Adjumani, Amudat, Amuria, Amuru, Apac, Bududa, Bukedea, Bulambuli, Bundibugyo, Kaabong, Kaberamaido, Kanungu, Katakwi, Kibuku, Kiryandongo, Kitgum, Kotido, Kween, Moroto, Moyo, Nakapiripirit, Napak, Ngora and Yumbe. Using a purposive sampling method, a sample of 7 districts comprising of 4 districts (Adjumani, Amudat, Kitgum and Moroto) where UNFPA had ongoing programme implementation of all/most of the four thematic interventions (SRH, AY, GEWE and PD) and 3 other districts where UNFPA had previous presence (Arua, Iganga and Kyegegwa) was visited during data collection. The selection process took into account the context, region and whether the district was a refugee hosting or not. Other factors which were considered and used in the selection of the interventions were the number of interventions in each district as well as exposure, that is, the duration of implementation of the project.

The evaluation focussed on UNFPA-supported programmes and projects at national and sub-national levels, reviewing the 4 thematic intervention areas.[55] It included the cross-cutting aspects of humanitarian assistance, coordination and partnerships and the integration of different programme areas and related synergies.

1.3 Methodology and Process

1.3.1 Evaluation Criteria and Evaluation Questions

The evaluation utilised four of the standard evaluation criteria drawn from the United Nations Evaluation Group (UNEG)/Organisation for Economic Cooperation and Development (OECD) namely relevance, efficiency, effectiveness and sustainability.[56],[57] In addition, coordination mechanisms within the United Nations Country

[54] Revised TOR for UGA.CPE _ version Sep 16-2145hrs.
[55] GoU/ UNFPA 8th Country Programme Document (2016-2020)
[56] Handbook on 'How to Design and Conduct a Country Programme Evaluation at UNFPA" (2019).
[57] The DAC Principles for the Evaluation of Development Assistance. OECD (2000).

Team (UNCT), that is, the UN Delivering as One, was evaluated as well as the coordination of the CP8 at national and sub-national levels. Based on these evaluation criteria, the ET adopted the 10 key evaluation questions developed to guide the evaluation.

Evaluation Questions
Relevance **EQ1:** To what extent is the CP8 is aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups, goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)? **EQ2:** To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response? **EQ3:** To what extent has the programme integrated gender and human rights-based approaches? **Effectiveness** **EQ4:** To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Where the planned geographic areas and target groups successfully reached? **EQ5:** What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development? **Efficiency** **EQ6:** How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimize achievement of results described in the 8th CP? **EQ7:** To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions? **Sustainability** **EQ8:** To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies? **EQ9:** What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment? **Coordination** **EQ10:** To what extent has UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms? To what extent was the coordination of CP8 functional? **Note:** EQ10 was revised to contain a second part of the question related to coordination mechanism outside UNCT.

1.3.2 Methods of Data Collection

The evaluation utilized qualitative and quantitative data collection methods, which included a desk review of relevant CP8 documents, KIIs with stakeholders at national and sub-national levels, FGDs and observations. The specific data sources were provided in the Evaluation Matrix. The evaluation used a participatory process actively involving UNFPA staff, key stakeholders and beneficiaries.

Document review

Key informant interview

Focus group discussion

Observation

The data collection methods, which were used are elaborated in forthcoming sections.

1.3.2.1 Document Review

The evaluation involved extensive review of documents, to inform the evaluation design, and to triangulate with primary sources. The Evaluation Manager identified and provided the main documents for the evaluation team as per UNFPA Evaluation Handbook guidelines. Additional documents included planning, monitoring and evaluation reports on programme thematic areas.

1.3.2.2 Focus Group Discussions

The participants for the FGDs were selected using purposive sampling in order to ensure that they have relevant characteristics required to answer the evaluation questions. The CPE team targeted project/ programme beneficiaries including women, adolescents/youth, men, key populations/Most-At-Risk Populations (MARPs), persons living with disabilities (PLWD) and refugees. The FGDs were planned bearing in mind that the projects/ programmes are implemented as integrated packages.

The FGDs provided qualitative insights into the respective interventions. Each utilized a semi-structured schedule appropriate to the group, with key questions around specific topics. Each of the FGDs was facilitated by one of the three consultants with assistance from a trained translator/ senior research assistant. The FGDs were conducted in the local languages of the beneficiaries and transcribed verbatim into English.

1.3.2.3 Key informant interviews

Stakeholders were selected for participation in the evaluation using purposive sampling. In this regard, the stakeholder map was used for stakeholder sampling for data collection. Key Informant Interviews (KIIs) were held with stakeholders using semi-structured schedules built on the key evaluation questions. Stakeholders for KIIs were drawn from the national, local government and community level. At the national level these included: Office of the Prime Minister (Commissioner for Refugees), Ministry of Health, Ministry of Gender, Labour and Social Development, Ministry of Education of Education and Sports, National Population Council/Population Secretariat, Uganda AIDS Commission, Uganda Bureau of Statistics (UBOS), UN agencies: Resident Coordinator's Office, UNFPA, UNICEF, WHO, UNDP, UN Women, UNHCR and UNAIDS. Other IPs at national level include: Makerere University School of Public Health, Makerere University Centre for Population and Development, Economic Policy Research Centre (EPRC), Reproductive Health Uganda (RHU), AIDS Information Centre (AIC), Inter Religious Council of Uganda (IRCU), Straight Talk Foundation (STF), Agency for Cooperation, Research and Development (ACORD), Reach a Hand Uganda (RAHU), International Rescue Committee (IRC), CARE International, BRAC Uganda LTD, OUTBOX Uganda Ltd among others. At the Local government level, the evaluation targeted the following: Chief Administrative Officers (CAOs), District Health Officers (DHOs), District Planners, District Community Development Officers (DCDOs), District Education Officers (DEOs), Representatives of IPs at the DLG Level and UNFPA Field Staff. In addition, the team interacted with relevant funding agencies including SIDA, EU, DANIDA, DFID, Netherlands Development Cooperation, KOICA, and Irish Aid among others. The people who were interviewed are shown in Annex 2.

1.3.2.4 Observation

Field observations were standardised and facilitated by the use of an observation guide. The observation guide used in field visits is provided in Annex 4.

1.3.2.5 Profile of Stakeholders Consulted

The stakeholders map was used for the selection of key respondents disaggregated by gender and categories [refer to Annex 2 (key informants) and Annex 8 (FGDs)]. The evaluation consulted and interviewed 208 people (66 percent females; 34 percent males) as shown in Table 1. The analysis in terms of percentages for the different categories is shown in Figure 1.

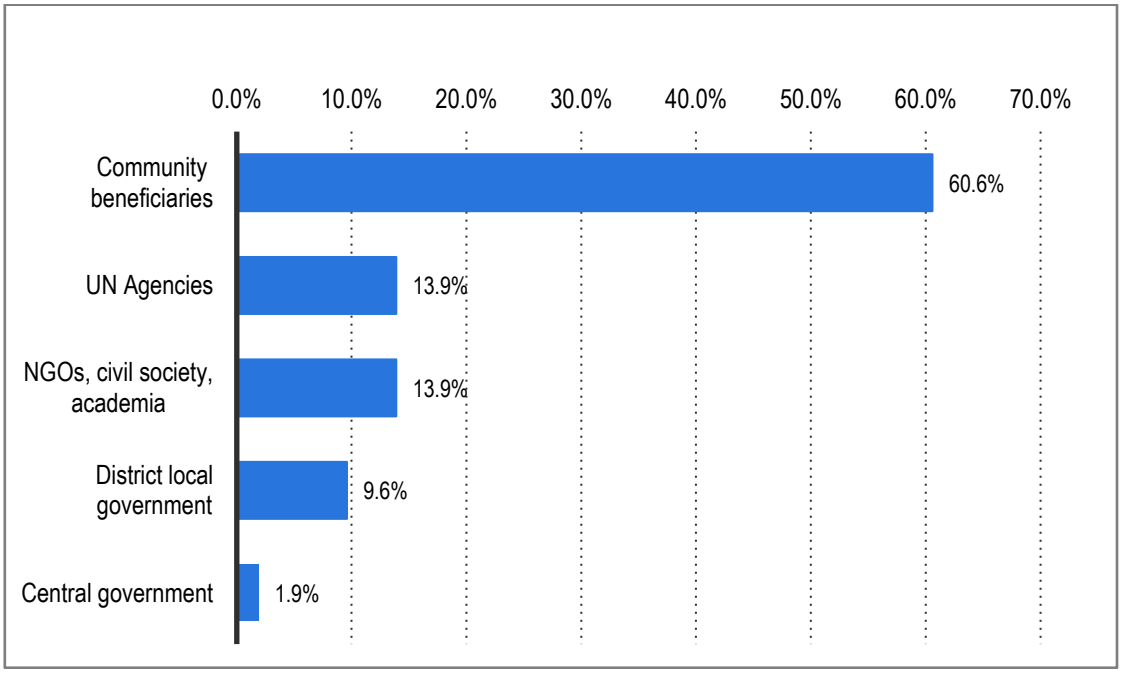
Table 1: People consulted through KIIs or FGDs by stakeholder type and by level of analysis

Stakeholder category	Gender			
	Female	Male	Total	%
Central government (ministries, departments and agencies)	2	2	4	2

Stakeholder category	Gender			
	Female	Male	Total	%
District local government (CAOs, DHOs, DCDOs, Planners)	6	14	20	10
NGOs, civil society, academia	15	14	29	14
UN agencies	17	12	29	14
Sub-total	**40**	**42**	**82**	
Community beneficiaries (women, men, adolescents, MARPs, PLWD)	98	28	126	60
Total	**138**	**70**	**208**	**100**

Source: Evaluation team analysis

Figure 1: People consulted through KIIs or FGDs



Source: Evaluation team analysis

The community beneficiaries (FGD participants) comprised of 78 percent women and 22 percent men. The age range for adult women was 26-50 years while that for men was 26-45.; the adolescent age range was 16-24 years as shown in Table 2.

Table 2: Characteristics of community beneficiaries (FGD participants) across districts visited

District	Gender			Age range (years)
	Female	Male	Total	
Moroto	21	12	34	Adult women 26-25; adult men 26-45; adolescents 16-21
Amudat	8	4	12	Adolescents 20-24
Iganga	12	0	12	Adult women 26-50;
Adjumani	24	0	24	Adult women 30-40; adolescents 18-24
Kitgum	17	0	17	Adult women 26-50; adolescents 20-24
Arua	16	0	16	Adult women 30-50; adolescents 20-24
Kyegegwa	0	12	12	Adult men 26-45
Total	**98**	**28**	**126**	
Percent	**78%**	**22%**	**100%**	

1.3.3 Ethical Considerations

The evaluation was conducted in accordance with the UNFPA Evaluation Policy, United Nations Evaluation Group Ethical Guidelines, Code of Conduct for Evaluation in the UNEG, [58] and the United Nations Norms and Standards for evaluation in the United Nations System.[59] The evaluation team adhered to the following accepted codes of conduct such as: a) adhering to the international norms and standards, b) seeking consent from respondents, c) maintaining confidentiality, d) keeping sensitive information, e) avoiding bias, f) being sensitive to issues of discrimination, g) avoidance of harm and (g) respect for dignity and diversity. The ethical considerations were achieved through ensuring that each member of the ET behaved in an ethical manner. An intensive brainstorming session among the ET members on ethics in evaluation studies ensured that each member of the ET was well equipped to deal with ethical issues during the conduct of the CPE.

Obtaining consent: The evaluation team obtained oral/written consent from all respondents before they were interviewed including adolescent respondents who were aged below 18 years. For the adolescents who were below the age of 18 years, the evaluation team obtained both parental permission and child assent in order the adolescents to participate in the FGD sessions.

Differentiation of participants: On the selection of different age groups, gender and vulnerable categories of people, the evaluation team was guided by the UN Sustainable Development Group programming principle of 'Leaving No One Behind'[60] and the different target beneficiaries of UNFPA programme in the districts.

1.3.4 Data Collection Tools

The evaluation questions were translated into information needs, as displayed in the Evaluation Matrix in Annex 4. The Evaluation Matrix linked the evaluation questions with corresponding assumptions that were tested (operational definitions/indicators), sources of information and methods of data collection. In this regard, the Evaluation Matrix was further used as a basis for the development of the tools in the evaluation.

1.3.5 Selection of Districts and Stakeholders

The UNFPA Evaluation Handbook stipulates comprehensive stakeholder selection criteria. The country programme in Uganda is relatively big. As already mentioned in section 1.2, the evaluation team sampled the districts to be visited from the UNFPA 25 districts where most of the resources of the CP8 were invested. The selection process also took into account the context, region and whether the district is a refugee hosting or not. Other factors which were considered and used in the selection of the interventions were the number of interventions in each district as well as exposure, that is, the duration of implementation of the project. The districts with relatively larger numbers of interventions and projects with a duration of implementation of more than a year were selected into the sample. This was done mindful of the observation that the most part of the first year of project implementation is usually devoted to inception activities.

The resultant sample of 7 districts comprised of 4 districts (Adjumani Amudat, Kitgum and Moroto) where UNFPA had UNFPA had ongoing programme implementation of all/most of the four thematic interventions and 3 other districts where UNFPA had a previous programme presence namely, Arua, Iganga and Kyegegwa. Out of the 7 districts selected, three were refugee hosting districts (Adjumani, Arua and Kyegegwa). An account of the presence of regional/ referral hospitals which serve as regional hubs for SRH integration was also considered and the districts were Arua, Kitgum and Iganga. The stakeholder's map (see Annex 5) was also used to identify the geographical location and programmes/projects of IPs. The different stakeholders were consulted during data collection and validation of findings.

1.3.6 Data Analysis

Data analysis was done based on the four thematic areas of the CP8.

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[58] United Nations Evaluation Group, UNEG Ethical Guidelines, accessible at: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=102 and UNEG Code of Conduct for Evaluation in the United Nations system, accessible at: http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=100.

[59] http://www.unevaluation.org/document/detail/102

[60] https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams-interim-draft

1.3.6.1 Qualitative Data

The qualitative data obtained from primary sources such as KIIs, FGDs and field visits were analysed using the content and thematic analysis frameworks. This involved organizing data according to themes related to the evaluation objectives, evaluation questions and the criteria. In addition, the CPE team considered emerging themes that were generated in the process of collecting and analysing qualitative data. Some striking quotes and human stories from beneficiaries are cited verbatim in the findings to support the thematic analysis. Story lines from participants were analysed using narrative analysis.

1.3.6.2 Quantitative Data

The quantitative data from secondary sources from CP8 documents such as Strategic Programme Reports, Annual Reports, Quarterly Reports, Reports from IPs, among others was analysed using descriptive statistical methods involving tabulations and graphing of the data. The raw data from the census, Uganda Demographic Health Survey (UDHS), District Health Information System (DHIS) II, Health Management Information System (HMIS), national GBV database, among others, was re-analysed where needed in order to derive up-to-date indicators.

1.3.6.3 Contribution Analysis and Triangulation

Contribution analysis was used to assess the coherence of the results chain and intervention logic in the CPD and the effectiveness of the UNFPA CP8 in achieving activities and outputs and their contribution to outcome results in the component areas. All the evaluation criteria were addressed and analysed for the component areas and also with respect to implementation modalities and efficiencies. In addition, triangulation analysis allowed the drawing of conclusions and recommendations from different outcomes including both planned and unexpected outcomes. The formats of the UNFPA Evaluation report as specified in the UNFPA Handbook on Evaluation were used for tabulation and analysis to organise the findings within the main body of the report.

1.3.7 Data Quality Assurance

Throughout the field phase, the team leader ensured that all members of his team correctly understood which types of information must be collected, and how this information should be recorded and archived. Data quality was maintained by triangulating the data sources and methods of collection and analyses. Validation of preliminary findings, by key stakeholders, enhanced the quality of data collected ensuring absence of factual errors or errors of interpretation and no missing evidence that could materially change the findings. In addition, the ET together conducted the first KIIs and FGDs in one district (Iganga), to ensure consistency in the data collection process, particularly with regard to questioning, probing and recording of data. The secondary data was obtained from various documents provided by the CO and other stakeholders. The quality of the secondary data was satisfactory for use in the evaluation.

1.3.8 Evaluability Assessment, Limitations and Risks

The anticipated main limitations during the evaluation and potential risks are provided in Table 3. The manner in which the limitations and risks were mitigated is described thereafter below the table.

Table 3: Limitations and Risks and mitigation measures

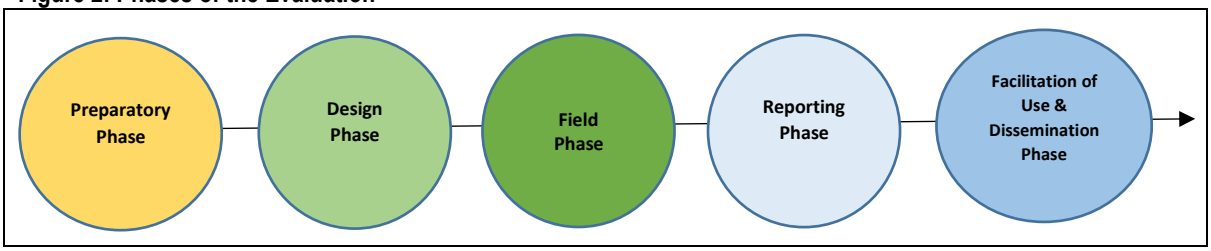
Limitation	Risk	Mitigation Measure
Challenges related to scheduling of interviews and focus groups due to sparsely populated sites and long distances covered (mainly in the Karamoja region)	This had the potential of prolonging the data collection phase beyond the planned itinerary. It also had the potential risk of having limited involvement of PLWD.	The evaluation team obtained actual location of sites plus the distances and planned the travel schedule accordingly. During the preparation of FGD sessions, the mobilisers were asked to contact PLWD to attend.
Challenges in scheduling appointments with key stakeholders for secondary data acquisition and programme reports (absence from office due to other commitments)	This had the potential of having a sample bias with regard to coverage of stakeholders	The evaluation team shared the CPE agenda with the relevant stakeholders in good time. In addition, the requests for interview appointments were made in advance and the team made follow up calls prior to the appointments. Of those few staff who were unavailable for interviews, their colleagues were approached and

Limitation	Risk	Mitigation Measure
		requested for interviews.
Challenges related to the multi-lingual setting in the districts of Uganda	The risk was that the evaluation team would not be able to effectively communicate with some of the beneficiary populations during data collection.	The evaluation team identified and recruited capable local translators for each district visited and they helped in translating and recording during the facilitation of the FGDs with beneficiaries.
Challenges with finance data that was captured up to Q3 of 2019	The risk was that this would lead to insufficient data for the whole year. The data would constitute a misrepresentation of the said year.	The evaluation team continual capturing of finance data in the UNFPA CO ensured that the team was able to source and obtain complete financial data for inclusion in the analysis and reporting. These measures guaranteed that complete financial data was used for the year in question.
Potential bias from stakeholder interviewees	In qualitative data-collection interviews, there was an inherent risk that stakeholders might filter information or try to present information under a specific light.	The evaluation organized, facilitated, and engaged in conducting interviews with strategies to put interviewees at ease at all times.
Potential bias in selecting stakeholders to participate in interviews and group discussions	As with most evaluations, a potential bias existed in working with country offices to select key informant interview and group discussion participants.	The external and local independent evaluation consultants impartially selected stakeholders to participate in interviews and group discussions.
Potential analytical bias from the evaluation team	As with all qualitative interview exercises, humans have the tendency to be easily influenced by the factors surrounding some information.	Interviewers from the evaluation team took detailed notes that were validated with the rest of the evaluation team.
Tight time pressures have constrained opportunities for collective reflection	The evaluation timeline has been such that the process has been highly intensive for a small team, and thus the report has been developed under tight time pressure with modest time for reflection.	The team have tried to work together where possible and ensured knowledge exchange and opportunities for reflection
Lack of availability of some interviewees	Some key staff and stakeholders were unavailable for interview.	Of those staff who were unavailable for interview, their colleagues were approached and requested for interview.

1.3.9 Process Overview

There were five phases of the CPE namely: 1. Preparatory phase; 2. Design phase; 3. Field phase; 4. Reporting phase; 5. Facilitation of use and dissemination phase which are shown diagrammatically in Figure 2.

Figure 2: Phases of the Evaluation



Source: Adapted from UNFPA CPE Handbook

The evaluation team started with the design phase. The various activities undertaken during the CPE and the timelines are shown in the CPE Agenda in Annex 7.

CHAPTER 2: Country Context

2.1 Development Challenges and National Strategies

Uganda is a landlocked country in the East African region and borders the Democratic Republic of Congo (DRC) to the West, Kenya to the East. Tanzania to the South, Rwanda to the South West and South Sudan to the North. The recent political instability in some of the surrounding countries namely DRC and South Sudan has caused the displacement of their populations and Uganda has experienced a humanitarian situation as result of a high refugee influx.

Uganda is a low income country with a Human Development Index of 0.516 (2017) which is within the category of low human development.[61] In 2017, Uganda was ranked 162 out 178 countries. Between 1990 and 2017, Uganda's HDI increased from 0.311 to 0.516, which was an increase of 66.0 percent. Table 4 shows Uganda's progress in each of the Human Development Index (HDI) indicators. Between 1990 and 2017, Uganda's life expectancy at birth increased by 14.7 years, mean years of schooling increased by 3.3 years and expected years of schooling increased by 5.9 years. It is further observed from the data in Table 4 that Uganda's GNI per capita increased by 119.6 percent between 1990 and 2017.

Table 4: Uganda's HDI Trends Based on Consistent Time Series Data and New Goal Posts

Year	Life expectancy at birth	Expected years of schooling	Mean years of schooling	GNI per capita (2011 PPP$)	HDI value
1990	45.5	5.7	2.8	755	0.311
1995	44.2	5.6	3.4	906	0.321
2000	47.1	10.8	3.9	1.031	0.398
2005	52.6	10.7	4.4	1.187	0.437
2010	57.2	11.0	5.7	1.490	0.486
2015	59.6	11.2	5.7	1.635	0.505
2016	59.9	11.3	5.7	1.654	0.508
2017	60.2	11.6	6.1	1.658	0.516

Source: UNDP Human Development Reports for Uganda

2.1.1 Population Dynamics

2.1.1.1 Population Size and Growth

The population of the country was 34.9 million in 2014 and it is projected to grow at 3 percent.[62] The growth rate decreased slightly from 3.2 percent between the 1991 and 2002 censuses, to 3.02 percent between the 2002 and 2014 censuses.[63] Statistics from the 2014 National Population and Housing Census[64] point to the challenges and opportunities faced by the country. Uganda has one of the fastest growing and most youthful population in the world (persons below 18 years) and about 52 percent of which comprises of children under the age of 15 years.[65] The population of the youth aged between 18-30 years stands at 23 percent a large proportion of which is unemployed and much more underemployed.[66] In addition, Uganda's population is characterised by a high dependency ratio, estimated at 103 implying that for every 100 economically active persons, there are 103 dependents.[67]

2.1.1.2 National Strategies and Response on Population and Development

Uganda made significant development progress over the last 50 years and transitioned from recovery to growth.[68] Since 2002, the economy grew at an average of 6.4 percent annually.[69]

[61] UNDP Human Development Report of 2018
[62] 2014 National Population and Housing Census
[63] National Population and Housing Census, 2014
[64] Uganda Bureau of Statistics (UBOS), 2016
[65] Population Secretariat (POPSEC), 2013
[66] Uganda Bureau of Statistics (UBOS), 2016
[67] Uganda Bureau of Statistics (UBOS). 2016
[68] National Development Plan II (2016-2020)
[69] National Population and Housing Census, 2014

The GoU developed a 30-year Vision to develop from a predominantly peasant and low-income country to a middle-income country by 2040. The GoU's strategy is to implement Vision 2040 through three 10-year plans, six 5-year NDPs and other sub-national level frameworks. One of the GoU's top priorities for achieving Vision 2040 is to address the country's population growth. The GoU is currently implementing the second NDP from which the UNDAF 2016-2020 strategic intent pillars [Governance; Human Capital Development (HCD); and Sustainable Inclusive Economic Development (SIED)] were designed to contribute towards transformative development.

2.1.1.3 Vision 2040 Priorities

Uganda aspires to create a more sustainable age structure by reducing the high fertility rate through increased access to quality reproductive health services, keeping all children of school going age in school with more emphasis on the girl child. The Uganda Vision 2040 points out the availability of appropriate and adequate human capital as one of the key factors to harnessing of the demographic dividend (DD) and accelerate the country's transformation through productivity and technological growth.

2.1.1.4 NDP II Priorities

The NDP II (2015/16-2019/20) prioritises the human capital development, which will focus on increasing the stock of a skilled and healthy workforce towards the production of human capital to accelerate the realisation of the DD. The NDP II identifies the DD as one of the 6 strategies for achieving the development objectives.

2.1.1.5 National Population Policy (NPP)

Uganda has the National Population Policy (NPP) 2008 and the National Population Policy Action Plan (NPPAP), 2011-2015 that address the country's major PD issues. Despite economic growth in the past decade, many Ugandans still live in poverty and face social and economic inequalities. Uganda needs to address its high fertility rate, increase the number of youth who attend secondary school and higher, and strengthen job creation so that families, communities and the nation as a whole, can benefit from the anticipated 'DD'.[70]

2.1.1.6 NPAP Priorities

The NPAP priorities include, improving health status of the population, having planned urbanisation and human settlements, monitoring of population trends and patterns, effective social welfare programmes for special interest groups, reducing the unmet need for family planning (FP), and improving Reproductive Health (RH) seeking behaviour. In addition, the generation of age and gender-disaggregated data is essential in addressing population issues.

2.1.1.7 GoU Commitment and Response on Demographic Dividend

Since the launch of the first DD report, the following actions took place: GoU commitment to FP budget increased by 30 percent and the allocation to FP commodities rose from US $3.3 million to US$5 million projected for five years; GoU set aside US $ 72 million for the Youth Livelihood Programme and US $ 410k for the Youth Venture Capital Fund. These programmes enabled the youth to access business and entrepreneurship skills; In the education area, there were increased public and policy pro-youth skilling and vocation training debate, which has strengthened the Skilling Uganda programme targeting the youth population; Expanding access to FP services through the Alternative Distribution Strategy; this opened up a private sector window to distribute free FP commodities. With support from UNFPA, the National Planning Authority (NPA) and the NPC took the following critical steps:

- Development of the National Demographic Dividend Roadmap, aligned to the Theory of Change;
- Development of the FP Planning Costed Implementation Plan (FP-CIP 2015–2020) to reduce the high unmet need for FP from 34 percent to 10 percent and increase the modern contraceptive prevalence rate (CPR) to 50 percent by 2020.

[70] National Development Plan II (2016-2020)

2.1.2 Sexual and Reproductive Health

2.1.2.1 Maternal Health

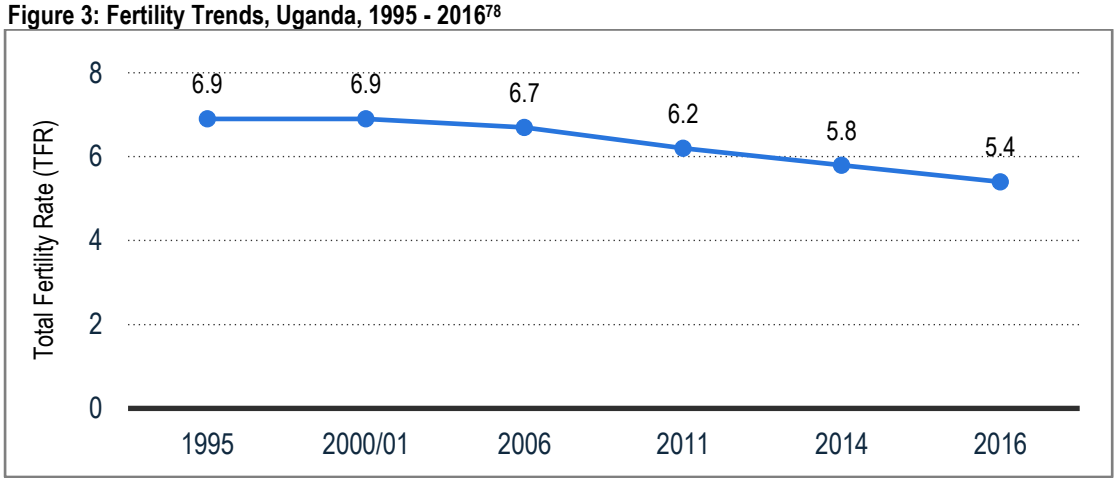
Uganda's Maternal Mortality Rate (MMR) is one of the highest in the world. The MMR in Uganda declined from 506 per 100 000 live births (1995)[71] to 438 (2011)[72] and to 336 (2016).[73] The decline in maternal and perinatal mortality is in line with the goal of the 2015/16 - 2019/2020 Health Sector Development Plan (HSDP) which was aimed at achieving Uganda Vision 2040 of a healthy and productive population that contributes to socio-economic growth and national development. In Uganda, slow progress was made in the reduction of maternal and perinatal mortality despite the increase in skilled birth attendance to 73 percent[74] from 59 percent[75] Information on how many women or/and babies died, where they died and why they died is important in improving the quality of care offered to pregnant mothers and their unborn babies.

The HSDP provided for a multi - pronged approach towards reducing the maternal mortality. Key among these were the operationalization of EmONC Services at Health Centre (HC) IIIs, IVs and Hospitals. This was to include the establishment of maternal death reviews, scaling up goal oriented antenatal care (ANC) including the provision of Intermittent Preventive Therapy in pregnancy (IPTp) and FP services with special emphasis on improving logistics and increasing availability to adolescents. Notably, if all unmet need for modern FP methods was satisfied in Uganda, maternal mortality would drop by 40 percent, and unplanned births and induced unsafe abortions would decline by 85 percent.[76]

2.1.2.2 Fertility and Contraception

Uganda has a slow but declining total fertility rate (TFR) of 5.4 children per woman as compared to the target of 5.1 children per woman by 2020.[77] Women who live in the rural areas have on average almost two more children than women who reside in urban areas (TFR of 5.9 versus 4.0 children respectively). The data in Figure 3 provides fertility trends in Uganda from 1995 (6.9 children per woman) to 2016 (5.4 children per woman). The data in Figure 2 confirms the decline in fertility in Uganda that has been observed in this analysis.

Figure 3: Fertility Trends, Uganda, 1995 - 2016[78]



Source: Uganda Statistical Abstract, 2018, Uganda Bureau of Statistics (UBOS).

The fertility rate remains high in Uganda mainly due to early marriages, high teenage pregnancies, high school dropout rates, and high un-met need for FP, leading to poor maternal health and a high child-dependency ratio. The unmet need for FP is high at 28 percent[79] among the marrieds. Only 39 percent of currently married women

[71] Uganda Demographic Health Survey, 1995
[72] Uganda Demographic Health Survey, 2011
[73] Uganda Demographic Health Survey, 2016
[74] Uganda Demographic Health Survey, 2016
[75] Uganda Demographic Health Survey, 2011
[76] Guttmacher Institute. Unintended Pregnancy and Induced Abortion in Uganda, 2006.
[77] Uganda Demographic Health Survey, 2016
[78] Statistical Abstract, 2018, UBOS
[79] UDHS, 2016

use contraception, with 35 percent using a modern method. This is up from 30 percent and 26 percent respectively in 2011.[80] The modern CPR varies greatly between rural (41 percent) and urban areas (33 percent).

2.1.2.3 Youth and Adolescent Sexual Reproductive Health

About 25 percent of adolescents aged 15-19 years in Uganda had begun childbearing.[81] Adolescent girls accounted for a significant proportion of maternal deaths in Uganda annually. Some drivers of these reproductive health challenges were rooted in gender and social norms that encourage large families, early child marriage, teenage pregnancy, and the limited access to youth-friendly reproductive health services. About 46percent of girls were married below the age of 18 years.[82] In the context of Uganda, Adolescent Friendly Health Services (AFHS) are defined as services that are geographically accessible, affordable, acceptable, welcoming and provide confidentiality for the adolescents.[83]

The proposed minimum package included: information on sexuality, growth and development, reproductive health services, counselling services, life-skills education and recreation services. A number of studies and reports showed that adolescents in Uganda engaged in sexual relations at an earlier age and suffered the consequences of early or un-timed pregnancies, and were exposed to high prevalence of sexually transmitted infections and HIV/AIDS.[84],[85] Other key problems, which affected adolescents include unmet reproductive health needs; for example, resulting in low FP usage. For instance, in Uganda, among adolescents aged 15-19 years, the unmet need for FP was 30 percent while the met need for FP (using all methods) was 22 percent.[86]

2.1.2.3 HIV/AIDS

Since the early 1980's, the HIV and AIDS epidemic had a great impact on the population with an unacceptably high HIV prevalence among those aged 15 to 49 years estimated at 6 percent[87] down from 7.3 percent in 2011.[88] Even though Uganda had recorded a reduction in the national prevalence of HIV from 7 percent to 6 percent, the prevalence was still high among females (7.6 percent) compared to males (4.7 percent).[89] Between the ages of 15-24 years, HIV prevalence among females was up to three times that of males (0.8 percent) in males compared to 3.3 percent in females. Among adolescents aged 10-24 years, females took on the largest burden, accounting for over 70 percent of new infections. Pregnant women living with HIV had between a two to ten times increased risk of death than uninfected pregnant women.[90] Therefore, integrating comprehensive HIV services with maternal health services was therefore fundamental to reducing maternal morbidity and mortality. Mortality significantly reduced as a result of interventions aimed at improving uptake and use of Anti-retrovirals (ARVs). The sector achieved near universal coverage of those in need of Anti-Retroviral Therapy (ART) (76 percent of the target based on previous guidelines, which were recently revised).

2.1.2.4 National Strategies and Response to SRHR and HIV/AIDS Issues

The policies and strategies put in place to improve SRHR include the following: The Investment Case for Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda 2016/17 - 2019/20 (MoH); the 2nd National Health Policy (2010/11 to 2019/20): Its major aim is to contribute towards the overall development goal of the GoU by improving the health status of Ugandans thus increasing and improving on the Human Capital Development; the current 3rd HSSP III (2015/16 - 2019/20) was developed to operationalize the NHP II and the health sector component of the NDP II; Road Map for Accelerating the Reduction of Maternal and

[80] UDHS, 2016
[81] Uganda Demographic Health Survey, 2016
[82] UNICEF, 2015
[83] UNICEF/MoH, 1998
[84] National Council for Children, 1999
[85] Bohmer & Kirumira 1997
[86] Uganda Demographic Health Survey, 2016
[87] 2016 Uganda Population-based HIV Impact Assessment (UPHIA)
[88] Uganda AIDS Indicator Survey, 2011
[89] Uganda Population-Based HIV Impact Assessment. 2016-2017. ICAP/CDC/MOH, 2017
[90] USAID & Maternal and Child Health Programme: Maternal Mortality and HIV: An Overview. https://www.mchip.net/sites/default/files/Maternal%20Health_HIV%20Briefer.pdf

Neonatal Mortality and Morbidity in Uganda 2006-2015 (GoU/MoH); MPDSR Guidelines, 2017; Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14); Uganda National SRHR and HIV Integration Strategic Plan; National HIV and AIDS Strategic Plan (2015/16 - 2019/20); Uganda HIV/AIDS Prevention and Control Act. 2014; and National Condom Programming Strategy (2013 - 2015) among others.

The policies and strategies focusing on the adolescents included the following: Uganda National Adolescent Health Policy 2004; Adolescent Health Policy and Service Standards - May 2012; National Sexuality Education Framework 2018; National Strategy on Child Marriage and Teenage Pregnancy, 2014/2015-2019/2020; Formative Research to Guide the Implementation of Ending Child Marriage and Teenage Pregnancy in Uganda, 2015; and Guidelines on adolescent youth friendly services among others.

2.1.3 Gender Equality, Sexual and Gender Based Violence and Social Inclusion

2.1.3.1 Issues on Gender, SGBV and Social Inclusion

Despite the obvious international emphasis on gender and youth inclusion in health care services, most national programmes were scarcely adequate in promoting equitable access to quality health services for desired behavioral change.[91] In Uganda, gender mainstreaming across sectors both at the national and local government levels was emphasized. There was a chain of problems created for women as a result of sexual and gender-based violence (SGBV) and specifically gender norms which gave men dominance over women. Women in Uganda were more than twice as likely to experience sexual violence as men. The Female Genital Survey Report of 2017 highlighted existence of negative beliefs for instance, 22 percent of the population surveyed believed that the practice of Female Genital Mutilation/Cutting (FGM/C) gave acceptance of the girls to peers while 17 percent believed that it made a girl acceptable for marriage.

For the social progress index (SPI), Uganda was ranked 111 out of 128 countries with a score of 49.59 compared to the global average of 64.85.[92] Scores range between 0-100 SPI scores reflect absolute performance from good to bad. The index benchmarks basic human needs, foundations of wellbeing (education, health, access to information and quality of the environment) and opportunity (rights, freedoms, tolerance and inclusion). According to the index, an inclusive society is one where every individual can pursue his or her human right to a life of dignity and worth. Uganda was ranked 121 out of 159 countries in the 2016 Gender Inequality Index (GII) with a score of 0.522, compared to the global average of 0.443.

2.1.3.2 National Strategies and Response on Gender and SGBV

There is a Uganda Gender Policy which makes gender responsiveness mandatory for development practitioners. The policy conforms to the regional and global obligations on GEWE that Uganda is party to. In addition, GoU put in place various national laws, policies and action plans that directly address GBV. For example, the National Action Plan (NAP) for implementing the UN Security Council Resolution 1325, 1820 and the Goma Declaration 6 on violence against women defines a systematic framework for national actions and monitoring systems to assess progress and impact of anti-GBV interventions at all levels. The policies and strategies put in place included: Uganda Gender Policy (2007); Gender Action Plan. 2014 – 2017; National Policy and Elimination Plan on Gender Based Violence 2014; UNDP Uganda Gender Equality Strategy 2014 – 2017; National Male Involvement Strategy for the Prevention and Response to Gender Based Violence in Uganda (May 2017); Guidelines to Implement the Policy on Prevention and Response to Sexual Harassment (2018 - to be approved); National Referral Pathway, Guidelines for establishment and management of GBV shelters; GBV Coordination Forum and National Gender Based Violence Database (NGBVD); National Policy on Disability, 2003; Domestic Violence Act 3, 2010; Prohibition of FGM Act 5, 2010; and Multi-media Strategy Against Gender Based Violence, 2016 among others. In addition, the MoES developed and issued a set of guidelines on dealing with VAC in schools. The Uganda Police Force established a GBV Directorate at the Uganda Police Headquarters, developed guidelines to respond to GBV cases and established SGBV desks at District Police stations.

[91] UNFPA, 2017

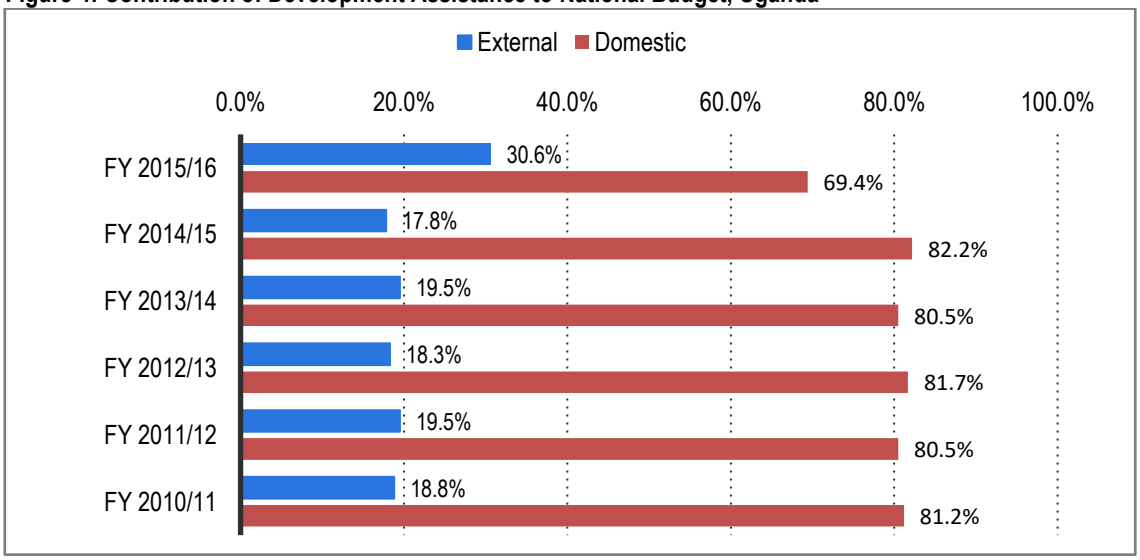
[92] Social Progress Index (SPI) Report 2017

2.2 The Role of External Assistance

Uganda still relies on development assistance to supplement its budget. External assistance flows to Uganda have averaged at about USD 760 million annually between 2001 and 2014. This included both grants and loans. The NDP recognises the important role played of Official Development Assistance (ODA) provided by partner governments and International Organisations in Uganda's recovery, growth and poverty eradication efforts. Official development aid corresponded to about 10 percent of Uganda's gross national income (GNI).[93]

Although aid as a proportion of government expenditure fell significantly as domestic revenue increased, the Plan also recognised that in the short to medium term development assistance continues to have an important role to play. Multilateral aid contributed a greater share than bilateral. The major multilateral institutions included the International Development Association (IDA) of the World Bank, African Development Bank, IFAD, Global Fund and the European Union (EU). Some of the leading bilateral donors were the UK, Norway, Ireland, Denmark and Germany. Many emerging economies have become important providers of development assistance. The trend was reinforced by the transition of some developing countries from being aid recipients to being aid donors such as Brazil, Russia, India, China, and South Africa, popularly called the BRICS). Currently amongst the group of emerging donors, only China and South Korea committed significant support. The government's data on aid flows suggested that the finance received from these sources was still less than 10 percent of all development assistance.

Figure 4: Contribution of Development Assistance to National Budget, Uganda[94]



Source: Approved Budget estimates. Ministry of Finance. Planning and Economic Development

In the past, over 98 percent of UNFPA non-core resources came from small group of traditional bilateral donors[95]. The Uganda Country Office was moving to diversify and broaden its partnership base to include emerging market economies as well as exploit the potential of multilateral institutions including the European Union. World Bank and African Development Bank. A Resource Mobilisation Team and Strategy was in place to spearhead the mobilisation of financial resources for co-financing and enhance advocacy on the International Conference on Population and Development (ICDP) agenda and the UNFPA mandate in Uganda.[96]

[93] Donor Mapping Report. Twesiime Fredrick of TAG Consulting for the UNFPA
[94] Approved Budget estimates. Ministry of Finance. Planning and Economic Development
[95] Donor Mapping Report. Twesiime Fredrick of TAG Consulting for the UNFPA
[96] Donor Mapping Report. Twesiime Fredrick of TAG Consulting for the UNFPA

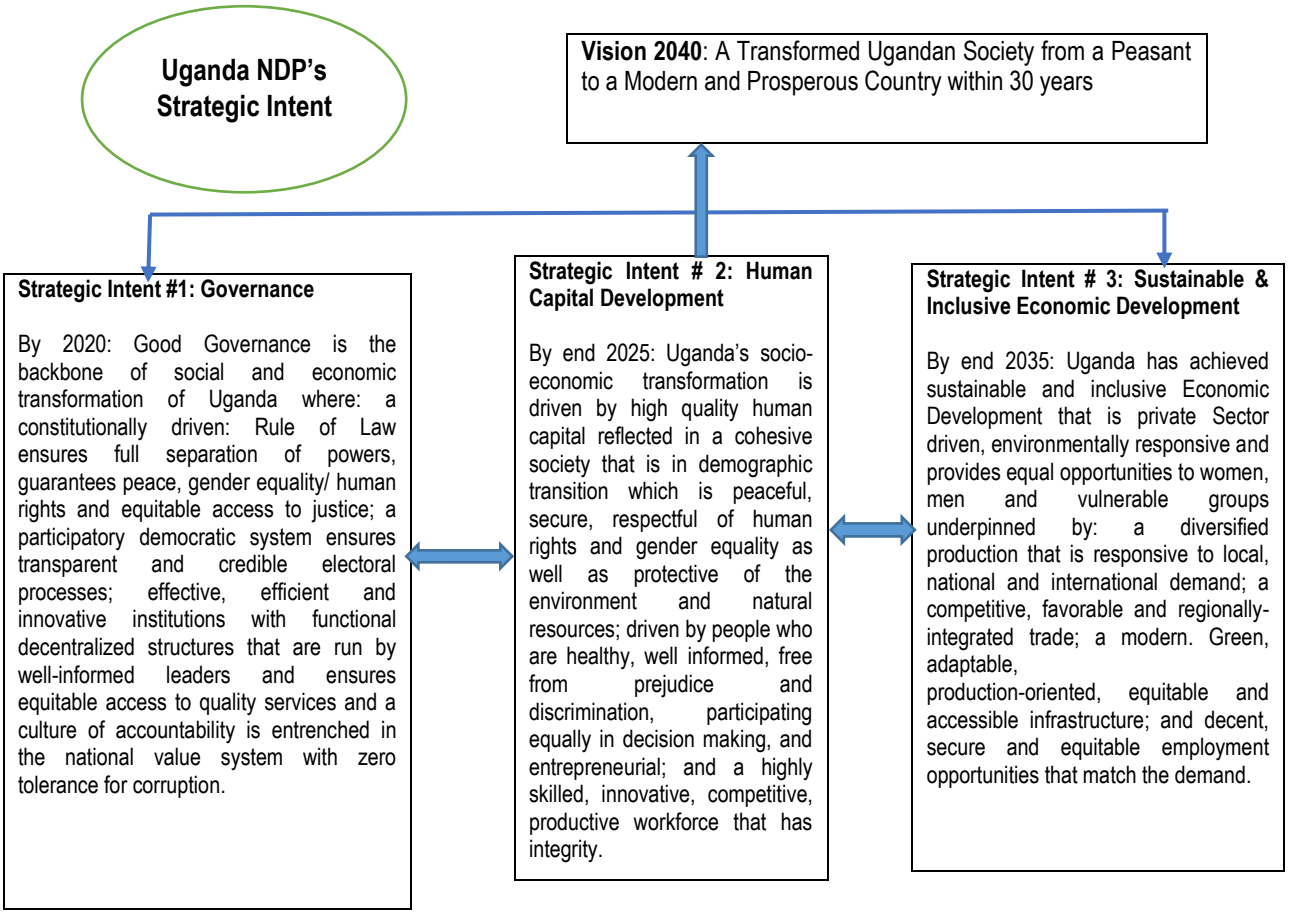
CHAPTER 3: UNFPA Response and Programme Strategies

3.1 United Nations and UNFPA Strategic Response

The UNCT[97] works in partnership with and supports the GoU towards achieving its national development priorities and results. The partnership was guided by the UNDAF (2016-2020) for Uganda. The development of the framework was led by the GoU and guided by the United Nations Development Group (UNDG) programming and other related international principles, including a human rights based approach, the 2030 Agenda for Sustainable Development to ensure greater focus on transformational results.

The UNDAF (2016-2020) focused on 3 strategic areas of Governance. Human Capital Development (HCD), and Sustainable and Inclusive Economic Development (SIED). The priorities were aligned to GoU's defined Theory of Change (ToC) articulated in its Vision 2040. This recognized that good governance, respect for human rights, promotion of gender equality, environmental sustainability and the building of a strong human capital base were the foundation for sustainable economic development and long-term growth (Refer to Figure 5).

Figure 5: United Nations and UNFPA Strategic Response



The UNDAF articulated 12 outcomes that cut across the 3 strategic intents outlined above. UNFPA contributed to 4 outcomes, specifically Outcome 1.3 on Institutional development, transparency and accountability; Outcome 2.2 on Health: Outcome 2.4 on Addressing GBV and Violence against Children (VAC); and Outcome 2.5 on HIV and AIDS response. The UNCT implemented UNDAF through the Delivering as One (DaO)[98] approach. UNDAF

[97] UNCT comprises of 22 resident and non-resident UN agencies.

[98] DaO is an initiative by the United Nations aimed at making the UN better coordinated and more efficient and effective. Within countries the UN aims to achieve this through having one leader, one programme, one budget framework, one voice and one house/shared common services.

programming is under One leader- an empowered Resident Coordinator (RC) and an empowered UNCT that works together with clear accountability. Some of the key gains of the approach included joint programming and convergence around special target groups and geographic areas.

3.2 UNFPA Response through the Country Programme

UNFPA Country Programme articulated the organisation's contribution to achieving national priorities, goals and results as set out in the UNDAF. The Programme, which followed a five-year cycle, was harmonised with the UNDAF and with country programmes of other UN organisations. The CP8 contributed to the UNFPA Global goal of the Strategic Plan, 2018-2021, which is to "achieve universal access to sexual and reproductive health, realise reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality".

3.2.1 UNFPA Previous Cycle Strategy, Goal and Achievements

The 7th GoU/UNFPA Country Programme (CP7) was originally from 2010 to 2014 but had a one year extension to the end of 2015 in order to align the 8th CP to the programming cycle of UNDAF II (2016-2020). In terms of programmatic focus, the CP7 was initially designed (as guided by the UNFPA Global Strategic Plan) around three priority areas of (a) Population and Development, (b) Reproductive Health and (c) Gender Equality and Reproductive Rights. This design guided programme implementation for two years (2010-2011). Following a mid-term review of the UNFPA Global Strategic Plan in 2011, the CP7 was revised to align with the revised UNFPA Global Strategic Plan, the latter which adopted a refined strategic focus on SRHR, and on supporting greater progress towards Millennium Development Goal (MDG) 5 and the ICPD agenda.

Under the SRH component, UNFPA supported (a) development of national policies and guidelines on SRH; (b) procurement and distribution of contraceptives through the alternative distribution mechanism to channel FP commodities to private not-for-profit organizations; (c) securing government commitment to increase budget for FP; (d) sponsorship of trainee midwives; and (e) establishment of youth-friendly services in schools and health facilities. Under gender, the programme contributed to number of policies towards prevention of GBV, FGM; mainstreaming of GBV prevention and response in the health, justice, social development and security sectors; increased service delivery of GBV response services. In PD, the programme contributed to the undertaking and in-depth analysis of the 2011 Uganda Demographic and Health Survey and the national panel surveys (2012, 2013) as well as the 2014 National Population and Housing Census. It also fostered a paradigm shift towards support for FP among political leaders through modelling of the DD; and supported advocacy efforts to ensure passing of the National Population Council Act, 2014. The evaluation of the CP7 in 2014 identified the need to: (a) address the fistula backlog; (b) ensure adequate staffing for midwifery and FP at health facilities; (c) scale up maternal and perinatal death review, emergency obstetric care, youth friendly services, comprehensive SE and HIV/AIDS prevention for high-risk populations; (d) expand demand generation to reach underserved communities; and strengthen the commodity supply management system; (e) implement GBV related policies, monitor and report on international instruments; (f) strengthen management information systems to provide regular data; (g) generate evidence to inform decision-making.

The key lessons learnt from CP7 were: (a) building strategic partnerships with the GoU, UN agencies, donors and Civil Society Organisations (CSOs) galvanises national support for the ICPD agenda; (b) working directly with DLGs increases ownership and sustainability of programme interventions; and (c) strengthening community engagement for social norm change is key in addressing gender-based violence and in promoting abandonment of female genital mutilation.

3.2.2 Current UNFPA Country Programme

The CP8 provided support for the key priority interventions in SRH focusing on Maternal Health, FP and HIV/AIDS prevention; AY; GEWE; and PD. The delivery of the programme utilised the national, sectoral and decentralised channels to achieve programme results. The CP8 had four Strategic Outcomes namely:

1. **Strategic Outcome 1 (SRH**): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access.
2. **Strategic Outcome 2 (AY)**: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual reproductive health.
3. **Strategic Outcome 3 (GEWE)**: Advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalised women, adolescents and youth.
4. **Strategic Outcome 4 (PD):** Strengthened national policies and international development agendas through integration of evidence-based analysis on PD and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.

The outputs under each strategic outcome and the linkage to the high level UNDAF Strategic Outcomes and the National Priority (under NDP II) are shown in Table 5.

Table 5: Uganda Country Programme: Strategic Outcomes and Operational Outputs

National Priority (under NDP II): Enhance Human Capital Development. Key results area: Increase access to high-quality health services	
UNDAF Outcome 2.2: By end 2020, universally accessible, effective and efficient health systems delivering preventive, promotive, curative and rehabilitative services that are contributing to: reduced mortality and morbidity, especially among children, adolescents, pregnant women and other vulnerable groups; and sustained improvement in population dynamics. **UNDAF Outcome 2.5**: By end 2020, a multi-sectoral HIV/AIDS response that is gender and age-responsive, well-coordinated, effective, efficient and sustainably financed, to reverse the current trend and reduce the socio-economic impact of HIV and AIDS.	
UNFPA Strategic Outcomes	**Programme Outputs**
Strategic Outcome 1 (SRH): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access	**Output 1**: National and district governments have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings.
	Output 2: National and district governments have the capacity to increase the demand for and the supply of modern contraceptives.
	Output 3: Increased national capacity to deliver integrated sexual and reproductive health and HIV/AIDS prevention programmes that are free of stigma and discrimination.
Strategic Outcome 2 (AY): Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual reproductive health.	**Output 1**: Increased national capacity to conduct evidence-based advocacy/ interventions for incorporating adolescents and youth sexual reproductive health needs in national laws, policies and programmes, including humanitarian settings.
Strategic Outcome 3 (GEWE): Advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalised women, adolescents and youth.	**Output 1**: National and district governments have the capacity for the protection and advancement of reproductive rights and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings.
Strategic Outcome 4 (PD): Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.	**Output 1:** National institutions and district governments have the capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings.

UNFPA implemented CP8 of UNFPA support to the GoU which responded to the national priorities as articulated in the Vision 2040, the NDP II (2015/16-2019/20), the UNDAF (2016-2020), and the UNFPA Global Strategic Plans 2014-2017 and 2018-2021. The CP8 supported the GoU in delivering Sustainable Development Goals (SDGs) particularly Goal 3: Health; Goal 4: Education; Goal 5: Gender; Goal 16: Peaceful societies; and Goal 17: Partnerships.

The implementation of the CP8 was operationalized through the Country Programme Business Plan (2016-2020) which was an instrument for joint accountability for the results between GoU and UNFPA. The role of UNFPA was complementary to that of GoU. The CP8 covered 43 districts including 25 core districts with the worst SRHR indicators. The original **25 core districts** are: Abim, Adjumani, Amudat, Amuria, Amuru, Apac, Bududa, Bukedea, Bulambuli, Bundibugyo, Kaabong, Kaberamaido, Kanungu, Katakwi, Kibuku, Kiryandongo, Kitgum, Kotido, Kween, Moroto, Moyo, Nakapiripirit, Napak, Ngora and Yumbe. The impact of refugees on the GoU/UNFPA CP8 was not foreseen at the time of signing of the Business Plan of the CP8. However, UNFPA CO had been pro-active to respond to protracted and widespread refugee influx by mobilising additional resources and by strengthening its presence in the field. For the period 2018, UNFPA mobilised US$ 500,000 for rapid response and an additional US$ 2.2 million for Central Emergency Response Fund (CERF) unfunded emergency projects.

Theory of Change and Programmatic Focus: The CP8 focused on the afore-mentioned four outcomes and six outputs covering SRH, AY, GEWE and PD and there were various key interventions linked to each output. The Theory of Change was reconstructed by the Evaluation Team and the diagrammatic representation is shown in Figure 6.

Figure 6: Theory of Change for 8th GoU/UNFPA CP (Reconstructed)

Detailed descriptions of the linkages between results (outcome and output indicators) and interventions are found under **Effectiveness (EQ 4 and 5)**, where an evaluation of the Results and Intervention logic for the different strategic outcome areas have been made.

The Evaluation Team consulted various documents namely: NDP II, UNFPA Global Strategic Plans (2014-2017 and 2018-2021), UNFPA Country Programme Document, UNFPA Business Plan, UNFPA Country Office Annual Reports (2016 - 2019), Evaluation Report for CP7, UNDAF 2016-2020 and UNDAF Mid-Term Review Report among others. In addition, the ET held consultations with the UNFPA CO technical staff on their thematic areas. The major change made was to include an end point for all outputs and strategic outcome statements for CP8 that is **end of 2020** so that they are time bound.

3.2.3 Country Programme Financial Structure

3.2.3.1 Allocation of Budget, 2016-2020

UNFPA initially committed US $ 88.4 million over the five years of the programme of assistance to the GoU (2016-2020), of which USD 32.4 million (37 percent) was to be obtained from regular resources and USD 56 million (63 percent) through co-financing modalities and/or other resources. The GoU committed a total of $75

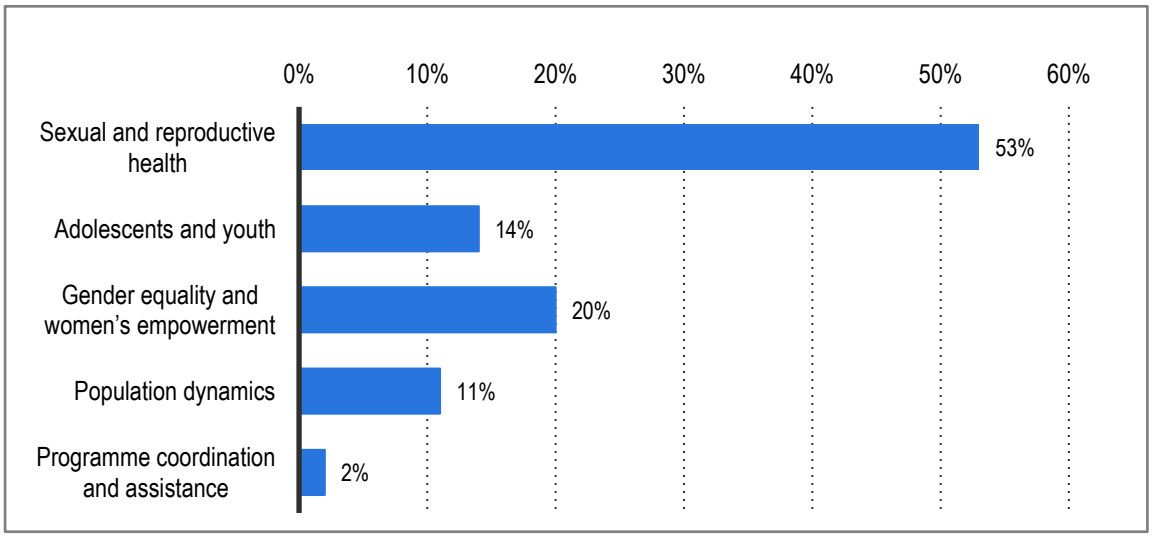
000 ($ 15 000 per year) as a contribution to UNFPA Global Core Resources/ Fund as well as counterpart funding to the programme in form of in-kind contributions such as equipment, transport, human resources/personnel, premises, recurring and non-recurring support cost except as provided by UNFPA and/or other UN agencies. The financial resources for the 5 years were distributed as showcased in Table 6.

Table 6: Allocation of Budget 2016-2020 (US$)

Strategic Plan Outcome Area					Funding Source Allocation		
		Regular Resources	Other Resources	Total	Regular	Other	Total as % of Total Budget
1	Sexual and Reproductive Health	21,700000	25,000,000	46,700,000	46%	54%	53%
2	Adolescents and Youth	2,000000	10,000,000	12.000,000	17%	83%	14%
3	Gender Equality and Women's Empowerment	3,000,000	15,000,000	18,000,000	17%	83%	20%
4	Population Dynamics	4,200,000	6,000,000	10,200,000	41%	59%	12%
Programme Coordination and Assistance		1,500,000	-	1,500,000	100%	0%	2%
Total		**32,400,000**	**56,000,000**	**88,400,000**	**100%**	**100%**	**100%**

The SRH component accounted for the highest allocation (53 percent) of which 46 percent was financed by regular resources and 54 percent by other resources. The GEWE component followed with 20 percent of the budget allocation but with only 17 percent to be financed by regular funds. The AY component accounted for 14 percent of the budget but with 17 percent coming from regular funds. The PD component was allocated only 12 percent of the budget but with a significant part (41 percent) to be financed by regular funds. The allocations are provided in Figure 7.

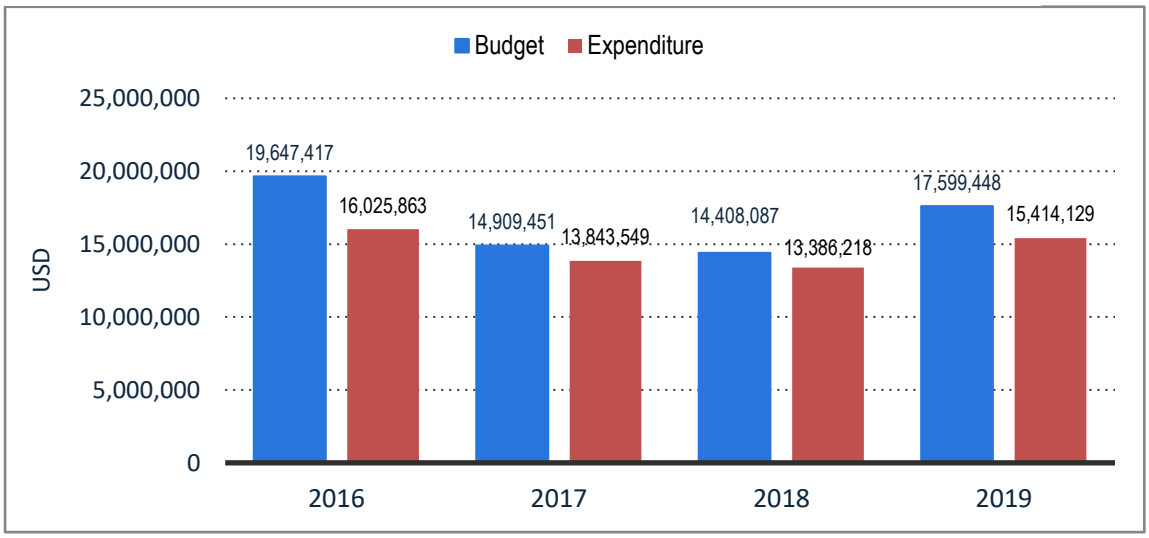
Figure 7: Allocation as Percentage of Total Budget



3.2.3.2 Evolution of Overall Budget and Expenditure, 2016 - Mid 2019

The budget and expenditure evolution over the five year review period for the evaluation is shown pictorially in Figure 8. It was observed that there was a reduction of both budget and expenditure in 2017 and 2018 compared to 2016.

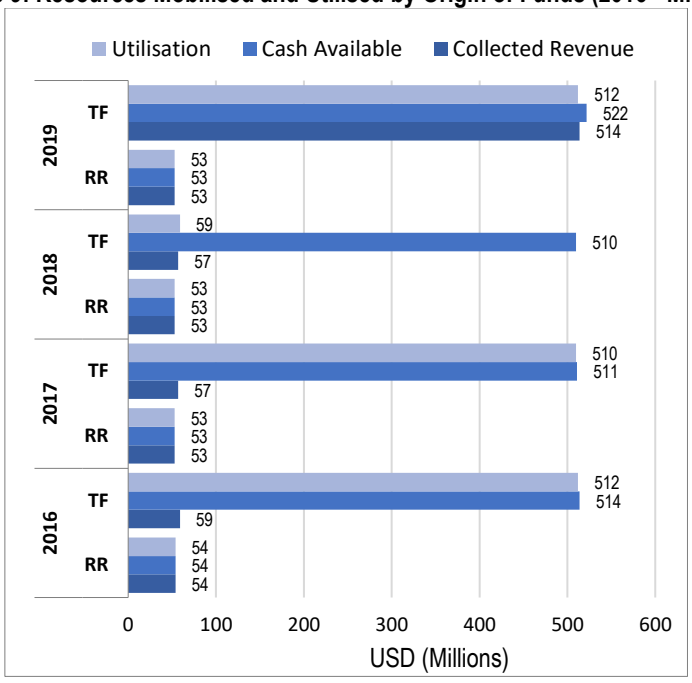
Figure 8: Evolution of Overall Budget and Expenditure, 2016 - Mid 2019



3.2.3.3 Collected/Cash Available and Utilisation by Origin of Funds

The total collected/ cash available between 2016 and Mid-2019 was higher for Trust Funds /mobilized sources than the regular ones. The same pattern was true in 2016, 2017, 2018 and part of 2019 as shown in the data in Figure 9.

Figure 9: Resources Mobilised and Utilised by Origin of Funds (2016 - Mid 2019)



Key: TF = Trust Funds/ Mobilised Funds; RR = Regular/ Core Resources

3.2.3.4 Mobilised Resources by Development Partner

The Government of Sweden has contributed the largest share (22 percent) of UNFPA funding, 6 percent of this was allocated towards the heath sector and 16 percent towards GBV. Government of Denmark followed with 16 percent also towards the health sector, gender and GBV and then UNFPA HQ with 11 percent allocated towards all sectors. The funding priorities of donors[99] were in response to GoU needs and priorities as enshrined in

[99] UNFPA Donor Mapping Report 2016

government's overarching development frameworks such as the NDP and Vision 2040. Table 7 showcases the mobilised resources per development partner /source over the period under review.

Table 7: Mobilised resources per Development Partner/Source

Partners of UNFPA	Sector	Overview	Funding Period	Committed Amount ($)	Contrib'tn (%)
SIDA	Health	Improving MNCH and Adolescent Health	Nov. 2015 – Nov. 2018	4,700,000	5.66
SIDA	GBV	UN Joint Programme on GBV Total fund to the programme: $ 28,750,004	2018 - 2023	13,572,396	16.36
KOICA	Adolescent Health	Prevention of teenage pregnancy and child marriage	May 2016 - 2018	5,000,000	6.03
UK/DFID	Health	Strengthening national capacity for FP uptake through policy regulation, financing and sustainable FP planning	2017 – 2021	3,900,602	4.70
Denmark	Health/ Humanitarian Response/ Gender/ Young People, GBV	Women, Adolescents and Youth Rights and Empowerment	2018 – 2022	13,000,000	15.67
European Union	GBV	Spotlight Initiative to Eliminate VAWG, including SGBV and HP (5 RUNOs) Total to Joint Programme = $42,449,024	2019 - 2020	4,987,971	6.01
Packard Foundation	Young People Enterprise	Towards youth enterprises	Aug. 2015 - Early 2018	750,000	0.90
Irish Aid	HIV/AIDS	Joint UN Programme on HIV/AIDS (JUPSA)	Jun. 2016 - 2020	2,700,000	3.25
Kao Cooperation, Japan	Menstrual Hygiene Management	Grant to Eco Smart Pads (U) Ltd. Funds to improve sanitary pads		22,962	0.03
Norway			2016 - 2017	1,926,239	2.32
Austria		ADA 2135-00/2018	Expires Nov. 30, 2021	3,682,044	4.44
Netherlands	Health	Advancing Sexual Reproductive Health and Rights (SRHR) in West Nile & Acholi Sub-regions	Oct. 2019 – Sep. 2023	7,364,095	8.88
CERF (UOF28/87/42)	Humanitarian Response	18-UF-FPA-013	2016 - 2019	1,868,774	2.25
CERF (UOG35/99)	Humanitarian Response	19-UF-FPA-019	2018 - 2019	1,594,704	1.92
CERF (UOG58/42)	Humanitarian Response		2016 and 2018	2,256,315	2.72
TF USA (USA46)			2016	265,626	0.32
UNDP Multi- Partner Trust Fund		MPTF Project No. 00101638 & MPTF Project No. 00111644	2016 - 2019	3,721,250	4.49
UNAIDS		UBRAF/18-19/UNFPA/Ctry/BRM/05 & UBRAF/18-19/UNFPA/Ctry/BRM/05A	2016 - 2019	723,560	0.87
UNICEF (UNJ18)			2016 - 2019	2,000,132	2.41
UNFPA core and non-core Resources (NB: **several partners are contributing** towards this)	Health/ Gender/ Young People/ Data/ Human Rights	Core funds from UNFPA HQ for 2018. Also includes earmarked resources for UNFPA supplies, Maternal UNFPA Health Fund, Regional funds, Innovations, HIV etc	2016 - 2019	8,930,307	10.76
				82,966,977	**100**

3.2.3.5 Cash Available/Allocated versus Expended Resources, 2016 - Mid 2019

UNFPA developed annual Resource Mobilisation Plans based with an indicative budget needed to deliver on each of the four strategic outcome areas as stipulated in the 8th Country Programme. The CP8 made good use of mobilised resources over the four-year period under review with an overall implementation rate of 97 percent. Outcome 2 (Adolescents and Youth) expenditure as compared to the mobilised resources was the highest with an implementation rate of 98 percent. Table 8 shows the details of resources available/allocated and expended per outcome over the period 2016 - Mid 2019.

Table 8: Mobilised versus Expended Resources for 2016-2019

	Cash Available/Allocated					Expenditure					Implementation rate %				
Outcome	**2016**	**2017**	**2018**	**2019**	**Total $**	**2016**	**2017**	**2018**	**2019**	**Total $**	**2016**	**2017**	**2018**	**2019**	**Total**
Sexual Reproductive Health (SRHR)	10.7	9.5	8.4	6.3	34.90	8.5	8.0	8.4	8.9	33.80	79%	84%	100%	141%	**97%**
Adolescent Sexual Reproductive Health and Rights (AYSRH) -	2.5	2.7	3.4	3.0	11.60	3.2	3.2	3.5	1.6	11.40	126%	117%	103%	53%	**98%**
GEWE Human Rights GBV and Harmful Practices	2.2	1.4	1.2	4.3	9.13	1.8	1.6	1.4	3.7	8.50	82%	114%	114%	86%	**93%**
Population Dynamics	0.7	0.1	0.3	0.8	1.85	0.6	0.1	0.4	0.8	1.85	92%	100%	133%	94%	**100%**
Programme Coordination and Assistance	0.0	0.0	0.0	0.2	0.29	0.0	0.0	0.1	0.1	0.20	100%	100%	125%	50%	**69%**
Total - USD	**16.08**	**13.72**	**13.37**	**14.60**	**57.8**	**14.08**	**12.87**	**13.75**	**15.05**	**55.75**	**88%**	**94%**	**103%**	**103%**	**97%**

CHAPTER 4: EVALUATION FINDINGS

4.1 Relevance: Evaluation Questions 1, 2 and 3

EQ1: To what extent is the CP8 is aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups, goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?
EQ2: To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?
EQ3: To what extent has the programme integrated gender and human rights-based approaches?

The CP8 was developed in consultation with a wide spectrum of partners, including the government, civil society and other development partners, United Nations organisations, academia and the private sector.[100] The beneficiaries who were further consulted by the IPs so as to customise interventions according to their needs, is summarised in Annex 8. The CP8 was aligned with national priorities, as outlined in Uganda Vision 2040, National Development Plan II (2015/2016-2019/2020), the United Nations Development Assistance Framework (2016-2020) and the UNFPA Strategic Plan 2014-2017, and contributed to harnessing the DD while taking into account the lessons learned from the previous country programme.

> *"All thematic sectors (SRH, AY, GEWE and PD) of the CP8 fit in very well within the wider context of the agenda of the GoU. It is also in line with the SDGs and Agenda 2063*", reported a KI respondent at the national level.

The CP8 response was informed by evidence of priority population needs.[101] The direct beneficiaries of the programme were women and young people, especially adolescent girls, PLWD and most at risk populations MARPs). The CP8 targeted districts with poor SRH indicators. However, during the implementation of CP8, sub-national beneficiaries especially DLGs reported that there were instances of limited regular downstream consultations to check on their changing needs.

> *"There were meetings held in 2015 and 2016 between our district officers and UNFPA about the district's priorities. However, when the programme started and continued, there was less consultations held with us since UNFPA was no longer channelling money direct to the district as it had been the case in the previous country programme. As such some of our new needs could not be attended to",* reported a DLG key informant, Kitgum District.

4.1.1 Sexual and Reproductive Health

4.1.1.1 SRH Relevance

The development of CP8 programmatic interventions was based on validated baseline data on SRH arising from service data, national socio-economic and SRHR policies; the National Development Plan (II); UNFPA Strategic Plan (2011 - 2016); as well as global priorities, including the MDGs and later, SDGs, and the ICPD Plan of Action. There was alignment with local contexts and strategic priorities across jurisdictional levels facilitated responsiveness of interventions for SRH-specific health indicators.

Specifically, the SRH outputs 1, 2 and 3 of the CP8 was aligned to the National Health Policy II (2010/11 - 2019/20); Health Sector Strategic Plan (HSSP) III (2015/16 - 2019/20); Uganda Family Planning Costed Plan (2015-2020); Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14); National SRHR and HIV Integration Strategic Plan; National Obstetric Fistula Strategy.

> *"The SRH component of CP8 is well aligned to the national priorities and those at regional and international levels. SRH supports the reduction of maternal mortality and the target is to reduce*

[100] GoU-UNFPA 8th Country Programme Business Plan (2016-2020)
[101] Uganda Demographic Health Survey 2016.

maternal mortality to 135 per 100,000 births by 2030 through addressing issues of obstetric care and teenage pregnancy, among others", said a KI respondent at the national level.

These outputs were also aligned to the National Policy on HIV and AIDS (2011); National HIV and AIDS Strategic Plan (2015/16 - 2019/20); Uganda HIV/AIDS Prevention and Control Act (2014); National Condom Programming Strategy (2013 - 2015); and Revised Reproductive Maternal Neonatal Child Health (RMNCH) Sharpened Plan. UNFPA contributed to the development of the above policies and strategies. The outputs also relate to various guidelines namely: WHO Consolidated Guideline on Self-Care Interventions for Health: SRHR; Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015 (GoU/MoH); Implementation Guide for the National Strategy for Integration of SRHR and HIV (2017 - 2021); National Integrated Prevention of Mother to Child Transmission of HIV Policy Guidelines; and Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines, 2017.

The SRH component addressed the needs of the beneficiaries in the UNFPA supported districts. Beneficiaries who were interviewed during the FGD sessions[102] in seven districts all reported that IPs made consultations with them prior the commencement of activities.

"The implementing partner consulted our communities on their needs first. The representatives of the beneficiaries requested for health/medical services and they were granted e.g. FP, HIV/AIDS testing and cervical cancer screening. Communities identified SGBV as a serious problem and the partner trained us how to handle it", said adult women during an FGD session in Ruyonza sub-county, Kyegegwa District.

4.1.2 Adolescents and Youth

The Adolescent and Youth output 1 of the CP8 was aligned to the following policies, strategies and frameworks: National Adolescent Health Strategy (2011-2015); National SE Framework (2018); National Strategy to End Child Marriage and Teenage Pregnancy (2014/2015 - 2019/2020); Adolescent Health Policy and Service Standards (May 2012); Multi-sectoral Framework for Adolescent Girls (2017/18 - 2021/22); WHO Global Accelerated Action for the Health of Adolescents (2017) - Guidance to Support Country Implementation; UN Uganda Adolescence and Youth Strategy (2010 - 2020). The formulation of the some of the interventions under AY was informed by the Report on the Formative Research Ending Child Marriage and Teenage Pregnancy in Uganda (2015). The output also related to other documents such as the Sexuality Education minimum package for the out-of-school young people; Uganda Violence Against Children Survey Findings from a National Survey (August 2018); Implementation Guide for the National Strategy for Integration of SRHR and HIV (2017 - 2021).
The AY component was relevant to the needs of the adolescents and youth. Those who were consulted during the district visits confirmed that they were consulted by the IPs about their priorities.

"The implementing partner consulted us (the girls) about our needs and they trained some trainers of trainers who taught us about early pregnancies, early marriages, school drop outs, how to avoid STIs and engage with village saving and loan associations", reported adolescent girls during an FGD session in Omugo sub-county, Arua District.

In terms of the changing environment, CP8 has particularly responded to the increasing humanitarian challenges of the past few years especially the influx of refugees (including adolescents and youth) from the neighbouring countries of South Sudan and Democratic Republic of Congo.

4.1.3 Gender Equality and Women's Empowerment

The CP thematic component on Gender Equality and Women Empowerment (GEWE) shared similar strategic intent with UNDAF (2015-2020), UNFPA Strategic Plans (2014-2017; 2018-2022), National Development Plan II (NDP II, 2016-2020), and Vision 2040 (2013). These recognised and prioritized gender equality and empowerment of women as a means to inclusive growth and social development. The thematic component was also aligned to the sustainable development agenda, particularly SDG 5 on gender equality and empowerment of

[102] Annex 8: FGD Analysis - summaries

all women and girls. The strategic interventions proposed are based on SDG indicators and targets for example indicator 5.1.1 on legal frameworks for gender equality and non-discrimination, indicator 5.2.1 on violence against women from an intimate partner.

The CP in terms of design and content was aligned to existing gender equality policies including the Revised National Policy on Elimination of Gender Based Violence in Uganda (2019); The National Male Involvement Strategy for Prevention and Response to Gender Based Violence in Uganda (2017); and the National Strategy to End Child Marriage and Teenage Pregnancy (2014/2015 – 2019/2020) which all have strategic actions aimed at reducing gender inequality, promoting women empowerment, and eliminating harmful practices. It suffices to note that UNFPA through the CP GEWE component in partnership with other UN agencies and other development partners was at the helm and provided strategic technical leadership in developing and supporting dissemination of most of the policy frameworks and plans aimed at GEWE. UNFPA also supported mechanisms to contribute to elimination all forms of GBV/discrimination of women and girls.

4.1.3.1 Coherence with Needs of Target Groups

The CP8 GEWE thematic component responded to existing gendered inequalities and women rights violations. More than 1 in 5 women aged 15-19 years had experienced sexual violence compared to 8 percent of men, while 56 percent of ever-married women and 44 percent of ever-married men had experienced spousal violence. There were high levels of tolerance for wife beating, with 49 percent of women and 41 percent of men agreeing that it is justified for a man to beat his wife for some given reasons. Several communities were practicing FGM with the national prevalence standing at 0.3 percent. Among FGM survivors, 52 percent reported experience of both mutilation and sexual violence. Reporting and service seeking behaviour following experience of violence was poor. Only 33 percent of women and 30 percent of men sought help to end the violence or get a service, with majority seeking help from their own families.[103] Child and early marriage was prevalent. Forty-nine percent of women ages 20-24 were married before turning 18 years.[104] The teenage pregnancy rate was high, standing at 25 percent.[105] There was evidence on causal pathways between GBV, SRHR and HIV. For example, a significant proportion of pregnant women reported experience of violence and were more likely to develop obstetric complications such as hypertension and premature rupture of membranes.[106] It was also evident that child marriage and teenage pregnancy increased the risk of STIs, HIV/AIDS, cervical cancer, gender-based violence, persistent and enduring inequalities, social stigma and isolation.[107] This necessitated integrative and holistic programming.

EQ2: To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?

The evaluation found out that UNFPA largely responded or adapted to the changes in national needs and contexts. For example, the agency was able to effectively respond to the emerging multiple women and child rights abuses among the refugee population. Although GBV incidents remain underreported, in 2017 alone 5,001 new incidents were identified, managed, documented, and reported across 12 refugee settlements. This happened in the face of the weak and at times non-existent protection systems.[108] The programme responded by improving response to needs of survivors by providing quality essential services and trainings.

UNFPA was also able to respond to emerging practices meant to maintain FGM, particularly cross-border FGM. The agency supported partners to hold dialogues with border communities which resulted, among other things, the passing of the Alakas resolution on cross border FGM. Discussions with stakeholders revealed that UNFPA

[103] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.
[104] Uganda Bureau of Statistics 2016, The National Population and Housing Census 2014 – Main Report, Kampala, Uganda.
[105] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.
[106] Kaye DK, Mirembe FM, Bantebya G, Johansson A, Ekstrom AM (2006). Domestic violence during pregnancy and risk of low birth weight and maternal complications: a prospective cohort study at Mulago Hospital, Uganda. *Trop Med Int Health*, 11(10), 1576-84.
[107] SPRINT Training on the Minimum Initial Services Package (MISP) for Sexual Reproductive Health in Crisis: A Course for Coordination Team, 2013.
[108] GBV IMS annual report for Uganda refugee settlements and urban Kampala. January — December 2017. https://reliefweb.int/sites/reliefweb.int/files/resources/64127.pdf

would have benefitted more if it took a strategic step to harmonize its efforts to address cross-border FGM with its sister agency in Kenya. UNFPA should also take keen interest in emerging internal migration patterns of families that practice FGM. It should also pay attention to refugees migrating to Uganda from high FGM practicing countries like Somalia. This has programme implications as efforts to eliminate the practice can no longer be limited to traditional FGM practicing communities.

The evaluation identified several context specific challenges and needs that have to be paid attention to further strengthen GEWE response. There were changes in the manifestation of SGBV in Karamoja region brought about by the disarmament programme. Most notable, field discussions with key informants revealed that before disarmament, youth were perceived as the source of wealth through cattle raiding (to restock kraals). However, with after disarmament, the focus had turned to girls through early/child marriage as the source of restocking of kraals. This was seen as an alternative path to the gain of livestock wealth. Slow adjustment to alternative forms of livelihoods, as a consequence of disarmament, also contributed to idleness of youth and the burden of alcoholism which was a key risk factor for SGBV.[109] In Busoga sub-region, field discussions revealed that sugar cane growing increased exponentially and generated multiple risks for SGBV such as school dropout, teenage pregnancy and food insecurity. These needed to be adequately studied and understood for effective GBV and SRHR programming.

> "*Yes, such incidents occur, you can be surprised to see a young girl pregnant and when you ask, what happened they will tell you that she was raped while going to the shop or to fetch water, or when she was coming back from school. Sugar cane growing has contributed to high levels of famine in this region because our husbands think that 300,000Ugx is a lot of money and they rent out their land for years yet 300,000Ugx cannot even sustain them for two weeks because they just drink alcohol. Hence living the family in absolute poverty with no food and land for farming,*" reported adult women during an FGD session, Iganga district.

There was emerging evidence on climate change as a risk factor for GBV.[110] Field discussions revealed that climate change effects such as drought erodes livelihoods, resilience, and coping mechanisms of local communities. Consequently, women and girls engaged in negative coping including exchange of sex for food. Time poverty also increased during this period since women and girls had to spend more time collecting water and firewood. Similarly, some studies showed that the oil and gas sub-sector in Uganda and the construction of associated infrastructures including the oil pipeline had unintended outcomes that exacerbate risk factors and drivers for GBV and VAC.[111]

Response to refugee influx: During the CP8, Uganda experienced an unprecedented influx of refugees, mainly from South Sudan and the Democratic Republic of Congo, much more than had been anticipated at the time of designing of the CP8. The evaluation indicated that the Uganda UNFPA CO particularly responded rapidly, effectively and efficiently to the increasing humanitarian challenge over the years; enabled by their field presence as well as strong partnership with other partners, especially government and other UN agencies. The DLG authorities in the refugee hosting districts visited confirmed the active, swift and effective involvement of UNFPA in emergency interventions.

> *"UNFPA has been supporting various IPs in the refugee settlement camps in Arua district for many years and the district leadership appreciates the support so far provided",* reported a KI participant in Arua town, Arua District

In this light, the evaluation found that the CP8 interventions were aligned to the Health Sector Integrated Refugee Response Plan (2019-2022) and the Comprehensive Refugee Response Framework (CRRF), thereby addressing the needs of beneficiaries, particularly those of women, adolescents and youth.

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[109] WHO (2006). Intimate Partner Violence and Alcohol. World Health Organization, Geneva Switzerland. https://www.who.int/violence_injury_prevention/violence/world_report/factsheets/fs_intimate.pdf

[110] UNFPA (2018). Vulnerability to drought: Building resilience for women and young people in Uganda. Issue Brief 06. Special Edition, July, 2018.

[111] Bukuluki, P and Mugisha, J. (2013). Governance and Livelihoods in Uganda's oil rich Albertine Graben. International Alert.

"Our community groups were consulted by the implementing partner about our needs in August 2018 and then the implementing partner conducted a training that lasted three days in December 2018", reported adult women refugees during an FGD session in Mireiyi refugee settlement Adjumani District.

"We were consulted by CARE about their future activities in our locality and after they went through the sub-county office. Following the consultations, they conducted training on prevention of early marriages, teenage pregnancies and GBV; family planning; survival skills through income generating activities; and school drop-outs", reported adult women in Omogo sub-county in Arua District.

Response to changing global funding: The CO experienced significant reduction in funding during 2017/2018, apparently a global situation. As illustrated in Figure 9, the CO has since responded to this challenge by mobilising more through various initiatives.[112]

For example, during the evaluation period, the UNFPA mobilised a total of US$ 48.5m from the United Kingdom (U$ 3.9m), Government of Sweden (US$ 18.3m); the Government of Denmark (US$ 13m); the Netherlands (US$ 1.9m); Irish government (US$ 2.7m), European Union (Us$ 4.99m) and the Austrian government (Us$ 3.7m). The amount of resources raised appeared to be trending the annual amount indicated in the Business Plan, as shown in Table 7 on page 21.

EQ3: To what extent has the programme integrated gender and human rights based approaches?
The overall programming of CP8 and resource mobilisation was approached from the angle of gender equality and rights programming. Right from the onset, the CP8 adopted the key principles of the 2030 Agenda, including: (a) the protection and promotion of human rights; (b) the prioritization of leaving no one behind and reaching the furthest behind first; (c) strengthening cooperation and complementarity among development, humanitarian action and sustaining peace; (d) reducing risks and vulnerabilities and building resilience; (e) ensuring gender-responsive approaches at all levels of programming; and (f) a commitment to improving accountability, transparency and efficiency. These principles helped to anchor the CP8 conceptualization and implementation into dimension of integration of gender and human rights based approach in all its work with partners and communities.

For example, the EU Spotlight Initiative, a multi-year elimination of violence against women and girls programme, provided an entry point for provision of SRHR, GBV, harmful practices (FGM and child marriage) and HIV services. Through the EU Spotlight Initiative and the UN Joint Programme on GBV (2018-2023), UNFPA and other UN agencies in partnership with GoU unequivocally put gender equality and the human rights based approach at the core of SRHR, GBV and harmful practices.

Furthermore, the GoU/UNFPA CP supported the integration of SGBV and SRHR/HIV in programmes targeting young people such as the Empowerment and Livelihoods for Adolescents (ELA) programme, the Youth Enterprise Model (YEM), Involvement of Men in Accountable Practices (IMAP), and Let Girls Be Girls Campaign, a campaign using teenage pregnancy using gender and human rights based approach as an entry point to address GBV, harmful practices, fistula, maternal death, and increase uptake of FP. The ELA programme showed significant impact in reducing adolescent sex, pregnancy and births by 76 percent.

The CP8 also supported through funding and technical assistance (TA) development and implementation of several policies that mainstream gender and rights. The National GBV Policy and Action Plan, the Costed RMNCH Plan, the National Male Involvement Strategy, the National Strategy for Ending Child Marriage, the National Policy for Sexual Reproductive Health and Rights all had at their core gender and human rights based programming principles. For example, the National Policy for SRH and Rights included a strong focus on SRHR for adolescents and clearly linked SRHR to GBV, HIV and programming to address harmful practices (especially child marriage and teenage pregnancy). This increased opportunities for delivering FP services to adolescents/young people under 15 years of age that had been left out as the focus had remained on women of reproductive age. Similarly, the MoH in partnership with UNFPA trained 40 trainer of trainers from MoH, districts, IPs both in humanitarian and development in Minimum Initial Service Package (MISP) for SRHR and clinical care

[112] UNFPA Donor Mapping Report 2016

prevention and management of GBV survivors. This was a clear indication of addressing gender and rights in SRH/GBV and HP in development and humanitarian settings.

The programme facilitated creation of community level structures for example Male Action Groups (MAGs), IMAP, and SASA! Community activists who delivered or linked communities to integrated prevention and response services. For example, UNFPA also worked with young entrepreneurs to develop software applications namely SafePal, The Zone, and GetIN to scale up access to SRHR/HIV and SGBV information and linkage to services. These innovations were rolled out to selected districts across the country. The programme also supported efforts that strengthened capacities for response services in the sectors of health, police, judiciary, and psychosocial care. In emergency contexts, UNFPA recruited and deployed midwives in service delivery points serving refugee settlements and maintained functional ambulance systems to facilitate referrals to facilitate meeting the rights of refugees to SRHR and FP in line with gender and human rights principles.[113]

The integrated approach contributed to increased access and uptake of SRH/HIV and SGBV services. In 2017, 894 survivors of FGM accessed integrated related services including management of fistula, information on SGBV, SRHR.[114] It also strengthened linkages and collaborations across sectors, increased knowledge on timely reporting for GBV prevention and response among health workers, improved handling of GBV cases among health workers and JLOS actors, and less burden to survivors.[115] In some UNFPA supported districts, GBV has been integrated in district work plans and budgets, though challenges remained in realizing release of funds to implement activities.

Effective integrated delivery of services was however hindered by capacity gaps and skills among service providers on integrated SRHR/HIV and GBV services delivery, health systems challenges specifically on supplies stock outs and attrition/transfer of staff, unavailability of services at referral points, and inadequate human resource. Also, existing capacity to deliver services did not match with the demand that was created for services. Furthermore, there was no clear guidelines on integrated delivery of rights. The stakeholders were grappling with figuring out what an integrated package of services entailed and how to effectively deliver it. Within the integration of gender equality and rights, limited systematic attention was paid to exploring the intersections between violence against women and violence against children (VAC).

4.1.4 Population Dynamics

The PD component was aligned to Vision 2040 which clearly articulates a middle-income state for Uganda by 2030. Through the consultative processes it was realized that Uganda could realise a DD unless the youthful population were translated into a resource that could contribute to the economic growth of the country. The PD component was further aligned to NDP II as it clearly referred to the harnessing of the DD as well as the demographic transition, human capital pillar, skilling of the young people, contribution of FP to achieving the DD and ensuring that the girl child remained in school. It was further observed that all these aspects were aligned to the frameworks such as The Africa That We Want 2060. Uganda aspires to become a middle-income country by 2040 with a GDP per capita of US$ 9,500. The current GDP per capita is US$ 825. The country recognized that its population was a resource but 47.9 percent was below 15 years or 75 percent were below 30 years. To transform this population into economic dividend the government targeted investments in the young population and created a productive youth bulge to contribute to economic development.

Consultative meetings were held with government and partners around population issues. The basis of the results was the ICPD, 2014 Census, the UDHS 2016 as well as household survey data, which brought out specific areas that required interventions. During the development of the CP8 using the available evidence, the different partners came together and brought out key issues around population that needed to be incorporated in the CP. It was realized that Vision 2040 was already encapsulating issues that needed urgent attention, for example issues around the young population and how the young population could be harnessed into a dividend. At that time, the major issues coming out were the high dependency, the child-dependency rates and the young population. It was realized through an interrogation of population data that the country had a high dependency

[113] UNFPA 2018 Annual Report – Uganda
[114] UNFPA 2017 Annual Report – Uganda
[115] UNFPA 2016 Annual Report – Uganda

rate and not a youth bulge, i.e. people that could participate in the economy. The ICPD was useful in that it provided areas in PD that the country was progressing well and those that it was not. This helped guide the consultative processes into areas that needed urgent attention. Some of the issues that came up as priorities besides the youthful population was maternal health, teenage pregnancy. This informed the processes for the development of the PD component in the CP8.

4.2 Effectiveness: Evaluation Questions 4 and 5

EQ4: To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
EQ5: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

4.2.1 Sexual and Reproductive Health

4.2.1.1 The Intervention and Results logic for Sexual reproductive health

The Strategic outcome 1 (SRH) had three outputs namely: Output 1: National and district governments have capacity to deliver comprehensive high quality maternal health services, including in humanitarian settings; Output 2: National and district governments have capacity to increase demand for and supply of modern contraceptives; and Output 3: Increased national capacity to deliver integrated SRH and HIV/AIDS prevention programmes that are free of stigma and discrimination.

Table 9 below displays the indicators for the three outputs and interventions designed to achieve them as well the extent to which the indicators were achieved.

Output 1 aimed to enhance capacities of the health system to carry out emergency obstetric care; to prevent, detect and report maternal and neonatal death; and to prevent and repair obstetric fistula. UNFPA supported both national and district local governments by building capacity of health workers at all levels, through training and strengthening coordination and support supervision. Furthermore, UNFPA provided equipment and other support infrastructure required for emergency obstetric care, post abortion care, obstetric fistula management; the MISP for Reproductive Health in humanitarian settings; as well as perinatal death reporting and surveillance. Furthermore, UNFPA provided financial and technical support to (a) towards advocacy initiatives for increased government financial and human resources for maternal health and family planning; (b) the MoH to establish a performance monitoring scorecard mechanism to ensure access to high-quality care according to human rights principles; (c) both national and local governments to establish strong partnerships and coordination mechanisms to enhance integration of SRHR interventions, including preparedness and response in humanitarian settings; (d) the Nurses and Midwifery Council to strengthen the midwifery programme and provide equipment to health facilities for provision of emergency obstetric care.

Output 2 focused on ensuring adequate stock of reproductive health, especially FP, commodities at health facilities and increased uptake of SRH (FP) services. As such, major investments were in the following interventions: (a) increased government financial support for SRH, especially FP; (b) strengthening human resources for health to increase the coverage of service delivery points that are capable of providing quality FP services. This included providing technical and financial support towards training of health workers at health facilities and the community, as well as advocating for a policy of task-shifting in the area of SRH; (c) technical capacity was provided to develop the FP CIP which has enhanced fundraising using the gap analysis. The CIP laid out the government's proposed strategies to increase access to FP, reduce unmet need and increase the modern CPR from 26 percent to 50 percent by 2020. (d) UNFPA supported financially and technically, the design and scaling up of the Alternative Distribution System for FP commodities, thus opening up the private sector window to distribute free FP commodities through the Alternative Distribution Mechanism. This has increased availability of commodities in rural and hard-to-reach areas (d) UNFPA invested in demand-creation for FP services, e.g. through the use of community champions and other community resource persons; (e) through the community-based distribution strategies community outreaches, social marketing and social franchising, stakeholders have been able to expand access to remote and hard to reach areas.

Output 3 aimed to strengthen condom programming at national and subnational levels; establishing functional regional hubs for SRH/HIV for MARPs and having a costed strategic plan for SRH/HIV integration. To strengthen condom programming, UNFPA supported implementation of the 10-step strategic approach to comprehensive condom programming, including training of health workers in quantification; establishing an electronic condom logistic distribution system; UNFPA supported the establishment of regional hubs through infrastructure development, provision of equipment and supplies and training of health workers. UNFPA supported ministries of health, education and gender and social development to deliver integrated and coordinated HIV and SRH programmes for young people; in particular in providing technical support in the development of an integration strategy, and implementation of integrated SRH/HIV services at facility and communities – through training of health workers, and strengthening data management systems. UNFPA championed the use of religious and cultural institutions to scale up social and behavioural change interventions; and the use of evidence to improve HIV and sexually-transmitted infections programming for young people.

4.2.1.2 Evaluation of the Results and Intervention Logic for SRH Component

The theory of change underlying the SRH component, as outlined in the CPD is generally based on a sound intervention logic. The strategic outcome and the three outputs which are contributing to the attainment of the outcome were articulated well. Although the CP implementation period (2016-2020) was indicated in the introduction of the CP Business Plan, it would have been useful to indicate the end point/year in the outcome statement so that it is clear when the attainment of the outcome is expected. The linkages between activities for planned interventions for the outputs were clear as well as linkages between outputs and the outcome. The indicators for outcome and outputs were sufficient to measure the progress. However, some output indicators were stated as categorical; requiring only "Yes" or "No" as the only options for measuring achievement. These categorical measurements fell short of clearly defining the quality, processes and parameters of measurement. As the indicator on MISP - *proportion of humanitarian settings where 'Minimum Initial Service Package' is implemented*, the target set (10) was lower than the baseline (50) and no particular reason was documented. In the course of the CP implementation, three additional indicators were added against the outcome and output 1 respectively which was a good decision. The reason for their addition was to have them act as proxy indicators. There was no evidence of stated assumptions in the CP Business plan which was a major omission.

The strategic interventions for increasing the national and district capacity to deliver comprehensive high quality maternal health services were: Functionalization of HC IVs; provision of basic amenities and infrastructure to support EmONC services; enhancing performance of midwifery services in underserved areas; functionalization of Maternal and Perinatal Death Surveillance Response (MPDRS) committees at community, health facility and district level; strengthening the national capacity for obstetric fistula management including social reintegration. The key interventions for improving the capacity to increase the demand for and supply of modern contraceptives were: community-based distribution of FP commodities; increasing demand and uptake of FP services; provision of technical support to improve commodity forecasting, procurement and supply chain management system at national and district levels. The interventions for increased national capacity to deliver integrated SRH and HIV/AIDS prevention programmes were: Strengthening the comprehensive condom programming at national and sub-national levels; expanding coverage of SRH/HIV programming for key populations; and strengthening SRH/HIV integration at policy, systems and service delivery levels. The CO provided adequate human, financial, material and management resources which were required for the implementation of various interventions and eventual achievement of quality SRH services.

Progressive improvement in some of the outcome indicators over the years [skilled birth attendance from 59 percent in 2011[116] to 73 percent in 2016[117]; CPR from 35 percent in 2016 to 36.3 percent in 2018[118] and couple years of protection (CYP) from US$ 217k in 2016 to US$ 409k in 2019[119]] is evidence that SRH interventions were contributing to the outcome and impact results in reducing maternal morbidity and mortality and ensuring planned families.

[116] Uganda Demographic Health Survey, 2011

[117] Uganda Demographic Health Survey, 2016

[118] Performance Monitoring and Accountability (PMA2020) (April-May 2018) Round 6

[119] MoH/UNFPA M&E data

4.2.1.3 Achievement of Planned Results

Altogether, the evaluation assessed performance of 11 output indicators linked to the above 3 outputs and the underlying interventions. The results are summarised in Table 9. Nine out of the 11 (82 percent) output indicators met the defined targets while 2 (18 percent) did not.

The sections that follow describe achievement of targets by thematic areas under SRH, namely, maternal health, FP and SRH/HIV Integration.

Table 9: Summary of Achievements for SRH

UNFPA Strategic plan outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access			
Outcome Indicators for CP8 Percentage of births attended by skilled health personnel Baseline: 58; Target: 80 Contraceptive prevalence rate Baseline: 30; Target: 50 Number of new and continuing users of modern FP methods (proxy of above; not in Business Plan or RIM) Baseline 243,868 (new users); Target 275,868 Percentage of women and men aged 15-49 years who used a condom at last high risk sex (sex with a non-marital, non-cohabiting partner) Baseline: 35; Target: 50			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q3 of 2019 against Output Indicator Targets**	**Remarks**
Output 1: National and district governments have capacity to deliver comprehensive high quality maternal health services, including in humanitarian settings			
Percentage of health facilities in target districts with capacity to provide emergency obstetric care. Baseline: 65; Target: 70% for HC III 60% for HC IV 100% for hospital	Functionalise Health Centre (HC) IVs Provide the Basic amenities and infrastructure to support provision of EmONC services in 25 UNFPA target districts with equipment as per MOH standards Provide technical support for continuous quality improvement of SRH services with special focus on 34 target districts Enhance performance of midwifery services in underserved areas	**Achievement (%)** 8% of HC IIIs with capacity to provide EmONC (below target by 72%); 7% of HC IVs with capacity to provide EmONC (below target by 53%); 7% of hospitals with capacity to provide EmONC (below target by 93%)	
Existence of a functional national system for maternal death surveillance and response. Baseline: No; Target: Yes	Functionalize MPDRS committees at community, health facility and district level	**Achievement:** Yes	
Proportion of maternal deaths notified through the Ministry of Health (e.g. through HMIS,	Functionalize MPDRS committees at health facility and district level to report through DHIS II	**Achievement:** 2018: T =50%; Actual (A) =56%; Achieved 112% 2019: T =75%; A =65%; Below target by 10%	Proxy for the above indicator;

UNFPA Strategic plan outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access			
Outcome Indicators for CP8 Percentage of births attended by skilled health personnel Baseline: 58; Target: 80 Contraceptive prevalence rate Baseline: 30; Target: 50 Number of new and continuing users of modern FP methods (proxy of above; not in Business Plan or RIM) Baseline 243,868 (new users); Target 275,868 Percentage of women and men aged 15-49 years who used a condom at last high risk sex (sex with a non-marital, non-cohabiting partner) Baseline: 35; Target: 50			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q3 of 2019 against Output Indicator Targets**	**Remarks**
Maternal Deaths Surveillance and Response system) - proxy of the above			otherwise not in the CPD
Number of fistula cases treated annually. Baseline: 2000; Target: 5,000	Strengthen national capacity for obstetric fistula management including social reintegration	**Achievement** 2016: T =3,000; A =1,350: 45% of target achieved 2017: T =3,500; A =2,045: 58% of target achieved 2018: T =4,000; A =1,793: 45% of target achieved 2019: T =4,500: A =1,686: 38% of target achieved	
Existence of Midwifery workforce policies based on the ICM - WHO standards exist	Enhance performance of midwifery services	**Achievement:** Yes	
Costed national action plan(s) to scale-up maternal and newborn health services exists as a result of an emergency obstetric and newborn care		**Achievement:** Yes	
Proportion of humanitarian settings where 'Minimum Initial Service Package' is implemented. Baseline: 50;Target: 10	Strengthen national capacity for emergency preparedness and response to ensure implementation of SRH/Minimum Initial Service Package (MISP) for Reproductive Health in humanitarian settings	**Achievement** 2016: T =80%; Actual =55% - Behind target 2017: T =85%; A =100% - Achieved; target exceed by 15% 2018: T =90%: A =100% - Achieved; target exceed by 10% 2019: T =100%: A =100% - Achieved	
Output 2: National and district governments have capacity to increase demand for and supply of modern contraceptives			
Percentage of health facilities in target districts without stock-outs of at least three family planning methods.	Community-Based Distribution, social marketing of FP commodities	**Achievement:** 2016: T =45%: Actual =45% - Achieved 100% of target 2017: T =50%: A =45%[120] - Below target 2018: T =60%: A =74%[121] - Achieved; target exceed by 14%	

[120] Carried from previous year since no SDP survey was conducted in 2017

UNFPA Strategic plan outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access			
Outcome Indicators for CP8 Percentage of births attended by skilled health personnel Baseline: 58; Target: 80 Contraceptive prevalence rate Baseline: 30; Target: 50 Number of new and continuing users of modern FP methods (proxy of above; not in Business Plan or RIM) Baseline 243,868 (new users); Target 275,868 Percentage of women and men aged 15-49 years who used a condom at last high risk sex (sex with a non-marital, non-cohabiting partner) Baseline: 35; Target: 50			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q3 of 2019 against Output Indicator Targets**	**Remarks**
Baseline: 75; Target: 90		2019: T =70%: A =74%[122] - Achieved; target exceeded by 4%	
Proportion of health facilities in target districts with at least two staff that can offer both short-term and long-acting methods. Baseline: 85;Target:100	Train of health professionals to provide a high-quality method mix in family planning, according the family planning human rights protocol and latest edition of 2016 MEC wheel	**Achievement:** 2016: T =61%; Actual =61%: Fully achieved 2017: T =65%; A =65%: Fully achieved 2018: T =70%: A =85%: Achieved - target exceeded by 15% 2019: T =75%: A =77%: Achieved - target exceeded by 2%	
Number of target districts with at least four elements of demand generation for family planning. Baseline: 8;Target: 1	Increase demand and uptake of family planning service	**Achievement:** 2016: T =20; Actual =15 - Below target by 5% 2017: T =25: A =26 - Achieved; exceeded target by one district 2018: T = 25: A = 26 - Achieved; exceeded target by one district 2019: T = 25: A = 26 - Achieved; exceeded target by one district	
Existence of a national functional logistics management information system for forecasting and monitoring reproductive health commodities. Baseline: No; Target: Yes	Provide technical support to improve commodity forecasting, procurement and supply chain management system at national and district levels	**Achievement:** 2016: T =No: Actual =No - On track 2017: T =No: A =Yes - Achieved earlier than planned 2018: T =No: A =Yes - Achieved earlier than planned 2019: T =No: A =Yes Achieved earlier than planned	
Output 3: Increased national capacity to deliver integrated sexual and reproductive health and HIV/AIDS prevention programmes that are free of stigma and discrimination			
Uganda achieves implementation stage of the UNFPA 10-step strategic approach to comprehensive condom programming. Baseline: No (8/10);	Strengthen the condom programme at national and sub-national levels	**Achievement:** 2016: T =7: Actual =8 - exceeded target 2017: T =8: A =8 - Fully achieved 2018: T =10: A =9 - below target 2019: T =10: A =9 - below target	

[121] SDP survey 2018

[122] SDP survey 2018

UNFPA Strategic plan outcome 1 (Sexual and Reproductive Health): Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access			
Outcome Indicators for CP8 Percentage of births attended by skilled health personnel Baseline: 58; Target: 80 Contraceptive prevalence rate Baseline: 30; Target: 50 Number of new and continuing users of modern FP methods (proxy of above; not in Business Plan or RIM) Baseline 243,868 (new users); Target 275,868 Percentage of women and men aged 15-49 years who used a condom at last high risk sex (sex with a non-marital, non-cohabiting partner) Baseline: 35; Target: 50			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q3 of 2019 against Output Indicator Targets**	**Remarks**
Target: Yes (10/10)			
Number of functional regional hub /networks supporting sexual and reproductive health and HIV services for most–at–risk populations. Baseline:0; Target:5	Expand coverage of SRH/HIV programming for key populations and at risk young people to achieve optimal coverage	**Achievement:** 2016: T =3: Actual =5 - exceeded target by 2 additional hubs 2017: T =5: A =5 - Fully achieved (100%) 2018: T =5: A =7 - Achieved 140% of target 2019: T =5: A =7 - Achieved 140% of target	
Number of costed national and district strategies/plans that integrate sexual and reproductive health and HIV. Baseline: 2; Target: 9	Strengthening SRH/HIV integration at policy, systems and service delivery levels	**Achievement:** 2017: T =8: Actual =6 - Below target by 2 2018: T =9: A =15 - Exceeded target by 5 more strategies developed 2019: T =9: A =15 - Exceeded target by 6 more strategies developed	

4.2.1.2.1 Achievement of Maternal Health Indicators

(a) Emergency Obstetric and Neonatal Care

Basic EmONC (BEmONC) is critical to reducing maternal and newborn death.[123] This care, which can be provided with skilled staff in health centres, large or small, includes the capabilities for carrying out seven signal functions (SF) of EmONC. Comprehensive emergency obstetric and newborn care (CEmONC), typically delivered in hospitals, includes all the basic functions above, plus capabilities for two other functions namely performing caesarean sections and safe blood transfusion. The SF for EmONC consist of life-saving treatments and procedures including administering parenteral antibiotics (SF1), administering uterotonic drugs (SF2), administering anticonvulsants (SF3), manual removal of placenta (SF4), removal of retained placenta products (SF5), assisted vaginal delivery (SF6), newborn resuscitation (SF7), cesarean sections/delivery (SF8) and blood transfusion (SF9).[124] UNFPA supported MoH to ensure that HC IIIs carry out BEmONC and HC IVs and hospitals perform CEmONC.

The capacity of health facilities to provide EmONC was still low (8 percent for HC IIIs; 7 percent for HC IVs) compared to the BEmONC targets set in 2016 (80 percent of HCIIIs; 80 percent of HC IVs and 100 percent of hospitals). The limited capacity for EmONC provision was related to inadequate staffing of critical cadres (midwives, anaesthetists, medical doctors and laboratory attendants); poor provision of the basic amenities (e.g. medical equipment; essential drugs and supplies) and infrastructure ((lighting, water, sanitation, examination and waiting rooms).[125]

> *"This is a HC IV facility but we do not have anaesthetist or blood bank, so for those patients who require caesarean sections we just refer them to the nearest hospital,"* reported a KI respondent in Arua District.

[123] Setting standards for Emergency Obstetric and Newborn Care, UNFPA 2014.
[124] Monitoring Obstetric Care: Handbook (WHO, UNFPA, UNICFF, AMDD), 2009
[125] UNFPA Country Office Annual Reports 2016, 2017, 2018

The main underlying factor for this poor performance was the absence of vacuum extractors in several health facilities. If the target health facilities were equipped with the vacuum extractors, or if this equipment was removed from the assessment criteria, the overall performance of this indicator would jump to 56 percent.[126] Whereas the functionality of HC IVs improved by 10 percent from 58 percent in 2016 to 68 percent in 2019 (January - October) in UNFPA supported districts, those with the capacity to carry out EmONC) was 7.8 percent.[127] This implies that the risk of mothers getting complications during labour and delivery remained high, despite improvement in the functionality of HCIVs.[128]

The number of HC IVs was fewer than HC IIIs and the majority of HC IVs did not have anaesthetists and laboratory staff, lacked facilities for blood storage which meant that caesarean sections and blood transfusion could not be carried out. It was reported that UNFPA focused more in upstream than downstream activities.

> *"UNFPA invested more in upstream activities such as support to MoH in formulation of SRH policies and guidelines than in downstream ones such health staffing, equipping health facilities, setting up blood transfusion facilities, which would have had more direct impact on the capacity for EmONC",* said one KI at the national level.

For significant improvement of EmONC provision to happen, UNFPA needs to invest in advocacy in the following game changers:

- strong advocacy to MoH and DLGs for the recruitment and deployment of critical staff cadres to those HC IVs without - anaesthetists, laboratory attendants /technicians, theatre attendants, medical officers
- upgrading of some HC IIIs into HC IVs especially in the hard-to-reach areas to improve coverage
- provision of essential medical equipment items and especially those directly related to EmONC
- setting up of a sustainable ambulance referral system to allow mothers with complications to be referred from lower level HCs to higher ones

> *"The current ambulance referral system in Adjumani is addressing the needs of pregnant mothers especially those who get complications and have to be referred to a higher level health facility",* said a KI respondent, Adjumani District.

(b) Maternal and Perinatal Death Surveillance Response (MPDSR)

UNFPA supported MoH in the implementation of MPDSR cycle at national and sub-national levels with emphasis of strengthening maternal death notification, quality reviews and responsiveness to recommendations as part of the key indicators for improving service delivery in health facilities. UNFPA supported the compilation and dissemination of the Annual MPDSR Report (September 2019) to ensure continued quality improvement.[129]

There was increased awareness among stakeholders on the use of MPDSR as a quality improvement tool for mitigating occurrence of maternal deaths.[130] However, the functionality of MPDSR Committees at district and health facility level remained a key challenge and the main weaknesses were as follows:

- Majority of facility MPDSR committees were not fully constituted and non-functional.
- The MDPSR committees at both district and facility levels were not well oriented on the process of MPDSR, the formulation of the MPDSR committee, the roles of the members and the reporting mechanism to MOH.
- The revised tools were not available at both district and facility levels.
- Inadequate technical support supervision provided by the some district MPDSR committees to health facilities; and this was because the district MPDSR committees were not functioning.

In order to improve the MPDSR system further, the following things need to be advocated by UNFPA in liaison with MoH: [131]

[126] UNFPA Country Office Annual Report, 2018.
[127] UNFPA Country Office Annual Reports 2016,2017, 2018, 2019
[128] UNFPA Country Office Annual Report, 2018.
[129] MoH: Annual MPDSR Report (September 2019)
[130] MoH: Annual MPDSR Report (September 2019)

- Strengthen the MPDSR committees at district and facility level through orientation of the members about their roles and responsibilities on the committees
- Strengthen the community level intelligence/surveillance for maternal deaths
- Encourage and monitor pregnancy mapping and tracking by VHTs and
- Orient political/technical leaders on the importance of MPDSR and safe motherhood

(c) Fistula

The prevalence of fistula (obstetrics and GBV related) in Uganda is 2 per cent, with 1,900 new cases happening annually, and a backlog of 200,000 cases unattended.[132] UNFPA supported the government ministries to strengthen the national capacity for obstetric fistula management including social reintegration. UNFPA with other partners through the National Fistula Technical Working Group supported the review and costing of the fistula strategy to align to the national and international policies.

> *"UNFPA has supported the government ministries to strengthen the national capacity for obstetric fistula management including social reintegration",* reported one KI respondent at the national level.

The goal of the National Obstetric Fistula Strategy is to accelerate prevention and management of obstetric fistula in Uganda.[133] It has three objectives namely: to reduce the incidence of obstetric fistula; to reduce the prevalence of obstetric fistula, and to reintegrate all women affected by obstetric fistula into social life. There are two priority areas of prevention and treatment. The objective of the prevention priority is reduce the incidence of obstetric fistula while the treatment priority is to reduce prevalence of obstetric fistula. Awareness creation and visibility of the fistula problem and the need to address it at national, district and community levels was done through fistula walks, community dialogues and commemoration of the National Fistula Day. Through the UNFPA Maternal Health Thematic Fund, support was provided for training of surgeons, provision of equipment and fistula repairs at the national referral, regional hospitals and selected Private Not for Profit facilities. The achievement of fistula repair (cases repaired versus annual targets) was 45 percent (2016), 58 percent (2017), 45 percent (2018) and 38 percent (2019)[134], but there is still limited coverage and the backlog is still huge. It was reported that the women with fistula were stigmatized, lived in isolation and did not come out openly.

> *"Living with a leaking hole in my private parts was a nightmare. I was never comfortable and people did not want to be near me because I was always leaking and smelling. I would just stay indoors most of the time before I had a repair"*, narrated an FGD participant in Layamo sub-county, Kitgum District.

> *There is inadequate awareness within the communities about the importance of fistula repair and limited re-integration of the fistula survivors into the general community"*, reported on KI respondent at the national level.

It was reported that limited funding for fistula repair was a major concern to be addressed by UNFPA and other players.

> *"With USAID pulling out to support fistula work in Uganda, there is reduced funding for fistula and UNFPA is now the only development partner left supporting interventions on fistula. UNFPA's contribution should include advocacy to continue to support fistula repair which is integrated into the routine services at general and referral hospitals and the re-integration of survivors into their communities"*, said one KI respondent at the national level

[131] MoH: Annual MPDSR Report (September 2019)
[132] National Obstetric Fistula Strategy, MoH.
[133] National Obstetric Fistula Strategy, MoH.
[134] UNFPA Country Office Annual Report 2018.

UNFPA hands over demonstration equipment items for maternal health improvement to Ministry of Health, Uganda. Photo by UNFPA/Uganda

(d) Minimum Initial Service Package

The CO planned to establish a MISP for Reproductive Health in emergency settings to help mitigate risks in the event of an onset of humanitarian crises.[135] The planned targets were well achieved for each year in 2017 (118 percent), 2018 (111 percent) and 2019 (100 percent). All humanitarian settings have MISP implemented as per the defined package by the SPHERE project. With support from UNFPA, MISP was implemented in the nine major refugee settlements (Arua, Moyo, Yumbe, Adjumani, Kiryandongo, Rwamwanja, Kyangwali, Nakivale and Oruchinga) for the three major refugee influx emergencies from South Sudan, DR Congo and Burundi.[136] As a result of the above, the affected population especially women and girls were able to access SRH information and services, adolescent SRH services, FP services, emergency reproductive health kits and dignity kits.

> *"At the health facility within this refugee camp, we always get ante-natal and family planning services; this is the case for women and girls whether refugees or not"*, reported an FGD participant at Mireiyi Refugee Settlement, Adjumani District.

There were some challenges which affected the effective delivery of SRH services in humanitarian settings namely: (a) Delayed approval from the National Drug Authority (NDA) of the RH kits leading to a delay in procurement and shipment of the kits. The CO had an advocacy meeting with NDA's Executive Director that facilitated the process; (b) Lack of storage infrastructure in new refugee settlements which led to some delays in service provision. The CO provided medical tents in order to facilitate SRH services provision. Additional tents were set up for women and youth spaces; and (c) Large refugee influxes which were much more than planned for numbers led to overstretching of resources to serve the large population.

(e) Challenges in Maternal Health: The main challenges encountered in maternal health were inadequate funds which limited the implementation coverage; human resources issues related to recruitment; poor staff retention and staff absenteeism which affected accessibility and quality of services; stock out of commodities, supplies and

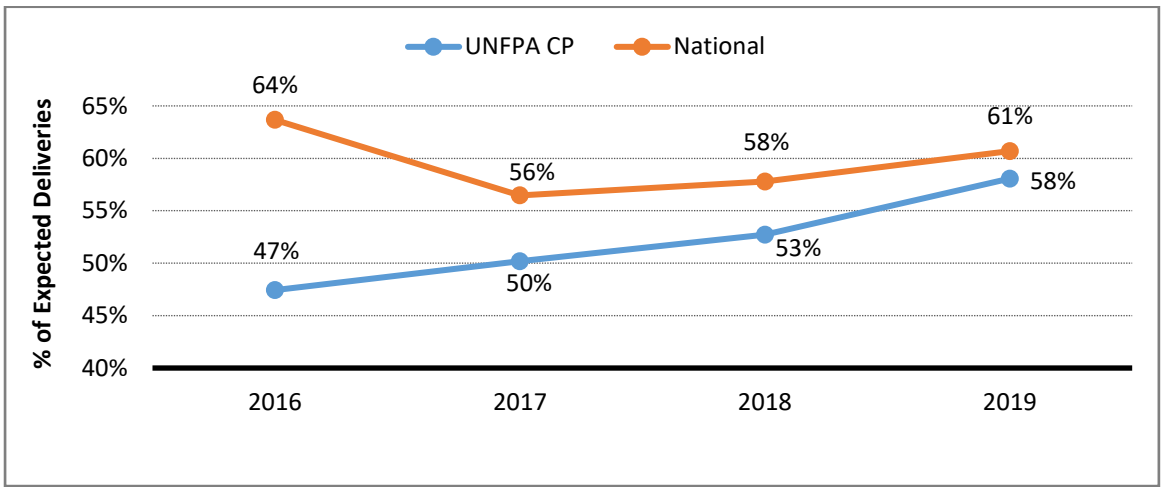
[135] UNFPA Business Plan 2016-2020.
[136] UNFPA Country Office Annual Reports 2017, 2018, 2019.

equipment at service delivery points hence hindering the provision of a method mix and quality services; bureaucracy at implementing partner level delayed implementation of interventions.

(f) Achievement of Strategic Outcomes in Maternal Health

Trends in health facility deliveries: Facility-based deliveries have been used as a proxy for skilled birth attendance (SBA). The assumption for the use of the proportion of health facility deliveries as a proxy for SBA is that the birth attendants at health facilities have the necessary competent skills to provide care during childbirth and are trained, accredited and skilled health professionals (such as midwives, clinical officers, doctors, or nurses).[137] The skilled health professional must also be supported by appropriate standards of practice (education, training and regulation), and operates within an enabling environment (a functioning health system, comprising six building blocks). The proportion of facility-based deliveries improved from 47 percent in 2016 to 58 percent in 2019 in UNFPA-supported districts which indicated that mothers were continuing to come to health facilities to deliver (refer to Figure 10).

Figure 10: Trends in Expected Deliveries in Health Facilities (Proxy for SBA)



However, the quality of obstetric care might have been below the expected standard, given that the proportion of health facilities in the target districts which were able to offer all the signal functions of EmONC was 8 percent for HC IIIs and 7 percent for HC IVs and hospitals compared to the targets of 70 percent of HC IIIs, 60 percent of HC IVs and 100 percent of hospitals.[138] As afore-mentioned, the critical factors undermining the ability of health facilities to offer all signal functions of the EmONC were inadequate staffing level of critical cadres, inadequate provision of the basic amenities and infrastructure.

4.2.1.2.2 Achievement of Family Planning Indicators

Family Planning is a flag-ship programme for UNFPA. UNFPA facilitated MoH to develop the Uganda Family Planning Costed Plan (2015-2020); Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14). Universal access to safe, affordable and voluntary FP methods is central to realizing the transformative goal of achieving zero unmet need of FP. Reducing unmet need for contraception would prevent around 30 percent of maternal deaths, reduce child mortality by up to 20 percent, and avert over one million abortions in Uganda.[139] Additionally, FP contributes to universal education, women's empowerment, prevention of HIV, poverty reduction, and environmental sustainability, making it one of the most cost-effective health and development interventions needed to achieve Vision 2040. The NDP II recognized FP as a key and integral factor in poverty reduction, by supporting realization of a DD - a necessary factor for Uganda to attain a middle income country status by 2040.[140]

[137] Definition of skilled health personnel providing care during childbirth: The 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA.

[138] UNFPA Country Office Annual Reports 2016, 2017, 2018

[139] Family Planning Investment Case for Uganda.

[140] National Development Plan II.

(a) Supply Component

All of the planned targets under FP were achieved: (i) by the time of the CPE, 74 percent of health facilities registered no stock-outs of at least 3 FP common methods compared to a target of 70 percent set for 2019); (ii) at least 77 percent of target health facilities had at least two staff that had been trained and had the knowledge and skills to offer both short-term and long-acting FP methods relative to a target of 75 percent for 2019; (iii) a functional national logistics management information system for forecasting and monitoring reproductive health commodities was in place. It was reported that the supply side of FP received more investment from UNFPA than the demand side.

> *"UNFPA has been a major player and at the forefront of ensuring an adequate supply of FP commodities in the country",* said a one KI respondent at the national level.

(b) Demand Component

All targets relating to adequacy of FP commodities, of human resource capacity and a functional supply chain system were met; as well as targets for demand creation into the community. Interventions for demand generation often contribute to sustained high levels, or increased levels of FP uptake.[141] Although all the number of districts supported to implement demand creation exceeded the targets much earlier on, the achievement remained stagnant for the rest of the programme cycle. It was reported that some women had got empowered as far as FP was concerned – in terms of attitude toward FP, and/or use of FP.

> *"The women in our area been empowered with knowledge on family planning and are aware of the traditional FP methods (abstinence, breastfeeding) and modern methods (pills, condoms, implants, intra-uterine device) and making good diets. Those who have never got pregnant are able to delay getting pregnant and able to say no to sex when approached",* said an FGD participant in Omugo sub-county, Arua District.

UNFPA therefore needs to invest in the advocacy for demand side of FP which means support to MoH and other IPs on interventions aimed at increasing the awareness of the public about FP. Some of the interventions include: outreaches by VHTs/community health workers or health facility staff; use of local radios and television programmes; Information Education and Communication (IEC) materials (eg, leaflets/brochures) distributed at health facilities; and FP programme logos placed on all forms of materials, from T-shirts to health facility signs.

(c) Achievement of Strategic Outcomes in FP

Generally, FP indicators improved with CPR increasing from 35 percent in 2016 to 36.3 percent in 2018.[142] Performance Monitoring and Accountability (PMA2020) uses innovative mobile technology to support low-cost, rapid-turnaround surveys to monitor key indicators for FP. PMA2020/Uganda is led by the Makerere University's School of Public Health at the College of Health Sciences, in collaboration with the Uganda Bureau of Statistics and the MoH. Overall direction and support was provided by the Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health and funded by the Bill & Melinda Gates Foundation.

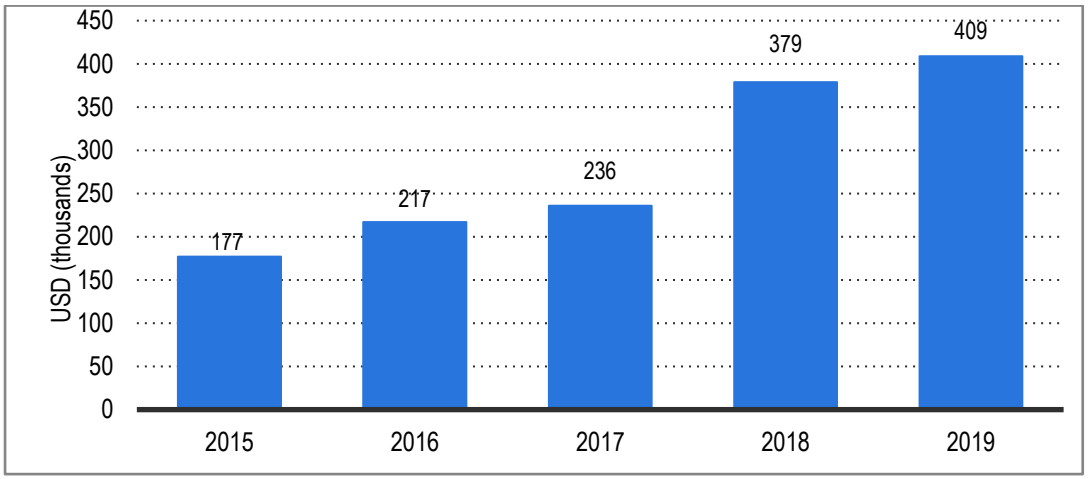
The unmet need for FP also declined from 28 percent in 2016[143] to 26.0 percent in 2018.[144] The percentage of health facilities reporting no stock-out of at least 3 FP commodities in the last 3 months was 47 percent in 2018[145] compared to the baseline of 45 percent in 2015. It was reported that there were some health facilities which experienced stock-outs while others did not.

[141] Independent Thematic Evaluation: UNFPA Support to Family Planning, 2008-2013
[142] Performance Monitoring and Accountability (PMA2020) (April-May 2018) Round 6
[143] UBOS, 2016
[144] Performance Monitoring and Accountability (PMA2020) (April-May 2018) Round 6
[145] MoH: Service Delivery Point survey, 2018

"In some instances, we run out of FP items at this health facility and are forced to borrow from the nearby facilities", reported a HC III in-charge in Kitgum District.

The success of UNFPA in the supply side of FP contributed to a continuous improvement in the CYP, from the time when the programme started in 2016 up to 2019 as shown in Figures 11.

Figure 11: Total CYP in CP8 (in 25 core districts)*



Source: MoH/UNFPA M&E data
***The figure for 2019 is based on linear extrapolation.**

***(d) Challenges*:** The specific challenges encountered in achieving targets related to FP[146] were inadequate capacity at service delivery points in logistics management information system (LMIS) due to limited human resource for supply chain management; the existence of dissenting views from key stakeholders, especially religious, cultural and community leaders, on contraception, and particularly for young people. It was reported that the inter-religious leaders' platform that was facilitated by UNFPA assisted to harmonize faith-based leaders' position and align to government policy on contraception at national and district levels.

"The Muslim leaders in West Nile districts have worked closely with Reproductive Health Uganda and DHO on matters related to SRH especially FP services so that our members benefit from those services", said a KI respondent in Arua town, Arua District.

4.2.1.2.3 Achievement of Integrated SRH and HIV/AIDS prevention Indicators

(a) Condom programming

UNFPA's 10-step approach for comprehensive condom programming (CCP) has the development phase (steps 1-4) and the implementation phase (steps 5-10).[147] The 10 steps are shown in Table 10.

Table 10: Ten Steps for CCP

No.	Description of Steps
	Developmental Phase
Step 1	Establish a national condom support team
Step 2	Undertake a situation analysis
Step 3	Develop a comprehensive and integrated national strategy for male and female condoms
Step 4	Develop a multi-year operational plan and budget
	Implementation Phase
Step 5	Link the multi-year operational plan with the national commodity security plan
Step 6	Mobilize financial resources
Step 7	Strengthen human resources and institutional capacity
Step 8	Create and sustain demand for condoms

[146] UNFPA Annual Report 2018.
[147] UNFPA Comprehensive Condom Programming: A guide for resource mobilisation and country programming.

No.	Description of Steps
Step 9	Strengthen advocacy and engage the media
Step 10	Monitor programme implementation routinely, conduct research and evaluate outcomes

UNFPA supported government on the comprehensive condom programming using this strategic approach to scale up CCP that encourages the participation of donors and international agencies while placing ultimate responsibility for decision-making and implementation in the hands of national partners.[148]

UNFPA CO was on track on the achievement of the target for implementation stage of the UNFPA 10-step strategic approach in 2016 (114 percent) and in 2017 (100 percent) until 2018 and 2019 when there was under-achievement of the same (9/10). It was reported that GoU funding for condom supply was limited.

> *"The main constraint has been the inadequate GoU funding towards mobilizing internal resources for condom supplies which at the moment is almost 100 percent funded by donors. If external funding for condoms ceased, there would be a huge crisis and its attendant implications",* said a KI respondent at the national level.

(b) Challenges: The main challenges encountered in CCP[149] included the inadequate supply chain for condoms which continued to be a barrier to access and to meet the demand that had been created. The total market approach (TMA) also resulted in a reduced number of public sector condoms. TMA means that all three sectors - public, social marketing, and commercial - work together to increase condom use for all population segments and grow the market in a responsible way.

(c) MARPs or key population programming

One of interventions for key population programming was to support integration of SRH and key issues for adolescents, young people and MARPs into national HIV strategic and planning frameworks and resource mobilisation strategies.[150] The CP's main focus areas aimed to reach marginalised populations including MARPs [commercial sex workers; Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI); uniformed forces, long distance transport community, fisher folk] through:

- Supporting the implementation of the National MARPs programming Framework for delivery of comprehensive package on HCT, Condom, SMC, STI, FP, SBCC, etc. This activity involves MARPs mapping around selected hubs, development/review and utilization of programme delivery and monitoring tools, programme reporting, MARPs community engagement
- Strengthening HIV prevention programming in hotspots/urban areas to reduce on new HIV infections

UNFPA CO was on track on the establishment of functional regional hub /networks supporting SRH and HIV services for MARPs and achieved beyond the annual targets set (167 percent in 2016, 100 percent in 2017, 140 percent in 2018 and 2019).[151] With UNFPA support, MoH led a process for developing standardized key population (KP) training tools that also stipulated the standard package of SRH/HIV services for KPs.

(d) Challenges in MARPs programming: Challenges in MARPs programming[152] included the lack of political support which resulted to the silencing of KP voices in various fora; the exclusion of particular groups of KPs specifically commercial sex workers, men who have sex with men (MSM) and LGBTI from the revised HMIS tools which in turn led to lack of data on key populations.

(e) SRH/HIV integration

Integrating SRH and HIV/AIDS policies, programmes and services is considered essential for meeting international and national goals and targets including the SDGs particularly Goals 3, 5 and the integration of HIV

[148] UNFPA Annual Report 2016.
[149] UNFPA Annual Report 2018.
[150] UNFPA Business Plan 2016-2020.
[151] UNFPA Annual Reports 2016, 2017, 2018, 2019.
[152] UNFPA Annual Reports 2017, 2018.

services into SRH services has been increasingly promoted[153]. UNFPA has been a key partner and a leader in promoting integrated SRH and HIV programming and particularly supported the MoH in the development of the revised National SRHR/HIV and SGBV Integration Strategy (2017) which guides integrated programming, and resource mobilisation by stakeholders engaged in SRHR/HIV and SGBV programming.[154] It was reported that there were national level governance and coordination structures which included the Integration Technical Core Team comprising of membership from the AIDS Control Programme and Reproductive Health Units of MoH and UN agencies (UNFPA, WHO and UNICEF and UNAIDS); National SRHR/HIV Task Team and the National SRHR/HIV Stakeholder's Forum.

> *"Under the leadership of MoH, there are technical platforms to support coordination, promote adherence to standards and facilitate learning"*, said one KI respondent at the national level.

These national level governance structures supported the districts to implement the policy, strategy and operational guidelines on SRH/HIV/GBV integration. At the sub-national level, the implementation of SRH/HIV/GBV integration was still weak especially at health service delivery points due to low staffing levels for midwives and nurses.[155]

(f) Challenges in SRH/HIV integration:

The main challenges encountered in SRH/HIV integration[156] include the following:

- Protracted policy development and endorsement processes which in turn delayed the process of implementation of the developed policies
- Weak support for SRH under the Global Fund (GF) HIV component; 90 percent of the current GF HIV funding supports HIV commodities, which left limited funding for prevention activities
- Human resource capacity gaps for integrated services, specifically SGBV services at health facilities. Majority of the health workers were not trained on SGBV thus affecting the quality of services and evidence collection. Retention of the few who were trained was also a challenge. UNFPA supported and plans to continue to advocate and scale up establishment of regional mentorship teams stationed at regional referral hospitals in order to build the capacity of staff to deliver integrated SRH/HIV and SGBV services

4.2.2 Adolescents and Youth

4.2.2.1 The Intervention and Results logic for Adolescent and Youth Programming

The Strategic outcome 2 (Adolescents and Youth) had one output namely: Increased national capacity to conduct evidence-based advocacy/interventions for incorporating adolescents and youth SRH needs in national laws, policies, and programmes, including humanitarian settings.

This output focused on enhancing life skills and empowerment of young people; and SE for both in-school and out-of-school young people; and provision of adolescent-friendly health services

With regard to supporting life skills and youth empowerment, UNFPA used an *Innovation Accelerator* (Up Accelerate) programme, to support Ugandan youth to develop business solutions to address SRHR challenges in their community with seed funding, business training, technical guidance and mentorship. In addition, UNFPA supported, financially and technically, the *Creation of safe and support spaces for adolescents:* UNFPA supported the establishment of safe spaces and support groups for both in-school and out-of-school youth and adolescents. The safe and support spaces usually offer private and confidential meeting environment in which adolescents share or are equipped with correct knowledge on SRH including FP, and is often stocked with SRH products such as sanitary pads. In the same spaces adolescent girls are given basic training in financial literacy. Furthermore, in the safe spaces, adolescent boys are sensitized on menstruation and menstrual hygiene so that they could support female students and create a less stigmatizing environment at school. The safe spaces were

[153] WHO, UNFPA, IPPF, UNAIDS, and UCSF. 2009. "Sexual and Reproductive Health and HIV Linkages: Evidence review and recommendations." www.unfpa.org/sites/default/files/pub-pdf/linkages_evidence_2009.pdf
[154] UNFPA Annual Progress Report, 2018
[155] Environmental Scanning, Partner and Resource Mapping for Sexual and Reproductive Health/HIV/Gender Based Violence Integrated Programmes in Uganda, UNFPA January, 2019
[156] UNFPA Annual Report 2018.

also linked to health facilities and health workers. As such, through the safe spaces, adolescents had access to health professionals on SHRH information and services.

Participation in leadership and economic activities: A number of young people were also reached with life skills education and socio-economic activities, through school health and sanitation club activities, YSLA groups/girls socio-economic empowerment platforms among others

Sexuality Education (SE): During the year, UNFPA supported the development and mainstreaming the National SE Framework for both in and out-of-school youth, including mainstreaming SE into the national curricula for secondary schools and development of SE guidelines for out-of-school youth. UNFPA supported provision of quality, adolescent-friendly services, as part and parcel of an integrated health services (Strategic Outcome 1)

4.2.2.2 Evaluation of the Results and Intervention Logic for Adolescents and Youth Component

The theory of change underlying the adolescent and youth component, as outlined in the CPD is not properly based on a sound intervention logic. Although the statements for the strategic outcome and the single output were articulated well, the strategic outcome indicator is at low level and narrow as it reads: Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV. Although the C8P implementation period (2016-2020) is indicated in the introduction of the CP Business Plan, it would have been useful to indicate the end point/year in the outcome statement so that it is clear when the attainment of the outcome is expected. The linkages between activities for planned interventions for the output were clear and may lead to the achievement of the output indicators but when put together the results were equivalent to an increased capacity for evidence-based advocacy and interventions. There was no evidence of stated assumptions in both the CP Document and the CP8 Business plan which was a major omission.

The CO did its best to provide the human, financial, material and management resources which were required for the implementation of various interventions and eventual achievement of quality adolescent SRH and youth friendly services.

4.2.2.3 Achievement of Planned Results

Altogether, the evaluation assessed performance of 4 output indicators and the underlying interventions. Three out of the 4 (75 percent) output indicators met the defined targets while 1 (25 percent) did not. The details of the indicators, baseline and target values, key interventions and level of annual achievements are shown in Table 11.

The three output indicators which met the defined targets by the time of the CPE, related to provision of life skills for adolescent girls, SE and youth participation in decision making. Provision of ASRH through youth friendly services in health facilities was lagging below the set targets for 2019, even though judgement was based mainly on the number of health workers trained in provision of adolescent-friendly health services only.

Table 11: Summary of achievements for Adolescents and Youth

Strategic plan outcome 2 (Adolescents and Youth): Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.			
Outcome Indicators for CP8 Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV Baseline: 45; Target: 75			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q4 of 2018 against Output Indicator Targets**	**Remarks**
Output 1: Increased national capacity to conduct evidence-based advocacy/interventions for incorporating adolescents and youth sexual reproductive health needs in national laws, policies, and programmes, including humanitarian settings.			
Number of marginalised adolescent girls reached by life skills programmes that	Life skills and empowerment for very vulnerable young people	**Achievement:** 2016: T = Not set; Actual (A)= 277648 2017: T =343,972; A =400,760; Achieved; target	Signature indicator; target not

Strategic plan outcome 2 (Adolescents and Youth): Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.			
Outcome Indicators for CP8 Percentage of young women and men aged 15-24 years who correctly identify ways of preventing sexual transmission of HIV Baseline: 45; Target: 75			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q4 of 2018 against Output Indicator Targets**	**Remarks**
build their health, social, or economic assets with UNFPA support	out of school	exceeded by 17% 2018: T =410,296; A =496,100: Achieved; target exceeded by 21% 2019: T =476,620; Actual = 558,770[157]; Achieved, target exceeded by 12.6% et 2020: T =560,520; Actual	set in 2016
Number of participatory platforms that advocate for increased investments in adolescents and youth, within development and health policies and programmes. Baseline: 0; Target:3	Support platforms for youth engagement and participation	**Achievement:** Not yet 2019: T = 3; Actual = 5 functional youth groups; Target achieved	
Number of national curricula that integrate comprehensive sexuality education in line with international standards. Baseline: 1; Target: 4	Support school-based Sexuality Education Support sexuality education for out of school	**Achievement:** 2016: T 0; Actual0 2017: T 1; Actual 1[158] 2018: T 3;; Actual 2[159] 2019: T 3 Actual 4[160]; Achieved; exceeding target by one 2020: 4 = 1. Final integrated lower secondary school curriculum, 2. Teacher's training curricula integrating SE, 3. A Sexuality Education minimum package for the out of school young people, 4. Vocational Training Institutions model curriculum.	
Proportion of health facilities in target districts providing adolescent-friendly health services as per national protocol. Baseline: 100% hospitals and 45% health centres; Target: 100% hospitals and 100% health centres	Support development and implementation of supportive AYSRH policies/strategies	**Achievement:** 2016: T =54%: Actual =42%; below target 2017: T =66%: A =80%: Achieved exceeding target by 20% 2018: T =78%; A =65%: Not achieved 2019: T =78%: A =65%: Not achieved	

(a) Life Skills and Empowerment of Youth

UNFPA strengthened efforts towards empowerment of young people through asset building including social, education, health and economic assets as well as supporting mentorship activities for young people especially vulnerable adolescent girls in over 25 districts in the country.[161] In addition, UNFPA supported life skills training and empowerment of out-of-school youth through ELA clubs and supporting their re-entry into formal education.

> *"The ELA club members under BRAC have been empowered with knowledge about income generating activities (e.g. bakery, goat rearing, and beads); saving within groups",* reported FGD participants in Moroto town, Moroto District.

[157] UNFPA CO tracking report

[158] Draft SE framework

[159] Launch of SE framework, and integration of SE in secondary school curriculum

[160] SE materials, in addition to above; also, SE guidelines for out-of-schools

[161] UNFPA Annual Reports 2016, 2017, 2018.

These efforts greatly strengthened the ability of girls to be able to address challenges like teenage pregnancy, child marriage and GBV.

> *"The life skills about health life style has helped us (adolescent girls) to avoid early and forced marriages, GBV, FGM, HIV infections and substance abuse",* reported FGD participants in Amudat District.

There were on-going government agricultural/livelihood programmes such as Operation Wealth Creation (OWC), National Agricultural Advisory Services (NAADS), Youth Livelihood Programme (YLP), Uganda Women Empowerment Programme (UWEP) etc which were benefitting the youth among others.[162] UNFPA should support MoH and MGLSD to integrate SRH services into these programmes and there is a big opportunity of reaching many young people given their country-wide reach.

(b) Sexuality Education (SE)

The SE is aimed at empowering the young people of Uganda to be better prepared to prevent and protect themselves against infections (HIV, STDs and non-communicable diseases), sexual abuse, early sexual debut, teenage/unplanned pregnancies and school dropout; able to immediately respond, mitigate and get desired relief when they are infected, abused, engaged in unplanned early sexual activities; able to embark on recovery and rehabilitation of themselves to reduce the long-term effects of such dangerous experiences and return to an educational track. UNFPA undertook advocacy and capacity development to improve access to comprehensive sexuality education for in-school and out of school young people.[163] The process entailed engagements with multiple stakeholders, notably the MoES, MGLSD, various religious leaders, and the National Curriculum Development Centre (NCDC) on integration of comprehensive SE in the school based education curriculum in accordance with international standards. MoES finally took several steps towards institutionalising SE in higher schools, beginning with a landmark launch of the National SE Framework in 2018; and development of the SE Operational Guidelines in 2018, which guided all SE related work in the country.[164] Aspects of SRHR and GBV were integrated into the curricula for lower secondary classes (senior one to senior four). The development of resource materials (training guides) for teachers and SE package for pupils was in progress at the time of CPE. With support from UNFPA, MGLSD validated the SE guidelines for out-of-school young people, and the Youth Engagement Strategy on SRHR as well as harmonising the SE guidelines with the National Parenting Guidelines.[165] However, it was reported that the GoU met opposition from some religious institutions on the content of SE in schools.

> *"There is still a level of resistance from sections of faith based organisations, and di**ff**erences of opinion within the public on the age-appropriateness of information, content and terminologies meant for CSE in primary schools. There is need for continuous dialogue between UNFPA and MoES on one hand and the faith based organisations on the other to reach a common ground"*, said a KI at ministry level at the national level.

(c) .Adolescent Sexual Reproductive Health and Rights (ASRHR)

UNFPA facilitated the MoH to develop SRHR policy and this was approved and cleared by the Ministry of Finance, Planning and Economic Development (MoFPED) with an issuance of certificate of financial implication. The SRHR Youth Engagement Strategy was validated by the MGLSD Technical Working Group (TWG) pending approval by top management. The provision of integrated SRHR information and services to young people was meant to be through youth friendly services (YFS).

The CO supported interventions to build capacity for the provision and integration of YFS in the health facilities and schools.[166] UNFPA supported MoES and IPs to create SRHR responsive environments, strengthened menstrual health management by learners, safe spaces in schools to improve counselling support for learners and integration of SRHR in district school inspection tools. MoH built the capacity of health workers to deliver

[162] Ministry of Gender, Labour and Social Development: Annual Performance Report 2018.
[163] UNFPA Annual Reports 2016, 2017, 2018.
[164] UNFPA Annual Report 2018.
[165] UNFPA Annual Report 2018.
[166] UNFPA Annual Reports 2016, 2017, 2018.

youth friendly activities and conduct outreaches to reach young people in hard-to-reach communities. However, the provision of YFS was limited given the few youth friendly corners /spaces that existed in health facilities, schools and communities.

> *"Some studies in Uganda and elsewhere have shown that youth corners /spaces have been found to be very costly and the integration of YFS in routine health services is recommended",* said a KI respondent at the national level.

(d) Platforms for Advocacy and Decision Making

UNFPA continued to support social innovations, which were led by young people and aimed at improving and increasing access to SRHR information and services through the development of online and digital platforms for SRH/HIV learning and information. With UNFPA support, the GetIN and SafePAL mobile applications were scaled up in two districts and they reached out to pregnant girls who were supported to access maternal and post-partum FP using the mobile application. It was reported that the online and digital applications became a potential of reaching many young people with information on SRHR due to the technological advances and increasing use of social media.

> *"We use interpersonal communication to mobilise young people on community dialogues and social media. We know that social media is a huge online platform in terms of reaching young people with SRHR information"*, said a KI respondent at the national level.

***(e) Challenges*:** Some notable challenges experienced included the following:

- Resistance from religious leaders to the introduction and institutionalisation SE such that they continued to undermine SE by calling upon administrators of religious founded schools not to accept the rollout of SE. UNFPA continued to support the MoES to continue engaging religious leaders to reach a consensus on this issue
- There was a slow pace of implementation of upstream activities due the restructuring within the MoH. Nevertheless, this issue was sorted out after the appointment of a focal point on school health.

4.2.3 Gender Equality and Women's Empowerment

4.2.3.1 The Intervention and Results logic for Gender Equality and Women's Empowerment

EQ4: To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?

EQ5: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

Strategic outcome 3 (GEWE) had one output namely: National and district governments have the capacity for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings. The output interventions are as follows: (a) support behavioural change strategies for addressing gender-based violence, female genital mutilation, teenage pregnancies, and child and forced marriage; (b) support advocacy for integration of gender-based violence prevention and response, and human rights in sexual and reproductive health programmes; (c) advocate for enforcement of policies and laws on gender-based violence; (d) provide technical support to the Ministry of Gender, Labour and Social Development and civil society to develop and implement multi-sectoral service standards and protocols that meet human rights standards; (e) support the MGLSD and civil society to monitor implementation, track accountability and report on sexual and reproductive health and rights commitments in regional and international instruments, including by using the Gender Score Card.

4.2.3.2 Evaluation of the Results and Intervention Logic for GEWE

The CPE team noted that for GEWE, there was a clear strategic linkage between planned interventions and the outputs. The output and strategic actions generally contributed to the outcome. The evaluation identified areas for improvement in some measures used to track progress. Measurements of the functionality of national inter-

agency coordination body on GBV and FGM, and that of accountability, tracking, and reporting systems to follow-up on reproductive rights obligations were stated as categorical; requiring only "Yes" or "No" as the only options. These categorical measurements fell short of clearly defining the quality, of processes and parameters of what constituted a functional coordination and accountability system. Similarly, although the outcome indicator: "percentage of women aged 15-49 years who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances" was relevant and aligned to DHS indicators, it was limited to largely capturing physical violence yet the CP8 conceptualized GBV to broadly encompass several forms including sexual, emotional and economic violence. CP8 also and particularly the programmes used to operationalize it drew clear linkages between GBV and harmful practices such as early and child marriage. This outcome indicator did not also provide the opportunity to measure the dynamics of power relations (power analysis) inherent in participation of women in making important decision making including those that affected their SRHR. Furthermore, although in the investment plan, the breakdown of interventions was more exhaustive in relation to gender equality and GBV in particular, apart from the indicator on FGM declarations, the output indicators in the Table 12 on GEWE did not clearly state indicators on social norm change indicators. The only indicator on social norm change in relation to GBV was therefore at outcome level and none at the output level.

4.2.3.3 Planned results and Achievements under GEWE

On the whole, as evidenced by the data showcased in Table 12, with regard to the performance of the output indicators, the majority (3 out of 4) of the output indicators under GEWE were achieved at 100 percent with one of these indicators; "number of national SRH plans, policies and programmes integrating gender-based violence prevention, protection and response interventions" over achieved (150 percent). Key informants attributed this to the implementation of the country programme in a participatory government-led process involving strategic partnerships with key government MDAs.

However, the output indicator on FGM community declarations targets for the year 2017 2018 and 2019 was not met. Target was fully achieved in 2016 (only... Achievement of the targets may have been affected by the reported surge in cases and change in practices (e.g. cross border and secrecy in carrying out FGM in hiding). Stakeholders attribute this to lack of consistent funding of FGM programming that affected the level and intensity of sustained social mobilisation and social norm change. Consistent, sustained funding and technical assistance for FGM abandonment campaigns and social norm change is critical to avoid relapses and push back.

Table 12: Summary of Achievements for GEWE

Strategic plan Outcome 3 (Gender Equality and Women's Empowerment): Advanced Gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youths			
Outcome Indicators for CP8 Advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. Percentage of women aged 15-49 years who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances. Baseline: 60; Target: 4			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q4 of 2018 against Output Indicator Targets**	**Remarks**
Output 1: National institutions and district governments have capacity for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings			
Existence of a functioning accountability, tracking and reporting system to follow up on the implementation of reproductive rights recommendations and obligations. Baseline: No; Target: Yes	Support the MGLSD and civil society to monitor implementation, track accountability and report on sexual and reproductive health and rights commitments in regional and international instruments, including by using the Gender Score Card. Advocate for enforcement of policies and laws on gender-based violence	**Achievement:** 2016: T = Yes; Actual =Yes; Achieved 100% 2017: T = Yes; Actual =Yes; Achieved 100% 2018: T = Yes; Actual =Yes; Achieved 100% 2019: T = Yes; Actual =Yes; Achieved 100%	

Strategic plan Outcome 3 (Gender Equality and Women's Empowerment): Advanced Gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youths			
Outcome Indicators for CP8 Advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. Percentage of women aged 15-49 years who think that a husband/partner is justified in hitting or beating his wife/partner under certain circumstances. Baseline: 60; Target: 4			
Output Indicators, Baseline and Targets	**Key Interventions**	**Achievements by Q4 of 2018 against Output Indicator Targets**	**Remarks**
Number of national sexual and reproductive health plans, policies and programmes integrating gender-based violence prevention, protection and response interventions. Baseline:2; Target: 4	Support advocacy for integration of gender-based violence prevention and response and human rights in sexual and reproductive health programmes	**Achievement:** 2016: T = 4 sector plans integrate the programme areas of GBV and RR in all the sectors (MoH, MGLSD, MOES, JLOS Police, UPDF, and FBO consortium); Actual =7; Achieved 175% 2017: T = Not set 2018: T = Not set 2019: T = 11; Actual 11; achieved	
Existence of a functioning national interagency coordination body on gender-based violence and female genital mutilation, including in humanitarian response. Baseline: No; Target: Yes	Provide technical support to the Ministry of Gender, Labour and Social Development (MGLSD) and civil society to develop and implement multi-sectoral service standards and protocols that meet human rights standards	**Achievement:** 2016: T = Yes (coordination mechanism integrates all aspects of GBV, FGM & GB in emergencies) 2017: T = Yes; Actual =Yes; Achieved 100% 2018: T = Yes; Actual =Yes; Achieved 100% 2019: T = Yes; Actual =Yes; Achieved 100%	
Number of communities supported by UNFPA that declare the abandonment of female genital mutilation. Baseline: 51; Target: 100	Support behavioral change strategies for addressing gender-based violence, female genital mutilation, teenage pregnancies and child and forced marriage	**Achievement:** 2016: T = 15; Actual =15; Achieved 100% 2017: T = 35; Actual =20; Achieved 57% 2018: T = 55; Actual =33 Achieved 60% 2019: T = 75; Actual = 46; Not achieved	

4.2.3.2 Achievements of strategic outcomes under GEWE

There is evidence to show that the programme contributed to the outcome indicator for the CP8, that is "advanced gender equality, women's and girls' empowerment and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth." The evaluation of the bridging phase of Joint Programme on GBV (JPGBV) reported a reduction in percentage of women who approved of wife beating, from 29 percent to 21 percent in Karamoja and 27 percent to 15 percent in the Northern region.[167] Qualitative evaluation findings showed some changes in norms that justify and normalize wife beating. Some sections of the communities understood that wife beating as a form of violence and not a mechanism of disciplining.

> *"In the past men and women used to have disagreements and these were being solved through violence. Men had that thinking that they should punish the women for what they have done. But now, men think of other means of resolving their differences, they have come to learn that when they beat their wives, they are harming them… it is not a punishment as they earlier thought"*, reported FGD participants from community activists, Moroto District.

The programme has made significant contributions to transformation of attitudes, values, norms that perpetuate GBV, FGM, and, child and forced marriage. Community level discussions revealed that men were adopting gender equitable practices specifically balancing power in relationships, shared decision making, and decrease in control over their partner's choices. Sections of the community disassociated FGM to marriageability of girls. Some families supported adoption of alternative rites of passages to adulthood, specifically attending school. Field discussions revealed awareness on FGM and its consequences and that some people stopped engaging in FGM.

[167] United Nations Joint Programme on Gender Based Violence Evaluation of the Bridging Phase Report 2017.

> *"The community members now know the complications brought about by FGM among girls including difficulties in childbirth, excessive bleeding after FGM which can lead to death",* reported during an FGD session for adult men, Moroto District.

> *"Since the introduction of SASA activities, there has been a noticeable reduction in cases of GBV for example, beating of wives, quarrelling and FGM practice…The community members know the dangers of GBV and the complications brought about by FGM among girls…and communities are aware about the law on prevention of FGM. There has been a reduction of cross-border FGM, that is girls crossing into Kenya for 'cutting' ",* reported during an FGD session for SASA community activists, Moroto District.

Similar findings were reported by a 2016 Uganda Bureau of Statistics study that indicated a decrease in the prevalence of FGM from 50 percent to 13 percent in Sebei region and from 95 percent to 67 percent in Karamoja region. Sections of the community attributed obstetric complications to FGM.

To achieve the above shifts, the programme utilized effective evidence-based strategies for the prevention of GBV and other harmful practices such as male involvement, and community social mobilisation. Under male involvement, the programme supported formation of community level male engagement structures such as Male Action Groups (MAGs), Role Model Men (RMM). For example, in 2017 and 2018 development years, UNFPA and partners established 115 MAGs under the Women Adolescents and Youth Rights and Empowerment (WAY) programme inclusive of young men and boys. These played a critical role in raising awareness on and promoting healthy and safe relationships and communities for women and girls.

> *"Some men have learnt the value of sharing domestic roles, taking children to school through SASA activities",* reported by adult men during an FGD session, Moroto District.

> *"Men have learnt to control their anger (GBV) while at home and how to approach wife and children in a friendly way",* reported by adult men during an FGD session, Kyegegwa District.

While this strategy made numerous contributions, UNFPA had not fully tapped into opportunities for working with men. There are several best practices that have been demonstrated as effective in Uganda in engaging men in prevention of GBV including "REAL Fathers", an effective, mentoring initiative to build young fathers' positive parenting practices and prevent men's violence in the home. The REAL Fathers Initiative is a culturally informed, tested intervention in Northern Uganda and Karamoja to prevent intimate partner violence, improve couple communication, prevent violence against children and improve parenting[168]. REAL Fathers Initiative targets young fathers aged 16 to 25 years with toddler children aged 1 to 3 years enrolling them into a mentorship programme lasting six and seven months.[169]

CP8 was heralded by stakeholders for adopting and scaling up models that have been tested and found to be effective in community mobilisation to reduce intimate partner violence particularly SASA![170], public denunciation of FGM, music dance and drama (MDD), multi media campaigns, community dialogues were utilized to build a critical mass of the population addressing GBV, FGM, and child and forced marriage. These were largely delivered by trained community volunteers, including SASA! community activists (CAs), peer educators, mentors, and cultural and religious leaders. These were also empowered to develop cultural gender principles that align with gender equality and non-discrimination and update referral systems to allow for case management in traditional courts. As a result, the Karimajong Gender Principles Book and Acholi Gender Principles Booklet were produced.

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[168] REAL Fathers Endline Report. December 2018. Washington, D.C.: Institute for Reproductive Health, Georgetown University, and Save the Children for the U.S. Agency for International Development (USAID).

[169] The REAL fathers Initiative implemented by Georgetown University aimed to reduce IPV and harsh punishment of children among young fathers in post conflict Northern Uganda through a mentoring programme. An impact evaluation (RCT) found reductions in both IPV and physical child punishment.

[170] SASA! was evaluated using a community cluster randomised trial which ran over four years from 2008-2011 and found to be effective at reducing violence physical partner violence, as well as reducing the social acceptance of physical and sexual violence in intimate partnerships.

Music, dance and drama, and games and sports in FGM prevalent districts were effective at attracting young people in and out of school.[171] This builds on existing evidence that underscores the utility of theatre in addressing myths and influencing behavior.[172] Community dialogues were equally effective since agreed upon actions informed development of Actions Plans with clear responsibility centres that were to be held accountable for results. Community resource persons, specifically SASA! change agents created peer support groups that have since evolved into multi-purpose initiatives for "improving socio-economic wellbeing and maintaining the momentum as GBV change agents".[173]

Public declaration against FGM was reported as a key contributor to abandonment of FGM. These were preceded by inclusive dialogue processes to ensured community buy-in. Key informants revealed that this contributed to sustenance of commitments made. The engagement of key community leaders, the public celebration of the declaration in presence of government officials and high profile supporters were also critical in influencing individuals to accept abandonment of FGM. UNFPA progressively moved towards achieving its target of number of communities declaring FGM abandonment with 68 out of 100 (68 percent) communities, which openly made such declarations. Notwithstanding this achievement, it fell short of the targets. Some key informants reported that there was a surge in the prevalence of FGM in some communities in the 2019 and this could be attributed to particularly the short-term nature of interventions, limited scope and geographical coverage, and lapses in funding for activities.

> *"We have been supporting communities to abandon FGM, however this year we have seen a resurgence of the practice",* said a key informant at the national level.

Field discussions indicated that the changes in practices around FGM and inconsistent funding affected sustained awareness and social mobilisation required for social norm change. Similar findings have been reported elsewhere.[174]

While the use of community social mobilisation strategies resulted into important shifts in attitudes and behavior, the evaluation and monitoring reports identified gaps in implementation of evidence-based models that constrained realization of more concrete results. The inadequate time and funding (including in some cases inconsistent funding) for programming affected reaching universal coverage or coverage needed to at least reach the critical mass required to spur social diffusion and create a social movement. This also affected the level of adherence to collective principles for social norm programming, including systematically working across the socio-ecological model and change matrix, using an intersectional, gender power analysis, ensuring sustained commitment, and supporting and investing in staff and community activists or facilitators.[175] This had a direct effect on fidelity to the approaches and has the potential to constraining social diffusion.[176]

Given that inadequacy of funds remained a challenge, UNFPA CO could benefit advocating for the use of evidence based approaches that attract use of considerably less resources. For example, Indashyikirwa model brings together recent learning in the field of GBV prevention targeting couples in the communities. The model provides 22 total sessions with each session taking three hours. A quantitative impact evaluation of the model showed that women who participate in the Indashyikirwa couples' curriculum, compared to women in the control group, experience a significant reduction in experience of physical and/or sexual Intimate Partner Violence (IPV) at both the interim 12-month point and the final 24-month outcome measure. Men who participated in the

[172] UNFPA & UNICEF 2017. Lessons from the field. Companion Booklet to the 2016 Annual Report of the UNFPA-UNICEF Joint Programme to End Female Genital Mutilation/Cutting: Accelerating Change Phase I and II (2008–2017)
[173] Good Practices under the UNJPGBV
[174] Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation: Accelerating Change Phase I and II (2008–2017)
[175] Community for Understanding Scale Up (CUSP). (2017). On the cusp of change: Effective scaling of social norms programming for gender equality.
[176] Community for Understanding Scale Up (CUSP). (2017). On the cusp of change: Effective scaling of social norms programming for gender equality.

couples' curriculum also reported significantly reduced perpetration of physical and/or sexual IPV compared to men in the control group, at both the interim 12-month assessment and with a significant intervention effect sustained at 24 months.[177]

Furthermore, UNFPA to some extent systematized or standardized the scale up of evidence-based approaches. However, the CP8 implementation did not made optimal use of the contributions of the ExpandNet framework on scale up.[178] The framework provides a conceptual framework, parameters and systematic steps for scale up interventions that have demonstrated effectiveness.

Public denunciation of FGM has been a key strategy for eliminating FGM. However, there was limited emphasis on supporting communities to fulfil and sustain their commitments. Key structures such as monitoring networks and committees who played a key role in countries like Burkina Faso in sustaining the community commitment to abandoning FGM[179] were not tapped into or adapted to work in the Uganda context.

UNFPA's multi media campaigns were effective in targeting several audiences. However, interactions with IPs and key informants revealed that there were inadequate efforts meant to ensure that all campaigns were as a norm and best practice informed by formative studies. Furthermore, the evaluation found that the messages were skewed towards awareness raising for behavioral change and not strong on building community level social movements that hold duty bearers and government accountable for provision of survivor centered services. The reach of print and visual media remained limited, specifically in some districts of Karamoja. Some campaigns were one-off. Evidence elsewhere has shown that one-off awareness campaigns are ineffective.[180]

Several stakeholders appreciated the active involvement of cultural and religious structures and noted that it was contributing to prevention efforts. However, it was noted that cultural structures such as the Karamoja Elders Association (KEA) contribution was sub-optimal because they did not have district specific structures, no clear work plan/activities and consistent budget to enable them engage with the Kraal leaders and elders in the affected districts. Similarly, religious leader's engagement was rated positively as a good practice. It was also noted in discussions at DLG and community level that the programming with religious leaders needed to be systematically structured with clear work plans, targets, deliverables, budgets and mechanisms to hold them accountable for results.

The 8th CP made contributions towards the strengthening of policy, legal, and accountability frameworks on GEWE. This contribution was through supporting processes meant to develop and or revise existing laws or policies. For example, in 2017, UNFPA supported a research on the Drivers of GBV in Uganda and results informed the amendments of the National Elimination of GBV Policy and its associated Plan. The policy provides a systematic framework for all efforts towards GEWE, human rights, male engagement, multi-sectoral approach, and integrative programming. UNFPA also provided technical and financial assistance to MGLSD to develop the National Male Involvement Strategy for the Prevention and Response to GBV (2017), which deliberately seeks to harmonize and guide activities and models for male engagement in prevention and response to GBV. In 2016, the MGLSD was supported to develop a Multimedia Strategy against Gender Based Violence (2016) meant to promote and sustain community participation in the prevention of GBV.

Furthermore, UNFPA supported the implementation of relevant laws and policies on gender equality and women empowerment through training of duty bearers and producing simplified versions of the laws, specifically the Anti-Female Genital Mutilation Act (2010). In the 2016 development year, 994 newly elected district counselors, 238 cultural leaders, 102 religious leaders, 74 district technical staff were trained on the correct application of relevant laws on GBV and their roles and responsibilities. Field discussions and monitoring reports showed improvement

[177] Kristin Dunkle, Erin Stern, Sangeeta Chatterji, and Lori Heise (2019). Indashyikirwa programme to reduce intimate partner violence in Rwanda: Report of findings from a cluster randomized control trial. http://careevaluations.org/wp-content/uploads/Indashyikirwa-evaluation.pdf

[178] WHO & EXPANDNET (2010). Nine steps for developing a scaling-up strategy

[179] UNFPA & UNICEF 2017. 17 was to end FGM. Lessons from the field. Companion booklet to the 2016 Annual Report of the UNFPA-UNICEF Joint Programme to End Female Genital Mutilation/Cutting: Accelerating Change.

[180] Fulu, Kerr-Wilson et al (2014); Arango et al (2014)

in legal literacy among the population, improved the application and interpretation of the laws by statutory actors, and deterrence from perpetration of violence and engagement in harmful practices like FGM.

There were still gaps in the legislations that impact on realization of gender equality and women economic empowerment. For example, neither the Penal Code nor the Domestic Violence Act (DVA) currently criminalizes marital rape. The DVA only considers persons in a "domestic relationship" with a perpetrator to be potential victims of "domestic violence"[181]. The Succession Act only permits widows of men who die intestate to inherit 15 percent of their deceased husband's estate (and homestead). The Employment Act limits sexual harassment to an employer or his representative and does not recognize physical, sexual and verbal abuse by co-workers. Similarly, the provisions on "spousal consent" in the Land Act fall short of recognizing co-ownership of land between spouses, which would permit women to control family land alongside their husbands.[182] There were bills aimed at women empowerment and gender equality that stalled over the years without being passed by Parliament e.g. the Marriage and Divorce Bill (2011) and the Sexual Offences Bill (2011).

UNFPA's engagement with MGLSD and civil society strengthened implementation of multi-sectoral interventions. This was achieved through developing multi-sectoral initiatives such as Spotlight Initiative to Eliminate Violence against Women and Girls, funding multi-sectoral GBV coordination at national and select DLGs, supporting development of multi-sectoral guidelines and protocols, and funding multi-sectoral mechanisms such as GBV shelters and special GBV court sessions.

Some of the concrete outcomes included a functioning national inter-agency coordination body on GBV and FGM, integration of GBV in seven sector plans such as that of the MoH, MGLSD, MoES, JLOS, and Uganda Peoples Defense Forces (UPDF). In 2016, thirty-two target districts integrated GBV in their development plans and half of these districts allocated funds for implementing GBV/FGM activities. However, the ET team did not find evidence on the release of the allocated funds. There was limited change in budgeting structures and modalities of implementation of MDAs. Consequently, some MDAs continued to operate in silos. MDAs and IPs lacked the requisite capacity to coordinate multi-sectoral efforts. There were parallel and a t times competing coordination structures. Multi-sectoral efforts were limited by the absence of an integrated and comprehensive data system on GBV and other harmful practices. Although there were concrete plans under the Spotlight Initiative GBV programme to address these gaps, they were still in process and had not yet impacted on the data systems. Also, collaborations with non-GBV traditional sectors for example Ministry of Water and Environment (MWE), Ministry of Agriculture, Animal Industries and Fisheries (MAAIF), Ministry of Energy and Mineral Resources among others were limited yet these ministries are strategic entities in terms of addressing some of the drivers and risk factors for GBV. Furthermore, accountability mechanisms for ensuring adoption of multi sectoral programming particularly to hold top management of ministries accountable were non-existent. There was no clear structure that could hold top management particularly Permanent Secretaries (Chief Accounting Officers for ministries) to ensure compliance to multi-sectoral programming for GBV and harmful practices. Such a structure could be located at the level of the Prime Minister's Office that has the mandate to hold top management of ministries accountable because all permanent secretaries of relevant ministries are at best at the same level.

While the CP8 championed multi-sectoral response to GBV, guidance on implementation of this framework remained limited in some aspects. For example, within JLOS, efforts to counter the backlash that survivors and witnesses experienced following participation in special court sessions were inadequate. Although special court sessions resulted into positive outcomes, it was reported that they were not been effective in deterring repeat perpetration due to lenient punishments.

> *"Many people got community service as a penalty; this is not enough to deter the practice",* said a key informant respondent at the national level.

The participants recognized the importance of GBV shelters that were put in place in the different target districts. However, they argued that they were limited to a few districts which undermined cross sectoral referrals and

[181] See McLean L and Bukuluki P. (2016). Uganda GBV Diagnostic Report for the World Bank. Kampala, Uganda.
[182] McLean L and Bukuluki P. (2016). Uganda GBV Diagnostic Report for the World Bank. Kampala, Uganda.

protection from further harm. The evaluation noted that there was limited investment in programmes meant to support reintegration of survivors of violence from shelters to the community.

> *"GBV survivors need safe, functional spaces that provide comfort. Currently this is not the case. This limits the level of protection to the survivors",* reported a key informant respondent, Moroto District.

The programme has supported the MGLSD and civil society to monitor, report and track accountability towards global norms on gender equality and women empowerment. This was through preparation and presentation of reports on the implementation of international instruments and national legislations such as UN Secretary General's report on FGM[183], development of accountability tracking tools such as the Accountability Tracking Tool for Human Rights Based Approach, drafting of responses to Country Reports on global norms, and trainings on monitoring systems for example the FGM online global monitoring system. As a result, the different reports on gender equality commitments informed the development of the MGLSD 2016-2020 Social Development Sector Plan. Despite progress realized, there were challenges to address particularly with community level oversight and accountability mechanisms. The beneficiaries lacked the requisite information and competency to demand for accountability for their rights and services.

The programme has strengthened data systems on GBV and other harmful practices. This was achieved through harmonizing and integrating the different databases that collect data on GBV and other harmful practices. For example, UNFPA supported efforts to redesign the Uganda SAUTI Helpline to handle both GBV and VAC cases. It also initiated efforts of linking the GBV MIS in refugee settlements to the National Gender Based Violence Data Base (NGBVD). UNFPA has also strengthened data systems through extending the reach of management information systems, specifically the NGBVD and supporting data analysis and its utilisation. As of November 2018, the NGBVD had been extended to 99 districts out of 124. Actors in 36 districts had been trained on the case management component of the NGBVD.

While there was progress, there were still gaps to be addressed. The NGBVD had not achieved universal district coverage. There were challenges related to compatibility and linkages to other databases and information management systems e.g. GBV cases reported at health facilities were not captured by the NGBVD. This calls for the development of a multi-sectoral data set. In addition, efforts to analyse and disseminate data to inform policy and programming remained inadequate.[184]

UNFPA has strengthened GBV response services particularly in refugee settlements.
The agency contributed to delivery of medical, mental health and psychosocial support (PSS), legal and justice, and safety and security services. This was achieved through development or strengthening of referral pathways, training of the health care workforce and security personnel, supporting safe spaces for women and girls such as GBV shelters, and pilot testing special court sessions.

Several achievements were realized. In 2018, 1754 SGBV survivor's in refugee settlements accessed quality life-saving care services with 56 percent receiving appropriate clinical care within 72 hours. UNFPA facilitated the procurement of health system supplies, including delivery beds, emergency reproductive health kits, and dignity kits. In the 2018 development year, forty service delivery points in refugee settlements were supported to provide clinical management of rape services. In emergency settings still, ninety personnel were trained on MISP.[185] In 2018, 14 special court sessions were held where 875 cases were cause listed, 788 cases disposed, while 37 cases were adjourned to most convenient sessions in 2019.

Field discussions indicated improved awareness and change in practices related to GBV in settlements. This was an indication that the programme was succeeding in changing knowledge, attitudes and practices at the community level.

[183] UNFPA 2018 Annual Report – Uganda
[184] The Denmark/Uganda Country Portfolio Performance Review
[185] UNFPA Country Office Annual Report, 2018

> *"The women have been empowered with knowledge about their rights and can relate well with their spouses; the cases of forced sex among spouses has reduced. …They have done counselling of people in the community especially people who prepare alcohol and those who consume it and as a result the production of alcohol has reduced significantly. The behaviour and attitude towards other people has significantly changed such that there is peaceful co-existence regardless of the differences in tribes",* reported by adult women during an FGD session, Mireiyi refugee settlement, Adjumani District.

Although progress was made, the evaluation identified several challenges and or gaps. Discussions with stakeholders revealed that there was a limited number of qualified professionals to handle psychosocial needs of survivors. Where Psychosocial Support (PSS) was provided, it did not adequately involve deeper therapeutic engagement to facilitate healing, empowerment and recovery. The capacity to diagnose and manage GBV-related trauma remained low.[186] In regard to referral, access to referral points remained a challenge due to the distance and costs involved. Linkages between health care facilities and community based services department of DLGs remained weak. Furthermore, effectiveness of accountability and feedback mechanisms was sub-optimal.

The CP8 has facilitated women and adolescent girl's empowerment. This was achieved through supporting innovations that provide effective solutions to women and girls empowerment such as ELA clubs and Farmer Field and Life Skills schools. FGDs with ELA club members and mentors revealed improvements in livelihoods, life skills, awareness of GBV and menstrual hygiene practices.

> *"The ELA club members have been empowered with knowledge about income generating activities (e.g. bakery, goat rearing, and beads, saving within groups, good customer care)… We now know the value of FP, menstrual hygiene and prevention of HIV; dangers of rape and GBV and their prevention",* reported by FGD participants from ELA clubs, Moroto District.

> *"The club activities will continue since members have got the knowledge and skills for making the books and selling them",* said FGD participants from an ELA club, Iganga District)

> *"Our members reported reduction of cases of early and forced marriages and GBV. The life skills about health life style have helped girls to avoid FGM, HIV infections, alcohol and substance abuse. The ELA members have got knowledge about financial literacy which has improved their handling of money within homes",* reported by FGD participants from an ELA club, Amudat District.

> *"The programme has changed lives in the communities since cases of GBV are now being handled and the number is reducing",* reported FGD participants from mentors of ELA clubs, Mireiyi refugee settlement, Arua District.

Evaluation reports provided evidence on significant improvements in the lives of women and adolescent girls following participation in the empowerment programmes. For example, an end of project evaluation for the Better Lives for Girls project found that girls who had participated in ELA clubs had improved access to SRHR information. The access had increased from 77 percent at baseline (2016) to 84.8 percent in 2019, exceeding the target of 81 percent. At the same time, utilization to SRH services increased from 19 percent at baseline to 27 percent in 2019. There was a statistically significant reduction in prevalence of teenage pregnancy from 7 percent at baseline (2016) to 3.9 percent in 2019, far better than the target of 6 percent.[187]

[186] Also see World Bank (2019). Assessment of Gender Based Violence and Violence Against Children Prevention and Response Services in Uganda's Refugee-Hosting Districts. World Bank, Kampala.
[187] Evaluation for Better Life for Girls Project, 2019

Empowerment and Livelihood for Adolescents (E LA) club girls during a session in a Manyata, Karamoja Region. Photo by UNFPA/Uganda.

4.2.4 Population Dynamics

4.2.4.1 The Results and the Intervention Logic for PD Component

Strategic outcome 4 (PD) has one output namely: National institutions and district governments have the capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings. The output interventions focused on the following: (a) providing technical support and logistics to ministries and local governments to generate, communicate and utilize evidence for planning and decision-making; (b) providing financial support to the Uganda Bureau of Statistics and research institutions to generate evidence through in-depth analysis of survey and census data; mapping demographic and geographic disparities and prepare for the 2020 census; and (c) strengthening management information systems for health, education, gender-based violence, vital statistics and humanitarian crisis profiling.

4.2.4.2 Evaluation of the Results and Intervention Logic for PD Component

The strategic outcome and the output of the PD component were coherent and well-focused with baseline and measureable targets and achievements as well as SMART indicators. The theory of change for this component was based on a comprehensive intervention logic. Similar to the observations made earlier in this report, although the implementation period of the 8th CP that is, 2016-2020 was provided in the introduction of the CP Business Plan, it would have been prudent to indicate the end point/year in the outcome statement so that it is clear when the attainment of the outcome is expected. It is observed that the relationships between activities for planned interventions for the output were clear. This was similarly observed with respect to the linkages between the output and the outcome. The measurement indicators articulated in the indicator framework were sufficient to measure the progress made with regard to PD. During the implementation period, two indicators were added to the indicator framework for the PD component, one focusing on the DD and another on the Atlas dashboard. These additions helped to improve the measurement capability of the indicator framework. The strategic interventions with regard to the PD component were to support ministries and local governments to generate, communicate and utilise evidence for planning and decision-making, support the Uganda Bureau of Statistics and research institutions to generate evidence through in-depth analysis of survey and census data; mapping demographic and geographic disparities and prepare for the 2020 census and third to strengthen management information systems for health, education, gender-based violence, vital statistics and humanitarian crisis profiling.

The data in Table 13 provides the summary of achievements under the PD component of the CP8.

Table 13: Summary of Achievements for PD

Strategic plan outcome 3 (Population and Development): Strengthened national policies and international development agendas through integration of evidence based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and Gender equality.		
Outcome Indicators for CP8 Number of national, sectoral and district plans that fully integrate population dynamics. Baseline: 15; Target: 30		
Output Indicators, Baseline and Targets	**Key Intervention (broad activity)**	**Achievements by Q4 of 2018 against Output Indicator Targets**
Output 1: National institutions and district governments have capacity for production and use of disaggregated data on population, sexual and reproductive health and gender-based violence, for formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings		
Number of functional national and district data management systems that allow for mapping of demographic and geographic disparities and socioeconomic inequalities.	Strengthen management information systems for health, education, gender-based violence, vital statistics and humanitarian crisis profiling.	**Achievement:** 2016: T = 2 (IMIS, NGBVD); Actual =2; Achieved 100% 2017: T = 3 (IMIS, NGBVD, HMIS); Actual =3; Achieved 100% 2018: T = 5 (IMIS, NGBV, HMIS, CRVS, EMIS); Actual = 5; Achieved 100% 2019: T = 6 (IMIS, NGBV, HMIS, CRVS, EMIS, LOGICS); Actual = 5 (IMIS, NGBV, HMIS, CRVS, EMIS); Achieved 83%
Number of in-depth analytical reports on sexual and reproductive health and youth-related themes from census and survey data.	Support the Uganda Bureau of Statistics and research institutions to generate evidence through in-depth analysis of survey and census data; mapping demographic and geographic disparities and prepare for the 2020 census.	**Achievement:** 2016: T = 1; Actual =1; Achieved 100% 2017: T = 2; Actual =4; Achieved 200% 2018: T = 2; Actual =4; Achieved 200% 2019: T = 3; Actual =4; Achieved 133%
Proportion of humanitarian crises in which assessments reflect adequate population, sexual reproductive health and gender based violence data profiling.	Provide technical support to use data in planning in humanitarian settings.	**Achievement:** 2016: T = 50%; Actual =0; Achieved 0% 2017: T = 60%; Actual =100%; Achieved 167% 2018: T = 60%; Actual =100%; Achieved 167% 2019: T = 60%; Actual =100%; Achieved 167%
Demographic dividend is mainstreamed and implemented at national and sub-national level (Existence of national development plans which explicitly integrate demographic dynamics, including changing age structure, population distribution and	Implement DD using multi-sectoral approach.	**Achievement:** 2016: T = 4; Actual = 4; Achieved 100% 2019: T = 8; Actual = 8; Achieved 100%

Strategic plan outcome 3 (Population and Development): Strengthened national policies and international development agendas through integration of evidence based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and Gender equality.		
Outcome Indicators for CP8 Number of national, sectoral and district plans that fully integrate population dynamics. Baseline: 15; Target: 30		
Output Indicators, Baseline and Targets	**Key Intervention (broad activity)**	**Achievements by Q4 of 2018 against Output Indicator Targets**
urbanization).		
Existence an up-to-date data system (Atlas/dashboard) for mapping out or illustrating vulnerability at district level and below.	Support the development of a system to enhance access to disaggregated population data.	**Achievement:** 2016: None 2019: T = 12; Actual = 12; Achieved 100%[1]

1 = Available 12 Costed Implementation Plans (CIPs) in districts; popularised in Thematic Working Groups (TWGs) and disseminated in various platforms.

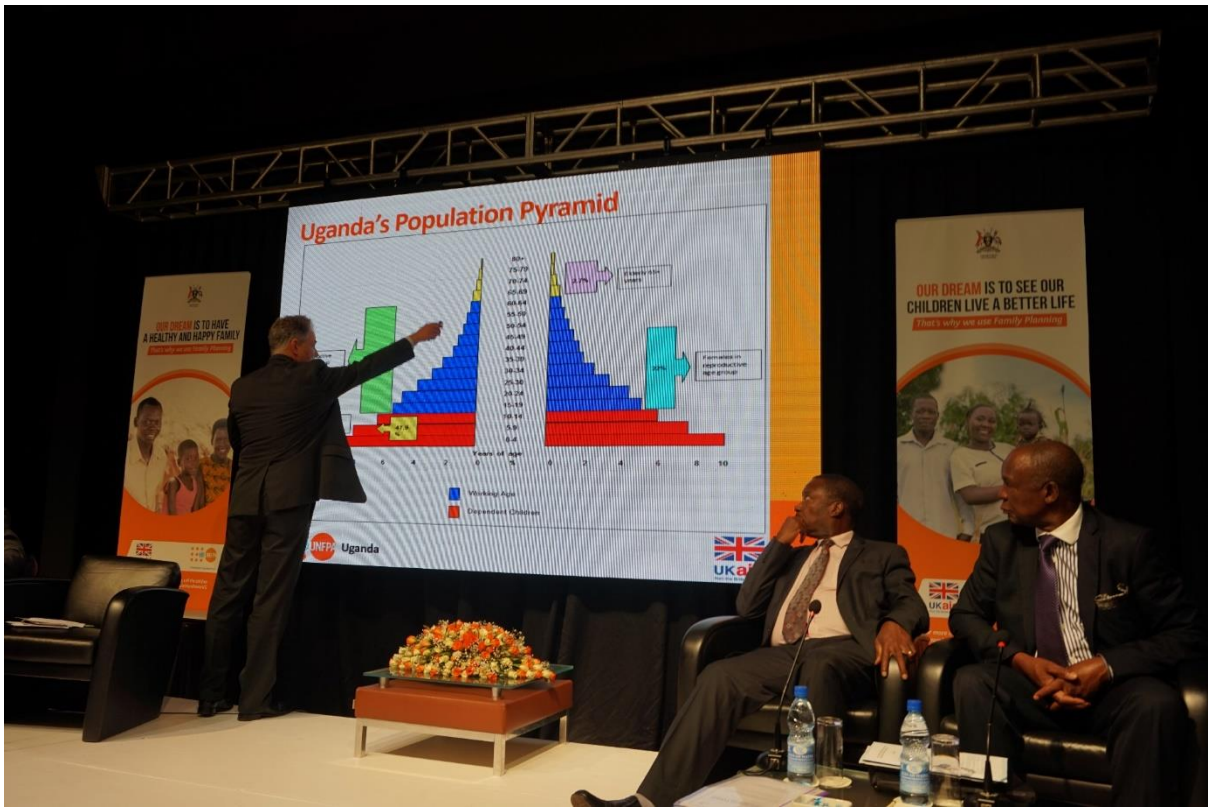
4.2.4.3 Achievement of Planned Results

The most central achievement for the PD component in the review period was work around the DD. In this regard, UNFPA supported the GoU to provide evidence on required investments for harnessing the DD. Based on the evidence from the census (2014), the UDHS (2016) and the Uganda National Household Survey (2016/17), the DD roadmap was launched during 2018. UNFPA through the National Planning Authority and National Population Council supported the modelling of the DD. Managing the youthful population in Uganda requires that the DD and structural change are harnessed to drive more rapid and sustainable economic growth. The modelling shows that Uganda's demographic indicators and emerging economic opportunities can be turned into a sizeable DD that can propel the country to achieving the socioeconomic transformation envisaged in Vision 2040.

Further to this work, UNFPA supported the development of the DD compliance tools. The DD compliance tools were used to assess compliance of sectors and districts in integrating DD indicators in the national, sector and district planning and budgeting frameworks. The districts that complied were issued with certificates of compliance for the implementation of the DD. In this regard, during 2019 the district compliance ranged from 46 percent to 68 percent. In the same vein, sector compliance to the integration of DD indicators ranged between 65 percent and 89 percent. This was evidence that the DD had been institutionalized in national planning and budgeting frameworks. In support of the initiatives around the DD, the following were achieved during the review period:

- In-depth analysis of data from existing datasets such as census 2014, UDHS and UNHS to model the contribution of SRH to harnessing of the DD. The purpose of these reports was to provide evidence for the DD in Uganda. The reports were widely used by all stakeholders including national government, districts and CSOs
- Modelling the contribution of FP to the SDGs. These reports showed the importance of closing the gap in unmet need for FP towards the realization of SDG goals and targets. Access to FP was a critical component of reproductive rights. Family planning also provided multi-faceted benefits to women and their families. In addition, it was also realized that FP was the first pillar of the DD
- In addition, an SDG dashboard was developed to monitor performance of the targets
- UNFPA supported the development of the National Costed Implementation Plan for FP and district FP-CIPs
- FP was the first pillar of the DD, therefore, UNFPA supported the integration of FP in the sector and district frameworks to ensure the allocation, release and expenditure on FP
- Through evidence, UNFPA supported the development of the FP Atlas and dashboard. This helped in the identification of areas of disparity
- At district level, UNFPA supported the engagement of district leaders to integrate FP/DD/ SRH and GBV indicators and resources to reach the last mile and ensure nobody was left behind

- UNFPA supported FP resource-tracking and the results of which were used to engage with parliamentary committees on health and finance to advocate for increase in resources for SRH and FP
- In addition, UNFPA supported the harmonization and strengthening of GBV/SRH information management systems including HMIS, NGBVD, EMIS, JLOS data system, Child help line and the GBV helpline



Launch of the Rise Programme in Kampala. Photo by UNFPA/Uganda

These achievements demonstrated that UNFPA was supporting the GoU in planning and decision making to realise the 'Future Uganda' and the 'Africa We Want', a programme to popularize Agenda 2063- through investment in young people.

As evidenced by the data showcased in Table 13, with regard to the performance of the output indicators, 2 out of 5 of the output indicators under PD were achieved beyond the target; another 2 of the output indicators were achieved at 100 percent while 1 output indicator was under-achieved at 83 percent.

The two indicators that were achieved beyond the target were as follows: number of in-depth analytical reports on SRH and youth-related themes from census and survey data; and the proportion of humanitarian crises in which assessments reflect adequate population, SRH and GBV data profiling. The two indicators that were achieved at 100 percent target were: that the DD is mainstreamed and implemented at national and sub-national level and existence of an up-to-date data system. The single indicator that was under-achieved at 83 percent was that regarding the number of functional national and district data management systems that allow for mapping of demographic and geographic disparities and socio-economic inequalities.

It should be noted the under achievement was associated with the indicator dealing with the number of functional national and district data management systems that allowed for the mapping of demographic and geographic disparities whereby by 2019, 5 out of the 6 (83 percent) databases had been successfully set up and were functional. The reasons for under achievement are articulated in section 4.2.4.3 as challenges in DD programming. The 5 functioning databases were the Integrated Management Information Systems (IMIS), National Gender Based and Violence (NGBV), Health Management Information Systems (HMIS), Civil Registration and Vital Statistics (CRVS), Education Management Information System (EMIS) and LOGICS.

In addition, sector and district investments in education and health contributed evidence for advocacy and engagement to implement the newly launched DD roadmap to accelerate harnessing of the DD in Uganda. In addition, skilling and job creation as well as highlighting areas of inequality that required investments facilitated the realisation of the DD in Uganda.

4.2.4.3 Challenges in PD programming

The challenges experienced during the review period included that the overwhelming demand for constituency specific data by Parliament slowed the pace for the production of other in-depth reports. It was noted that the Constituency reports would equally bring out constituent disparities and call for action from the Members of Parliament. In the same year, the handing over of the Civil Registration and Vital Statistics (CRVS) from the Uganda Registration Services Bureau (URSB) to the National Identification Registration Authority (NIRA), a government-led process was not finalised during the year as earlier anticipated. Against this background, UNFPA continued exploring with NIRA on the harmonisation of the information management systems with unique identifiers to ease reporting on access to services by individuals, at the same time. In addition, one major challenge was around sustaining commitment by leadership to invest in key pillars of the DD, especially in the allocation and disbursement of domestic resources. Furthermore, whereas evidence was provided to highlight inequalities in the country, sectors and districts were still challenged to move from the business as usual mode.

4.2.5 Leaving No One Behind

Were the planned geographic areas and target groups successfully reached?

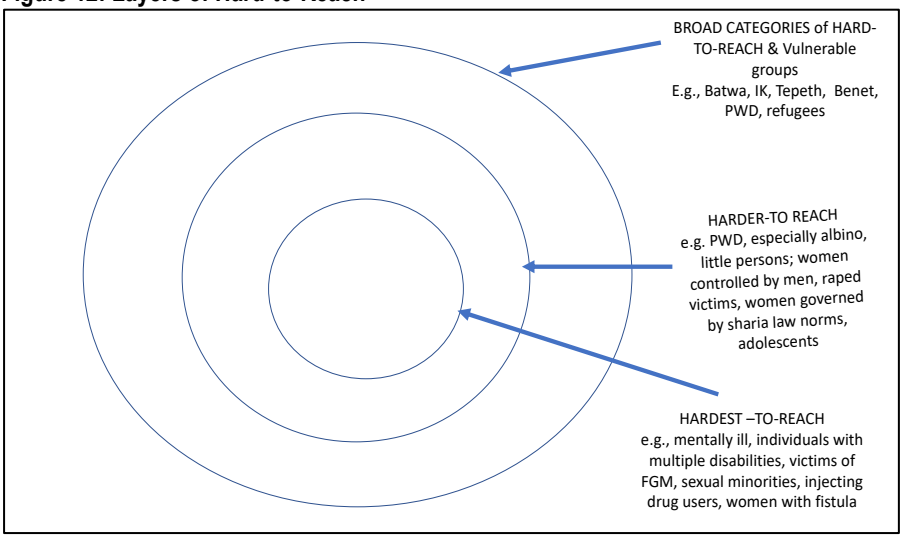
UNFPA CO is committed to the approach of 'Leaving No One Behind' which is one of the programming principles of the UN Sustainable Development Group (UNSDG).[188]

4.2.5.1 Identification of Hard-to-Reach Population

The CO operated in regions and districts where the developmental problems were highest.[189] These included all the eight districts of the Karamoja region and some districts in the Acholi sub-region which were recovering from the effects of the recent civil war by the Lord's Resistance Army. The CO used a composite index to identify these areas which have the hard-to-reach populations. The varying discourses on the definition of "hard-to-reach" suggest that within the broad categories of hard-to-reach groups in Uganda such as the Batwa, Ik, Tepeth, Benet, people with disabilities, refugees, there are sub-categories of harder-to-reach and hardest-to-reach sub-groups.[190] If not well identified and supported, these categories can still affect service access and usability even within a well-organized SRH service delivery system. UNFPA in liaison with MoH commissioned a study in 2018[191] to identify these groups and the metaphor of an onion-peeling helped to unravel the layers of hard-to-reach as they emerge from the broad categories of hard-to-reach groups as shown in Figure 12.

[188] https://unsdg.un.org/resources/leaving-no-one-behind-unsdg-operational-guide-un-country-teams-interim-draft
[189] UNFPA Uganda Country Programme Document, 2016-2020
[190] MoH, Minimum SRHR and Related Social Services Package for Hard-to-Reach and Vulnerable Groups in Uganda, 2018
[191] MoH, Minimum SRHR and Related Social Services Package for Hard-to-Reach and Vulnerable Groups in Uganda, 2018

Figure 12: Layers of Hard-to-Reach



Source: MoH, Minimum SRHR and Related Social Services Package for Hard-to-Reach and Vulnerable Groups in Uganda, 2018

(a) Hard-to-reach are forgotten by omission, stereotyping, exploitation or due to geographical location, policy and other structural factors. This group bears thoughts, behaviours and attributes that are widely accepted by the general public, and because they are accepted, they seem to represent the entire group.

(b) Harder-to-reach can be categorized as those individuals who, for some reasons, are disengaged by marginalization. These groups lack an active voice and place in society. Examples include mountain communities such as the Batwa (Kisoro and Bundibugyo Districts), Tepeth (Moroto District), Ik (Kaabong District), Benet (Kween District), and nomadic/pastoralist communities (Karamoja region and other districts in the cattle corridor). They may be difficult to reach but not disengaged or hard to hear.

(c) The hardest-to-reach often identify with the marginalized groups, but due to their intersecting identities, they may experience further marginalization and isolation. Some individuals in this layer exist because of the limitations imposed by existing national policies and laws that drive them underground. Examples of people in this category include drug users, individuals with different sexual orientation, girls subjected to FGM whose families keep them from public view to avoid legal consequences.

4.2.5.2 Approaches to reach the Hard-to-Reach Groups

The CO made some attempts to provide services for the hard-to-reach groups using a number of approaches[192] namely the Integrated package of SRHR services; SRHR voucher scheme; Village Health Teams for FP uptake; Peer education; SRHR outreaches for young people; Start Awareness Support and Action (SASA)!; Male Action Groups and Role Model Men among others.

- **Integrated package of SRHR services**: MoH with support from UNFPA developed an Integrated SRHR package by life cycle for hard-to-reach populations, hence specifically targeting the marginalized populations.[193] The Integrated SRHR package was designed to address some of the personal, geographical and structural issues. By implementing the integrated package of rights, UNFPA sought to galvanize political, financial and public support to ensure universal access to SRH and rights. An example of integrated approaches to SRHR service uptake was the SIDA funded UNFPA programme: "Enhanced Delivery of Integrated Sexual Reproductive Health and Rights Services in Districts with High Maternal Mortality Burden in Uganda", which was implemented in the Karamoja and Acholi regions between 2015 and 2018. The integrated RHR package was applied in the Karamoja region which has a number of hard-to-reach areas and marginalised groups such as the Ik in Kaabong District.

[192] MoH, Minimum SRHR and Related Social Services Package for Hard-to-Reach and Vulnerable Groups in Uganda, 2018
[193] Ministry of Health, Uganda: Minimum Sexual and Reproductive Health and Related Social Services Package for Hard-to-Reach and Vulnerable Groups in Uganda

- **SRHR voucher scheme for increased service uptake:** Vouchers are recognised as an important component in the drive to achieve universal health coverage. The Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) engagement project, which was implemented from 2015-2017 utilised the voucher system to increase the availability and access of FP services and maternal health services.

- **Village Health Teams for FP uptake**: UNFPA and MoH have used the Village Health teams (VHT) strategy over the years to increase utilisation of services in development and refugee settlements, especially to youth. An assessment revealed that this approach facilitated/expanded access to FP significantly in Uganda.[194]

- **Peer education**: UNFPA has previously implemented programmes using peer education approaches for years. Research studies have revealed that peers were the primary source of SRH information for young people and that programmes with peer educators can positively influence young people's attitudes and knowledge.[195]

- **SRHR outreaches for young people**: Under the WAY programme, which was implemented by UNFPA and partners in West Nile and Acholi regions (2018 2022), the outreaches and services were designed to respond to the needs of young people with a focus on establishing provider initiated contraception counselling and services for hard to reach populations, including young people, refugees etc.[196]

- **SASA!**: This is an evidence based community approach to support shared power and decision making promoting healthy life choice. The methodology is a community mobilisation intervention designed to prevent violence against women and HIV while promoting SRHR. SASA! is focussed on gender and protection thus making it relevant to hard-to-reach-reach populations such as the Karimojong. Furthermore, in humanitarian programming, community mobilisation and working with community activists through programming such as SASA! provided a framework to support power analysis and community dialogue to facilitate the process of transformation of harmful social norms.[197]

- **Male Action Groups**: The MAGs support engagement of men and boys as role models, agents of change, clients and mentors of men and boys on GBV prevention, promotion of gender equality, human rights, FP and SRHR, and linked survivors to services yielding increased support from men on prevention of gender based violence.[198] The approach of using MAGs was useful in the Karamoja region in that MAGs became imbedded within the community structures. In this regard, MAGS were part and parcel of community-based activism networks formed to raise awareness on positive fatherhood and educating community members about healthier and more equitable behaviours for men and women. Through a community participation approach, individuals were identified by community members and leaders based on criteria such as; those who keep their children in school, those seen to be responsible members of society, involved in supporting families, community advocacy, including even those known to be violent.

4.2.5.3 Service Delivery for Special Groups

Among the groups of people with special needs were people with different forms of disabilities and MARPs/key populations including commercial sex workers. The majority of health facilities did not cater for the needs of people with different forms of disabilities (physical, deaf, dumb and blind) due to lack of adequate infrastructure such user-friendly walking ramps, lack of health staff who were specifically trained to handle the blind, deaf and dumb. UNFPA needs to advocate to MoH, MoES and MGLSD to ensure that different service delivery approaches are established for these groups in order to have universal service coverage. Some key informants

[194] https://www.advancingpartners.org/sites/default/files/uganda_expanding_access_family_planning_services_community_level.pdf
[195] https://www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/peereducation.pdf
[196] Denmark/Uganda Country Portfolio Performance Review of WAY programme, October 2019
[197] SASA! was evaluated using a community cluster randomised trial which ran over four years from 2008-2011 and found to be effective at reducing violence, physical partner violence, as well as reducing the social acceptance of physical and sexual violence in intimate partnerships.
[198] UNFPA Country Office Annual Reports 2017, 2018

and FGD respondents proposed the use of community camping approaches that involve teams staging in a community for several days to ensure that they reach out to them in times that rhyme with their availability and needs.

Therefore, during the next CP9 programming, UNFPA should advocate and support efforts of the GoU at national and DLG levels to develop strategies for 'client-centred approaches' which should ensure that the hard-to-reach, harder-to-reach and hardest-to-reach categories of populations who are not effectively targeted by the traditional routine service delivery are also covered.

4.2.6 Unintended Results

It should be noted that the study did not observe or establish any unintended results during the implementation of this evaluation.

4.2.7 Lessons Learnt

The key lessons learnt that can contribute to the knowledge base of the UNFPA and partners and be applied in future programmes and policy development included the following:

Partnership with DLGs

(a) The implementation modality of GoU/UNFPA CP being known by the DLGs right at the beginning is key to success.
(b) In those districts where CSOs were accommodated at district offices, there was improved mutual trust and enhanced coordination.
(c) The presence of UNFPA staff within districts enhanced the visibility of UNFPA and improved coordination, sub-national level partnerships and quality assurance.

Thematic areas

(a) Strategic engagement with key sectors at senior management level produces quick results.
(b) Engaging religious and cultural leaders at individual entity level ensures that the voices of each is captured and consensus is attained to reduce on divergent views.
(c) Cross border issues related to FGM are still a challenge and requires more strategic engagement at all levels with active participation of UN agencies in Kenya and Uganda, cross border local governments and cross border communities.

4.3 Efficiency: Evaluation Questions 6 and 7

EQ6: How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
EQ7: To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; JP modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4.3.1 Funding Modalities, Reporting and Administrative Arrangements

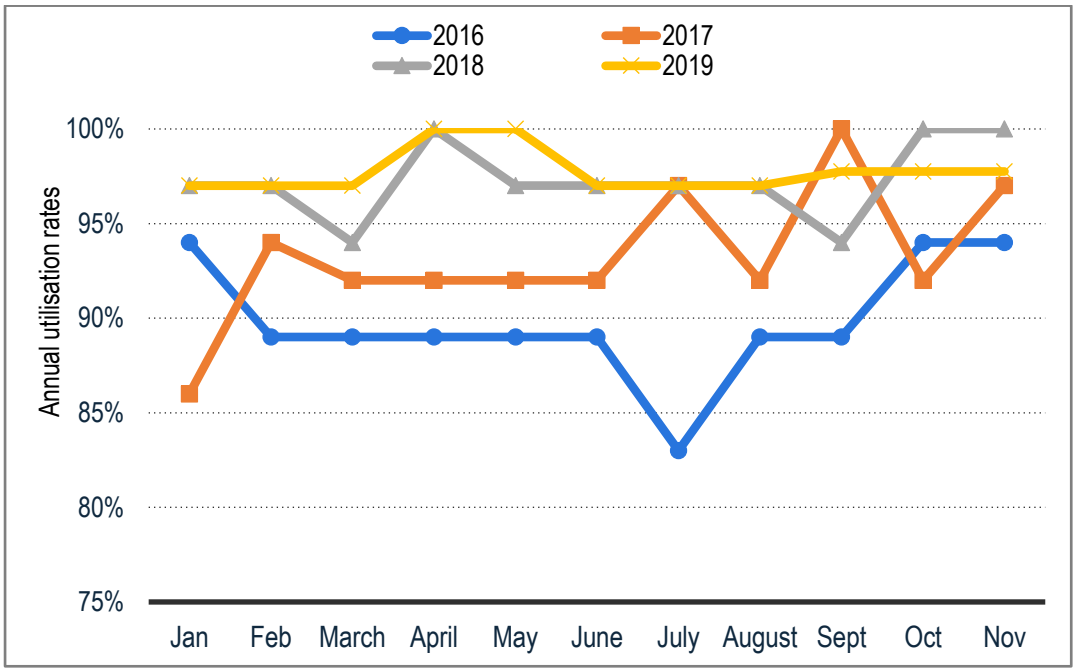
UNFPA has a clear and robust system for ensuring checks and balances, and to ensure that IPs are accountable for deliverables in a timely manner. The ET established that there was a strong and consistent system at UNFPA CO to review quarterly work plans, partner financial and programme reports and provide required feedback mainly on completeness, quality of reporting and absorption/utilisation rates of the funds. UNFPA CO ensured that regular audits were carried out and made public in line with good financial management practices. Leadership of UNFPA also took bold actions to reduce operational and transactional costs to improve efficiency by reducing the number of IPs from 50 in 2017 to 20 by 2018. Similarly, UNFPA was heralded by key stakeholders including other UN agencies for spearheading the integrated approach and the Integrated Field Support Strategy that contributed to financial and programmatic efficiency by reducing duplication and operational costs as well as increasing interactions and feedback between UNFPA CO and IPs particularly in the districts.

The M&E function within UNFPA provided a commendable framework for tracking the alignment of IPs' work plans with the Results Matrix by the adoption of the Global Programme System (GPS). The GPS contributed to fast tracking of assessment of the level of adherence of IPs' work plans to the Results Matrix. However, some key informants noted that the GPS had some challenges; in some cases it did not provide accurate information and had to be complemented by a manual tracking system for analysis of alignment of IP work plans. Therefore, an ingenious hybrid mechanism that applies the GPS and complemented by manual analysis is required.

4.3.2 Utilisation of Funds

Analysis of trends in the utilisation of funds of CP8 from 2016 to 2019 showed a commendable improvement in the utilisation of funds as shown in Figure 13 and Table 14.

Figure 13: Trends in Annual Utilisation of Funds



Source: ATLAS Financial Dashboard Summary (2016-19)
Key: Green colour represents adequate utilisation of funds; Yellow colour represents sub-optimal utilisation
*Note that the annual utilisation rates for 2019 for Oct – Nov are based on linear extrapolation.

Table 14: Trends in Annual Utilisation of Funds

Year	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov
2019	97%	97%	97%	100%	100%	97%	97%	97%	98%	98%	98%
2018	97%	97%	94%	100%	97%	97%	97%	97%	94%	100%	100%
2017	86%	94%	92%	92%	92%	92%	97%	92%	100%	92%	97%
2016	94%	89%	89%	89%	89%	89%	83%	89%	89%	94%	94%

Source: ATLAS Financial Dashboard Summary (2016-19)
Key: Green colour represents adequate utilisation of funds; Yellow colour represents sub-optimal utilisation
*Note that the annual utilisation rates for 2019 for Oct – Nov are based on linear extrapolation.

However, the ET identified areas for improvement. Almost all IPs observed that there was delayed disbursement of funds and this reduced the time available for them to engage in quality implementation of activities for a given quarter. Some partners noted that funds were received late, yet they needed time to implement, report and do accountability. In extreme cases, this left only half of the time to implement activities for the quarter thus affecting the quality and fidelity to implementation modalities.

In addition, the modalities of transfer of funds to districts and holding districts accountable posed a challenge. Apart from MGLSD that had signed MoUs with districts which enabled transfer of funds, other MDAs such as MoH had not yet done so and this has affected the ability of these MDAs to transfer funds in a timely and efficient manner to DLGs particularly for supervision, capacity building and coordination of activities. Challenges linked to lack of clear modalities for transfer of funds to DLGs made some MDAs with mandates to operate at national level to engage in direct implementation of activities at the community level which undermined the spirit of decentralization.

4.3.3 Personnel

Interactions with IPs revealed some challenges related to staffing and operational budgets versus programmatic activities and workload. Although this challenge affected almost all IPs, it was more pronounced particularly for IPs that received relatively small budgets. UNFPA CO generally uses a principle of operational costs not being more than 10 percent of the total budget to ensure that the largest part of the budget is for programmatic activities. However, this left IPs that had small budgets with limited funds to finance recruitment of staff. UNFPA CO should consider on a case by case basis balancing of programmatic and operational costs particularly enabling IPs that have small budgets but with a unique niche and expertise to recruit key technical staff commensurate to the workload.

4.3.4 Partnership Strategy, Implementation Arrangements and Joint Programming

UNFPA was proactive in partnering with other UN agencies on Joint programmes (e.g. UNJPGBV, JUPSA/KARUNA, ECM, FGM, SRH/HIV/GBV, EU Spotlights Initiative on GBV, SRHR and Harmful Practices) to enhance effectiveness and efficiency. This coupled with DaO provided a framework that enhances coordination, consultation, joint planning and implementation among UN agencies. Joint Programmes also reduced duplication of efforts at national and sub-national levels. This needs to be further strengthened given that it enhances efficiency.

Consultations at the national and DLG levels revealed some areas for improvement that had potential to affect efficiency in service delivery. It was noted that UNFPA changed the previous model of partnerships and disbursement of funds during CP7. Initially, DLGs were considered as IPs and UNFPA CO used to disburse funds directly to DLGs to support District AWPs. The funds were meant to support coordination, supervision, outreaches and trainings. Some of these functions, particularly coordination were being funded through the strategic partners (MGLSD), and KIIs revealed that efforts were underway to do the same through MoH. However, the downward side of it was that these efforts focus more on sectoral functions and less on cross-cutting functions critical for effective and efficient multi-sectoral coordination and accountability. There were also a few cases in some projects where funds were disbursed through IPs and this was perceived by DLG officials to undermine their mandate to coordinate, supervise and hold IPs accountable. Generally disbursing funds through MDAs such as NPC (as it is for the districts in the Karamoja region), MoH and MGLSD was a good strategy for reducing operational costs linked to having all districts as IPs. However, it required expediting signing of MoUs between districts and all relevant MDAs. Similarly, although signing MoUs between ministries (e.g. MOH, MGLSD) and DLGs was seen as being helpful, key informants noted that the roles/mandates of MDAs was policy formulation, technical assistance, support supervision and quality assurance. The MDAs did not have the legal mandate to hold DLGs accountable to implement activities or to demand and make them account for funds received. This mandate lies with the Ministry of Local Government (MoLG) which could hold Chief Administrative Officers and DLG staff accountable. MoLG was not engaged as a strategic partner of UNFPA in implementing the CP. The government's financial year (1st July - 30th June) is different from that for UNFPA (1st January - 31st December) and this mismatch further complicated the synchronization of quarterly fund transfers. However, despite the challenges above, gender and human rights dimensions were clearly visible and reflected in the planning and operational modalities of CP8 programmes and strategies both at the national and DLG levels.

The KIIs also revealed concerns at DLG level particularly about IPs that did not have field presence and have no partnerships with Community Based Organisations (CBOs) at the district or community level. Such IPs were perceived by DLGs not to be effective and efficient. They missed many critical coordination meetings and hardly had enough time to contribute to capacity building and mentoring of DLG staff and community structures. Therefore local/field presence would be made a pre-condition for selection of CSOs to work as potential IPs. At the very least, if an IP was highly specialized, it would be required to work in partnership with some CBOs that had been vetted and recommended by the DLGs.

4.3.5 Coverage

Key informants raised issues related to expansion, spreading thinly versus consolidation and increasing coverage of interventions in the current districts of operation. It was noted that in many districts, full coverage of all sub-counties and districts had not been achieved. Universal coverage for districts, sub-counties and parishes or villages was partly affected by funding and staffing constraints. Given that some models particularly for behavioral change requires reaching a critical mass for optimal diffusion to occur and social norm change, UNFPA should consider moving more towards consolidation and achieving universal coverage in contiguous districts/areas.

UNFPA CO had a clear strategic direction in relation to the implementation of the humanitarian-development-peace nexus and integrated it in its programmes in humanitarian settings. The goal was to foster strengthening the self-reliance of refugees by increasing their contribution to local development, decrease the need for long-term care and maintenance programmes, and reduce the potential for conflict between the hosts and refugees. Using its comparative advantage in integrated SRHR/HIV/GBV programming, UNFPA was actively involved in implementation of the Refuge and Host Population Empowerment (REHoPE) framework that sought to address the humanitarian and development needs of refugee-hosting districts in Uganda. UNFPA developed a strategy to guide systematic strengthening and implementation of the humanitarian-development peace nexus in all its SRHR, AY, GEWE and PD programmes in refuge hosting districts.

4.3.6 Decentralized Offices

By the time of the CPE, the CO operated two Decentralized Offices; one in Moroto that oversaw the Karamoja region and Eastern region and another in Gulu that oversaw the Northern and West Nile regions supported by field offices particularly in the humanitarian settings. Operating Decentralized Offices was considered by stakeholders as a key strategy for fostering visibility, technical assistance and enhancing the functions of coordination, sub-national level partnerships and quality assurance. However, the ET noted a number of areas for improvement. The Decentralized Offices were only two at the moment and had not expanded despite the expansion of the number of districts from the original 25 core districts to more than 40 districts. This number seemed to be on the rise partly because of the interests of donors in terms of geographical areas of operation and the consistent creation of new districts by the GoU. Similarly, the staffing in Decentralized Offices was low compared to the bigger geographical scope covered. It was therefore important to consider in the short term, the recruitment of at least one additional staff in Moroto and Gulu offices to beef up existing Decentralized Offices as plans were being made to open additional ones to cope with the rate of expansion. The strategy of posting staff in district field offices or sites was appreciated by DLG officials and needs to continue and should be consolidated.

Field presence was also in the form of the Women, Adolescents and Youth (WAY) programme. The five-year programme (2018-2022) enabled women and young people among refugee and host communities to live healthy, productive lives and contribute to their communities' development by strengthening their access to SRH and GBV prevention services. It was implemented in the districts of Arua, Yumbe, Moyo, Adjumani, Kitgum, Lamwo, Agago and Amuru, where SRH challenges and high prevalence of GBV were further complicated by the influx of refugees from South Sudan. The WAY programme was implemented by UNFPA and its partners namely MoH, MGLSD, CARE International, Communication for Development Foundation Uganda, Reach A Hand Uganda and Outbox. Through the Integrated Field Support and the WAY programme, UNFPA had over the past two to three years managed to register and expand its field presence. In addition, IFS facilitated increased interaction and timely feedback between UNFPA and the IPs in the field.

4.4 Sustainability: Evaluation Questions 8 and 9

EQ8: To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?

EQ9: What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

4.4.1 Ownership and Sustainability of Interventions

The implementation of the CP8 was government-led and guided by a comprehensive partnership strategy that fostered development of key strategic partnerships with key government MDAs, DLG departments, and communities. The partnership strategy facilitated active involvement of stakeholders at different levels and enabled them to actively contribute and also understand their roles in the planning, implementation, monitoring, and reporting on the programme activities.

The elements which indicated ownership and sustainability of interventions and results included the following:
(a) Use of existing structures: The CP8 was implemented through existing national and district structures and mandates. UNFPA's strengthening of existing structures ensured that the ownership of the programmes was assured.

> *"The technical capacity of district structures which has been built is an asset which will continue to be utilized",* reported a KI participant at district headquarter, Arua District

(b) Technical support to MDAs: UNFPA provided technical support to the MDAs such as MoH, MGLSD, MoES; Uganda AIDS Commission (UAC); NPC among others and the technical capacity built had the potential to allow these institutions to carry on implementing the various interventions in future.

(c) Capacity building of frontline workers: UNFPA invested in the capacity building of frontline workers in the districts through various trainings. Examples of the training conducted under the CP8 included training government planners in data and planning, health workers in delivery of RH and FP services, training fistula surgeons for routine fistula repair. The training targeted the personnel who were already in public service. In the short and medium term, these technical staff should be able to apply the skills they gained even with the end of UNFPA support.

> *"The technical capacity of district staff has been built after training by the IPs under the thematic components",* reported a KI participant, Kitgum District.

(d) Use of existing CSO Partners: The planned programme interventions were implemented by CSO partners with active participation of DLGs and communities. Field discussions and monitoring reports revealed that this resulted into increased ownership of the interventions. However, some challenges threatened sustainability efforts. Some IPs did not have field offices in some districts and their presence was not felt since the staff came in for a short time and got out. There were also weaknesses in the process of transitioning to new partners. It was observed that it was abrupt and inhibited the potential of building on previous gains as agencies with desired experience were replaced. An example in point was the IPs which were handling FGM interventions in the Sebei region. Targeting of grassroot CBOs had been limited yet such agencies were critical for community level effective response. DLGs also had challenges with coordinating refugee services because of the overlapping coordination structures with OPM.

The programme utilised community driven approaches that allowed communities to take lead on local activism for gender equality and empowerment of women and girls. For example, this led to the establishment of MAGs in a number of districts (Amudat, Adjumani, Arua, Kyegegwa among others). Evidence from the field showed that these structures had the potential to continue implementing activities even when formal support ends. For

example, in 2016 International Rescue Committee (IRC) community mobilisation programme for social norm change was phased out and only resumed in 2019. The agency found that the change agents that they were working with previously were still active.

> *"In Karamoja, though we closed in 2017 due to funds, the CAs continued to work, they had internalized their role in the communities… when we resumed activities in May 2019, those CAs were still active and we just took them over",* said a KI respondent, Moroto District.

The programme built the capacity of the DLGs, CSOs, and community structures on integrative delivery of rights. However, the challenges related to staff attrition, staff transfer, and low absorption capacity of staff trained, particularly by DLGs of Amudat and Moroto undermined capacity building as a facilitator for sustainability of achievements gained.

4.4.2 Strategic Positioning of UNFPA for Future CP Development

UNFPA's niche is the provision of high quality data on all the thematic components of the Country Programme and being able to support other UN agencies on their data needs. The latter was in line with one of the three key enablers for efficiency interventions defined by the UN Sustainable Development Group (UNSDG) Business Innovations Group (BIG] namely: **Mutual Recognition**, which, once endorsed, allows one UN entity to obtain services from another UN entity if the latter can provide services more efficiently.[199] The other comparative advantages of UNFPA were:

- Leadership in supporting the GoU to harness the DD which was key to the attainment of Uganda's goal to become a middle income country by 2030
- Leadership in policy advocacy for FP and Reproductive Health Commodity Security right from national to headquarter level
- Leadership in the implementation of the humanitarian-development-peace nexus and its integration in programmes in humanitarian settings
- Leadership in the coordination of joint UN programmes (eg. JPGBV, JP on Abandonment of FGM, JPECM, Integrated SRH/HIV/GBV programme)[200]

Some of the key lessons learnt from CP7[201] were that building strategic partnerships with the GoU, UN agencies, donors and CSOs galvanises national support for the ICPD agenda; and that working directly with DLGs increases ownership and sustainability of programme interventions. Given the above comparative advantages and the previous lessons learnt, UNFPA is strategically positioned to play an active role in the development of the new generation UNDAF (2021-2025) - the UN "Sustainable" Development "Cooperation" Framework (UNSCF).[202] According to the interviews held with some key national level stakeholders, UNFPA has a pivotal role to influence the strategic decisions that will be made by UNCT during the design and implementation of the UNSCF. However, this requires UNFPA's pro-active and continuous engagement with all key stakeholders within the existing coordination fora.

4.5 Coordination: Evaluation Question 10

EQ10: To what extent has UNFPA CO contributed to the functioning and consolidation of UNCT coordination mechanisms? To what extent were the coordination mechanisms for the Country Programme functional?

4.5.1 Coordination within UNCT

The UNFPA CO contributed positively to the UNCT and applied its comparative advantage for the effective and efficient running of the UN coordination mechanisms. UNFPA is an influential key player and since 2016, it has held key responsible positions in various committees and technical working groups contributing to the country's development agenda. Both UN agencies and GoU MDAs appreciated the important role UNFPA played in bringing multi-disciplinary strategic partners together to increase the efficiency and effectiveness of the country's development agenda. The active contribution was evident from the role UNFPA played in participating as chair,

[199] https://unsdg.un.org/2030-agenda/business-operations
[200] United Nations Development Assistance Framework (UNDAF) Mid-term Review Report, 2018
[201] GoU/UNFPA 7th CP Evaluation Report
[202] https://sdg.iisd.org/news/un-publishes-guidance-on-revamped-undaf/

co-chair, lead and member in technical working groups, thematic groups and joint initiatives. These included: HDP's group; MoH SRH/HIV/GBV integration TWG; MoH MCH cluster group; MoH Planning TWG, MoH Supervision, Monitoring, Evaluation and Research TWG (SMEAR); and MGLSD GBV TWG,

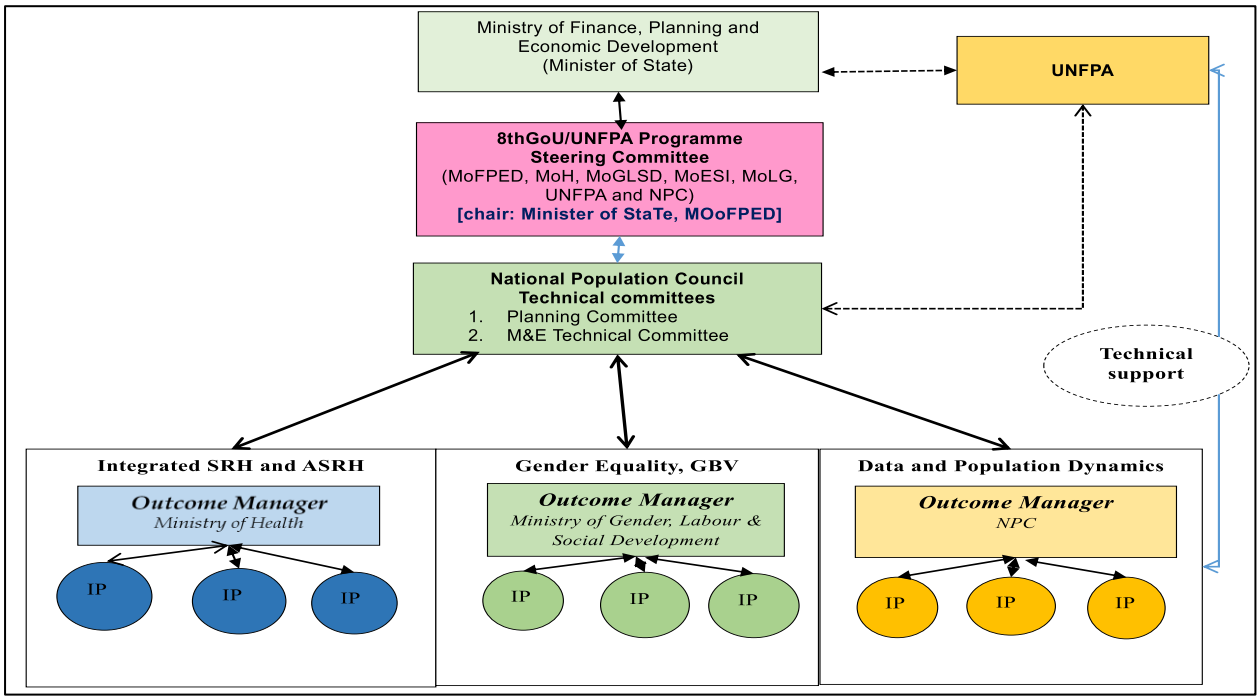
All key UN agencies who responded to the interviews indicated the important role UNFPA played in the country's overall development agenda, contributing effectively to improving UNCT coordination mechanisms, particularly strengthening advocacy in several areas was useful to other UN agency members.

UNFPA actively participated in the United Nations Development Coordination mechanisms namely: UNCT, PMT, OMT, IASC, H4, UNAC; CMG, M&E Group, UNCG. UNFPA Co-Leads with UNICEF on the Strategic Intent Pillar (SIP) on Human Capital Development (HCD) as well as being one of UNCT Leads (WHO, UNFPA) on the Outcome Result Group (ORG) 2.2 for Health and UNCT Co-Leads (UNFPA, UNICEF) ORG 2.4 for GBV and Violence Against Children under UNDAF. However, the Mid-Term Review of UNDAF 2016-2020 in 2018 showed that some ORGs were not fully functional as expected and recommended SIP heads facilitate greater harmonization of planned interventions at ORG level to realise greater efficiency gains. In this regard, UNFPA needs to actively advocate within the UNCT for improved functioning of ORGs.

4.5.2 Coordination at National Level

UNFPA has a robust and comprehensive partnerships strategy for the advancement of the ICPD agenda in the context of the Post-2015 SDG Agenda. The CP8 has a documented coordination structure which is shown diagrammatically in Figure 14.

Figure 14: Coordination Mechanism for the GOU/UNFPA CP8



The roles and responsibilities of various MDAs were well articulated. The overall GoU coordinator for CP8 is still the NPC whose role was to promote, coordinate, advocate for and monitor and evaluate the overall CP. In addition, NPC is still the current Chair of the Evaluation Reference Group. Through the provision of funds and technical support, UNFPA facilitated the coordination role of NPC whereby the latter was supposed to have quarterly meetings with the Outcome Managers (MoH for Outcomes 1 and 2; MGLSD for Outcomes 3; and NPC for Outcome 4). However, the feedback from key informant interviews indicated that NPC was not able to exercise its full coordination role due to limited funds availed. This had in turn led to not all quarterly meetings being held as required. The inadequate funding had to some extent also constrained the technical oversight by MoH, MGLSD and NPC over the different CSO IPs they were mandated to supervise in their respective sectors.

The coordination role of UNFPA was also highly commended in the following:

- UNFPA supported full functionality of SRH/HIV coordination platforms at MoH through the National Task Team on SRH/HIV integration and in 8 districts allowing key actors to identify and make input to the 2019 district and national level priorities for integration
- As a result of UNFPA guidance, leadership and support, the inter-agency gender-based violence coordination body and National GBV Reference Group was functional
- In humanitarian settings, UNFPA effectively performed its role of Co-Lead (with UNHCR) of the GBV working group at National Level and in refugee settlements.

4.5.3 Coordination at District Level

At the DLG level, the Chief Administrative Officer (CAO) is mandated to supervise all IPs in his/her district. UNFPA made good progress in improving support for coordination roles of DLGs particularly in the Karamoja region by channeling funds through NPC. In addition, UNFPA made substantial progress with MGLSD taking action to channel coordination funds to a number of DLGs. Memoranda of Understanding were signed between MGLSD and the DLGs concerned. Negotiations were still on-going between UNFPA and MoH for the latter to take similar action. However, the feedback from key informant interviews showed that the funds channeled through the ministries were used more on sectoral coordination rather than multi-sectoral coordination. In some cases, the coordination funds had been provided to DLGs by some IPs. The latter situation led to some tension between the two parties and also undermined the supervisory /technical oversight of DLGs over IPs to hold them accountable. UNFPA needs to explore more avenues of how to channel coordination funds to DLGs while at the same time ensuring a proper accountability system.

Interviews with DLGs and IPs indicated that the presence of UNFPA staff in the Decentralized Offices in Moroto town (Karamoja and Eastern regions); Gulu Municipality (Acholi sub-region and West Nile region) was highly appreciated and had to a large extent improved the interlocution between DLGs in those regions and UNFPA. Nevertheless, the technical staff in those offices were overstretched in covering wide geographical areas. As more funds become available, UNFPA should to strengthen the current Decentralized Offices with human resources and establish more in other in regions.

CHAPTER 5: Conclusions

5.1 Strategic Level

1. The GOU/UNFPA's 8th Country Programme was well aligned to national and international development priorities. The CP effectively responded to the changing environment and needs including humanitarian settings. **UNFPA is a strategic partner to the GoU, other UN agencies and leading bilateral agencies.**
CP8 was relevant and strategically aligned to national and international development frameworks. Wide stakeholder consultation at national and sub-national levels during the design of the CP8 enhanced ownership and relevance. The CP8 was responsive to changing national needs and environment especially in the increasing refugee influx and other emergencies (floods, landslides and drought). However, there were emerging needs such as climate change effects as a risk factor for GBV and harmful practices (early and child marriage), migration and cross-border movements (in relation to FGM) which needed more attention.

Origin: EQ1, 2; evaluation criteria: relevance, responsiveness
Recommendation: Strategic level R1.

2. UNFPA provided strategic leadership and advocacy for integrated programming with a focus on gender, human rights based approaches and leaving no one behind. The policies developed included: Revised National Policy on Elimination of Gender Based Violence in Uganda; National Male Involvement Strategy for Prevention and Response to Gender Based Violence in Uganda; and the National Strategy to End Child Marriage and Teenage Pregnancy. Integrated programming was strong particularly at national level, but required further strengthening at the sub-national level.
Most national policies and guidelines mainstreamed gender and human rights based approaches. However, there were capacity gaps in leadership and the implementation of the integrated programming particularly at the district and community level. The CP8 adopted approaches that ensured equity by using the composite index to target regions and districts with the worst indicators. However, the targeting of hard-to-reach communities (nomads, people with different types of disabilities, fishing communities, people leaving in mountainous areas and most-at-risk populations) was relatively weak and required adopting differentiated service delivery models that effectively respond to the unique needs and contexts of these populations.

Origin: EQ3 and 4; evaluation criteria: relevance, effectiveness
Recommendation: Strategic level R6.
Recommendation: Strategic level R8.

3. UNFPA was an active member of the UNCT and was a valued strategic partner of GOU and other key stakeholders. UNFPA embraced DaO under UNDAF more so within the context of UN Joint Programmes. The CP had a well-articulated coordination framework for the implementation of the programme at national and sub-national levels. However, fidelity to the coordination framework was not consistently followed particularly at the sub-national level.
However, NPC's effective coordination role was constrained by limited funding and instances of parallel coordination structures at DLG level whereby some IPs disbursed funds for coordination to DLGs. This created tension between IPs and DLGs and also had the potential to undermine the oversight role of NPC and DLGs over IPs.

Origin: EQ10 and 6; evaluation criteria: coordination and efficiency
Recommendation: Strategic level R2
Recommendation: Strategic level R3.

4. UNFPA geographical expansion provided opportunities to GoU and UNFPA to fulfill their mandates. However, the expansion was done at the risk of programmes being spread thinly which constrained consolidation of programmes and services in the core districts. The two Decentralized Offices in Moroto and Gulu are insufficient to cater for the Karamoja, Eastern, northern and West Nile regions.

Expansion had the potential to increase operational costs. Similarly, expansion was done without commensurate increase of the Decentralized Offices which had implications for the Decentralized Offices' capacity to provide oversight and quality assurance effectively and efficiently. The use of the Integrated Field Support (IFS) facilitated visibility of UNFPA and improves programmatic coordination between IPs and UNFPA at DLG level. However, IFS was constrained by the few Decentralized Offices and low staffing levels in Decentralized Offices and in the field.

Origin: EQ6, 7 and 10; evaluation criteria: efficiency and coordination
Recommendation: Strategic level R7.

5. UNFPA had a robust financial management and tracking system that facilitated programmatic and financial accountability. However, there were delays between requisition of funds by IPs and disbursement by UNFPA and this affected timely and quality implementation of interventions. The different planning/ financial years for government (July - June) and UNFPA (January - December) posed a challenge. UNFPA CO should review the length of time between requisition and disbursement of funds to enhance efficiency.
UNFPA had a clear and robust system of ensuring checks and balances, and that IPs were accountable for deliverables and funds disbursed in a timely manner but it required further strengthening to reduce the time between requisition and disbursement of funds. Modalities of transfer of funds to districts and holding them accountable posed a challenge. Apart from MGLSD that had signed MOUs with districts, other MDAs had not yet done so.

Origin: EQ6 and 10; evaluation criteria: efficiency and coordination
Recommendation: Strategic level R4.

6. The Intervention logic in the results framework was quite robust but some areas needed strengthening.
There was a clear strategic linkage between planned interventions and the outputs. The output and strategic actions generally contributed to the outcomes. However, some output indicators were stated as categorical; requiring only "Yes" or "No" as the only options for measuring achievement. These categorical measurements fell short of clearly defining the quality, processes and parameters of measurement. Some outcome indicators particularly in GEWE and AY were narrowly defined and therefore fell short of the progress towards the outcomes. In addition, the lack of documented assumptions for the intervention logic undermined the input-output-outcome causal linkages.

Origin: EQ4; evaluation criteria: effectiveness
Recommendation: Strategic level R5.

7. Data as a foundation for evidence based programming was well articulated in the CPD. However, the investment in data in terms of human and financial resources was sub-optimal.
Staffing for data management across all programmes and at strategic level was low. Consequently, the workload was heavy on the existing staff who were expected to cross check that there was alignment of IP work plans to the results matrix, to oversee research, learning and knowledge management.

Origin: EQ4 and 6; evaluation criteria: effectiveness and efficiency
Recommendation: Strategic level R9.

5.2 Programmatic Level

Conclusion 1: Although SBA improved over the years, the quality of obstetric care was low.
The low quality of obstetric care implied that some mothers and newborns could have been getting complications during delivery or even experiencing deaths. Not all EmONC signal functions were carried out by some HC IIIs and HC IVs.

Origin: EQ 4; Evaluation criteria: effectiveness; Programmatic Recommendation (PR) 1.

Conclusion 2: The MPDSR guidelines, 2017 were useful to guide implementation of MPDSR activities. The MPDSR system was functional but it needed further strengthening to attain full utility especially at sub-national level.

Origin: EQ 4; Evaluation criteria: effectiveness; PR 2.

Conclusion 3: The National Obstetric Fistula Strategy was valuable to guide fistula management. The current model for addressing obstetric fistula through treatment camps achieved results sub-optimally but it was not sustainable due to the substantial financial resources required. In addition, limited attention was given to the re-integration of fistula survivors.
Treatment of obstetric fistula cases through treatment camps yielded results in terms of reducing the backlog and but did not achieve the annual repair targets set. The number of fistula survivors who were re-integrated into their communities was very minimal and it was important that they were assisted to regain their dignity in society.

Origin: EQ 4; Evaluation criterion: effectiveness; PR 3.

Conclusion 4: UNFPA played a key facilitation role in development of the Uganda Family Planning Costed Plan (2015-2020) and the Uganda Reproductive Health Commodity Security Strategic Plan (2009/10 - 2013/14). There was unmet need for FP reduced over the years. However, there were still persistent FP commodity stock-outs experienced across the UNFPA supported districts which compromised access to FP services.
The FP interventions saw the uptake of FP services and commodities increase. However, occasional stock-outs were still experienced, due to weak systems for stock re-distribution (inter- and intra-district), commodity quantification and forecasting, and inadequate logistic management information system for FP commodities.

Origin: EQ 2; Evaluation criterion: effectiveness; PR 4.

Conclusion 5: Despite the passage of the National Sexuality Education Framework 2018, intervention in comprehensive sexuality education did not bear the intended result of SE integration in the school based education curriculum because of considerable resistance and differences in understanding amongst stakeholders.
There was resistance from faith based institutions and cultural leaders which led to minimal achievement in integration of SE in the primary school curriculum.

Origin: EQ 4: Evaluation criterion: effectiveness; PR 14.

Conclusion 6: Integrated SRH outreaches for youth in specific convergence points were more sustainable than stand-alone youth facilities such as youth friendly corners.
While adolescents and youth preferred free-standing facilities to services based within facilities, it was observed that youth friendly corners or spaces were expensive and not sustainable and therefore the YFS should be integrated into the routine health services.

Origin: EQ 4: Evaluation criterion: effectiveness; PR 9.

Conclusion 7: Use of digital and online platforms had the potential to increase access by adolescents and youth to SRH information.
By supporting digital innovation driven by young people, UNFPA was able to engage young people through technology and online platforms to increase their access to SRH information and services.

Origin: EQ 4; Evaluation criterion: effectiveness; PR 5.

Conclusion 8: Significant achievements with regard to the development of policies such as the Revised National Policy on Elimination of Gender Based Violence in Uganda; and the National Male Involvement Strategy for Prevention and Response to Gender Based Violence in Uganda), strategies and laws for

prevention and response to GBV, harmful practices and gender inequality was made. However, there were gaps in implementation.
The GoU made clear policy commitments to address GBV and the national policy set out clear mandates for government and other actors. Policies were also supplemented by a set of useful guidelines and protocols. However, there were resource and capacity constraints to implement the policies and guidelines.

Origin: EQ 4; Evaluation criteria: effectiveness; PR 8

Conclusion 9: Harmful/hegemonic masculinity remained a challenge to the realization of GEWE.
Despite the successes in social mobilisation, social norm change particularly in respect to harmful/hegemonic masculinity (patriarchal norms) that contribute to GBV and harmful practices remained a challenge to the realization of GEWE. Without shifting these norms which existed among some service providers as well as communities, significant progress of reducing prevalence of GBV was limited.

Origin: EQ 4; Evaluation criteria: effectiveness; PR 6.

Conclusion 10: Integrated women and girl's empowerment and livelihood strategies were effective in reducing the risk and vulnerability to GBV and harmful practices. However, focus on gender transformative programming and power analysis needs further strengthening.
Combining economic empowerment for women and girls with gender transformative programming integrated with SRHR was effective in reducing risks and vulnerability to GBV and harmful practices including early and child marriage. However, the package needed to be standardized and context specific. Women, youth and adolescent strategies were stronger at SRHR integration but relatively weak at gender transformative programming and power analysis.

Origin: EQ 4; Evaluation criterion: effectiveness; PR 7.

Conclusion 11: Scale up of coverage for GBV prevention interventions was sub-optimal.
There were several promising GBV prevention and response interventions. However, the key challenge was how to scale these up country-wide. Some of the most effective interventions were on a relatively small scale and tended to show impact on direct beneficiaries. The key priorities were to understand how to diffuse the impact beyond direct beneficiaries and what kinds of platforms that could be used to implement interventions at scale.

Origin: EQ 4: Evaluation criteria: relevance, effectiveness; PR 10.
Origin: EQ 4: Evaluation criteria: relevance, effectiveness; PR 11.

Conclusion 12: There were a number of gaps, challenges, and limitations with the legislation of gender equality related policies and laws (Marriage and Divorce Bill (2011) and the Sexual Offences Bill (2011) **at national level.**
Despite the many policies and laws aimed at promoting gender equality and women empowerment, there were bills that stalled over the years e.g. the Marriage and Divorce Bill (2011) and the Sexual Offences Bill (2011). There were some areas where legislation did not fully protect women and girls, for example: neither the Penal Code nor the Domestic Violence Act (DVA) currently criminalizes marital rape. The DVA only considers persons in a "domestic relationship" with a perpetrator to be potential victims of "domestic violence" (marriage, co-habitation and domestic workers).

Origin: EQ 4; Evaluation criteria: effectiveness; PR 12.

Conclusion 13: Significant progress was achieved in the provision of evidence on the required investments for harnessing the DD and the development of the demographic dividend compliance tools. The National Demographic Dividend Roadmap was valuable in guiding implementation of activities related to DD.
Challenges remained particularly in relation to adequate funding and capacity building at the DLG level.

Origin: EQ 4: Evaluation criteria: effectiveness; PR 13.

CHAPTER 6: Recommendations

Based on the conclusions, the following recommendations were developed in a consultative process, as a result of a participatory discussion with key informants, a workshop held with the CPE management and CO and follow-up rounds of validation with the evaluation reference group. The timeframe for the implementation of the recommendations has also been indicated under short-term, medium-term and long-term period.

6.1 Strategic Level

Short-term period

1. During the design and implementation of the 9th CP, priority should be given to wide consultations with key stakeholders at all levels during programme implementation, consolidation of strategic partnerships, and responsiveness to the changing environment and needs in development and humanitarian settings.

Operational Implications: The 9th CP should be absolutely aligned to international, national and sub-national priorities and needs as well as being responsive to the changing environment. UNFPA and its partners should ensure wide and continuous consultations with key stakeholders at all levels including marginalized, hard-to-reach and most vulnerable populations. The strategic partnerships have worked well and should continue in the 9th CP with UNFPA making the best use of its comparative advantage in resource mobilisation from regular and new sources. Technical implication - CO to support MDAs on the adoption of appropriate methods to continuously reach and consult the marginalized, hard-to-reach and most vulnerable populations; Financial implication - CO to ensure that adequate financial resources are available to respond to the changing environment and needs.

Priority: High; **Time Frame**: Short-term; **Target level**: UNFPA CO, MDAs, DLGs and IPs; **Based on Conclusion:** 1

2. There is need for the UNFPA CO to continue building and strengthening partnerships with other UN Agencies under the umbrella of DaO so that resources can be sourced and pooled together to support joint activities of the UNCT thereby enhancing the added value of UNFPA. Partnerships with bilateral development partners and MDAs should be strengthened. UNFPA should proactively explore strategic partnerships with other MDAs like MAAIF, MWE, Ministry of Energy and Mineral Resources (MoEMR) and OPM (Directorate of Disaster Preparedness) that have mandate to address drivers of GBV and harmful practices related to climate change effects, environmental degradation, informal mining, oil and gas sub-sector and emergencies.

Operational Implications: The technical implications are (a) under DaO, UNFPA should continue to optimally make use of its comparative advantage as a data and evidence driven agency and the leader in integrated programming anchored on gender and human rights as well as an agency with technical expertise multi-sectoral programming and the humanitarian aid-development nexus; (b) UNFPA should deliberately create strategic alliances with MDAs to increase opportunities for holistic programming for GBV prevention and elimination of harmful practices. This should be preceded by formative assessments on the GBV-harmful practices climate change and environmental degradation nexus in development and humanitarian settings; and analysis of risk factors for GBV, gender inequality and human rights violations in the expanding oil and gas sector, informal mining as well as during emergencies.

Priority: High; **Time Frame**: Short-term; **Target level**: UNFPA CO, MDAs, DLGs and IPs; **Based on Conclusion:** 3

3. The next CP (9) should continue and further strengthen the existing multi-sectoral coordination framework that guided CP8. It should streamline coordination to eliminate any possibilities of parallel

coordination frameworks that have potential to undermine the multi-sectoral coordination structure and mandate at national and sub-national levels.
Operational Implications: The technical implications are (a) There is need to review and streamline the mechanisms for transfer of coordination funds to the DLG to ensure timely access to these funds but at the same time facilitate oversight and accountability for DLGs and IPs; (b) There is need to ensure that one of the major scores in the selection of potential IPs should be the physical presence in regions and districts of operation. Relevant DLGs should also participate in vetting IPs that will implement activities in their areas of jurisdiction. This will further improve and strengthen relationships between IPs and DLGs.

Priority: High; Time Frame: **Short-term**; **Target level**: UNFPA CO, NPC, MDAs, DLGs; **Based on Conclusion:** 3

4. There is need to strengthen the financial management system to facilitate programmatic and financial accountability by paying particular attention to innovative strategies aimed at reducing time between requisition and disbursement of funds to IPs. UNFPA CO should have dialogue with MDAs on strategies of strengthening financial and programme accountability of DLGs. The CO should also review the current financial disbursement mechanisms to DLGs particularly to facilitate supervision, coordination and holding IPs accountable for results and deliverables.

Operational Implications: The technical implication is that there is need for training including coaching and mentoring of all IPs on the financial management systems, procedures, and accountability and reporting requirements of UNFPA. Particular attention should be given to the analysis of workload of IPs in relation to the staffing. The human resource implication is that the staffing at the finance unit at UNFPA should be strengthened to enhance timely review of financial reports and feedback to IPs.

Priority: High; **Time Frame**: Short-term; **Target level**: UNFPA CO; **Based on Conclusion:** 5

5. There is need to further strengthen the intervention logic in the results framework to ensure that it includes all the relevant outcome and output indicators as well as stronger alignment of interventions to the outcomes and outputs. Assumptions should also be explicitly factored into the intervention logic.

Operational Implications: The technical implication is that there is need to review current intervention logic to ensure a clearer strategic linkage between outcomes, outputs and planned interventions for each thematic component. As much as possible, CP9 should go beyond stating indicators in categorical form (yes, no) to strengthen measurements of the quality of outputs and the processes. Particularly for some outcome indicators of GEWE and AY, there is need to ensure that output and outcome indicators capture all critical elements and planned interventions that contribute explicitly contribute to towards achievement of the outcomes.

Priority: High; **Time Frame**: Short-term; **Target level**: UNFPA CO; **Based on Conclusion**: 6

Medium-term period

6. Strong strategic leadership and capacity building is needed to support integrated programming at national and the sub-national levels.

Operational Implications: There is considerable appreciation and efforts to adopt strategies for integrated programming in SRHR/ HIV, GEWE and PD particularly at the national level. However, there are capacity gaps and challenges in leadership and implementation of the integrated programming approach at sub-national level. The technical implication is that advocacy by the CO among top leadership of MDAs and DLGs for integrated programming should be a major priority for the next CP. There is need to systematize, standardize, monitor and establish accountability mechanisms for integrating gender equality, rights and gender transformative programming in existing GoU programmes.

Priority: High; **Time Frame**: Medium-term; **Target level**: UNFPA CO, MDAs, DLGs and IPs; **Based on Conclusion:** 2

7. Given the current wide geographical scope of operation; currently covering more than 40 districts to make strategic decisions about consolidation vs. expansion. UNFPA CO should review and consider consolidation by intensifying intra-district and sub-county coverage in existing districts rather than scattering interventions and therefore spreading thinly. The CO should establish 2 separate DOs for eastern region and West Nile regions and increase the number of staff to two in each of the existing two DOs.

Operational Implications: The financial and human resource implications are that as resources become available, the strategic focus should be on increasing the number of staff at DOs and field offices. This will increase visibility, technical assistance and quality assurance at regional and DLG levels where it is needed most.

Priority: High; **Time Frame**: Medium-term; **Target level**: UNFPA CO; **Based on Conclusion:** 4

8. In order to strengthen equity, the human rights based approach and leaving no one behind, the next CP should actively advocate for use of the differentiated service delivery model to facilitate effective response to the peculiarities of needs and diverse contexts of hard-to-reach populations and communities.

Operational Implications: Service delivery and programming models for the general population rarely effectively target hard to reach communities such as nomads, people with different types of disabilities, fishing communities, people leaving in mountainous areas, most-at-risk populations and the LGBTI. The technical implication is that UNFPA CO should lobby MDAs, DLGs and partners to make deliberate efforts to explore different specialized and context specific models that are effective in reaching these groups and communities. The CO should advocate for the application of lessons learnt from HIV and AIDS programming where adoption of these models has increased effectiveness of targeting and meeting the needs of hard-to-reach population groups and communities.

Priority: High; **Time Frame**: Medium-term; **Target level**: UNFPA CO, MDAs, DLGs; **Based on Conclusion:** 2

9. UNFPA CO and its partners should ensure that the next CP continues to strengthen focus on data and evidence-based programming. This will increase the comparative advantage of UNFPA and further increase its credibility among multi-lateral and bilateral donors as well as among the key government of Uganda sectors.

Operational Implications: The financial and human resource implications are that there is need to deliberately mobilize resources to increase investment in data with a focus human and systems at CO, among strategic MDAs and at DLGs. At UNFPA Country Office, more support is needed to ensure balance between workload and staffing to foster effective and quality research, monitoring, learning and knowledge management.

Priority: High; **Time Frame**: Medium-term; **Target level**: UNFPA CO, NPC, MDAs, DLGs; **Based on Conclusion:** 7

6.2: Programmatic Level

Short-term period

1. UNFPA should actively engage MoH to functionalize HC IVs and upgrading of some HC IIIs into HC IVs in order to ensure high quality of obstetric care.

Operational Implications: The technical implication is that the CO should actively advocate and invest in capacity building for the following interventions: functionalizing HC IVs as CEmONC centres and HC IIIs as BEmONC centres including the upgrading of some HCIIs to HCIIIs; deployment of appropriately skilled human

resource for health (midwives, anaesthetists, medical doctors and laboratory staff) including review of the staffing structure and norms; advocating and supporting the recruitment of above critical staff cadres; and the establishment of blood transfusion services (physical space and equipment for blood storage) and infrastructural capacity to perform caesarean sections (theatre rooms, equipment, lighting, running water and sanitation) in all HC IVs. There are human resource and financial implications due to the deployment of above health staff and the health infrastructure.

Priority Level: High; **Time Frame:** Short-term; **Target**: UNFPA CO, MoH; **Based on programmatic conclusion (PC) 1**

2. UNFPA should support MoH to improve the robustness of the MPDSR system.

Operational Implications: The technical implication is that the CO should engage MoH for the strengthening the MPDSR committees at national level and district; strengthening the community level intelligence/surveillance for maternal deaths; encouraging pregnancy mapping and tracking by VHTs; strengthening the accountability/feedback systems for health at community and national level ('baraza', RMNCAH score card); and orienting political/technical leaders on the importance of MPDSR and safe motherhood.

Priority Level: High; **Time Frame**: Short-term; **Target**: UNFPA CO, MoH; **Based on PC 2**

3. Fistula repair should be integrated into other routine health services and more attention should be given to the re-integration of fistula survivors in the general community.

Operational Implications: The technical implication is that the CO should engage MoH to ensure that treatment interventions are integrated and supported through routine health care in health facilities with special support and training. The intervention should be linked to efforts to prevent obstetric fistula, to raise community awareness on fistula and to generate demand through community mobilisation. UNFPA should mobilize resources to support MoH and other actors in the scale up the re-integration of fistula survivors through obstetric fistula counselling and care.

Priority Level: Medium; **Time Frame**: Medium-term; **Target:** UNFPA CO, MoH, DLGs; **Based on PC 3.**

4. MoH in liaison with UNFPA should support the scale up of interventions /mechanisms that address persistent FP commodity stock-outs by operationalizing the re-distribution strategy.

Operational Implications: The technical implication is that UNFPA should support MoH with the scale up of interventions /mechanisms aimed at addressing FP commodity stock-outs. These should include the following: strengthening systems for FP stock status tracking and implementing the re-distribution strategy (inter- and intra-district); supporting community-based distribution of contraceptives; building capacity for forecasting of RH supplies down to HC III level; strengthening the logistic management information system for commodities to the last mile; and strengthening the one warehouse strategy to deliver an adequate FP method mix.

Priority level: High; **Time Frame**: Short-term; **Target:** MoH, UNFPA CO; **Based on PC 4**

5. Continue the meaningful engagement of young people in all levels of adolescent and youth programming including the scale up investment in innovations by young people in use of digital and online platforms and other approaches to increase access of SRH information.

Operational Implications: The technical implication is that the CO should advocate for strengthened opportunities and platforms for adolescents and young people as effective advocates for their own SRH, for gender equality and to address their rights. This should involve capturing their priorities and insights in developing approaches to stimulate demand creation among their peers. Due to the increasing use of digital and online platforms, including social media by young people themselves, they should be involved in the design of these platforms.

Priority Level: High; **Time Frame**: Short-term; **Target:** UNFPA CO, MoH, MGLSD, IPs; **Based on PC 7.**

6. The CO should advocate for significant investment and systems strengthening to foster consistent and sustained social norm change targeting service providers, leaders and local communities. For these campaigns to be more effective, they should be informed by formative research.

Operational Implications: For harmful social norms to be addressed effectively, there must be sustained social norm change campaigns with good level of coverage to facilitate reaching a critical mass of community activists and to facilitate social diffusion. This should involve increasing the number of community activists and MAGs among others as well as building strong support systems following the socio-ecological model. The financial implication is that UNFPA should support formative research to assess the situation in specific communities which is essential prior to developing appropriate and effective interventions.

Priority Level: High; **Time Frame**: Short-term; **Target:** UNFPA CO, MGLSD; **Based on PC 9.**

7. UNFPA and its partners should consider streamlining and standardizing the integrated SRHR/HIV/GBV package of services for women, youth, and adolescent groups but with strong focus on vocational skills training, IGAs combined with gender transformative programming and power analysis.

Operational Implications: The technical implication is that UNFPA and IPs should review, strengthen and standardize the current integrated SRHR/HIV/GBV package of services to increase its focus on vocational skills training and IGAs. UNFPA should invest in building capacity of human resources of MDAs, DLGs and CSOs in gender transformative and power analysis programming component in groups should also be strengthened to address drivers and risk factors for GBV inherent in patriarchal norms.

Priority Level: High; **Time Frame**: Short-term; **Target:** UNFPA CO, MoH, MGLSD, MoES; **Based on PC 10.**

Medium-term period

9. Build further capacity for integration of youth and gender friendly services within health facilities and communities.

Operational Implications: The next CP should leverage resources for greater investment in establishing the capacity of health care workers to provide integrated youth and gender friendly SRH services and to undertake effective community outreach to generate demand.

Priority Level: Medium; **Time Frame**: Medium-term; **Target:** UNFPA CO, MoH, MGLSD; **Based on PC 6.10. The CO should advocate for and support the development of a clear, realistic and feasible scale up strategy and plan for effective GBV prevention and response interventions country-wide in order to create a strong impact in the reduction of GBV and harmful practices.**

Operational Implications: Advocacy efforts should be made to explore the use of the *Expandnet* model developed by WHO and that has proved to guide scale up in low and middle income country settings. The technical implication is that UNFPA should advocate for and support the use of these models to be adopted for scale up by other agencies and partners. It should invest in building capacity of key human resources in MDAs, DLG and CSOs to effectively use evidence based models for scale up of interventions.

Priority Level: Medium; **Time Frame:** Medium-term; **Target:** UNFPA CO, MGLSD, MoH, DLG; **Based on PC 11.**

11. UNFPA in conjunction with MGLSD, MoH and MoES should strengthen current efforts to streamline and harmonize the different databases on GBV and VAC at national and sub-national levels.

Operational Implications: The technical implication is that UNFPA in partnership with other UN agencies and MGLSD should support the NGBV database to be functional through expanding its district coverage. This will

require financial investments in building the capacity of human resources and addressing infrastructural gaps (equipment, ensuring constant internet connectivity).

Priority Level: High; **Time Frame**: Medium-term; **Target:** UNFPA CO, MGLSD, DLG; **Based on PC 11**

12. UNFPA and partners should foster targeted advocacy campaigns with Cabinet, Parliament and religious and cultural leaders as well as civil society and media to catalyse the process of passing the Bills (protection of women and children against human rights violations) into Law by Parliament and to be assented to by the relevant authority.

Operational Implications: UNFPA and partners should invest financial and human resources to effectively engage key stakeholders in government, parliament, civil society, media as well as religious and cultural leaders to expedite the passing of relevant legislation that increases the protection for women and girls through championing gender equality and the rights based approach. The technical implication is that the CO should advocate for the review of existing legislation to address the gaps in the protection of women and children from human rights violations.

Priority Level: Medium; **Time Frame**: Medium-term; **Target:** UNFPA CO, MDAs, Media; **Based on PC 12.**

Long-term Period

13. The country programme should focus on the momentum built on the DD as this a vehicle for the realization of Uganda as a middle-income country by 2040. In this regard, the CO should advocate for and support to increase and ensure adequate resource mobilisation for PD to match the current needs.

Operational Implications: UNFPA should advocate and popularize PD issues to ensure that it is prioritized for funding by government and donors. There is need to build the technical capacity of human resources at DLG level to effectively make use of DD compliance tools.

Priority Level: High; **Time Frame**: Long-term; **Target:** UNFPA CO, NPC; **Based on PC 13**

14. UNFPA should engage the MoES to develop an advocacy and stakeholder engagement plan to address SE and find common ground for SE integration in the primary school education curriculum.

Operational Implications: The technical implication is that UNFPA CO should engage more robustly with the key stakeholders to identify common ground on SE integration and to build capacity. This should achieve some bottom-line agreements on what to include, age appropriateness of content, and on sensitive terminologies. An advocacy and stakeholder engagement plan should be developed to reach the MoES, faith based organisations and other conservative communities.

Priority Level: Medium; **Time Frame**: Long-term; **Target**: UNFPA CO, MoES; High; **Based on PC 5.**

Annexes

Annex 1: Terms of Reference

TERMS OF REFERENCE

GoU/UNFPA 8th Country Programme
2016-2020

Country Programme Evaluation

TABLE OF CONTENTS

Acronyms

BL4G – Better Life for Girls

CMR – Child Mortality Rate

CO – Country Office

COAR – Country Office Annual Report

CP – Country Programme

CPE – Country Programme Evaluation

DSA – Daily Subsistence Allowance

EO – Evaluation Office

EQA – Evaluation Quality Assessment

ERG – Evaluation Reference Group

GoU – Government of Uganda

ICPD – International Conference on Population and Development

JPGBV- Joint Programme on Gender Based Violence

M&E – Monitoring and Evaluation

MMR – Maternal Mortality Rate

NDPII – (Second) National Development Plan

NEX – National Execution

NPC – National Population Council

SDG – Sustainable Development Goals

SP – Strategic Plan

SRAs – Strategic Results Areas

SRH – Sexual Reproductive Health

SRHR – Sexual Reproductive Health Rights

ToC – Theory of Change

UDHS – Uganda Demographic Health Survey

UHSIP – Uganda Health Sector Strategic and Investment Plan

UN – United Nations

UNCT – United Nations Country Team

UNDAF – United Nations Development Assistance Framework

UNEG – United Nations Evaluation Group

UNFPA – United Nations Population Fund

UNHS – Uganda National Household Survey

UPHIA – Uganda Population-based HIV Impact Assessment

YEM- Youth Enterprise Model

1. INTRODUCTION

The 8th Country Programme (2016 – 2020) of UNFPA support to the Government of Uganda responds to national priorities as articulated in the National Strategic Vision 2040, the National Development Plan II (2015/16 – 2019/20), the United Nations Development Assistance Framework (2016-2020), the UNFPA Strategic Plans 2014-2017, and 2018 - 2021. The UNDAF is based on four Strategic Results Areas (SRAs) namely: (i) Transformative Governance; (ii) Human Capital; (iii) Sustainable and Equitable Economic Growth; and (iv) Environmental Sustainability, Land Management and Human Security. UNFPA contributes to SRAs (i), (ii) and (iv).

This 8th Country Programme (CP8) is operationalized through a Business Plan signed in 2015 between the GoU and UNFPA, which is the instrument for joint accountability between GoU and UNFPA. Therefore, this endline evaluation assesses joint accountability of results between UNFPA and GoU. In addition, using the lessons learned, it will inform future decision making, in particular, the development of the next Country Programme.

The UNFPA Evaluation Policy requires Country Programmes to be evaluated a year before the end of the running Country Programme, particularly for a large Country Programmes like GoU/UNFPA CP8, and especially in a context of changing priorities. According to the business model of UNFPA Strategic Plan (SP) 2014-2017, as well as the SP 2018 - 2022, Uganda is placed in the red quadrant as a low income country, implying the Country Programme was designed to apply four programming strategies at the national and sub-county levels, namely: (a) advocacy and policy dialogue/advice; (b) knowledge management; (c) capacity development; and (d) service delivery.

The evaluation is expected to be designed and implemented in accordance with the UNFPA methodological Handbook (https://www.unfpa.org/EvaluationHandbook). The handbook is a practical guide to help the evaluation team apply methodological rigour throughout the different phases of the evaluation. It is expected that the evaluation team is well acquainted with the Handbook at inception stage of the CPE.

2. COUNTRY CONTEXT

Uganda's population has grown from 9.5 million in 1969 to 34.6 in 2014 (Census, 2014). It is projected to reach 75 million by 2040. With an annual population growth rate of 3%, Uganda has one of the fastest growing population in the world. The high population growth rate is attributed mainly to a high fertility rate. Although the fertility rate in Uganda has dropped from 6.2 in 2011 to 5.4 in 2016 (UDHS, 2016), Uganda's current level of fertility is still one of the highest in sub-Saharan Africa. There has also been a decline in mortality indices. Under-five or Child Mortality Rate (CMR) has decreased from 137 deaths in 2006 to 64 deaths per 1,000 live births in 2016 (UDHS, 2006; 2016). Maternal Mortality Ratio (MMR) has also decreased from 435 in 2006 to 336 deaths per 100,000 live births in 2016 (UDHS, 2006; 2016).

The decline in fertility rate has been slower than the decline in CMR and MMR. Consequently, the population of Uganda has increasingly become younger. Today, 68% of the population is below the age of 24 years; and about half (48%) of the population consist of young people under the age of 15 years.

The main underlying reasons for the high fertility rate is the high unmet need for family planning. Access to family planning in Uganda is inadequate, with unmet need standing at 28% (UDHS, 2016), one of the highest in sub-Saharan Africa. Modern Contraceptive Prevalence Rate among married women remains low despite the increase from 26% in 2011 to 35% in 2016 (UDHS, 2006; 2016).

Key bottlenecks to contraceptive use include limited access to SRH information and services by women and adolescents due to a weak health system, including inadequate number of skilled staff to provide a wide range of methods and youth friendly services. As such, approximately 25% of adolescent girls become pregnant before the age of 19, with teenage pregnancy rate of 25% (UDHS, 2016), which is one of the highest in Sub-Saharan Africa. Teenage pregnancy contributes up to 28% of maternal deaths in Uganda.

Sixty-five percent of Ugandan youth in the age bracket of 20-24 are unemployed; whereas 90 percent of those above 25 years are either unemployed or underemployed. Thus child dependency ratio in Uganda remains high, currently standing at 103 children per 100 working population. This hampers the ability of the family and the Government to provide basic needs and social services such as food, shelter, clothing, education, health, safe water and health services.

Nevertheless, the proportion of people living below the national poverty line has declined from 39 per cent in 2002 to 19.7 per cent in 2011. Although the poverty level has risen again to 21% in 2018 (UNHS[203], 2018), this achievement surpasses the country's Millennium Development Goal target of 25 per cent.

Maternal mortality ratio has also decreased from 438 per 100,000 live births in 2011 to 368 per 100,000 live births in 2016 (UDHS, 2011; 2016). Up to 28 per cent of maternal deaths are attributed to young girls aged 15-24 years. This is could partly be attributed to the increase in skilled birth attendance, which has increased increased from 42 per cent in 2006 to 73% per cent in 2016 (UDHS, 2006; 2016). However, Socio-cultural factors and gender inequality continue to deter access to services, especially in rural communities. Poorly coordinated community mobilization, along with inadequate male involvement in health, restricts women and young people from utilizing available services.

HIV prevalence increased from 6.4 per cent in 2005 to 7.3 per cent in 2011, and fell down again to 6.2% in 2017 (UPHIA, 2017). However, it remains higher among women, particularly in mid-northern central, south-western regions (UPHIA, 2017). Key drivers of HIV infections include risky sexual behaviour, low comprehensive knowledge on HIV, low individual risk perception and low access to services by most-at-risk populations. Weak integration of services, inadequate human resources and stock-outs of condoms and test kits further constrain HIV/AIDS prevention efforts.

High rates of sexually transmitted infections, sexual violence and unsafe abortion continue to affect the sexual reproductive health of adolescents. A number of factors – socio-cultural norms; low school attendance for girls; household poverty; lack of comprehensive sexuality education, both in schools and communities; and low coverage of youth friendly services at health facilities – force girls into early sexual relationships, early marriage and early child bearing, and constrain efforts to reduce teenage pregnancy.

Uganda has a strong policy and legal framework to promote gender equality. However, the implementation of the policies, as well as monitoring and reporting on recommendations from treaty bodies, remains weak. The prevalence of gender-based violence is high, with half of men and women aged 15 – 49 having experienced physical violence in 2016 since the age of 15. Although the national prevalence of female genital mutilation is only 1 per cent, it is much higher in certain communities

Uganda is currently facing Africa's largest refugee crisis with a total of 1,326,750 refugees from South Sudan and the Democratic Republic of Congo. The refugee crisis shows no sign of abating. Eighty-six per cent of the refugees are women and children while 60% of the refugee population are children under 18 years of age. Out of those, 52% are women, 35% are estimated

[203] UNHS: Uganda National Household Survey

to be young people (age 10-24), and about 37% are of reproductive age. The government has made refugee-hosting areas a national priority through the Settlement Transformative Agenda (STA) which is aligned to the National Development Plan II. The rapidly increasing number of refugees in the country has resulted in limited access to sexual and reproductive health care services and rights of women, girls and youth in refugee and host communities.

Uganda consistently collects census and survey population data; it has administrative information systems that provide data on sexual reproductive health, gender-based violence and HIV. However, national capacity for in-depth analysis of the data is limited; the administrative data is not regularly updated and analysed to inform decision-making. Although improving, the use of data on population dynamics to inform planning, policy formulation, implementation and monitoring remains low, both at national and district levels.

3. UNFPA PROGRAMMATIC SUPPORT TO GOVERNMENT OF UGANDA

The eighth Country Programme (CP) is being implemented by a wide spectrum of partners, including the Government, civil society, academia and the private sector at national level and in 25 districts. It is aligned with national priorities, as outlined in National Vision 2040, National Development Plan II (2015/2016-2019/2020), the United Nations Development Assistance Framework (2016-2020) and the United Nations Population Fund (UNFPA) Strategic Plan (SP) 2014-2017, and contributes to harnessing the demographic dividend while taking into account the lessons learned from the previous country programme. The programme supports the Government of Uganda in delivering the Sustainable Development Goals particularly: - Goal 3: Health; Goal 4: Education; Goal 5: Gender; and Goal 16: Peaceful Societies. The specific programme linkage to the National Development Plan, United Nations Development Assistance Framework, UNFPA SP and SDGs is elaborated under each of the programme outputs.

Direct beneficiaries of the programme are women and young people, especially adolescent girls, and most at risk populations. Targeting especially districts with poor sexual reproductive health indicators, the programme also addresses humanitarian preparedness and response.

The country programme contributes to[204]: -

Outcome 1: Sexual and reproductive health

Output 1: National and district governments have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings.

Interventions focus on the following: -

(a) supporting advocacy for increased government financial and human resources for maternal health and family planning;
(b) building a national accountability mechanism, including by scaling up maternal death surveillance and response, and establish a performance monitoring scorecard mechanism to ensure access to high-quality care according to human rights principles;
(c) supporting national and local governments in establishing strong partnerships and effectively coordinate integrated sexual reproductive health and rights interventions, including preparedness and response in humanitarian settings;
(d) strengthening the midwifery programme and provide equipment to health facilities for provision of emergency obstetric care, post abortion care, obstetric fistula management and the Minimum Initial Service Package for Reproductive Health in humanitarian settings.

[204] United Nations Population Fund Country Programme for Uganda (2016-2020) – See the "Results and Resources Framework for Uganda (2016-2020)"

Output 2: National and district governments have the capacity to increase the demand for and the supply of modern contraceptives.

Interventions focus on the following: -

(a) policy advocacy for task shifting and sharing among service providers, improving availability of integrated maternal health and family planning services;
(b) advocacy for progressive increment of resources to implement family planning scale -up plans;
(c) technical and financial support to improve commodity forecasting, procurement and supply chain management system at national and district levels;
(d) establishment of effective coordination mechanisms for family planning programmes;
(e) training of health professionals to provide a high-quality method mix in family planning, according to the new family planning human rights protocol; and
(f) support of community health extension workers' strategy to increase demand for family planning services.

Output 3: Increased national capacity to deliver integrated sexual and reproductive health and HIV/AIDS prevention programmes that are free of stigma and discrimination.

Interventions focus on the following: -

(a) support ministries of health, education and social development to deliver integrated and coordinated HIV and sexual and reproductive health programmes for young people;
(b) mobilize religious and cultural institutions to scale up social and behavioral change interventions;
(c) generate evidence to improve HIV and sexually-transmitted infections programming for young people; and
(d) support implementation of the 10-step strategic approach to comprehensive condom programming, including for most-at-risk populations.

Outcome 2: Adolescents and youth

Output 1: Increased national capacity to conduct evidence-based advocacy/ interventions for incorporating adolescents and youth sexual reproductive health needs in national laws, policies and programmes, including humanitarian settings.

Interventions focus on the following:

(a) advocate for the integration of comprehensive sexuality education in curricula for secondary schooling, teacher training (primary and secondary), vocational training and in developing a minimum package for out-of-school youth;
(b) support ministries of health, gender and education to coordinate adolescent sexual reproductive health initiatives and to provide youth-friendly services, especially for vulnerable adolescent girls, including in humanitarian settings;
(c) support youth networks to facilitate participation of young people in development processes, particularly in matters of sexual reproductive health and rights;
(d) promote evidence based social and behavioral change communication to address social norm barriers to adolescent sexual and reproductive health.

Outcome 3: Gender equality and women's empowerment

Output 1: National and district governments have the capacity for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings. Interventions focus on the following:

(a) support behavioral change strategies for addressing gender-based violence, female genital mutilation, teenage pregnancies, and child and forced marriage;
(b) support advocacy for integration of gender-based violence prevention and response, and human rights in sexual and reproductive health programmes;
(c) advocate for enforcement of policies and laws on gender-based violence;
(d) provide technical support to the Ministry of Gender, Labour and Social Development and civil society to develop and implement multisectoral service standards and protocols that meet human rights standards;

(e) support the Ministry of Gender, Labour and Social Development and civil society to monitor implementation, track accountability and report on sexual and reproductive health and rights commitments in regional and international instruments, including by using the Gender Score Card.

Outcome 4: Population dynamics

Output 1: National institutions and district governments have the capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender-based violence for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings.

Interventions focus on the following:

(a) support ministries and local governments to generate, communicate and utilize evidence for planning and decision-making;
(b) support the Uganda Bureau of Statistics and research institutions to generate evidence through in-depth analysis of survey and census data; mapping demographic and geographic disparities and prepare for the 2020 census; and
(c) strengthen management information systems for health, education, gender-based violence, vital statistics and humanitarian crisis profiling.

In contributing to all the above areas, the programme adopted a mode of engagement focusing on the following strategies: -

i) advocacy and policy dialogue/advice;
ii) capacity development;
iii) knowledge management and innovation; and
iv) service delivery in limited cases.

The implementation of the eighth GOU-UNFPA Country Programme is operationalized through Country Programme Business Plan which is an instrument for joint accountability for results between GoU and UNFPA. The role of UNFPA is complementary to that of GoU. UNFPA has risen to its commitment by contributing resources to support implementation of the CP8. The implementation of the programme is through the national and decentralized channels to achieve programme results. The 8th GoU-UNFPA CP currently covers 38 districts, including 25 core districts with the worst SRHR indicators, namely Kween, Moyo, Nakapiripirit, Napak, Ngora, Yumbe, Abim, Adjumani, Amuria, Amuru, Apac, Bududa, Bukedea, Bulambuli, Bundibugyo, Kaberamaido, Kaabong, Kanungu, Katakwi, Kibuku, Kiryandongo, Kitgum, Kotido, Amudat, and Moroto.

The impact of Refugees on the GoU/UNFPA CP8 was not foreseen at the signing of the Business Plan of the CP8. Nevertheless, UNFPA has effectively responded to the protracted and widespread refugee influx by mobilizing more resources and by strengthening its presence in the field. For period 2018, UNFPA mobilized US$500,000 for rapid response, and additional US$ 2.2 million for CERF unfunded emergency project. Today, UNFPA has a total seven decentralized offices covering all refugee hosting districts and the most hard-to-reach districts.

4. OBJECTIVES AND SCOPE OF EVALUATION

The Country Programme Evaluation (CPE) will contribute to the accountability of UNFPA for results, as well as analyze the relevance and performance of the 8th UNFPA-GoU Country Programme for Uganda 2016-2020. It is envisaged that the evaluation will also improve on the strategic positioning of the UNFPA Country Office in Uganda, facilitate organizational learning and support evidence-based programming.

The CPE will assess the programme's contribution to achieving development results at the country level, including constraining and facilitating factors of programme design and performance. The evaluation will apply appropriate methodology for assessing principle cross-cutting elements of equity and vulnerability, gender equality and human rights in the programmes/projects of this cycle. It will be based on the guiding principles, norms and standards for evaluations adopted at UNFPA, and will use specific evaluation criteria and evaluation questions.

4.1 Objectives

The overall objectives of the evaluation are:

i) Enhanced accountability of UNFPA to its donors, partners and other stakeholders for the relevance and performance of the country programme;
ii) Broadened evidence base, including lessons learned and practical recommendations, for input into the ninth (9th) programme cycle (2021-2025).

Specifically, the evaluation seeks to achieve the following objectives:

1. To provide an independent assessment of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme
2. To provide an assessment of the country office positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results
3. To provide an assessment of the extent to which programme implementation frameworks and modalities have enabled or hindered achievement of the programme outputs
4. To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming design

4.2 Timeframe

Within the framework of the above evaluation objectives, the CPE will cover the period from 2016 to 2020.

4.3 Geographic scope

The evaluation will focus primarily on the 8th GoU-UNFPA CP 25 core districts where most of the resources of the CP have been focused, namely the following districts[205]: Kween, Moyo, Nakapiripirit, Napak, Ngora, Yumbe, Abim, Adjumani, Amuria, Amuru, Apac, Bududa, Bukedea, Bulambuli, Bundibugyo, Kaberamaido, Kaabong, Kanungu, Katakwi, Kibuku, Kiryandongo, Kitgum, Kotido, Amudat, and Moroto) 7 refugee hosting districts which fall outside the 25 core districts. These are the districts where all/most of 4 thematic intervention areas have been implemented, namely (a) Sexual Reproductive Health; (b) Adolescents and Youth; (c) Gender Equality and Women Empowerment; and (d) Population Dynamics. Other districts will be considered on the basis of special programmes were or are being implemented in the course of the programme cycle, e.g. Kampala and Mubende.

[205] New districts have been created out of some of the original 25. The evaluation will focus on the traditional districts, including all those have been created out of them

5. EVALUATION CRITERIA AND QUESTIONS

In line with the methodology for CPEs as set out in the UNFPA Evaluation Office Handbook on *How to Design and Conduct Country Programme Evaluations* (2019)[206] the following aspects will be covered *viz* Relevance, Effectiveness, Efficiency, Sustainability and Coordination, as defined below: -

- ➔ **Relevance -** To both national priorities and UNFPA policies and strategies, and how they address different and changing national contexts.
- ➔ **Effectiveness** - The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes.
- ➔ **Efficiency -** In terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.
- ➔ **Sustainability -** The extent to which the benefits from UNFPA support are likely to continue, after it has been completed.
- ➔ **Coordination -** The extent which UNFPA has contributed to the coordination mechanism of the United Nations Country Team, the extent to which the Country Programme is aligned to the UNDAF in the country; and the extent to which the UNFPA Country Office is coordinating with other UN agencies in the country, particularly in the event of potential overlaps.

Key evaluation questions to be asked should include the following:

a. Relevance

i) To what extent the CP8 is aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups[207], goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?

ii) To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?

iii) To what extent has the programme integrated gender and human rights based approaches?

b. Effectiveness

i) To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)[208]? Were the planned geographic areas and target groups successfully reached?

ii) What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

[206] https://www.unfpa.org/EvaluationHandbook

[207] To what extent has UNFPA ensured that the varied needs of vulnerable and marginalized populations, including adolescents and youth, those with disabilities and hard-to-reach communities, have been taken into account in both the planning and implementation of all UNFPA-supported interventions under the country programme?

[208] Include an assessment of how well signature interventions (including Male Action Groups, Women's Safe Spaces, SASA!) were implemented, relative to minimum standards

c. Efficiency

i) How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimize achievement of results described in the CP?

ii) To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

d. Sustainability

i) To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?

ii) What are the main comparative strengths of UNFPA in Uganda[209]; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

e. Coordination

i) To what extent has UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?

The final evaluation questions and the evaluation matrix will be finalized by the evaluation team in the design report.

6. METHODOLOGY AND APPROACH

6.1 Evaluation approach

The evaluation will adopt an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at both national and sub-national levels. The evaluation will ensure the participation of women, girls and youths in particular, those from vulnerable groups of targeted populations.
The methodological design will include: an analytical framework; a strategy for collecting and analyzing data; specifically designed tools; an evaluation matrix; and a detailed work plan.

The evaluation team will develop the evaluation approach and methodology, including corresponding tools for collecting data, generally guided by the following: -

a) The Evaluation Handbook: "*How to Design and Conduct a Country Programme Evaluation at UNFPA", 2019*

b) United Nations Evaluation Group (UNEG)'s *(i) Norms and Standards for Evaluation; (ii) The UN Ethical Guidelines for Evaluators; (iii) Integrating Human Rights and Gender Equality in Evaluations*

[209] In the context of the new aid environment and in the era of new generation UNDAF?

The evaluators will be required to sign the Code of Conduct Prior to participating in the evaluation Exercise

6.2 Methodology

The CPE will be designed in such a way that will meet the objectives of the evaluation that are stipulated in section 4 above, by using a contribution analysis. Accordingly, t\he evaluation team will reconstruct the logic behind the country programme interventions (theory of change) for the period under evaluation from planning documents and represent it in a diagram to be presented in the inception report. The Theory of Change (ToC) reflects the conceptual and programmatic approach taken by UNFPA over the period under evaluation including the most important implicit assumptions underlying the change pathway. The ToC will include the types of intervention strategies or modes of engagement used in program delivery, the principles/guiding interventions, the elements of the intervention logic, the type a level of expected changes and the external factors and influence and determine the causal links depicted in the theory of change diagram. The ToC will be tested during the field and data collection phase.

Evaluators will analyse and interpret the logical consistency of the chain of effects: linking programme activities and outputs with changes in higher-level outcome areas, based on observations and data collected along the chain. This analysis should serve as the basis of a judgment by the evaluators on how well the programme under way is contributing to the achievement of the intended results foreseen in the country programming documents.

The finalization of the evaluation questions that will guide the evaluation should clearly reflect the evaluation criteria and indicative evaluations questions listed in the present terms of reference. They should also draw on the findings from the reconstruction of the intervention logic of the country programme. The evaluation questions will be included in the evaluation matrix (see Annex 7) and must be complemented by sets of assumptions that capture key aspects of the intervention logic associated with the scope of the question. The data collection for each of the assumptions will be guided by clearly formulated quantitative and qualitative indicators also indicated in the matrix.

Data Collection

The evaluation will use both qualitative and quantitative methods for data collection, including document review, group and individual interviews, focus groups and field observations as appropriate. The evaluation will consider both secondary and primary sources for data collection.

Secondary sources will inform the desk review that will focus primarily on programme reviews, progress reports, monitoring data gathered by the country office in each of the programme components, evaluations and research studies conducted and large scale and other relevant data systems in country. Primary data collection will include semi-structured interviews at national and subnational level with beneficiaries, government officials, representatives of implementing partners and civil society organizations and other key informants.

Field visits will be conducted on sample basis during which focus group discussions will be conducted with beneficiaries and observations will provide additional primary data. The evaluators will be required to take into account ethical considerations when collecting information. The evaluation team is expected to spend three weeks in Uganda meeting with stakeholders at national and sub-national levels. The proposed field visit sites, stakeholders to be engaged and interview protocols will be outlined in the inception report to be submitted by the evaluation team. When choosing sites to visit, the evaluation team should make explicit the reasons for selection. The choice of the locations to

visit at sub-national level needs to take into consideration the implementation of UNFPA's program components in those areas and done in consultation with the evaluation manager and ERG.

Data validation

The evaluators will use a variety of methods to ensure validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, validation of data will be sought through regular exchanges with the UNFPA programme staff and the Evaluation Reference Group. A validation workshop with members of the ERG and other key stakeholders will be conducted at the end of the field phase.

Data Analysis

The evaluation team will use a variety of both quantitative and qualitative methods to ensure that the results of the data analysis are credible and evidence-based. The analysis will be made at the level of programme outputs and corresponding components and their contribution to outcome level changes. The evaluation team is expected to ensure that

i. All findings and conclusions are substantiated by evidence
ii. bases for interpretations and conclusions are carefully described
iii. Analyses are presented against the evaluation questions/objectives and the indicators in the evaluation matrix
iv. Analyses are transparent about the sources and quality of data
v. Cause and effect links between an intervention and its end results are explained and any unintended outcomes highlighted
vi. Results are disaggregated by different target groups, including region, age and sex where applicable and feasible
vii. Analysis presented against contextual factors

Limitations to the methodology

The evaluation team will identify possible limitations and constraints during the data collection phase and present mitigating measures in the draft report.

7. EVALUATION PROCESS

The CPE will be undertaken in five phases, each of them involving several steps, with respective deliverables. Quality assurance measures should be integrated in all the phases to ensure high quality work.

Preparatory phase

This phase, managed by the UNFPA Country Office, will include: -

- Drafting of evaluation ToR and securing approval from the EO
- Establishing an Evaluation Reference Group (ERG)
- Selection, prequalification and hiring of the evaluation team
- Preparing the initial set of documentation for the CPE, including list of Atlas projects, stakeholder map which is the annex to the TOR), programme and financial data, all corporate and country specific reports e.g. Country Office Annual Report (COAR)
- A stakeholder map - the Evaluation Manager will prepare a preliminary mapping of stakeholders relevant to the evaluation (to be provided to the evaluation team)

The preparation phase may include a short *scoping mission* to the UNFPA Country Office by the Evaluation Team Leader to gain better understanding of the development context, UNFPA programme and partners, refine the evaluation scope, identify potential sites for field visits etc.

a. The Design phase

During the design phase, the Evaluation Team will perform the following tasks: -

- A review of all relevant documents available at the UNFPA Country Office, Regional Office and Headquarters levels regarding the 8th UNFPA Country Programme
- Mapping of stakeholders relevant to the CPE, including state and civil society stakeholders and indicating the relationships between different sets of stakeholders; the stakeholder map will be used for stakeholder sampling for data collection
- Reconstruction of the intervention logic of the programme, i.e. the theory of change meant to lead from planned activities to the intended results of the programme
- Finalization of the list of evaluation questions and preparation of the *evaluation matrix*
- Development of a data collection and analysis strategy, as well as a concrete work plan for the field phase

Once all the interviewees and field trips have been identified by the evaluators, the UNFPA Evaluation Manager (together with the country office staff) will organize the required logistical arrangements.

At the end of the design phase, the evaluation team will produce an evaluation **design report** summarizing the results of the above-listed steps and tasks. This report must demonstrate how the evaluators have understood the purpose and objectives of the CPE, its scope and criteria, the country's development context and programme intervention logic, selected evaluation questions, and should convincingly illustrate how the evaluators intend to carry out the evaluation and ensure its quality.

The design report must include the evaluation matrix, stakeholders map, final evaluation questions and indicators/criteria, evaluation methods to be used, information sources, approach to and tools for data collection and analysis, calendar work plan, including selection of field sites to be visited – prepared in accordance with the UNFPA Handbook *"How to Design and Conduct a Country Programme Evaluation"* and the structure of the final report. The design report should also present the reconstructed programme intervention cause-and-effect logic linking actual needs, inputs, activities, outputs and outcomes of the programme. The design report will be reviewed by the ERG and approved by the Evaluation Manager and UNFPA Regional Evaluation Adviser before the CPE field phase commences.

b. Field phase

After the design phase, the Evaluation Team will undertake a three-week mission in the country to collect and analyse the data required in order to answer the evaluation questions consolidated at the design phase, and to analyze the findings with a view to formulate preliminary conclusions. Fieldwork will commence with a briefing to CO staff on the evaluation. At the end of the field phase, the Evaluation Team will provide the UNFPA country office with a debriefing presentation on the preliminary results of the evaluation, with a view to validating these preliminary findings and testing tentative conclusions and/or recommendations.

c. Reporting phase

During this phase, the Evaluation Team will continue the analytical work initiated during the field phase and prepare a ***first draft of the final evaluation report***, taking into account comments made by the country office at the debriefing meeting. This first draft final report will be submitted to the Evaluation Reference Group for written comments. Comments made by the ERG and consolidated by the UNFPA Evaluation Manager will then allow the Evaluation Team to prepare a ***second draft of the final evaluation report***.

This second draft report will form the basis of a validation and dissemination seminar, which should be attended by the country office, as well as all the key programme stakeholders (including key national counterparts). The second draft of the final report will be reviewed by the Regional Monitoring and Evaluation Adviser including comments provided by the Country Office staff and stakeholders. The ***final report*** will be drafted shortly after the workshop, taking into account comments made by the programme stakeholders.

d. Quality Assurance

The Reporting Phase closes with the three-stage evaluation quality assessment (EQA) of the final evaluation report. The EQA process involves: (a) a quality assessment of the final evaluation report by the CO evaluation manager; (b) a quality assessment by the regional monitoring and evaluation adviser; (c) a final independent quality assessment by the Evaluation Office.

The first level of quality assurance of all evaluation deliverables will be conducted by the evaluation team leader prior to submitting the deliverables to the review of the CO.

The CO recommends that the evaluation quality assessment checklist (see below) is used as an element of the proposed quality assurance system for the draft and final versions of the evaluation report. The main purpose of this checklist is to ensure that the evaluation report complies with evaluation professional standards.

Evaluation quality assessment checklist:

1. Structure and Clarity of the Report To ensure report is user-friendly, comprehensive, logically structured and drafted in accordance with international standards.
2. Executive Summary To provide an overview of the evaluation, written as a stand-alone section including key elements of the evaluation, such as objectives, methodology and conclusions and recommendations.
3. Design and Methodology To provide a clear explanation of the methods and tools used including the rationale for the methodological choice justified. To ensure constraints and limitations are made explicit (including limitations applying to interpretations and extrapolations; robustness of data sources, etc.)
4. Reliability of Data To ensure sources of data are clearly stated for both primary and secondary data. To provide explanation on the credibility of primary (e.g. interviews and focus groups) and secondary (e.g. reports) data established and limitations made explicit.
5. Findings and Analysis To ensure sound analysis and credible evidence-based findings. To ensure interpretations are based on carefully described assumptions; contextual factors are identified; cause and effect links between an intervention and its end results (including unintended results) are explained.
6. Validity of conclusions To ensure conclusions are based on credible findings and convey evaluators' unbiased judgment of the intervention. Ensure conclusions are prioritised and clustered and include: summary; origin (which evaluation question(s) the conclusion is based on); detailed conclusion.
7. Usefulness and clarity of recommendations To ensure recommendations flow logically from conclusions; are targeted, realistic and operationally feasible; and are presented in priority order. Recommendations include: Summary; Priority level (very high/high/medium); Target (administrative unit(s) to which the recommendation is addressed); Origin (which conclusion(s) the recommendation is based on); Operational implications.
8. SWAP - Gender To ensure the evaluation approach is aligned with SWAP. (guidance on the SWAP Evaluation Performance Indicator and its application to evaluation can be found at http://www.unevaluation.org/document/detail/1452 and UNEG guidance on integrating gender and human rights more broadly can be found here: http://www.uneval.org/document/detail/980)

The second level of quality assurance of the evaluation deliverables will be conducted by the CO evaluation manager.

Finally, the evaluation report will be subject to assessment by an independent evaluation quality assessment provider. The evaluation quality assessment will be published along with the evaluation deliverables on the Evaluation Office website at: https://web2.unfpa.org/public/about/oversight/evaluations/

UNFPA Evaluation Office quality assurance system, based on the UNEG norms and standards and good practices of the international evaluation community, defines the quality standards expected from this evaluation. A key element is the evaluation quality assessment grid (EQA),[210] which sets out processes with in-built steps for quality assurance and outlines for the evaluation report and the review thereof. The EQA will be systematically applied to this evaluation.

e. Dissemination and Follow-up

During this phase, the country and regional offices, as well as relevant divisions at UNFPA headquarters will be informed of the CPE results. The evaluation report, accompanied by a document listing all recommendations, will be communicated to all relevant units within UNFPA, with an invitation to submit their response. Once filled, this document will become the *management response* to the evaluation. The UNFPA Country Office will provide the management response within six weeks of the receipt of the final evaluation report.

The evaluation report, along with the management response, and EQA of the report will be published in the UNFPA evaluation database within eight weeks since their finalization. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

8. EXPECTED DELIVERABLES

The Evaluation Team is expected to produce the following deliverables:

a) Inception (design) report including at least: -
   i) detailed evaluation work plan;
   ii) a stakeholder map;
   iii) the evaluation matrix (including the final list of evaluation questions and indicators);
   iv) the overall evaluation design and methodology including sampling, with a detailed description of the data collection plan for the field phase.

b) Debriefing note/preliminary report (Power Point) synthesizing the main preliminary findings, conclusions of the evaluation, to be presented and discussed with the country office just after the fieldwork phase.

c) First draft of the final evaluation report, presented for inputs from the Evaluation Reference Group.

d) A PowerPoint presentation of the results of the evaluation for the validation and dissemination seminar.

e) A final report based on recommendations from the validation and dissemination seminar.

9. INDICATIVE TIMEFRAME

CPE Phase ad Task	June				July				August				September				October				November			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparatory Phase																								
Drafting of the Terms of Reference																								

[210] Annex 6 presents the Evaluation Quality Assessment Grid.

CPE Phase ad Task	June				July				August				September				October				November			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Review and approval of Terms of Reference by ESARO and EO																								
Pre-qualification of consultants																								
Recruitment of the evaluation team																								
Design Phase																								
Evaluation Reference Group (ERG) meeting																								
Understanding of the UNFPA strategic response, programmatic response																								
Submission of design/inception report by the evaluation team																								
Field Phase																								
Data collection, analysis and debriefing																								
Reporting phase																								
1st draft final report																								
ERG meeting																								
Feedback to draft report																								
2nd draft final report																								
Feedback on 2nd draft final report																								
Final report																								
Dissemination and management response																								
Quality assessment of final report																								
Dissemination among stakeholders																								
Management response preparation																								

10. COMPOSITION OF THE EVALUATION TEAM

The evaluation will be conducted by an independent multidisciplinary evaluation team composed of two national experts and a national or international consultant for the position of evaluation team leader. The evaluation team is expected to have expertise covering each of the thematic area: i.e. a technical expert for each thematic area of the country programme – reproductive health, population and development, and gender[211]. The Team Leader is expected to have a solid background in *one* of the three thematic areas of the country programme (sexual and reproductive health; population and development; gender equality) and, in addition to his/her responsibilities as team leader, will also serve as a thematic specialist in the Evaluation Team—preferably as a sexual and reproductive health expert because of the number of indicators to be covered, and the working days allotted to this thematic area. The qualifications, experience and competencies of thematic specialists for each thematic area are described below.

Roles and Responsibilities of the evaluation team

- The team leader with be overall responsible for the evaluation process and the production of the draft and final evaluation reports. S/he will lead and coordinate the work of the evaluation team during all phases of the evaluation and be responsible for the quality assurance of all evaluation deliverables. She/he will liaise with the Evaluation Manager at the CO on various issues related to successful completion of the evaluation exercise.

[211] Adolescent and Youth SRH issues will be covered under SRH and Gender

- The Team Leader will have the requisite expertise in the development field and be experienced in conducting complex type of evaluations, like country programme evaluations, partnership evaluations, strategic evaluations, thematic multi-country evaluations. She/he will have overall responsibility for providing guidance and leadership in: development of the evaluation design including approach, methodology and workplan; drafting the design, draft and final reports, as well as brief summary for presentation at a dissemination workshop. The team leader will lead the CPE process and will provide guidance to the other team members. The team leader is also expected to be either the SRHR expert or the population expert.

- A sexual and reproductive health expert (Consultant) will provide expertise in sexual, reproductive and maternal health (including family planning, HIV prevention, and human resource management in the health sector) and adolescent health. She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to reproductive health and rights.

- A population expert (Consultant) will provide expertise in population and development issues (including census, democratic governance, population dynamics, monitoring and evaluation, legal reform processes, national and local capacity development and the national statistical system). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to population and development.

- A gender expert (Consultant) will provide expertise in gender equality issues (women and adolescents reproductive rights, prevention of discrimination and violence against women, etc). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to the national context and gender equality.

11. QUALIFICATIONS AND EXPERIENCE OF THE EVALUATION TEAM

a) Team Leader

- At least a Master's degree or equivalent in one of the following fields: Population studies, Statistics, Demography, Public health, Gender, Development Studies
- 10 years' experience in conducting complex evaluations in the field of development aid for UN agencies and/or other international organizations including experience in leading evaluations
- Substantive knowledge of sexual and reproductive health, population and development and gender equality
- Good knowledge Uganda's national development context
- In-depth knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods
- Experience in carrying out country programme evaluations
- Familiarity with UNFPA or UN operations

- Past experience as evaluation team leader in a related assignment(s).
- Excellent analytical, writing and communication skills
- Experience working with a multi-disciplinary team of experts
- Excellent written and spoken English
- Proven experience in policy development and analysis around reproductive health, gender, population issues and poverty reduction strategies for national consultants highly desirable
- Experience and understanding of UN programming processes. Knowledge of UN reforms is highly desirable.
- Experience and skills in using evidence-based, knowledge base creation and ability to develop systems for improved performance.
- Experience on evaluation of UN supported programmes will be an added advantage.

Sexual and reproductive health expert

- An advanced degree in Medicine or related fields, Health Economics, Epidemiology or Biostatistics.
- Specialization in public health;
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of sexual and reproductive health as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills

Population expert

- An advanced degree in Population studies, Statistics or Demography.
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of Population and development as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills

Gender and Development expert

- An advanced degree in Gender and Development, Sociology, Social Work.

- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of Gender Equality as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills

b) National Consultants

- Master's Degree in Population, Demography, Gender Studies, Public Health, Law, Development Studies related subject, or any other relevant field.
- Experience in the evaluation of UN supported programmes will be an added advantage.
- Proven experience in policy development and analysis around reproductive health, gender, population issues and poverty reduction strategies highly desirable.
- Experience and skills in using evidence-based, knowledge base creation and ability to develop systems for improved performance.
- Proven experience in programme evaluations and assessments.
- Evidence of an analytical work in the subject matter.
- Knowledge and experience with different funding modalities for support to the government.
- Excellent report writing, communication, interviewing and computer skills.

In summary, all Evaluation Team members should have in-depth knowledge of UNFPA programmatic areas and issues and challenges in the country. They should be committed to respecting deadlines of delivering outputs within the agreed timeframe. In addition, the members should be knowledgeable of issues pertaining to gender equality and human rights. The team might be assisted by a translator/interpreter, if deemed necessary.

The work of the Evaluation Team will be guided by the Norms and Standards established by the UN Evaluation Group. Team members will adhere to the Ethical Guidelines for Evaluators in the UN system and the Code of Conduct also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise.

12. REMUNERATION AND DURATION OF THE CONTRACT

The evaluation team will share workdays (person-days) as per the following tentative plan:

	Team Leadership*	**SRH Expert**	**Gender Expert**	**Population Expert**
Design phase	4	6	3	2
Field phase	8	20	21	10

Reporting phase	8	15	10	5
Dissemination including stakeholder meeting	1	1	1	1
TOTAL (days)	21	42	35	18

* The Team Leader is expected to be an expert in at least one of the thematic areas. He is allocated 21 working days for leading the team, additional to the time s/he will spend on specific thematic areas

The consultants will be paid an agreed daily rate within the UN consultants scale based on qualification and experience. Workdays will be distributed between the date of contract signature and end date of evaluation.

Payment of fees will be based on the delivery of outputs, as follows:

- Upon approval of the design report; 20%
- Upon satisfactory contribution to the draft final evaluation report; 40%
- Upon satisfactory contribution to the final evaluation report; 40%

All deliverables will be reviewed by reference group. Payments will be upon approval of deliverables by UNFPA.

Daily subsistence allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates as follows:
Payment of fees will be based on the delivery of outputs, as follows:

- Upon approval of the inception report; 30%
- Upon submission of a satisfactory draft final evaluation report; 50%
- Upon submission of satisfactory final evaluation report; 20%

Travel costs will be settled separately from the consultancy fees.

13. MANAGEMENT AND CONDUCT OF THE EVALUATION

The CPE will be conducted by an independent **Evaluation Team** whose members are pre-qualified by the UNFPA Evaluation Office, but will be managed by the **Evaluation Manager** of the UNFPA Uganda Country Office. The evaluation manager will oversee the entire process of the evaluation, from its preparation to the dissemination of the final evaluation report and manage the interaction between the team of evaluators and the reference group. He will serve as an interlocutor between evaluation team and the ERG, facilitate, and provide general and logistical support as needed for the evaluation. The evaluation manager will ensure the quality control of deliverables submitted by the evaluation team throughout the evaluation process, communicate this through the EQA process in collaboration with the **ESARO M&E Advisor** and prevent any attempts to compromise the independence of the team of evaluators during the evaluation process.
Although the Consultants will be hired as individuals, **they will be expected to work as a team**.

Team leader
The team leader has overall responsibility for quality assurance of the CPE. He/she is responsible for

1. drafting of the CPE draft and final reports
2. timely submission of the CPE reports
3. quality assurance on the field work
4. timely submission of the thematic reports

Team members

Working under the direct guidance of the team leader, each team member is responsible for

1. drafting the field work tools
2. conducting the fieldwork
3. drafting and submitting thematic reports to the team leader for clearance within agreed timelines

As per UNFPA's evaluation handbook, an **Evaluation Reference Group** (ERG) will be established and be tasked to provide constructive guidance and feedback on implementation and products of the evaluation, hence contributing to both the quality and compliance of this exercise. The ERG will be coordinated by the National Population Council (NPC) of the Ministry of Finance, Planning and Economic Development. The ERG will be composed of the evaluation manager and other relevant staff from; the UNFPA country office in Uganda; other staff from NPC; Uganda Bureau of Statistics; Ministry of Gender, Labour and Social Development; Ministry of Health; Ministry of Education; and Uganda Aids Commission.

The main functions of the reference group will be:

- To discuss the terms of reference drawn up by the Evaluation Manager;
- To provide the evaluation team with relevant information and documentation on the programme;
- To facilitate access of the evaluation team to key informants during the field phase;
- To discuss the reports produced by the evaluation team;
- To advise on the quality of the work done by the evaluation team;
- Provide feedback on the findings, conclusion and recommendations from the evaluation into future programme design and implementation.

The roles and responsibilities of the **Regional M&E advisor** are:

- Provides support (backstopping) to evaluation manager at all stages of the evaluation;
- Reviews and provides comments to the ToR for the evaluation;
- Assists the CO evaluation manager in identifying potential candidates and reviews the summary assessment table for consultants prior to it being sent to the EO;
- Undertakes the EQA of the draft final evaluation report;
- Provides support to the dissemination of evaluation results.

The roles and responsibilities of the HQ **Evaluation Office** are:

- Approves ToR for the evaluation after the review and comments by the regional M&E adviser (to be included in the draft ToR sent to the EO);
- Pre-qualifies consultants;
- Undertakes final EQA of the evaluation report;
- Publishes final report, EQA and management response in the evaluation database.

14. BIBLIOGRAPHY AND RESOURCES

The following documents will be provided to the consultants at the beginning of the evaluation

1. UNFPA Strategic Plan (2014-2017): https://www.unfpa.org/sites/default/files/resource-pdf/Strategic%20Plan%2C%202014-2017.pdf
2. UNFPA Strategic Plan (2018-2021): https://www.unfpa.org/sites/default/files/pub-pdf/18-044_UNFPA-SP2018-EN_2018-03-12-1244_0.pdf
3. Uganda Country Office Annual Results Plans (2016, 2017, 2018, 2019)
4. Uganda Country Office Annual Reports (COAR 2016, 2017, 2018)
5. Uganda UNDAF (2014-2018)

6. Uganda UNDAF (2016-2020): http://ug.one.un.org/sites/default/files/reports/UNDAF%202016-2020.pdf
7. GoU/UNFPA 8th Country Programme Document (2016-2020)
8. GoU/UNFPA 8th Country Programme Business Plan (2016-2020)
9. Relevant national policy documents for each programmatic area
10. Second National Development Plan (NDPII) 2015/16 – 2019/20: https://www.ugandainvest.go.ug/wp-content/uploads/2016/03/National-Development-Plan-2015-16-to-2019-20.pdf
11. Uganda Vision 2040
12. UNFPA Uganda Resource Mobilization Strategy (2016 – 2020)
13. UNFPA Uganda Partnership Engagement Plan (2016 – 2020)
14. Implementing Partner Progress (Work plan) Reports
15. Joint Programme Documents
16. Reports on core and non-core resources
17. Table with the list of Atlas projects
18. GoU/UNFPA 7th Country Programme Evaluation Report
19. Evaluation of the bridging phase of JPGBV
20. Endline evaluation of Better Life for Girls Project (BL4G)
21. Endline evaluation of Youth Enterprise Model (YEM) project
22. Good Practices documentation: BL4G, JPGBV
23. Mid Term Review of the Uganda United Nations Development Assistance Framework (UNDAF) 2014-2018, (2018)
24. Mid Term Review of the Uganda Health Sector Strategic and Investment Plan (UHSIP, July 2016-2020)
25. NEX audit reports (206, 2017, 2018) and SPOT Checks Reports (2018)
26. Quarterly workplan monitoring visits reports for all Implementing Partners in all the programmatic areas
27. Macro and Micro assessment reports of Implementing Partners
28. Joint Programme Documents and Evaluation Reports where available
29. Documentation on donor coordination mechanisms
30. Donor reports
31. Uganda Demographic Health Surveys, 2011, 2016: https://www.ubos.org/onlinefiles/uploads/ubos/UDHS/UDHS2011.pdf and https://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/Uganda_DHS_2016_KIR.pdf respectively
32. Uganda National Household Survey, 2018
33. Handbook on 'How to Design and Conduct a Country Programme Evaluation at UNFPA" (2019): https://www.unfpa.org/sites/default/files/admin-resource/UNFPA_Evaluation_Handbook_FINAL_pages.pdf
34. UNEG Code of Conduct (2008)
35. UNEG Ethical guidelines (2008)
36. UNEG Guidance document – Integrating Human Rights and Gender Equality in Evaluations (2014)
37. UNEG Norms and Standards (2016)

15. ANNEXES

1. Ethical Code of Conduct of UNEG/ UNFPA Evaluations

Ethical Code of Conduct of UNEG_U

2. List of Atlas projects for the period under evaluation

List of Atlas Projects.docx

3. Information on main stakeholders by areas of interventions

The Stakeholder Map.docx

4. Outlines of the design and final evaluation reports

Design report structure.docx

Final report structure.docx

5. Evaluation Quality Assessment template

Evaluation Quality Assessment Templat

6. Management response template

Management Response Template.

7. Evaluation Matrix Template

Evaluation Matrix Template.docx

Annex 2: List of Persons/Institutions Visited

S/N	Names	Gender	Organisation /Location	Designation
1	Dr. Jotham Musinguzi	M	National Population Council	Executive Director
2	Pamela Kakande	F	Uganda Bureau of Statistics	Senior Statistician (Population & Health Statistics)/UNFPA FP
3	Dr. Placid Mihayo	M	Ministry of Health	Reproductive Health Coordinator
4	Wilberforce Mugwanya	M	Ministry of Health	M&E Officer
5	Annet Kabarungi	F	Ministry of Gender, Labour and Social Development	Principal Gender Officer/ UNFPA Focal Point
6	Dr. Stephen O Wandera	M	Makerere University	Head of Department
7	Dr. Abel Nzabona	M	Makerere University	Lecturer
8	Birgithe Lund-Henriksen	F	UNICEF	Chief, Child Protection
9	Rebecca Nalumansi	F	Resident Coordinator's Office	FP Spotlight Initiative
10	Jotham Mubangizi	M	UNAIDS	Senior M&E Officer
11	Susan Doreen	F	UN WOMEN	Focal person Joint Programme on GBV
12	Kazuaki Kameda	M	UNHCR	Dep. Representative
13	Ellen Bajenja	F	ACORD	Director

S/N	Names	Gender	Organisation /Location	Designation
14	Delphine Pinault	F	CARE International	Director
15	Gilbert	M	Reach A Hand Uganda	Chief of Staff
16	Jackson Chekweko	M	Reproductive Health Uganda	Executive Director
17	Harriet Kezaabu	F	International Rescue Committee	Women Protection and Empowerment Coordinator
18	Humpfrey Nabimanya	M	Reach a Hand Uganda	Team Leader
19	Alan Sibenaler	M	UNFPA Country Office	Representative
20	Mareledi Segotso	F	UNFPA Country Office	Ag. Deputy Representative
21	Dr. Edson Muhwezi	M	UNFPA Country Office	Assistant Representative
22	Jacobson Maiken	F	UNFPA Country Office	Head Integrated Field Support & WAY Programme
23	Dr. John Odaga	M	UNFPA Country Office	Programme Specialist M&E
24	Abilio Alfeu	M	UNFPA Country Office	International Operations Manager (IOM)
25	Rosemary Kindyomunda	F	UNFPA Country Office	National Program Specialist HIV/SRH
26	Florence M. Tagoola	F	UNFPA Country Office	Programme Specialist, Population & Development
27	Esther Cherop	M	UNFPA Country Office	Program Analyst FGM
28	Moses Walakira	M	UNFPA Country Office	Programme Specialist FP
29	Edith Akiror	F	UNFPA Country Office	Programme Analyst GBV
30	Regina Mutiti	F	UNFPA Country Office	Finance Analyst
31	Deborah Nakabira,	F	UNFPA Country Office	Human Resources/Admin. Analyst
32	Dorah Komugisha	F	UNFPA Country Office	Admin. Associate
33	Ambrose Walubo,	M	UNFPA Country Office	Security Specialist
34	Doreen Kyomuhangi	F	UNFPA Country Office	Programme Assistant GBV
35	Prossy Nakanjako	F	UNFPA Country Office	Program Specialist Communications
36	Martha Songa	F	UNFPA Country Office	Program Analyst, Advocacy, Partnership & Networking
37	Prossy Nakabiito	F	UNFPA Country Office	HR Office, Consultant
38	Denis Bakomeza,	M	UNFPA	Program Coordinator, Arua
39	Patricia Nangiro,	F	UNFPA	Program Analyst GBV, Adjumani
40	Ssekyewa Desmond,	M	UNFPA	Program Analyst SRHR, Kyegegwa
41	Logwee Alfred	M	Moroto District	Chief Administrative Officer
42	Dr. Saggaki Patrick	M	Amudat Hospital	Medical Superintendent Amudat Hospital and former DHO Amudat District
43	Carol	F	BRAC Amudat	Project Officer
44	Frida Amuron	F	Amudat District	DCDO
45	Franscica Kotol	F	IRC Amudat	Field Officer
46	Charles Omuudu	M	Moroto District	DHO
47	Onyait Michael	M	IRC, Moroto	Response Officer
48	Ariko Angella Babra	F	IRC, Moroto	Programme Officer, Moroto
49	TBD	M	Tapac Sub County, Moroto	SAS
50	TBD	M	Tapac Sub County, Moroto	ACDO
51	Dr. Bernadette Sebadduka	F	UNFPA DO, Karamoja region	Programme Specialist, Head DO Karamoja
52	Jimmy Dombo	M	UNFPA DO, Karamoja region	Programme Assistant
53	Sam Batuuka	M	DLG Iganga	DCDO
54	Ademun Christine	F	BRAC Iganga	Programme Officer, BRAC ELA Club
55	Halima Namuwaga	F	BRAC Iganga	Programme Assistant ELA
56	Kisha Christine	F	BRAC Iganga	Programme Coordinator ELA
57	Joy Kisila	F	DHO Office, Iganga	Senior Nursing Officer, MCH
58	Ann Rose Baluka	F	DHO Office, Iganga	Assistant DHO, MCH
59	Christopher Kilama	M	DLG, Kitgum	District Planner
60	Margaret Aryemo,	F	DLG, Kitgum	Assistant DHO

S/N	Names	Gender	Organisation /Location	Designation
61	James Okello P'Okidi	M	DLG, Kitgum	District CDO
62	Josephine Anek	F	CARE International, Kitgum	Project Officer
63	Albert Ongom	M	Reach a Hand Uganda, Kitgum	Project Officer
64	Pelosi Atoo	F	BRAC, Kitgum	Ag. Reg. Coordinator / Programme Assistant
65	Margaret Aryemo	F	DHO Office, Adjumani	Assistant DHO
66	Max Martin Mukula	M	DLG, Adjumani	Chief Administrative Officer
67	Salome Amuge	F	LWF, Adjumani	Team Leader
68	Elizabeth Kaboyo	F	LWF, Adjumani	Protection Coordinator
69	Paul Oola	M	CARE International, Adjumani	Male Engagement Officer
70	John Baptist	M	CARE International, Adjumani	Male Engagement Assistant
71	Robert Charles Ogwang	M	DLG, Arua	Chief Administrative Officer
72	Paul Bishop Drarebu	M	DLG, Arua	Ag. DHO/ADHO, MCH
73	Richard Obio,	M	DLG, Arua	District CDO
74	Ismael Tuku	M	Lugbara Cultural Institution	Prime Minister
75	Sheikh Abujafar Karala	M	UMSC, Arua	District Khadi
76	Habib Aluma	M	UMSC, Arua	Regional Secretary West Nile
77	Cinderella Anena	F	CARE International, Arua	Male Engagement Officer
78	Levi Byaruhanga	M	IRC, Arua	Regional Coordinator
79	Dr. Lily Achayo	F	IRC, Arua	Deputy Health Manager
80	Dr. Alan Harogha	M	Omugo HC IV, Arua	Medical Officer In-Charge
81	Dr. Julius Balinda	M	DLG, Kyegegwa	District Health Officer
82	Ezra Kalya Kasaija	M	DLG, Kyegegwa	District CDO

Annex 3: List of Documents Consulted/Reviewed

Annual Statistical Abstract Statistical Abstract (UBOS, 2018)
Endline evaluation of Better Life for Girls Project (BL4G) UNFPA-KOIKA
Evaluation Matrix Template
Female Genital Survey Report, 2017
Five (5)-Year Interagency SGBV Strategy Uganda, 2016-2020
GBV Evaluation Uganda Case Study
GBV Report FINAL 29 Nov
GBV Report FINAL 29 Nov
Good Practices documentation: BL4G, JPGBV
GoU/UNFPA 8th Country Programme Document, 2016-2020
GoU: National Development Plan II, 2016-2020
GoU: National HIV and AIDS Strategic Plan, 2015/16 - 2019/20
GoU: Uganda National Policy on HIV and AIDS, 2011
GoU: Uganda Vision 2040
GoU-UNFPA 7th Country Programme Evaluation Report
GoU-UNFPA 8th Country Programme Business Plan, 2016-2020
Guttmacher Institute, Unintended Pregnancy and Induced Abortion in Uganda, 2006
Handbook on 'How to Design and Conduct a Country Programme Evaluation at UNFPA
HIV/AIDS Sero-Survey 2014
Human Development Report (2013). UNHS 2012/13, UBOS
Implementing Partner Progress (Work plan) Reports
Information on main stakeholders by areas of intervention
Joint Evaluation of the UNFPA-UNICEF Joint Programme on the Abandonment of FGM: Accelerating Change Phase I and II (2008–2017)
List of Atlas projects for the period under evaluation
Mid Term Review of the Uganda Health Sector Strategic and Investment Plan (UHSIP, July 2016-2020)
Ministry of Gender, Labour and Social Development: Annual Performance Report, 2018
Ministry of Gender, Labour and Social Development: Gender Action Plan, 2014-2017
Ministry of Gender, Labour and Social Development: Uganda Gender Policy, 2007
Ministry of Gender, Labour and Social Development: Uganda Violence Against Children Survey Report, 2018
MoH: Family Planning Costed Implementation Plan (FP-CIP, 2015-2020
MoH: Health Sector Development Plan (HSDP), 2015/16 - 2019/2020
MoH: Implementation Guide for the National Strategy for Integration of SRHR and HIV, 2017 - 2021
MoH: Maternal and Perinatal Death Surveillance and Response Guidelines, August 2017
MoH: Mid Term Review of the Uganda Health Sector Strategic and Investment Plan, 2011-2014
MoH: National Condom Programming Strategy, 2013-2015
MoH: National Integrated Prevention of Mother to Child Transmission of HIV (PMTCT) Policy Guidelines, 2013
National Budget Framework Paper (FY2017/18-FY2021/22)
National mid-year population projections 2015-2050 (UBOS, 2018)
National mid-year population projections 2015-2050 (UBOS, 2018)
National Population Council: Harnessing Uganda's Demographic Dividend: Evidence from National Transfer Accounts, July 2018
National Population Council: Uganda Demographic Dividend Roadmap, December 2018
National Population Policy (NPP), 2008
National Population Policy Action Plan (NPPAP), 2011-2015
Revised TOR for UGA.CPE _ version Sep 16-2145 hours
Social Progress Index (SPI) Report, 2017
Status of Uganda Population Report, 2018
UBOS: National Population and Housing Census, 2014
UBOS: Uganda Demographic Health Survey Reports (2011, 2016)
UBOS: Uganda National Household Survey, 2016-17
UBOS: Uganda Population-Based HIV Impact Assessment, 2016-2017. ICAP/CDC/MOH, 2017
Uganda Country Office Annual Reports (COAR 2016, 2017, 2018)

Uganda Country Office Annual Results Plans (2016, 2017, 2018, 2019)
Uganda Demographic Health Surveys, 2011, 2016
Uganda Demographic Health Surveys, 2011, 2016
UNDP Human Development Report 2018
UNEG Ethical guidelines (2008)
UNEG Guidance document – Integrating Human Rights and Gender Equality in Evaluations (2014)
UNEG Norms and Standards (2016)
UNFPA Annual Progress Reports (2016, 2017, 2018, 2019)
UNFPA Atlas Projects CP8
UNFPA Donor Mapping Report, 2016
UNFPA Mid-Term Evaluation_Report_20181005
UNFPA Strategic Plan (2014-2017)
UNFPA Strategic Plan (2014-2017)
UNFPA Strategic Plan, 2014-2017
UNFPA Strategic Plan, 2018-2021
UNFPA Supplies Mid-Term Evaluation Report
UNHS 2012/13 & UNHS 2016/17, UBOS
UNHS 2012/13. UBOS
United Nations: Report of Mid-Term Review of UNDAF (2016-2020)
United Nations: UNDAF Strategic Plan, 2016 -2020
UPHC 2014, UBOS
USAID & Maternal and Child Health Programme: Maternal Mortality and HIV: An Overview. https://www.mchip.net/sites/default/files/Maternal%20Health_HIV%20Briefer.pdf
WHO, UNFPA, UNICEF, AMDD: Monitoring Emergency Obstetric Care: A handbook, 2009

Annex 4: The Evaluation Matrix

a) Population and Development

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
Population and Development component				
Relevance	**EQ1**: To what extent is the CP8 aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups, goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?	Review and compare priorities from UNFPA and Government of Uganda documents to establish the level of alignment of the CP8 PD focus to the National priorities and beneficiary need. Evidence of CP8 contribution to the national development priorities. Level of adherence to national related PD needs during CP8 implementation The choice of target groups for UNFPA supported interventions is consistent with identified and evolving needs as well as national priorities. Extent to which the targeted people were consulted in relation to programme design and activities throughout the programme.	Strategic Documents: GoU/UNFPA 8th CPD, NDPII, Vision 2040, UNDAF, Relevant Sector Strategic Plans (esp. Health, Education, Gender, JLOS & NPC) & District Development Plans. National level Stakeholders: UNFPA CO staff, Other UN Agencies, IPs (Head Offices), Donors, and Focal Point Persons from relevant government agencies: NPC, POPSEC, UBOS, NPA, MoH, MoLG, MGLSD, MoJCA (JLOS) Chief Administrative Officers, District Health Teams (DHT), District Planner/Population Officers, DCDO, DEO, JLOS representatives (Police-CFPU, Magistrates), IPs in field sites, Relevant community structures (cultural and religious leaders, local council representatives, community activists, Male Action Groups etc), and relevant programme beneficiaries (including women, men, young people).	Documents review Key Informant Interviews Focus Group Discussions (FGDs) Field visits/ observations
	EQ2: To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?	Evidence of taking into consideration, national and sub-national levels, the needs of the target beneficiary institutions, and population groups including MARPs, PWDs, Refugees and IDPs		
	EQ3: To what extent has the	Separate components are		• Document Review • Key Informant Interviews • Focus group discussions • Field visits and

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
	programme integrated gender and human rights based approaches?	integrated in planning with cross cutting aspects such as gender and equity and human rights based approaches.		observations
Efficiency (results against resources) organisational and Programmatic efficiency)	**EQ4:** How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP? **EQ5:** To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?	‣ Adequacy of resources (Financial, Personnel etc) to deliver the programme PD outputs/results ‣ Appropriateness of the IPs selected to deliver the PD results ‣ Timely transfer of funds ‣ Effective mechanisms to control waste and fraud ‣ Focus of UNFPA resources on high impact activities	Relevant Programme, Administrative and Financial Management Documents including: - AWPs - Project standard progress reports - Financial Reports from Implementing Partners and UNFPA (Atlas reports) - Audit Reports for IPs - Field Monitoring Visit Reports Stakeholders at National Level: UNFPA staff (including programme, finance/ administrative departments), Representatives of IPs (Head offices), Representatives of Donors, Other UN agencies (esp. UNCT, UNDP, UN Women, UNICEF) and Government agencies including; NPC/POPSEC, UBOS, NPA, MoLG, MGLSD, MOH, MOES, District Level/ DLG: Chief Administrative Officers, Heads of DLG departments including Health, JLOS, Education, Planning.	Key Informant Interviews Focus group discussions Field visits and observations
Effectiveness	**EQ6:** To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes).	*Data generation/ availability* Existence of new national Survey Reports supported by UNFPA (UDHS, National Household Surveys, Census, Population	Relevant Documents: - NDP II, Relevant Sectoral Policies, Strategic Plans, Annual Reports, MTRs etc	Document review Key Informant Interviews Focus group discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
	Where the planned geographic areas and target groups successfully reached?	Projections/ modelling & National Panel Survey). Availability of in-depth analytical reports (on Maternal Health (MH), Young People, GBV and SRHR) and district profiles from Census, UDHS and Panel Surveys. Availability and access to Web-based Integrated Management Information Systems. Existence of gender statistics and Score Card. District statistical Abstracts Existence of functional integrated sectoral database at the District Level *Data use for integration of population dynamics in relevant national and sub- national plans and programmes* Availability of National Planning Guidelines (for Sectors and LGs) that include integration of population dynamics in the plans. Existence of manual to integrate population dynamics and utilised by the sectors and districts. Existence of National, Sectoral and district Plans that integrate population dynamics. Existence of District Action Plans that incorporate need for gender and population disaggregated data in the targeted districts.	(esp. for Health, Education, Gender & POPSEC) - UNDAF and its work plans and progress reports - Annual Work Plans for IPs - Country Programme Annual Review Reports and Standard Progress Reports - Relevant Data bases at the national and DLG level including: HMIS, DHIS II, NGBV data base, EMIS, M&E data bases and Reports etc) Other Special Study Reports National level Stakeholders: UNFPA staff (leadership, programme and finance and administrative staff) Representatives of Donors) - Other UN agencies (esp. UNCT, UNICEF, UNAIDS, WHO & UN Women) - Representatives of Donors, IPs (Head offices), and - Government agencies including; NPC/ POPSEC, UBOS, NPA, MoLG, MGLSD, MoH, MOES, - District Level/DLG: - Chief Administrative Officers, District Health Teams (DHT), District Planner/ Population Officers, DCDO & DEO, Field level IPs. - Programme beneficiaries including women, young people and men, and	

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
		Capacity and Advocacy for integration Evidence of technical capacities for integration of population dynamics into plans and programmes among targeted National and District staff. Existence of a functional Youth coordination structure /network for engaging young people in planning/policy dialogue and programme. Leadership advocacy and champions' mobilisation for support of population. User-friendly PD advocacy and awareness materials produced and used by leadership. The National Population Council Act passed by parliament.	relevant community structures including cultural and religious leaders, local council representatives.	
	EQ7: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?	Innovative approaches Key lessons in programming. Good practices and lessons documented	Documents: Programme documents Quarterly and annual reports. Field and progress reports Good practice documentation Documentaries Evaluation Reports Special Studies National level Stakeholders: UNFPA staff (leadership, programme and finance and administrative staff). Other UN agencies IPs (Head offices), and Government incl; NPC/POPSEC, UBOS, NPA,	Review documents Key Informant Interviews Focus Group Discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			Academia (Makerere University Centre for Population and Development, EPRC), MoLG, MGLSD & MOH District Level: District Level: Chief Administrative Officers, District Health Teams (DHT), District Planner/ Population Officers, DCDO & DEO, Field level IPs. Programme beneficiaries including women, young people and men, and relevant community structures including cultural and religious leaders, local council representatives.	
Sustainability	**EQ8:** To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies? **EQ9:** What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and	Established sustainability mechanism for the programme. The Likelihood of the programme and its benefits to be sustainable. Established systems to continue the programme. Capacity development including staff training. Community and country ownership including financial resource commitments. Partner organizations with sustainability plans. Existence of Scale-up plans/strategies.	Documents: Relevant Sectoral Policies and Strategic Plans Annual Work Plans for Implementing Partners Country Programme Reports CPAP; AWPs; Reports; IP progress reports, relevant sector strategic plans Annual Review Reports and Standard Progress Reports Country Office Annual Reports Special Study reports reports and mid-term review reports, Strategic plan evaluations for sectors including health, education, community/social sectors. National Level Stakeholders: UNFPA staff, Government, IPs	Documents review Key informant interviews Focus group discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
	changing aid environment?		staff, District leaders and Heads of Departments (Health, Education, Community Services, Planning, Relevant Field level IPs. Programme beneficiaries: including women, young people and men, and relevant community structures (e.g. LCs, Cultural and Religious Leaders, Community Activists, Male Action Groups).	
Coordination	**EQ10:** To what extent has UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?	Evidence of active participation in UN technical working groups; Evidence of participation & leadership in humanitarian coordination structures; Area of Responsibility (AoR) and SRHR, PD, GBV working groups at national & sub-national level., Evidence of leading role played by UNFPA in the working groups and/or joint initiatives corresponding to mandate areas; Evidence of sharing of information between UN agencies. Evidence of joint programming initiatives (planning) & M&E.	• Minutes of UNCT working groups • Programming documents regarding UNCT joint initiatives • Monitoring/evaluation reports of joint programmes and projects • Minutes of Humanitarian Country Team (HCT) and related humanitarian space for coordination • Minutes and relevant documents on UN and National level coordination mechanisms for SRH, GBV and HIV integration • UNDAF progress reports on coordination mechanisms • Minutes and Reports of relevant DLG Coordination Structures for thematic areas/issues	Documentary analysis Interviews with UNFPA country office staff Interview with the UNRC Interviews with other United Nations agencies

b) Sexual and Reproductive Health and Rights

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
Sexual Reproductive Health and Rights component				
Relevance	**EQ1**: To what extent is the CP8 is aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups, goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?	Review and compare priorities from UNFPA and Government of Uganda National and sector specific plans to establish the level of alignment of the CP to SRHR priorities and beneficiaries' needs. Alignment to SRHR priorities in UNDAF and the NDP as well as sector policies and plans. Evidence of CP alignment SDGs and ICPD.	Documents (ICPD; CPD; AWPs; CPAP) Strategic Documents: GoU/UNFPA 8th CPD; Country Programme Results Matrix; Revised UNFPA Strategic Plan; Final Evaluation of the GoU/UNFPA 8th CP; GoU strategic documents (NDP II, Vision 2040, relevant sector strategic Plans, annual reports, mid-term reviews (for Health, Social/Gender, Education, POPSEC, UAC etc.) Programme reports; Health facility records; IP documents and records; Target Districts records and documents; National Level Stakeholders: UNFPA staff, Other UN agencies (e.g. UNDP, UNHCR, UNICEF & WHO) Relevant GOU Agencies including Office of the Prime Minister (OPM), MOH, MGLSD, MoES, MoJCA,	Document review Key Informant Interviews at national and district level Focus group discussions with beneficiaries at the community level Field visits and observations
	EQ2: To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?	Level of adherence to SRHR priorities in the UNFPA Global Strategic Plan and to the RMNCH plan and other sector specific priorities. Level of adaptation to the Refugee and Host Population Empowerment Strategic Framework (REHOPE) and the humanitarian aid-peace-development nexus		

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			NPC, IPs staff (HQ), Members of TWGs for SRH, FP and GBV Reference Group, District leaders and Heads of Departments (Health, Education, Community Services, Planning, Relevant Field level IPs. Programme beneficiaries: including women, young people and men, and relevant community structures (e.g. LCs, Cultural and Religious Leaders, Community Activists, Male Action Groups).	
	EQ3: To what extent has the programme integrated gender and human rights based approaches?	Review to establish if the CP addressed the needs of the most vulnerable populations including MARPs/key populations, PWDs, refugees, host populations, adolescents and young people.	National level Stakeholders: UNFPA staff (leadership, programme and finance and administrative staff) •Other UN agencies IPs (Head offices), and Government including; NPC/POPSEC, UBOS, NPA, Academia, MoLG, MGLSD, JLOS (MoJCA) & MOH, MoES, Members of TWGs for SRH, FP and GBV. District Level Stakeholders: Chief Administrative Officers, District Health Teams (DHT), District Planner/Population	

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			Officers, Community Services (DCDOs, Probation Officers, CDOs) & DEOs, Relevant Field level IPs. Programme beneficiaries: including women, young people and men, and relevant community structures including VHTs, cultural and religious leaders, local council representatives, community activists etc	
Efficiency	**EQ4:** How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP? **EQ5:** To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?	Adequacy of resources (Financial. Personnel etc) to deliver the programme RH out puts/results. Appropriateness of the IPs selected to deliver the RH results. Timely transfer of funds. Effective mechanisms to control waste and fraud. Focus of UNFPA resources on a key high impact activities. Comparison of results achieved to the resources. Could the same outputs be achieved with less expenditure?	Relevant Programme Documents, Administrative and Financial Management Documents including: AWPs; Project standard progress reports; Financial Reports from Implementing Partners and UNFPA (Atlas reports); Audit Reports for IPs; Field Monitoring Visit Reports; Stakeholders at National Level: UNFPA staff (including programme, finance/administrative	Document review Key informant interviews Focus group discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			departments), Representatives of donors, IPs (Head offices), representatives of Donors, Other UN agencies and Government agencies including; NPC/POPSEC, MGLSD, MOH, MOES, District Level/DLG: Chief Administrative Officers, Heads of DLG departments including Health, JLOS, Education, Planning and Community Services.	
Effectiveness (achievement of results)	**EQ6:** To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes). Where the planned geographic areas and target groups successfully reached?	Percent (%) of Health Facility deliveries in target districts. Evidence of supportive legislative, policy and financing environment for work of midwives. Availability and use of revised national midwifery training curriculum. Existence of amended Nurses and Midwifery Act Handbook and Midwifery Implementation Plan. Number of midwifery training institutions with capacity to train midwives (midwifery tutors, skills lab. practicum sites). Number of Regional Referral Hospitals offering Fistula repair	Documents: Annual Work Plans for Implementing Partners Country Programme Annual Review Reports and Standard Progress Reports Country Office Annual Reports Other Study reports Existing data bases at national and sub-national levels including: HMIS, DHIS II, UDHS database, Census data, EMIS, NGBV Database etc Stakeholders at National Level: NFPA staff (including programme, finance/administrative	Document review Key informant interviews Focus Group Discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
		services on routine basis. Number of women treated for Fistula with UNFPA support. Percent (%) of Hospitals and HC IVs with functional capacities for Post Abortion Care services (3 staffs trained & MVA kits). Percent (% maternal deaths notified and audited in target districts. Capacity of professional midwifery associations to represent midwives and midwifery profession. Number of districts with capacity to implement MISP.	departments), Representatives of donors, IPs (Head offices), representatives of Donors, Other UN agencies and Government agencies including; NPC/POPSEC, MGLSD, MOH, MOES, National Association for Nurses and Midwives, Directors of Nurses and Midwifery Training Schools, District Level/DLG: Chief Administrative Officers, Heads of DLG departments including Health, JLOS, Education, Planning and Community. Programme beneficiaries: including women, young people and men, and relevant community structures including VHTs, cultural and religious leaders, local council representatives & community activists	
	EQ7: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?	Innovative approaches Key lesson in programming Good practices Documented lessons and good practices	National Level Stakeholders: UNFPA staff, Government, IPs staff, District leaders and Heads of Departments (Health, Education, Community Services), Planning, field level IPs,	Review documents, Key Informant Interviews, Focus Group Discussions, Field visits and observations.

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			Programme beneficiaries, Relevant Field level IPs, Programme beneficiaries: including women, young people and men, and relevant community structures including VHTs, cultural and religious leaders, local council representatives, male action groups &community activists etc	
Sustainability	**EQ8:** To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies? **EQ9:** What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?	Established sustainability mechanism for the programme. The Likelihood of the programme and its benefits to be sustainable. Established systems to continue the programme. Capacity development including staff training. Community and country ownership including financial resource commitments Partner organizations with sustainability plans.	Documents: Relevant Sectoral Policies and Strategic Plans, Annual Work Plans for Implementing Partners, Country Programme Reports, AWPs; Reports; IP progress reports, relevant sector strategic plans, Annual Review Reports and Standard Progress Reports, Country Office Annual Reports, Special Study reports, reports and mid-term review reports, Strategic plan evaluations for sectors including health, education, community/social sectors, National Level Stakeholders:	Documents review Key informant interviews Focus group Discussions Field visits and observations

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
			UNFPA staff, other UN agencies, Government agencies including OPM, MOH, MGLSD, NPA etc, IPs staff (HQ), District leaders and Heads of Departments (Health, Education, Community Services), Planning, field level IPs and Programme beneficiaries, Relevant Field level IPs, Programme beneficiaries: including women, young people and men, and relevant community structures.	
Coordination	**EQ10:** To what extent has UNFPA Country Office contributed to the functioning and consolidation of UNCT coordination mechanisms?	Evidence of active participation in United Nations technical working groups. Evidence of participation in humanitarian coordination structures. Area of Responsibility (AoR) and SRHR technical working groups. Evidence of the leading role of UNFPA in the technical working groups corresponding to its mandate areas. Evidence of sharing of information between United Nations agencies. Evidence of joint programming	Minutes of UNCT working groups, Programming documents regarding UNCT joint initiatives, Monitoring/evaluation reports of joint programmes and projects, Minutes of Humanitarian Country Team (HCT) and related humanitarian space for coordination. Minutes and relevant documents on UN and National and DLG Level Coordination mechanisms for SRH, GBV and HIV integration. UNDAF progress reports on	Documentary analysis Interviews with UNFPA country office staff Interview with the UNRC Interviews with other United Nations agencies

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
		initiatives (planning). Evidence of joint implementation and monitoring of programmes	coordination mechanisms. National Level Stakeholders: UNFPA staff, other UN agencies, Government agencies including OPM, MOH, MGLSD, NPA, IPs staff (HQ)	

c) Gender Equality and Women's Empowerment

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
Gender Equality and Women's Empowerment component				
Relevance	**EQ1:** To what extent is the CP8 is aligned to national priorities (including Vision 2040, NDP II), new generation UNDAF, sectoral priorities; coherence with needs of target groups, goals of the ICPD Programme of Action, SDGs, and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)? to gender and women empowerment? **EQ2:** To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?	Review and compare priorities from UNFPA and Government of Uganda documents. Evidence of alignment with international and regional instruments including SDGs and ICPD. Evidence of adaptation to meeting the needs of the target populations including population in underserved areas and marginalised women including humanitarian settings and MARPs. Cultural and context sensitivity. Adaptation to changes in operating environment and needs of the beneficiaries.	Documents: Programme reports and documents. Strategic documents: including Vision 2040, NDP II and sector strategic plans, District plans. Grantee organization documents and records, Target districts records and documents, Existing databases including NGBV database, HMIS, DHIS II, Police Crime Reports, UDHS and Census Data, AIDS Indicator Survey Data, Routine M&E data, etc. National level stakeholders: UNFPA staff IP staff, GoU staff including MGLSD, MoLG, MoH, Education and MoJCA (Justice, Law and Order Sector) and National GBV Reference Group. DLG Level Stakeholders: Heads of Health, Community Services, Education, Police (CID & CFPU), Magistrates & Prosecutors, Field level IPs, Programme beneficiaries (women, men, young people, and community	Document review Focus group discussions Key Informant Interviews
	EQ3: To what extent has the programme integrated gender and human rights based approaches?			• Review key documents; • Key Informant Interviews • Focus Group Discussions • Field visits and observations

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
			structures including VHTs, community activists, male action groups, mentors / role models, cultural and religious leaders.	
Efficiency (Results against resources) organisational and Programmatic efficiency)	**EQ4:** How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP? **EQ5:** To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?	Adequacy of resources (Financial, Personnel etc.) to deliver the programme? Appropriateness of the IPs selected to deliver programme results. Timely transfer of funds. Effective mechanisms to control waste and fraud. Focus of UNFPA resources on a key high impact activities. Comparison of results achieved to the resources. Could the same outputs be achieved with less expenditure?	Documents: AWPs, Project standard progress reports, Financial Reports from Implementing Partners and UNFPA (Atlas reports), Audit Reports for IPs, Field monitoring reports, Vision 2040, NDP II and sector strategic plans and annual reports, MTRs of sector plans, District plans and annual reports, Grantee organization documents and records, National Level Stakeholders: UNFPA staff (including finance/admin departments) IP staff, GoU staff including MGLSD, MoLG, MoH, Education and MoJCA (Justice, Law and Order Sector) and National GBV Reference Group. DLG Level Stakeholders: Heads of Health, Community Services, Education, Police (CID & CFPU), Magistrates & Prosecutors, Field level IPs	Document Review Key informant interviews Focus group discussions Field visits and observations

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
			Programme beneficiaries: Women, men, young people, and relevant community structures including community and religious leaders, cultural leaders, Community Activists, Male Action Groups etc.	
Effectiveness	**EQ6:** To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Where the planned geographic areas and target groups successfully reached?	Targeted districts plans and budgets that incorporate Gender-Based Violence prevention/ response and reproductive rights interventions. Number of Gender-Based Violence survivors utilising response services in targeted districts. Number of sectors implementing the international instruments and national legislation (Domestic Violence Act, Penal Code Act and relevant GBV policies and Action plans) for GBV prevention and management. Number of target districts that have a functional system in place to regularly record GBV incidence. Number of selected GBV related policies/legislation passed into law by the Parliament of Uganda. High level National Policy and political commitments on GBV prevention. Availability and use of SOPs; referral pathways for GBV prevention and response. Availability and use of policy/guidelines on clinical	Documents: Existing data bases/MIS including DHIS II, HMIS, EMIS and GBV data base, Police Crime Reports, UDHS, Census data, etc. Routine M&E data collected by IPs, Project progress and monitoring reports. National Level Stakeholders: UNFPA staff (including finance / administrative departments) IP staff, GoU staff including MoGLSD, MoLG, MoH, Education and MoJCA (Justice, Law and Order Sector) and National GBV Reference Group, DLG Level Stakeholders: Heads of Health, Community Services, Education, Police (CID & CFPU), Magistrates & Prosecutors, Field level IPs, Programme beneficiaries: Women, men, young people, relevant community structures including community and religious leaders, cultural leaders, community	Document review Data extraction Key informant interviews Focus group discussions Field visits and observations

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
		Management of Rape, survivor centred approach, guidelines for Mental Health and Psychosocial Support (MHPSS). Number of personnel in relevant sectors trained in GBV prevention and response programming in humanitarian and post-conflict situations. Number of communities that declare the abandonment of FGM/C. Legal awareness about FGM/C legislation. Existence District and IP plans that integrate GBV prevention and response. GBV in Pastoral outreach structures and school GBV prevention and response programmes. Functional district and community structures for GBV prevention and response including District GBV prevention and response alliances, Community Groups (e.g. Male Action Groups, Community Activists, Community Action Teams etc) for GBV prevention and response. Livelihood interventions that incorporate gender transformative elements. Ordinances including by-laws and resolutions passed by the district and sub-national leadership,	Activists, male action groups, para-social workers	

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
		cultural and religious leaders. Cultural and religious institutions that integrate GBV prevention and response in their strategic plans or work plans.		
	EQ7: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?	Innovative approaches (e.g. SASA, Male Action Groups, ELA, Gender Transformative programming in women Economic Empowerment Programmes, GREAT, REAL Fathers etc) Good practices and lessons learnt	Document Review including Peer Reviewed Publications and Routine M&E data/reports, Documentaries, Representatives from UNFPA office, donors, other UN agencies, IPs and Government; staff of relevant DLG departments including Health, JLOS, Community Services, Programme beneficiaries including women, men, young people and relevant community GBV prevention and coordination structures including Male Action Groups, Mentors, Community Activists, Cultural and Religious Leaders, Local Councils, Para-legals etc.	Review documents Key Informant Interviews Focus Group Discussions, Field visits and observations.

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
Sustainability	**EQ8:** To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any? To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies? **EQ9:** What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?	• Established sustainability mechanism for the programme • The likelihood of the programme and its benefits to be sustainable • Established systems to continue the programme • Capacity development including staff training • Community and country ownership including financial resource commitments • Partner organisations with sustainability plans	Documents: Routine M&E data collected by IPs, Project progress and monitoring reports, Project/programme evaluation reports, PAP, AWPs, programme reports; IP Strategic Plans, Evaluation Reports, Routine M&E data. ational Level Stakeholders: NFPA staff (including finance / administrative departments) IP staff, Other UN Agencies. GoU staff including MGLSD, MoLG, MoH, Education and MoJCA (Justice, Law and Order Sector) and National GBV Reference Group. DLG Level Stakeholders: Heads of Health, Community Services, Education, Police (CID & CFPU), Magistrates & Prosecutors, Field level IPs. Programme beneficiaries: Women, men, young people, relevant community structures including community and religious leaders, cultural leaders.	Documents review Key informant interviews Focus group discussions Field visits and observations
Coordination	**EQ10:** To what extent has UNFPA Country Office contributed to the functioning and consolidation of	Evidence of active participation in United Nations working groups and providing leadership on GBV	Documents: Minutes of relevant coordination structures and mechanisms at	Documentary analysis, Interviews with UNFPA country office staff,

Criteria	Evaluation questions	What to check for	Data Sources	Data Collection method
	UNCT coordination mechanisms?	integration with SRH and other services. Evidence of participation and leadership in humanitarian coordination structures for GBV prevention and response. Area of Responsibility (AoR) and GBV technical working groups at national level and sub-national levels. Evidence of the leading role played by UNFPA in the technical working groups and/or joint initiatives corresponding to its mandate areas in relation to GBV prevention and response. Evidence of joint programming initiatives (planning, implementation & M&E).	National and district level, Guiding documents for coordination structures including UNCT, IP coordination forums and GBV Reference Group minutes and reports etc. Representatives from UNFPA office, Other UN agencies, donors, IPs and Government (OPM, MGLSD, NPC, JLOS, MoES, NPA); staff of Relevant DLG departments including Health, JLOS, Community Services & Education	Interviews with the UNRC, Interviews with other United Nations agencies, Focus group discussions with district and community Gender and GBV coordination structures.

Annex 5: Stakeholders' Map

Donors	Implementing Agencies	Other partners	Beneficiaries
Maternal Health			
Strategic Plan outcome: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilised integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence.			
Country programme outputs: **1. National and district governments have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings.** **2. National and district governments have the capacity to increase the demand for and the supply of modern contraceptives.** **3. Increased national capacity to deliver integrated sexual and reproductive health and HIV/AIDS prevention programmes that are free of stigma and discrimination**			
Atlas Project :UGA08HIV			
UNAIDS/UBRAF	• Aids Information Centre • IRCU		MARPS, Young people at risk of HIV Nationally and in Amudat, Bududa, Gulu, Isingiro, Kampala, Katakwi, Namayingo, Yumbe)
SIDA (Together for SRH)	• Ministry of Health • Aids Information Centre • Inter-religious Council (U) • Ministry of Gender	Global Fund, Global Financing Facility, US President's Emergency Plan for AIDS Relief (PEPFAR), GAVI, European Union (EU), USIAD RITES	Adolescent girls and young people, pregnant and breastfeeding women, PLHIV, men who have sex with men (MSM), LGBTI, and sex workers (SWs). DLGs of Kampala, Isingiro, Katakwi, Amudat, Gulu, Namayingo, Bududa, Yumbe
UNDP - MPTF Office (JUPSA)	• Ministry of Health • Uganda Aids Commission, • Ministry of Gender, • District Local Governments	Irish Aid, WHO, IOM, ILO, UNAIDS,UNDP,UNESCO,UNHCR,UNWOMEN MoFPED,	PLHIV, MARPS – Karamoja & vulnerable communities Young people, HIV +ve pregnant women, Health workers, health facilities,
SIDA Regional programme (SRH/HIV Linkages)	• Kotido DLG • Moroto DLG • Amudat DLG • Nakapiripirit DLG • Abim DLG • Napak DLG • Kitgum DLG • Aids Information Centre • Uganda Aids Commission	UNAIDS	• Women, Boys, Girls, Couples, • Key Populations • Political leaders • In & Out of School 10-24 • Cultural & Religious leaders
UNDP - MPTF Office/Irish Aid JP UGA HIV/AIDS Support	• Ministry of Health • Moroto DLG	Ministry of Education FAO,ILO,IOM,UNAIDS 3	Adolescent girls and boys, MARPS, Religious & cultural institutions, Refugees, HIV infected persons, pregnant

	• Kotido DLG • Kaabong DLG • Ministry of Gender • Amudat DLG • Nakapiripirit DLG • Abim DLG • Uganda Aids Commission • Napak DLG • Straight Talk Foundation • IRC • BRAC • RAHU • AIC • DEX	UNDP,UNESCO, UNHCR UNICEF,UNWOMEN, WHO	mothers.
Atlas Project : UGA08CMH			
US (Life-saving sexual reproductive health services)	• ACORD • IRC • CARE • ACTION AID	ARC	Refugee women in Adjumani, Rwamwanja & Kyangwali, Arua.
Multiple: Austria, Finland, Luxembourg, Netherlands, Private, Sweden, UK, Intel, Laerdal Foundation, Germany, GE Healthcare, Friends of UNFPA (Thematic Trust fund for Maternal Health) (ZZT05/ZZT06)	• Ministry of Health • Ministry of Education		Uganda Mid-wifely Association, Fistula survivors, Mid-wifely Training Schools, Health facilities), Mothers, VHTs, Health workers
Multiple: Ireland, Norway, Poland, Korea, Spain, Iceland, Australia, AFU, UN Foundation, Private Individual, European Voice, OnebyOne, JOICFP, Luxembourg, KATVIG APS (Fistula)	• Ministry of health	RHU	Health Facilities, Fistula Patients - National
Embassy of Sweden (SIDA SEA 75)	• Ministry of Health • Ministry of Education & Sports • Ministry of Gender, Labour and Social Development • Population Secretariat • World Health Organization • Reproductive Health Uganda • Straight Talk Foundation		Mid-wives, Community Extension Workers, Min-midwifery Association, Health Facilities, Health Workers, Women, Youth, Young girls,

	• BRAC Uganda • Uganda Catholic Secretariat • Church of Uganda • Communication for Development Foundation Uganda (CDFU) • 10 District Local Governments: Kaabong, Moroto, Abim, Napak, • Nakapiripirit, Amudat, Kotido, Gulu, Lamwo and Kitgum		
Norway/DFID (UNFPA) Global Programme on RMNCH	• NPC • Ministry of Health • Marie Stopes Uganda • RHU • Uganda Catholic Secretariat	UNICEF, WHO, MGLSD, JLOS UNWomen, FAO	Young people & Women
ADOLESCENT Youth Sexual Reproductive Health			
Strategic Plan outcome:: Every adolescent and youth, in particular adolescent girls, is empowered to have access to sexual and reproductive health and reproductive rights, in all contexts			
Country programme output: Increased national capacity to conduct evidence based advocacy/interventions for incorporating adolescents and youth sexual reproductive health needs in national laws, policies and programmes, including humanitarian settings			
Atlas Project : UGA08AYP			
Denmark (Innovations)	• Kanungu DLG • DEX • Reach a Hand Uganda		Young people in Kanungu and Kampala
KAO Corporation	OUTBOX	ECOSmart	Adolescent Girls in Kampala, Bundibugyo, Kasese and Ntoroko.
United Kingdom – PreMDESA (Innovations)	Outbox		• Young Social Entrepreneurs in 8 target district • Women & girls at Risk of Sexual Violence & Abuse (Nationally)

Donors	Implementing Agencies	Other partners	Beneficiaries
GENDER/GBV&R			
Strategic Plan outcome: Gender equality, the empowerment of all women and girls, and reproductive rights are advanced in development and humanitarian settings			
Country programme output: National and district governments have the capacity for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings.			
Atlas Project :UGA08GBV			
Republic of Korea (KOICA)	• Ministry of Gender • UBOS • Ministry of Health, • Ministry of Education and Sports • Ministry of Gender • BRAC • Straight Talk Foundation • Reproductive Health Uganda (RHU • Inter-Religious Council of Uganda (IRCU) • Reach a Hand Uganda (RAHU)	Population Media Center (PMC)	Adolescent Girls (10-19),Health Workers, Teachers, Religious & cultural leaders and Parents in 14 districts (Amuria, Bududa, Butaleja, Iganga, Kapchorwa, Katakwi, Mayuge) (Abim, Amudat, Kaabong, Kotido, Moroto, Nakapiripirit, Napak)
UNICEF_UNFPA Global programme to End Child Marriage (Canada, EU, Italy, Netherlands, UK, UN Foundation)	• BRAC • UNICEF • DEX		• Young boys & Girls in Karamoja region. • Child mothers in the districts of Abim, Amudat, Amuria, Bududua, Butaleja, Iganga, Kaabong, Kapchorwa, Katakwi, Kotido, Mayuge, Moroto, Nakapiripirit and Napak, Kampala, Mubende and Amuria.

UNDP - MPTF Office (EU-spotlight)	• UBOS • Ministry of Health • Ministry of Gender • Ministry of Education • Ministry of Justice • BRAC • NPA • ACORD • IRCU • IRC OUT BOX	UNICEF, UNWOMEN, UNHCR,EOC, JLOS	• Women's Rights Groups, parliament, women and girls in Kasese, Kitgum, Kyegegwa, Tororo
SIDA (Joint Programme on GBV)	• Ministry of Gender, • Ministry of Health • Ministry of Education • UBOS • NPA • NPC • MoJCA	UPF, ODPP, JLOS secretariat, ULRC, Parliament of Uganda, Academia, CSOs, FBOs, Cultural Institutions, DLGs, Schools, Institutions of Higher learning, Media and Private sector	GBV survivors, Young people, Sexually active males, Refugee population, Women and Men 50 years and above, Health workers (Doctors, Clinical Officers and Midwives), • Psychosocial service providers, Social Workers and selected CSOs, Safety and security service providers (Police and Safe Shelters), Legal mediation and justice service providers (Prosecutors, State Attorneys, Magistrates and Judges; Selected CSOs and Informal justice mechanisms) , All Health Care providers, teachers, parents, cultural and religious leaders, private sector, at national level and in districts of Abim, Amuria, Kaabong, Kaberamaido, Kiryandongo, Kotido, Napak, Nakapiripirit, Pader, Yumbe, Moroto, Gulu, Bundibugyo and Kampala.
Norway (Joint Programme on GBV)	• CARE • Ministry of Gender • Child Fund International • Action Aid • Ministry of Health		Gulu, Amuru, Kitgum, Pader, Kotido, Moroto, Kabong, Lira, Dokolo, Amuria, Moroto, Kaabong and Kotido.
CANADA (Joint Programme on FGM)	• Ministry of Gender	UNICEF	Adolescent Girls in Karamoja & Sebei

	• Church of Uganda • NPC • Ministry of Health • Reproductive Health Uganda		
Denmark (WAY)	• Ministry of Health • Communication for Devt • Reach a Hand • CARE • Ministry of Gender • DEX		Women (10-49), Young men (10-24), Health Care & GBV Service Providers, teachers, community activists, parents, religious and cultural leaders in the districts of Adjumani, Agago, Arua, Amuru, Kitgum, Lamwo, Moyo, Yumbe.
UK DFID (RISE)	• NPC • Ministry of Health • UBOS • Ministry of Gender • Ministry of Education • NPA • Marie Stopes Uganda • Makerere University • RAHU		Women, Adolescents and humanitarian communities in the districts of Abim, Amudat, Kaabong, Kotido, Moroto, Napak, Nakapiripirit, Yumbe, Adjumani, Moyo, Arua, Lamwo, Kyegegwa, Kikuube, Kamwenge, Kiryandongo, Nabilatuk, Isingiro, Koboko
Packard Foundation	• Straight Talk Foundation • DEX		Adolescent Youth in Kampala & Mubende
Humanitarian (3006E)	• CARE • LWF • ACORD • IRC		Refugees
Canada/Norway (Humanitarian- Emergency Fund -ZZH06)	ACORD		Refugees & Host communities of Palorinya Imvepi, Palabek , Kiryandongo, Kyaka II Kyangwali
OCHA/CERF (Under-funded Emergency)	IRC, CARE,ACORD, DEX		Congolese & South Sudanese Refugees in Uganda (Nyumanzi, Ayilo 1&2, Baratuku, Boroli, Alere, Olur 1&2, Mirieyi settlements in Adjumani

			District; Kiryandongo Settlement, Rhino Camp in Arua District)
OCHA/CERF(Rapid Response)	IRC, ACORD		South Sudanese Refugees: Elegu reception centre, Nyumanzi transit centre and Pagirinya, Maaji III settlements in Adjumani District Rhino Camp Settlement in Arua District Bidibidi Settlement in Yumbe District.
POPULATION DYNAMICS			
Strategic Plan outcome: Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development			
Country programme output: National institutions and district governments have the capacity for the production and the use of disaggregated data on population, sexual and reproductive health and gender based violence for the formulation and monitoring of evidence based policies, plans and programmes, including in humanitarian settings			
Atlas Project UGA08PD			

Annex 6: Data Collection Tools

UNFPA Uganda - Population and Development (PD)
Key Informant Interview Guide for Implementers of the PD Component

Key Informants

- UNFPA PD staff; National Planning Council (NPC), National Planning Authority (NPA), Uganda Bureau of Statistics (UBOS), Makerere University Centre for Population and Applied Science (CDAP), Economic Policy Research Centre (EPRC) at Makerere University Kampala
- Planning Departments of Ministry of Health; Ministry of Gender, Labour and Social Development, Ministry of Education and Sports, Ministry of Justice and Constitutional Affairs, Ministry of Local G
- Chairpersons or Vice Chairpersons of District Planning Committees and Heads of Relevant DLG Departments including Health, Community Services & Education (Amudat, Amuria, Gulu, Kampala, Kitgum, Kiryandongo, Moroto Districts)

General Introduction - Purpose of the evaluation

I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa.

Core interview: objectives of the interview guide transformed into questions

1. **Objective: <u>Rationale</u> for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)**

Possible questions:

a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
b. Who was consulted regarding the design?
c. What other actors have been involved, how does this activity contribute to that of others?

2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts**

Possible questions:

a. To what extent is the 8th Country Programme (CP8) aligned to national priorities (including Vision 2040, National Development Plan (NDP) II (2015/16-2019/20)?
b. To what extent is the CP8 aligned to national priorities (including new generation UNDAF, sectoral priorities, and coherence with needs of target groups?
c. To what extent is the CP8 aligned to the SDGs and the International Conference on Population and Development (ICPD) Programme of Action and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?
d. To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?
e. To what extent has the programme integrated gender and human rights based approaches?

3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.

Possible questions:

a. How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
b. To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).

Possible questions:

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any?
b. To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?
c. What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. To what extent has UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms?

7. **Objective: Interviewee recommendations**

UNFPA Uganda - Population and Development (PD)
Key Informant Interview Guide for Implementers of the PD Component

Key Informants

- Chairpersons or Vice Chairpersons of District Planning Committees & Heads of Relevant DLG Departments including Health, Community Services & Education (Amudat, Amuria, Gulu, Kampala, Kitgum, Kiryandongo, Moroto Districts)

General Introduction - Purpose of the evaluation

I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa.

Core interview: objectives of the interview guide transformed into questions

1. **Objective: <u>Rationale</u> for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)**

Possible questions:

a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
b. Who was consulted regarding the design?
c. What other actors have been involved, how does this activity contribute to that of others?

2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts**

Possible questions:

a. To what extent is the CP8 aligned to national priorities (including Vision 2040, National Development Plan (NDP) II (2015/16-2019/20)?
b. To what extent is the CP8 aligned to national priorities (including new generation UNDAF, sectoral priorities, and coherence with needs of target groups?
c. To what extent is the CP8 aligned to the SDGs and the ICPD Programme of Action and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?
d. To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?
e. To what extent has the programme integrated gender and human rights based approaches?

3. **Objective: Efficiency of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.**

Possible questions:

a. How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
b. To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4. **Objective: Effectiveness of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

5. **Objective: Sustainability of the benefits from UNFPA support likely to continue, after CP has been completed**

Possible questions:

a. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any?
b. To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?
c. What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

6. **Objective: Existence and functioning of coordination mechanisms**

Possible questions:

a. To what extent has UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms?

7. **Objective: Interviewee recommendations**

UNFPA Uganda – Sexual Reproductive Health and Rights
Key Informant Interview Guide for Implementers of the Programme

Key Informants

- UNFPA RH staff; UNFPA Humanitarian Team; Office of the Prime Minister (OPM); Ministry of Health; Ministry of Gender, Labour and Social Development; Ministry of Education and Sports; Ministry of Justice & Constitutional Affairs; NPC, NPA, UBOS, Makerere University SPH; Inter-Religious Council of Uganda & Heads of Relevant DLG Departments including Health, Community Services, Planning & Education, Police [CFPU, CID], Judicial Officers & Probation Officers)
- CSO/NGO IPs (ACORD, AIC, BRAC, CARE, IRC, LWF, OUTBOX, RAHU, RHU, STF)

General Introduction - Purpose of the evaluation

I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa.

Core interview: objectives of the interview guide transformed into questions

1. **Objective: <u>Rationale</u> for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)**

Possible questions:

a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?
b. Who was consulted regarding the design?
c. What other actors have been involved, how does this activity contribute to that of others?

2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts**

Possible questions:

a. To what extent is the CP8 aligned to national priorities (including Vision 2040, National Development Plan (NDP) II (2015/16-2019/20)?
b. To what extent is the CP8 aligned to national priorities (including new generation UNDAF, sectoral priorities, and coherence with needs of target groups?
c. To what extent is the CP8 aligned to the SDGs and the ICPD Programme of Action and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?

d. To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?
e. To what extent has the programme integrated gender and human rights based approaches?

3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.

Possible questions:

a. How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
b. To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).

Possible questions:

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any?
b. To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?
c. What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid

environment?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. To what extent has UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms?

7. **Objective: Interviewee recommendations**

UNFPA Uganda – Sexual Reproductive Health and Rights
Key Informant Interview Guide for Other Key Players

UN Agencies, Donors, and Organizations that are not implementing the programme but are key players in the sector (Resident Coordinator, others in humanitarian assistance)

General Introduction - Purpose of the evaluation
I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa.
Core interview: objectives of the interview guide transformed into questions
1. Objective: <u>Rationale</u> for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity) **Possible questions:** a. How relevant do you perceive UNFPA's work to be in regard to national objectives and priorities including the humanitarian situation for refugees? b. How well does the UNFPA activities/work support the national structures that are in place? **2. Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts** **Possible questions:** a. To what extent is the CP8 aligned to national priorities (including Vision 2040, National Development Plan (NDP) II (2015/16-2019/20)? b. To what extent is the CP8 aligned to national priorities (including new generation UNDAF, sectoral priorities, and coherence with needs of target groups? c. To what extent is the CP8 aligned to the SDGs and the ICPD Programme of Action and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)? d. To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response? e. To what extent has the programme integrated gender and human rights based approaches?

3. **Objective: Efficiency of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.**

Possible questions:

a. Please comment how and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
b. Please comment to what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4. **Objective: Effectiveness of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

5. **Objective: Sustainability of the benefits from UNFPA support likely to continue, after CP has been completed**

Possible questions:

a. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any?
b. To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?
c. What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

6. **Objective: Existence and functioning of coordination mechanisms**

Possible questions:

a. To what extent has UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms?

7. Objective: Interviewee recommendations

UNFPA Uganda - Reproductive Health and Rights
Focus Group Discussion for adolescents and youth

General Introduction - Purpose of the evaluation
I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa. In this FGD, I am (we are) looking at how effectively UNFPA has helped adolescents and youth to understand the issues in health.
Core interview: objectives of the interview guide transformed into questions
1. Objective: Rationale for the project and activities undertaken **Possible questions:** a. What were, and are your priority needs as far as adolescent sexual reproductive health is concerned? 2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts** **Possible questions:** 3. How well does the activity/work of UNFPA fit in with the adolescents and youth in this district? 4. What effect do you think the work should have, with which groups? **5. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.** **Possible questions:** **a.** Did your work receive the needed support from UNFPA? b. Did the youth network receive any other support in connection with the UNFPA work and who provided this support? **6. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).** **Possible questions:** a. Can you provide examples of success of the approach/activity (e.g. box game, peer counseling) both long term and short term?

b. How useful are these activities to communicate the RH messages?
c. What are the lessons and good practices that should be continued and/or replicated elsewhere?

7. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. Can the youth networks carry on the work without UNFPA?
b. What will help the youth networks to carry on the SRH work on their own?

8. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

9. **Objective: FGD group recommendations**

UNFPA Uganda - Reproductive Health and Rights
Focus Group Discussion for women of reproductive age (15-54 years) / girls

General Introduction - Purpose of the evaluation
I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa. In this FGD, I am (we are) looking at how effectively UNFPA has helped women / girls to understand the issues in health and access SRH and FP services.
Core interview: objectives of the interview guide transformed into questions
1. Objective: <u>Rationale</u> for the project and activities undertaken **Possible questions**: a. What were, and are your priority needs as far as sexual reproductive health and rights is concerned? 2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts** **Possible questions:** a. How well does the activity/work of UNFPA fit in with the needs of women / girls in this district? b. What effect do you think the work should have, with women / girls? **3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.** **Possible questions:** **a.** Did the women / girls or your groups receive the needed support from UNFPA? b. Did the women / girls or your groups receive any other support in connection with the UNFPA work and who provided this support? **4. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. Can you provide examples of success of the approach/activity (e.g. box game) both long term and short term?
b. How useful are these activities to communicate the SRH messages?
c. What are the lessons and good practices that should be continued and/or replicated elsewhere?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. Can the women / girls or your groups carry on the work without UNFPA?
b. What will help women / girls or your groups to carry on the SRH work on their own?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. Do you receive support from other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

7. **Objective: FGD group recommendations**

UNFPA - Reproductive Health and Rights
Focus Group Discussion for men and men action groups (MAGs)

General Introduction - Purpose of the evaluation

I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa. In this FGD, we are looking at how effectively UNFPA has helped men and men action groups (MAGs) to understand the issues in health and access SRH and FP services.

Core interview: objectives of the interview guide transformed into questions

1. **Objective: <u>Rationale</u> for the project and activities undertaken**

Possible questions:

a. What were, and are your priority needs as far as sexual reproductive health and rights is concerned?

2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts**

Possible questions:

a. How well does the activity/work of UNFPA fit in with the needs of men and MAGs in this district?
b. What effect do you think the work should have, with men /MAGs?

3. **Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.**

Possible questions:

a. Did the men or MAGs receive the needed support from UNFPA?
b. Did the men and MAGs receive any other support in connection with the UNFPA work and who provided this support?

4. **Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. Can you provide examples of success of the approach/activity (e.g. box game) both long term and short term?
b. How useful are these activities to communicate the SRH messages?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. Can the men and MAGs carry on the work without UNFPA?
b. What will help the men and MAGs to carry on the SRH work on their own?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. Do you receive support from other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

7. Objective: Lessons learnt and best practices

Possible questions:

a. What would have done differently with the same resources?
b. What was the most and least successful approach in the delivery of CP outputs?
c. What are the lessons and good practices that should be continued and/or replicated elsewhere?

8. Objective: FGD group recommendations

UNFPA - Reproductive Health and Rights
Focus Group Discussion for refugees (women or men)

General Introduction - Purpose of the evaluation
I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa. In this FGD, I (we) want to understand how helpful this work has been for your community. (Services provided: dignity kits with soap, towels, etc., brochures on gender and RH rights, psychosocial counseling, SRH/HIV and FP services; ambulance referral service).
Core interview: objectives of the interview guide transformed into questions
1. Objective: <u>Rationale</u> for the project and activities undertaken **Possible questions:** a. What were, and are your priority needs? b. How well have you been consulted about your needs? **2. Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts** **Possible questions:** a. Did you help plan the services you have received? b. What effect do you think the work should have, with which groups? **3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.** **Possible questions:** a. Did you receive the services when you needed them? Were there delays? b. Did you receive what you expected? Were you consulted afterwards about your use of the items and services? **4. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. Can you provide examples of success of the services or activities?
b. How do you think the activities can be improved?
c. What was helpful for you regarding your health (psychosocial support, learning, access to contraceptives, birth spacing)?
d. Will the activities/services be useful in the future?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. Can you carry on the work without UNFPA?
b. What will help you carry on the SRH work on your own?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. Do you receive support from other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

7. Objective: Lessons learnt and best practices

Possible questions:

a. What would have done differently with the same resources?
b. What was the most and least successful approach in the delivery of CP outputs?
c. What are the lessons and good practices that should be continued and/or replicated elsewhere?

8. **Objective: FGD group recommendations**

UNFPA Uganda – Gender Equality
Key Informant Interview Guide for Implementers of Gender Equality Component

Key Informants

- UNFPA Gender Equality staff; Ministry of Gender, Labour and Social Development; Ministry of Health; Ministry of Education and Sports; Ministry of Justice & Constitutional Affairs; Directorate of Public Prosecution; Justice Law Order Sector (JLOS); Police Child and Family Protection Units; & Heads of Relevant DLG Departments including Health, Community Services, Planning & Education, Police [CFPU, CID], Judicial Officers & Probation Officers).
- CSO/NGO IPs (ACORD, BRAC, CARE, IRC, LWF, RAHU, RHU).

General Introduction - Purpose of the evaluation

I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa.

Core interview: objectives of the interview guide transformed into questions

1. **Objective: <u>Rationale</u> for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)**

Possible questions:

c. How relevant do you perceive UNFPA's work to be in regard to national objectives and priorities including the humanitarian situation for refugees?
d. How well does the UNFPA activities/work support the national structures that are in place?

2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts**

Possible questions:

a. To what extent is the CP8 aligned to national priorities (including Vision 2040, National Development Plan (NDP) II (2015/16-2019/20)?
b. To what extent is the CP8 aligned to national priorities (including new generation UNDAF, sectoral priorities, and coherence with needs of target groups?
c. To what extent is the CP8 aligned to the SDGs and the ICPD Programme of Action and UNFPA Strategic plans (2014 – 2017; 2018 – 2022)?
d. To what extent has UNFPA been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies? What was the quality of such a response?

e. To what extent has the programme integrated gender and human rights based approaches?

3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.

Possible questions:

c. How and to what extent has the Country Office made use of its funding, personnel, administrative arrangements, time and other inputs to optimise achievement of results described in the 8th CP?
d. To what extent did the intervention mechanisms (partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs, including those specifically related to advancing gender equality and human rights as well as those with gender and human rights dimensions?

4. Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).

Possible questions:

a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?

5. Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed

Possible questions:

a. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions, if any?
b. To what extent have the partnerships built by UNFPA promoted national ownership of supported interventions, programmes and policies?
c. What are the main comparative strengths of UNFPA in Uganda; and how can these strengths and lessons learned from the previous CPs be used for strategic positioning for future CP development in humanitarian and development nexus, in the era of new generation UNDAF and changing aid environment?

6. Objective: Existence and functioning of <u>coordination</u> mechanisms

Possible questions:

a. To what extent has UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms?

7. **Objective: Interviewee recommendations**

UNFPA - Gender Equality
Focus Group Discussion for Beneficiaries (Separately for women, men, and young people, community structures including community activists, male action groups)

General Introduction - Purpose of the evaluation
I am (we are) part of a three-person team to evaluate GoU/UNFPA's 8th Country Programme (2016-2020) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting districts of Kampala, Moroto, Amudat, Amuria, Gulu, Amuru, Adjumani, Arua, Kiryandongo and Kyegegwa. In this FGD, we are looking at how effectively UNFPA has helped you to understand the issues related to gender equality and empowerment, gender based violence and harmful practices.
Core interview: objectives of the interview guide transformed into questions
1. Objective: <u>Rationale</u> for the project and activities undertaken Possible questions: a. What were, and are your priority needs as far as gender equality and empowerment? 2. **Objective: <u>Relevance</u> of the project/activities to both national government and UNFPA policies and strategies and how they address different and changing national contexts** **Possible questions:** a. What were, and are your priority needs in respect to gender equality and women empowerment? b. How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme? **3. Objective: <u>Efficiency</u> of use of UNFPA resources (partners, staff, money, global experience) in terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results.** **Possible questions:** a. Were you receiving services in a timely manner/whenever you needed them? b. Did agency/ institution seek for your feedback on the services/activities being implemented? c. How well did the agency/institution use this feedback to improve services/activities?

4. **Objective: <u>Effectiveness</u> of the approaches/activities/projects (The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes).**

Possible questions:

a. How well has the programme managed to support your gender equality and women empowerment needs? Possible probes: What changes has this programme brought about in your lives?
b. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development?
c. Are there any changes that should be have been made in order to improve services or activities?

5. **Objective: <u>Sustainability</u> of the benefits from UNFPA support likely to continue, after CP has been completed**

Possible questions:

a. Are you engaged in gender equality and women empowerment activities by other agencies or individuals?
b. Do they work together?

6. **Objective: Existence and functioning of <u>coordination</u> mechanisms**

Possible questions:

a. How well has the programme been able to work within existing community structures?
b. Do you think the existing structures are able to take on work/part of the work that is being implemented?

7. **Objective: FGD group recommendations**

Observation Guide
Key issues to observe: • External environment (brief description). • Youth Friendly Spaces (Safety, Recreation Facilities, Games/Sports, TV). • Ease of access to services (location, transport access, surroundings etc.). • Standard Operating Procedures (SOPs). • Availability of (e.g. IEC/BCC) materials, leaflets and posters etc. (e.g., variety, numbers, documents to take away etc., language, attractiveness, relevance, range). • Availability of stocks for family planning commodities (including observing stock in and stock outs, medical Kits). • PEP Kits • Sufficiency of facilities: size, counseling/ consultation rooms, crowdedness, equipment (space for relaxation as well as service provision, whether all equipment is working, what sort of condition the rooms and equipment are in, etc.). • Functional sanitation services that offer privacy. • Referral Directories and forms. • Minutes of coordination meetings. • Clubs activities e.g. for ELA Clubs activities, Activities of Male Action Groups. • Evidence of trainings (E.g. Training materials in life skills, vocational skills, livelihood skills). • Income Generating Activities (IGAs). • Training equipment. • IPs reports and other relevant materials. • Services provided to beneficiaries. • Counselling rooms at Health Facilities and Police. • Police Forms and other Administrative Records. • Interactions between staff and clients. • Waiting times and streamlined flow of service provision/staff to client ratio.

Annex 7: CPE Agenda

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	DESIGN PHASE					
Day 1 (Thu. 3rd Oct. 2019)	11.00-16.00 Evaluation team (ET) meeting	Evaluation team internal meeting	Metropole Hotel, Kampala	N/A	N/A	Preparation of the briefing session with Deputy Country Rep.; review of individual agendas; Listing of documents to obtain from UNFPA office.
Day 2 (Fri. 4th Oct.)	10.30-12.00 Briefing meeting with Deputy Rep.	Ms. Mareledi Segotso	Country Office, Plot 12A Baskerville Ave, Kampala	N/A	N/A	Presentation of the evaluation team; preliminary discussions; understanding the 8th CP; clarifying expectations
	12.00-13.00 Briefing meeting with Human Resource Dept.	Ms. Deborah Nakibira	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Clarifying contractual issues
	13.00-13.30 Security training by Security Associate	Mr. Ambrose Walubo	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Clarifying security issues to ET for smooth running of the evaluation process
	14.00-18.00 ET internal work	ET preparatory work	Individual residences	N/A	N/A	Understanding the 8th CP
Day 3 (Sat. 5th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 4 (Sun. 6th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 5 Mon. 7th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 6 Tue. 8th Oct.)	09.00-18.00 CP Portfolio presentation by programmatic area	Heads and technical officers of each programmatic area	Country Office, 12A Baskerville Ave, Kampala	Head of Integrated Field Support; Head of Pop. & Dev't; Head of Gender Equality; Head of SRH /HIV	N/A	Brief the evaluation team on the actual portfolio being implemented
Day 7	08.00-18.00	Evaluation team internal work	Individual	N/A	N/A	Development of the design report

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
(Wed. 9th Oct.)	Document review and drafting design report		residences			
Day 8 (Thu. 10th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 9 (Fri. 11th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 10 (Sat. 12th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 11 (Sun. 13th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 12 (Mon. 14th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Individual residences	N/A	N/A	Development of the design report
Day 13 (Tue. 15th Oct.)	08.00-18.00 Document review and drafting design report	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Development of the design report
	Further consultation on design report	Evaluation Manager	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Development of the design report
Day 14 (Wed. 16th Oct.)	08.00-13.30 Document review; make guides for interviews, FGDs and observation	Evaluation team internal meeting	Metropole Hotel, Kampala	N/A	N/A	Development of the design report
	14.00 Submit draft design report & meet Deputy Rep; EM	Ms. Mareledi Segotso; Mr. John Odaga	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Submission of the design report for review by CO
Day 15 (Thu. 17th Oct.)	09.00-12.00 Receive and address the input & comments from EM on draft design Report	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
Day 16 (Fri. 18th Oct.)	08.00-18.00 Further document review; address comments; finalise guides for FGDs, interviews & observation	Evaluation team internal work	Individual residences	N/A	N/A	
Day 17 (Sat. 19th Oct.)	08.00-18.00 Further document review; address comments; finalise guides for FGDs,	Evaluation team internal work	Individual residences	N/A	N/A	

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	interviews & observation					
Day 18 (Sun. 20th Oct.)	08.00-18.00 Finalise draft design report (including finalising guides for FGDs, interviews; annexes)	Evaluation team internal work	Individual residences	N/A	N/A	
Day 19 (Mon. 21st Oct.)	08.00-18.00 Finalise draft design report (including finalising guides for FGDs, interviews; annexes)	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
Day 20 (Tue. 22nd Oct.)	08.00-17.00 Finalise and submit 2nd draft Design Report to EM	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
	11.00-12.00 Consultation meeting with EM	Mr. John Odaga	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
Day 21 (Wed. 23rd Oct.)	08.00-18.00 Prepare presentation, further document review and finetune guides for interviews & FGDs	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
Day 22 (Thu. 24th Oct.)	08.00-18.00 Prepare initial presentation, further document review and fine-tune guides for interviews & FGDs	Evaluation team internal work	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Improvement on the draft design report
Day 23 (Fri. 25th Oct.)	0.88-18.00 Incorporate comments on the Inception/ Design Report from EM and Regional Office	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Finalisation of the design report
Day 24 (Sat. 26th Oct.)	09.00-15.00 Incorporate comments on the Inception/ Design Report from EM and Regional Office	Team Leader	Metropole Hotel Kampala	N/A	N/A	
	16.00 Submit Final draft Inception/ Design Report	Team Leader	Metropole Hotel Kampala	N/A	N/A	
Day 25 (Sun. 27th Oct.)	09.00-17.00 Further document review	Evaluation Team	Individual residences	N/A	N/A	
Day 26 (Mon. 28th Oct.)	08.00-11.30 Further document review; refining of tools; finalisation of workplan & CPE	Evaluation Team	Metropole Hotel Kampala	N/A	N/A	
	12.00-15.00	Evaluation Manager	Country Office,	N/A	N/A	To ensure smooth running of field

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	Meeting on logistical preparations for fieldwork phase		12A Baskerville Ave, Kampala			work activities
	15.30-18.00 Further document review; refining annexes of design report	Evaluation Team	Individual residences	N/A	N/A	
Day 27 (Tue. 29th Oct.)	08.00-18.00 Further document review; refining of tools; finalisation of workplan & CPE	Evaluation Team	Metropole Hotel Kampala	N/A	N/A	
Day 28 (Wed. 30th Oct.)	08.00-17.00 Preparation of presentation to ERG	Evaluation Team	Metropole Hotel Kampala	N/A	N/A	
Day 29 (Thu. 31st Oct.)	10.00-11.00 CP portfolio briefing by CO programme staff	Dr. John Odaga, Evaluation Manager	Country Office	N/A	N/A	Detailed brief to the evaluation team (ET) on the actual portfolio being implemented & coordination of CP
	11.00-12.00 CP portfolio briefing by CO programme staff	Ms. Jacobson Maiken, Head Integrated Field Support & WAY Programme	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	12.00-13.00 CP portfolio briefing by CO programme staff	Ms. Rosemary M. Kindyomunda, National Program Specialist HIV/SRH	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	14.00-15.00 CP portfolio briefing by CO programme staff	Programme Specialist Gender	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	15.00-16.00 CP portfolio briefing by CO programme staff	Ms. Florence M. Tagoola, Programme Specialist, Pop. & Development	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	16.00-18.00 Further document review	Evaluation Team	Individual residences	N/A	N/A	Evaluation Team
Day 30 (Fri. 1st Nov.)	10.00-11.00 CP portfolio briefing by CO programme staff	Mr. Abilio Alfeu, International Operations Manager (IOM)	Country Office	N/A	N/A	Detailed brief to the evaluation team on management & coordination of CP
	11.30-13.00 CP portfolio briefing by CO programme staff	Ms. Esther, Program Analyst FGM	Country Office	N/A	N/A	Detailed brief to the evaluation team on the actual portfolio being implemented
	13.00-14.00 Meeting with Evaluation Manager on field phase preparation	Dr. John Odaga, Evaluation Manager Mr. Charles Mutalya	Country Office	N/A	N/A	Smooth running of the forthcoming field phase activities
	15.30-18.00	Evaluation Team	Metropole hotel	N/A	N/A	Improvement on the draft design

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	Further document review; revision and finalisation of draft Design Report		Kampala			report
Day 31 (Sat. 2 Nov.)	0.900-18.00 Preparation of power point presentation of Design Report	Evaluation Team	Metropole hotel Kampala	N/A	N/A	A succinct and comprehensive summary of the Design Report for ERG members
Day 32 (Sun. 3 Nov.)	0.900-18.00 Preparation of power point presentation of Design Report	Evaluation Team	Metropole hotel Kampala	N/A	N/A	A succinct and comprehensive summary of the Design Report for ERG members
Day 33 (Mon. 4 Nov.)	09.00-14.00 Present CPE Design Report in general briefing session (plenary)	ERG members; CO technical heads	NPC, Statistics House Plot 9 Colville Street Kampala	N/A	N/A	Present Design Report; validation of the evaluation matrix, the intervention logic, tools and the overall agenda
	14.30-18.00 Incorporate comments on the Inception/ Design Report	Evaluation team internal meeting	Country Office	N/A	N/A	Finalisation of the Design Report
Day 34 (Tue. 5 Nov.)	08.00-09.00 Finalise sections of final Inception/ Design Report	Evaluation team internal work	Country Office	N/A	N/A	Finalisation of the Design Report
	09.00-10.30 CP portfolio briefing by CO programme staff	Dr. Edson Muhwezi, Assistant Representative	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	12.00-13.00 CP portfolio briefing by CO programme staff	Ms. Edith Akiror, Programme Analyst GBV Ms. Doreen Kyomuhangi	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	14.00-15.00	Prossy Nakanjako, Program Specialist Communications	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	16.00-17.00 CP portfolio briefing by CO programme staff	Ms. Martha Songa, Program Analyst, Advocacy, Partnership & Networking	Country Office	N/A	N/A	Detailed brief to the ET on the actual portfolio being implemented
	18.00 Submit Final Inception/ Design Report	Dr. Joshua Kembo Team Leader	Metropole Hotel Kampala	N/A	N/A	Receipt and approval of Design Report by EM
	FIELD PHASE					
Day 35 (Wed. 6 Nov.)	09.00-09.30 Interviews with CO management staff	Mr. Alan Sibenaler, Representative	Country Office 12A Baskerville	N/A	N/A	Detailed brief to the evaluation team on management & coordination of

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
			Ave, Kampala			CP; Partnerships with other UN agencies as DaO and joint programmes.
	10.00-11.00 Meeting at UNAIDS	Dr. Jotham Mubangizi, Senior M&E Officer Cell: 0759523349	UNAIDS, Shimoni Road, Kampala	Output 3 of SRH	Criteria 2, 4 and 7	Implementing partner and focal person on Joint SHR/HIV/GBV integrated programme; Lead on Joint UN Program of Support on HIV/AIDS (JUPSA)
	11.30-12.30 Meeting at WHO (**NB**: same building. with UNAIDS)	Dr. Olive Sentumbwe Focal person on Joint SHR/ HIV/GBV programme	WHO, Shimoni Road, Kampala	PU0014 Output 3 of SRH, Output 1 of GEWE	Criteria 2, 4 and 7	Implementing partner and focal person on Joint SHR/HIV/GBV integrated programme
	14.00-15.00 Meeting at UNICEF (**Interviewer – Paul K**, In-charge on Gender Equality)	Ms Mahoua Parums Deputy Representative Focal person, Joint Program on Abandonment of FGM	UNICEF, Plot 9 George Street Kampala	PU0081 Output 1 of GEWE	Criteria 2, 4 and 7	Implementing partner and focal person on Joint program on Abandonment of FGM; Joint SHR/HIV/GBV integrated programme;
	14.00-15.00 Meeting at UNHCR (**Interviewer – John M**, In-charge of SRH)	Mr. Kazuaki Kameda, Dep. Representative HIV/AIDS Focal person	UNHCR, Plot 11/13, Mackenzie Close, Off Mackenzie Vale, Kololo, Kampala	Output 3 of SRH	Criteria 2, 4 and 7	Implementing partner of CRRF; Implementing partner on HIV/AIDS and beneficiary on capacity building activities to deliver quality HIV/AIDS services for PLHIV & vulnerable people
	14.00-15.00 Meeting at National Population Council (NPC) (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Mr. Jotham Musinguzi, Executive Director NPC	NPC, Statistics House Plot 9 Colville Street Kampala	PGUG01 Output 1 of PD	Criteria 2, 4 and 7	Implementing partner at national level on P&D; Beneficiary of CB activities for the production and the use of disaggregated data on population, SRH and GBV for policies, plans and programmes, including humanitarian settings
	15.00-16.00 Meeting at National Planning Authority (NPA) (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Dr. Joseph Muvawala Chairperson, NPA	NPA, Statistics House Plot 9 Colville Street Kampala	Output 1 of PD	Criteria 2, 4 and 7	Implementing partner at national level on P&D; Beneficiary of CB activities for the production and the use of disaggregated data on population, SRH and GBV for policies, plans and programmes, including humanitarian settings
Day 36 (Thu. 7 Nov.)	09.00-10.00 Meeting at UN Resident Coordinator's Office - UNDP Office premises	Ms. Rebecca Nalumansi Programme contact on Spotlight Initiative	RCO (at UNDP Country Office) Uganda, Plot 11	Output 1 of GEWE	Criteria 2, 4 and 7	UN agencies Delivering as One; and Partnerships with UNFPA; Implementing partner and

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	(**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Cell: rebecca.nalumansi@one.un.org	Yusuf Lule Road, Kampala			programme contact on Spotlight Initiative – To elimination violence against women and girls
	09.00-10.00 Meeting at UN Women (**Interviewer – Paul K**, In-charge on Gender Equality)	Ms. Susan- Doreen Focal person, Joint Programme on GBV susan.oregede@unwomen.org	UN Women Plot 11, Yusuf Lule Road P.O. Box 7184 Kampala, UGANDA	Output 1 of GEWE	Criteria 2, 4 and 7	Implementing partner and focal person on UNFPA-UN Women Joint programme on GBV; and Spotlight Initiative (elimination of violence against women and girls)
	09.00-10.00 Meeting at Ministry of Health (**Interviewer – John M**, In-charge of SRH)	Dr. Placid Mihayo Reproductive Health Coordinator Cell: mihayo1963@yahoo.co.uk	Ministry of Health, Plot 6 Lourdel Rd, Nakasero, K'la	PGUG03 Outputs 1 and 2 of SRH	Criteria 2, 4 and 7	Implementing partner on SRHR and beneficiary on capacity building activities to deliver high quality maternal health, demand for FP & integrated SRHR/HIV services
	10.30-11.30 Meeting at Ministry of Health (**Interviewer – John M**, In-charge of SRH)	Ms. Agnes Bako Chandia Focal Person SRHR/ HIV bakuchandia@gmail.com 0772885201	Ministry of Health, Plot 6 Lourdel Rd, Nakasero, K'la	PGUG03 Outputs 1 and 2 of SRH	Criteria 2, 4 and 7	Implementing partner on SRHR and beneficiary on capacity building activities to deliver high quality maternal health, demand for FP & integrated SRHR/HIV services
	11.00-12.00 Meeting at Ministry of Gender, Labour and Social Development (MGLSD) (**Interview by Paul B**, In-charge of Gender Equality)	Ms. Annet Kabarungi Commissioner Gender, MGLSD	MGLSD, Plot 2, Simbamanyo House/ George Street, Kampala	PGUG12 Output 1 of GEWE	Criteria 2, 4 and 7	Implementing partner at national level on gender equality, and empowerment of women & girls; Beneficiary on capacity building (CB) activities to deliver protection and advancement of RH rights, and delivery of multi-sectoral GBV prevention and response services, including in humanitarian settings
	11.00-12.00 Meeting at Uganda Bureau of Statistics (UBOS) (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Dr. Mukiza Executive Director UBOS chris.mukiza@ubos.org	NPA, Statistics House Plot 9 Colville Street Kampala	PGUG02 Output 1 of PD	Criteria 2, 4 and 7	Implementing partner at national level on P&D; Beneficiary of CB activities for the production and the use of disaggregated data on population, SRH and GBV for policies, plans and programmes, including humanitarian settings
	14.00-15.00 Meeting at Makerere University School of Public Health (MUSPH) (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	MUSPH Focal person, (UNFPA funded activities)	Mulago Hill Road, adjacent to the Mulago Hospital Complex	PN5602 Output 1 of PD	Criteria 2, 4 and 7	Implementing partner and beneficiary of CB activities on product availability and data generation from Service Delivery Point (SDP) surveys

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	14.00-15.00 Meeting at Ministry of Education & Sports (MoES) (**Interview by Paul B**, In-charge of Gender Equality)	Mr. Ismael Mulindwa MoES Focal Person, Gender Unit ismaelmulindwa@yahoo.com	Embassy House, on King George VI Way, at the corner with Parliament Avenue, Kampala	PGUG13 Output 1 of AYSR	Criteria 2, 4 and 7	Implementing partner at national level on Adolescents and youth sexual reproductive health; empowerment of women & girls
	14.00-15.00 Meeting at Ministry of Justice & Constitutional Affairs (MoJCA), Justice, Law and Order Sector (JLOS) (**Interviewer – John M**, In-charge of SRH)	Ms. Rachael Odoi, Director, JLOS Secretariat rodoi@jlos.go.ug 0772 552416	MoJCA, Parliament Avenue, Baumann House, Level 3, Kampala	Output 1 of GEWE, Output 1 of SRH	Criteria 2, 4 and 7	Implementing partner at national level reproductive rights protection and GBV prevention; and beneficiary of CB on Justice, Law and Order Sector (JLOS)
	1600-17.00 Meeting at CARE International (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Ms. Delphine.Pinault Director, CARE International Delphine.Pinault@care.org	Plot 1B Kira Road, 2nd Floor Kalamu House, Kampala	PN5924 Output 1 of SRH, Output 1 of GEWE	Criteria 2	Implementing partner of comprehensive maternal health services; reproductive rights protection and GBV prevention
	16.00-17.00 Meeting at International Rescue Committee (IRC) (**Interview by Paul B**, In-charge of Gender Equality)	Director, IRC Contact: Harriet Kezaabu Harriet.Kezaabu@rescue.org	Plot 7, Lower East Naguru Road, Kampala	PN5916 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner of coordinated humanitarian action; comprehensive maternal health services; reproductive rights protection and GBV prevention
	16.00-17.00 Meeting at BRAC Uganda Ltd (**Interviewer – John M**, In-charge of SRH)	Mr. Francis Tabu Director, BRAC 0772623347 tabu.drachi@brac.net	Plot 880, Heritage Road, Nsambya Kampala	PN6576 Outputs 1 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing partner of Integrated SRH and HIV/AIDS prevention; reproductive rights protection and GBV prevention
Day 37 (Fri. 8 Nov.)	09.00-10.00 Meeting at ACORD (**Interviewer – Joshua K**, In-charge of Pop. & Dev't and Team Leader)	Ellen Bajenja Director, ACORD ellen.bajenja@acordinternational.org	Plot 1272, Block 15 Nsambya, Kampala	PN5991 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner of coordinated humanitarian action; comprehensive maternal health services; data generation; reproductive rights protection and GBV prevention
	09.00-10.00 Meeting at Reach a Hand, Uganda (RAHU) (**Interviewer - Paul B**, In-charge of Gender Equality)	Mr. Gibert Chief of Staff, RAHU 0788652043 Humpfrey Nabimanya Team Leader 0774 256 109	Plot 7502, Block 244, Heritage Village, Kansanga, Gabba Rd, Kampala	PN6577 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner on SRHR; Gender Equality and beneficiary on CB activities to deliver high quality services for SRH; gender equality & women's empowerment
	09.00-10.00 Meeting at AIDS Information Centre (AIC) (**Interviewer – John M**, In-charge of	Dr. Sheila Biugi Executive Director AIC sheila.birungi@aicug.org **Contact:** Dr. Hilda Kizito	Plot 1321 Musajja - Alumbwa road, Kisenyi Kampala	PN6580 Output 3 of SRH Output 1 of GEWE	Criteria 2	Implementing partner of Integrated SRH and HIV/AIDS prevention; reproductive rights protection and GBV prevention

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	SRH)	hilda.kizito@aicug.org Mr. Minsi Monja, SRH & Communications Manager; Focal person on SRH/HIV integrated programme 0702 907505				
	11.00-12.00 Meeting at Lutheran World Federation (LWF) (**Interviewer - Paul B**, In-charge of Gender Equality)	Jessy Kamstra Director, LWF jesse.kamstra@lutheranworld.org	Plot 1401, Ggaba Road, Nsambya, Kampala	Output 1 of GEWE	Criteria 2	Implementing partner of coordinated humanitarian action (GBV in emergencies); comprehensive maternal health services; reproductive rights protection and GBV prevention
	11.00-12.00 Meeting at OUTBOX Uganda Ltd (**Interviewer – John M**, In-charge of SRH)	Mr. Richard Zulu Lead, OUTBOX 0752624006	OUTBOX, Lumumba Ave, Kampala	PN6609 Output 1 of AYSR	Criteria 2	Implementing partner at national level on Adolescents and Youth, in particular adolescent girls, being empowered to have access to SRH; Beneficiary of CB activities to conduct evidence based advocacy/interventions for incorporating adolescents and youth SRH needs in national laws, policies and programmes, including humanitarian settings
	14.00-15.00 Meeting at Reproductive Health Uganda (RHU)	Mr. Jackson Chekweko Executive Director, RHU	Plot 2, Katego Road, Tufnell Drive, Off Kira Road, Opposite Uganda Museum	PN5916 Output 1 of SRH	Criteria 2	
	14.00-15.00 Meeting at Inter-Religious Council of Uganda (IRCU)	Mr. Joshua Kitakule Executive Director IRCU Meet Charles - 0772694941	IRCU, Plot 245 Sentema Rd, Kampala	PN6584 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner on SRHR; Gender Equality and beneficiary on CB activities to deliver high quality services for SRH; gender equality & women's empowerment
Day 38 (Sat. 9 Nov.)	09.00-17.00 Preparation for fieldwork	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	
Date	**Activity/ institution**	**People to meet**	**Location**	**Location Link with the CP**	**Selection criteria**	**Justification**
	FIELD PHASE Team A: Districts of Iganga (1 day), Moroto, Amudat and Iganga (4 days)					
Day 39	**14.00-16.00**					1. Evaluator in charge of Population

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
Sun. 10 Nov.	**Evaluation Team travels from Kampala to Iganga**					and Development and Team Leader - **Joshua Kembo**; 2. Evaluator in charge of Gender Equality - **Paul Bukuluki**. (**Team A**) 3. Evaluator in charge of SRH - **John Mark Mwesigwa (Team B**)
Day 40 (Mon. 11 Nov.)	09.00-09.30 Courtesy call /meeting at Iganga DLG authority	Mr. D. Kawoya Chief Administrative Officer, Iganga Cell: 0772494206	Iganga town	N/A	N/A	Overall coordinator of Implementing Partners at district level on SRH, gender equality and women's empowerment services
	10.00-11.00 Meeting at District Community Dev't Office Meeting at District Community Development Office (DCDO)	Mr. Samuel Batuuka, DCD Officer Cell: 0772481748	Iganga town	Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment;
	11.30-12.30 Meeting with CSO implementing partner on (1) Better Lives for Girls (BL4G) project ending early teenage pregnancy and early child marriages (ECM); (2) SRHR integration into Empowerment & Livelihood for Adolescents (ELA)	IP field staff Project Manager, BRAC	Iganga town	PN6576 Output 1 of GEWE Output 1 of SRH Output 1 of AYSR	Criteria 2	Implementing partners on protection of reproductive rights, prevention of early child marriages (GPECM) Implementing partner on SRHR integration into Empowerment & ELA; socio-economic asset building through ELA
	14.00-15.30 FGD session among women on ending early child marriages (ECM)	Women beneficiaries	One of the nearby sub-counties (Iganga)	PN6576 Output 1 of GEWE	Criteria 2	Final beneficiaries on prevention of early child marriages (GPECM)
	16.00-17.30 FGD session among Adolescents/ Youth on ending early child marriages (ECM)	Adolescents/Youth beneficiaries	One of the nearby sub-counties (Iganga)	PN6576 Output 1 of AYSR	Criteria 2	Final beneficiaries on prevention of early child marriages (GPECM)
Day 41 (Tue. 12 Nov.)	07.00-18.00 **Travel from Iganga to Moroto by road**					Evaluator in charge of Gender Equality – **Paul K**. (**Team A**)
	07.00-18.00 **Travel from Iganga to Kitgum by road via Soroti and Gulu**					Evaluator in charge of SRH - **John Mark Mwesigwa (Team B**)
	09.00-11.00 **Travel from Iganga to Kampala (capital city) by road**					Evaluator in charge of Population and Development and Team Leader - **Joshua Kembo**
Day 42 (Wed.13 Nov.)	09.00-09.30 Courtesy call /brief meeting at UNFPA	UNFPA field staff: Ms. Bernadette Ssebadduka,	Moroto town	N/A	N/A	Implementing Partner at district level on district CB activities for SRH,

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	field office, Moroto (**Team A**)	Programme Coordinator Cell: 0776222102/ 0756137137				gender equality and women's empowerment
	10.00-11.00 Courtesy call /meeting at Moroto DLG authority (Team A)	Chief Administrative Officer, Moroto	Moroto town	N/A	N/A	Overall coordinator of Implementing Partners at district level on SRH, gender equality and women's empowerment services
	11.00-12.00 Orientation of research team	Research Assistants (already selected)	Moroto town	N/A	N/A	
	12.00-13.00 Meeting at District Community Development Office, Moroto (**Team A**)	Ms. Margie Lolem, District Community Development Officer (DCDO) Cell: 0751800237	Moroto town	Output 1 of SRH Output 1 of GEWE		Implementing Partner at district level on SRH, gender equality and women's empowerment;
	14.00-15.00 Meeting at District Health Office, Moroto DLG (**Team A**)	Charles Onyang Omuudu District Health Officer, Moroto Cell: 0776000247	Moroto town	PGUG09 Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment
	15.30-16.30 Meeting with CSO Implementing Partner on GBV/SRH and ELA (**Team A**)	Project Manager, BRAC IP field staff, BRAC	Moroto town	PGUG09 Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment;
	15.30-16.00 Meeting at District Planning Office (**Team A**)	Mr. Opio Pollar, District Planner Cell: 0782356355	Moroto town	PGUG09 Output 1 of PD	Criteria 2	Beneficiary of CB activities for the production & the use of disaggregated data on population, SRH & GBV for policies, plans and programmes
Day 43 (Thu. 14 Nov.)	09.00-11.00 FGD session on GBV and FGM prevention (**Team A**)	Women beneficiaries (Moroto District)	Katikekile sub-county (Tepeth County)	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV & FGM
	11.30-13.30 FGD session on GBV and FGM prevention, Moroto (**Team A**)	Girl beneficiaries (Moroto District)	Katikekile sub-county (Tepeth County)	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV & FGM
	14.00-16.00 FGD session on GBV and FGM prevention (**Team A**)	Adult Men Beneficiaries (Moroto District)	Katikekile sub-county Hqr (Tepeth County)	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV & FGM
Day 44 (Fri. 15 Nov.)	09.00-10.00 Meeting District Population Committee, Moroto (**Team A**)	District Population Committee members	Moroto town	Output 1 of PD	Criteria 2	Beneficiary of CB activities for the production & the use of disaggregated data on population, SRH & GBV for policies, plans and programmes

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	10.30-11.30 Meeting with CSO Implementing Partner on GBV Meeting with CSO Implementing Partner on SRH/HIV prevention (**Team A**)	IP field staff, IRC Project Manager, International Rescue Committee (IRC)	Moroto town	PN5916 Output 1 of GEWE Output 1 of AYSR	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV Implementer on SRH/HIV prevention programming for in/out of school 10-24 year olds
	12.00-13.30 Meeting with CSO Implementing Partner on HIV/AIDS prevention (KARUNA) (**Team A**)	IP field staff, RAHU Project Manager, RAHU	Moroto town	PN6577 Output 3 of SRH	Criteria 2	Final beneficiaries on Karamoja Connect to reach more young people with leadership orientation opportunities and their engagement in SRH/HIV/GBV programming
	14.00-15.30 Meeting with cultural & religious institutions GBV & FGM (**Team A**)	Cultural and Religious leaders	Moroto town	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV especially FGM
	14.00-15.30 Meeting with CSO Implementing Partner on GBV/SRH and ELA (**Team A**)	Project Manager, BRAC IP field staff, BRAC	Moroto town	PN6576 Output 1 of GEWE; Output 1 of SRH Output 1 of AYSR	Criteria 2	Implementer on integrating GBV/SRH and Livelihood (ELA) among youth
Day 45 (Sat. 16 Nov.)	09.00-18.00 Further documents review; compiling /arranging notes from various interviews and FGDs (**Team A**)	Evaluation Team	Respective district towns	N/A	N/A	To ensure data is of good quality and is kept safely
Day 46 (Sun. 17 Nov.)	14.00-16.00 **Travel from Moroto to Amudat District by road**					Evaluator in charge of Gender Equality - Paul K. (**Team A**)
Day 47 (Mon. 18 Nov)	09.00-09.30 Courtesy call /meeting at Amudat DLG authority (Team A)	Mr. Wasswa Masokoyi Chief Administrative Officer, Amudat	Amudat town	PGUG23	Criteria 2	Overall coordinator of Implementing Partners at district level on SRH, gender equality and women's empowerment services
	10.00-11.00 Orientation of research team	Research Assistants (already selected)	Amudat town	N/A	N/A	Support to the evaluator while in Amudat District
	11.00-12.00 Meeting at District Community Development Office, (**Team A**)	Mr. Freda Amuron Imma, District Community Development Officer Cell: 0782254269	Amudat town	Output 1 of SRH Output 1 of GEWE		Implementing Partner at district level on SRH, gender equality and women's empowerment;
	12.30-13.30 Meeting at District Health Office, Moroto DLG (Team A)	Dr. Peter Kusolo District Health Officer, Amudat	Amudat town	PGUG23 Outputs 1, 2 and 3 of SRH;	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment;

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
				Output 1 of GEWE		
	14.00-15.00 Meeting with District Population Committee, Amudat (**Team A**)	District Planning Officer, Amudat; District Population Committee members	Amudat town	PGUG23 Output 1 of PD	Criteria 2	Beneficiary of CB activities for the production and the use of disaggregated data on population, SRH & GBV for policies, plans and programmes
	15.30-17.00 Meeting with CSO Implementing Partner on multi-sector VAW/VAC/HP essential services and integrated SRHR services (**Team A**)	IP field staff, IRC Project Manager, IRC	Amudat town	PN5916 Output 1 of GEWE Output 1 of SRH	Criteria 2	Implementing Partner for CB of KAWUO staff & Community development Officers (CDOs) on VAW/VAC/HP essential services and integrated SRHR services
Day 48 (Tue. 19 Nov.)	09.00-10.00 Meeting with CSO Implementing Partner GBV/SRH and livelihoods (**Team A**)	IP field staff, BRAC Project Manager, BRAC	Amudat town	PN6576 Output 1 of GEWE Output 1 of AYSR	Criteria 2	Implementing partner for GBV/SRH and livelihoods groups for young girls out of school at high level of vulnerability
	10.30-13.00 Meeting with CSO implementing partner on SRH/HIV integration; joint HIV prevention programs (**Team A**)	IP field staff, AIDS Information Centre (AIC) Project Manager, AIC	Amudat town	PN6580 Outputs 1, 2 and 3 of SRH	Criteria 2	Implementing Partner of CB activities on integration of SRH/HIV programmes; Joint UN Program Support on AIDS (JUPSA) /KARUNA
	14.00-15.30 FGD on prevention of GBV and FGM	Women beneficiaries (Amudat)	Loubrin, Amudat Sub-county	PGUG12 Output 1 of GEWE	Criteria 2	Beneficiaries on prevention of GBV and FGM
	15.30-17.00 FGD on prevention of GBV and FGM	Adolescents/Youth beneficiaries (Amudat)	Loubrin, Amudat Sub-county	PGUG12 Output 1 of GEWE	Criteria 2	
Day 49 Wed. 20 Nov.)	09.00-16.00 **Travel from Amudat town to Iganga District by road**					Evaluator in charge of Gender quality (**Team A**)
Thu. 21 Nov.	09.00-09.30 Courtesy call /brief meeting at Iganga DLG authority	Mr. D. Kawoya Chief Administrative Officer, Iganga Cell: 0772494206	Iganga town	N/A	N/A	Overall coordinator of Implementing Partners at district level on SRH, gender equality and women's empowerment services
	10.30-11.30 Meeting at District Health Office, Moroto DLG (**Team A**)	Dr. Muwanguzi District Health Officer, Iganga Cell: 0772436474	Iganga town	Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment;
	12.00-14.00 FGD session among men on ending early child marriages (ECM)	Men beneficiaries	One of the nearby sub-counties (Iganga)	PN6576 Output 1 of GEWE	Criteria 2	Final beneficiaries on prevention of early child marriages (GPECM)
	14.30-16.00	Sub-county CDO	Sub-county near	Output 1 of GEWE	Criteria 2	Implementing partners on protection

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	Meeting with Community Dev't Officer (CDO) on BL4G project on ending early child marriages (ECM) (**Team A**)		Iganga town	Output 1 of SRH		of reproductive rights, prevention of early child marriages (GPECM)
Fri. 22 Nov.	09.00-10.00 Meeting at District Education Office	District Education Officer, Iganga	Iganga town	Output 1 of AYSR		Implementing partner on adolescent sexual reproductive health and empowerment
	10.30-11.30 Meeting at Iganga magistrate Court	Chief Magistrate, Iganga	Iganga town	Output 1 of GEWE	Criteria 2	Implementing partner on GBV courts: Health and child protection systems for adolescent girl-friendly health & protection services
	14.00-16.00 Group meeting with cultural and religious leaders on ECM, SRHR issues	Cultural leaders and religious leaders representing different faiths	Iganga town	Output 1 of GEWE Output 1 of SRH		Final beneficiaries on prevention of early child marriages (GPECM) and protection of reproductive health rights
	16.00-18.00 Transcription of FGD sessions		Iganga town	N/A	N/A	
Sat. 23 Nov.	09.00-13.00 Compiling /arranging notes from various interviews and FGDs	Evaluation Team	Respective district towns	N/A	N/A	To ensure data is of good quality and is kept safely
Sun. 24 Nov.	09.00-18.00 Further documents review; compiling /arranging notes from various interviews and FGDs	Evaluation Team	Respective district towns	N/A	N/A	To ensure data is of good quality and is kept safely
Mon. 25 Nov.)	09.00-11.00 **Travel from Iganga to Kampala by road**					Evaluator in charge of Gender quality (**Team A**)
Date	**Activity/ institution**	**People to meet**	**Location**	**Location Link with the CP**	**Selection criteria**	**Justification**
	FIELD PHASE Team B: Districts of Iganga (1 day), Kitgum, Adjumani, Arua and Kyegegwa					
Day 40 (Mon. 11 Nov.)	09.00-09.30 Courtesy call /meeting at Iganga DLG authority	Mr. D. Kawoya Chief Administrative Officer, Iganga Cell: 0772494206	Iganga town	N/A	N/A	Overall coordinator of Implementing Partners at district level on SRH, gender equality and women's empowerment services
	10.00-11.00 Meeting at District Community Dev't Office Meeting at District Community	Mr. Samuel Batuuka, DCD Officer Cell: 0772481748	Iganga town	Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRH, gender equality and women's empowerment;

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	Development Office (DCDO)					
	11.30-12.30 Meeting with CSO implementing partner on (1) Better Lives for Girls (BL4G) project ending early teenage pregnancy and early child marriages (ECM) (2) SRHR integration into Empowerment & Livelihood for Adolescents (ELA)	IP field staff Project Manager, BRAC	Iganga town	PN6576 Output 1 of GEWE Output 1 of SRH Output 1 of AYSR	Criteria 2	Implementing partners on protection of reproductive rights, prevention of early child marriages (GPECM) Implementing partner on SRHR integration into Empowerment & ELA; socio-economic asset building through ELA
	14.00-15.30 FGD session among women on ending early child marriages (ECM)	Women beneficiaries	One of the nearby sub-counties (Iganga)	PN6576 Output 1 of GEWE	Criteria 2	Final beneficiaries on prevention of early child marriages (GPECM)
	16.00-17.30 FGD session among Adolescents/ Youth on ending early child marriages (ECM)	Adolescents/Youth beneficiaries	One of the nearby sub-counties (Iganga)	PN6576 Output 1 of GEWE	Criteria 2	Final beneficiaries on prevention of early child marriages (GPECM)
Day 41 (Tue. 12 Nov.)	07.00-18.00 **Travel from Iganga to Kitgum by road via Soroti, Gulu District**					Evaluator in charge of SRH – **John M.** (**Team B**)
Day 42 (Mon. 13 Nov.)	09.00-10.00 Courtesy call/ meeting at Kitgum DLG authority (**Team B**)	Mr. Martin Jacan Gwokto, Chief Administrative Officer (CAO) Cell: 0772460408	Kitgum town	N/A	N/A	Overall coordination of Implementing Partners at district level for coordination of SRHR/GBV integration; gender equality and women's empowerment services;
	10.00-11.00 Orientation of research team	Research Assistants (already selected)	Kitgum town	N/A	N/A	
	11.30-12.30 Meeting at District Community Development Office, Kitgum DLG (**Team B**)	Mr. Okello James Pokidi, District Community Development Officer (DCDO) Cell: 0772890583	Kitgum town	PGUG33 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRHR/GBV integration; Beneficiary of CB activities on protection of reproductive rights, prevention of GBV
	14.00-15.00 Meeting at District Health Office, Kitgum DLG (**Team B**)	District Health Officer, Kitgum	Kitgum town	PGUG33 Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing Partner at district level on SRHR/GBV integration; Beneficiary of CB activities on protection of reproductive rights, prevention of GBV
	16.00-17.00 Meeting at District Planning Office	Mr. Christopher Kilama District Planner Cell: 0773323233	Kitgum town	PGUG33 Output 1 of PD	Criteria 2	Implementing Partner at district level on SRHR/GBV integration; Beneficiary of CB activities on protection of reproductive rights,

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
						prevention of GBV
Day 43 (Thu. 14 Nov.)	09.00-10.00 Meeting with CSO Implementing Partner on SRHR and VAW/VAC/HP (**Team B**)	IP field staff, ACORD Project Manager, ACORD	Kitgum town	PN5991 Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementer of integrated SRHR services and coordinated multi-sector VAW/VAC/HP essential services
	10.30-11.30 Meeting with CSO Implementing Partner on GBV (**Team B**)	IP field staff, CARE Project Manager, CARE	Kitgum town	PN5924 Output 1 of GEWE Output 1 of AYSR	Criteria 2	Implementer of adolescent SRHR and empowerment through skilling and asset building (ELA).
	12.30-14.30 FGD session on SRHR and prevention of ECMs (**Team B**)	Women beneficiaries (Kitgum District)	One of the Wards in Kitgum town	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of early child marriages (ECMs)
	15.00-17.00 FGD session on SRHR and prevention of ECMs (**Team B**)	Adolescents/Youth beneficiaries (Kitgum District)	One of the Wards in Kitgum town	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of early child marriages (ECMs)
Day 44 (Fri. 15 Nov.)	09.00-11.00 Group meeting with cultural and religious institutions, Kitgum (**Team B**)	Cultural and religious leaders	Kitgum town	Output 1 of GEWE		Final beneficiaries on protection of reproductive rights, prevention of GBV especially FGM
	11.30-13.30 FGD session on SRHR and prevention of ECMs (**Team B**)	Adolescents/Youth beneficiaries (Kitgum District)	One of the Wards in Kitgum town	Output 1 of GEWE		
	14.00-17.00 **Travel from Kitgum town to Adjumani District by road**					Evaluator in charge of SRH - John M (**Team B**)
Day 45 (Sat. 16 Nov.)	08.30-09.00 Courtesy call /meeting at UNFPA field staff	Ms. Patricia Nangiro, Program Analyst GBV Cell: 0782600545	Adjumani town	N/A	N/A	Implementing Partner at district facilitating district engagement on SRH and HIV and gender equality and women's empowerment services
	10.00-10.30 Courtesy call /meeting at Mirieyi Refugee Camp Commandant (**Team B**)	Camp Commandant, Refugee Settlement	Adjumani town	N/A	N/A	Beneficiary at district level on SRH and HIV and gender equality and women's empowerment
	11.00-13.00 FGD session on adolescent SRH & GBV issues (activities done by LWF) (**Team B**)	Women beneficiaries (Refugees, Adjumani)	Mirieyi refugee settlements in Adjumani	Output 1 of AYSR Output 1 of GEWE	Criteria 2	Final beneficiaries on women and adolescents' empowerment; protection of reproductive rights, prevention of GBV
	14.00-16.00 FGD session on adolescent SRH (activities done by LWF) (**Team B**)	Adolescents/Youth beneficiaries (Refugees, Adjumani)	Mirieyi refugee settlements in Adjumani	Output 1 of AYSR	Criteria 2	Final beneficiaries on women and adolescents' empowerment; protection of reproductive rights, prevention of GBV
Day 46 (Sun. 17 Nov.)	09.00-18.00 Further documents review; compiling /arranging notes from various	Evaluation Team	Adjumani town	N/A	N/A	To ensure data is of good quality and is kept safely

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	interviews and FGDs					
Day 47 (Mon. 18 Nov)	08.30-09.00 Brief meeting at UNFPA field office	Ms. Patricia Nangiro, Program Analyst GBV Cell: 0782600545	Adjumani town	N/A	Criteria 2	Implementing Partner at district facilitating district engagement on SRH and HIV and gender equality and women's empowerment services
	09.00-09.30 Courtesy call /meeting at Adjumani DLG authority (**Team B**)	Mr. Gabriel Rogers Bwayo Chief Administrative Officer, Adjumani Cell: 0781560782	Adjumani town	N/A	N/A	Overall coordination of Implementing Partners at district level for coordination of SRHR/GBV integration; gender equality and women's empowerment services;
	10.30-11.30 Meeting at District Community Development Office, Adjumani DLG (Team B)	Mr. Habib Abubakar, DCDO Cell: 0772543174	Adjumani town	PGUG32 Output 1 of GEWE Output 1 of SRH	Criteria 2	Implementing Partner and beneficiary at district level on SRH and HIV and gender equality and women's empowerment
	12.00-13.00 Meeting at District Health Office, Adjumani DLG (**Team B**)	Dr. Bhoka George Didi District Health Officer Cell: 0772869894	Adjumani town	PGUG32 Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing partner and beneficiary of CB activities on protection of reproductive rights, prevention of GBV
	14.00-15.00 Meeting at District Planning Office (**Team B**)	Mr. Moini Fred, District Planner Cell: 0772370866/ 0791755787	Adjumani town	PGUG32 Output 1 of PD	Criteria 2	Implementing partner and Beneficiary of CB activities on protection of reproductive rights, prevention of GBV
	15.30-16.30 Meeting at Probation Office	Mr. Mawadri Ramadhan Drami, Probation and Social Welfare Officer (PSWO) Cell: 0772841354	Adjumani town	PGUG32 Output 1 of GEWE	Criteria 2	Implementing partner and Beneficiary of CB activities on protection of reproductive rights, prevention of GBV
Day 48 (Tue. 19 Nov.)	09.00-10.00 Meeting District Population Committee, Amuru(**Team B**)	District Population Committee members	Adjumani town	PGUG32 Output 1 of PD	Criteria 2	Beneficiary of CB activities for the production & the use of disaggregated data on population, SRH & GBV for policies, plans and programmes
	10.30-11.30 Meeting with IP on Learning & Innovations (WAY); District Engagement and Coordination (**Team B**)	IP field staff, Reproductive Health Uganda (RHU) Project Manager, RHU	Adjumani town	PN5538 Output 1 of GEWE Output 1 of AYSR	Criteria 2	Implementing Partner of WAY programme and beneficiary at district level for CB on district engagement and coordination
	12.00-13.00 Meeting with IP on ambulance referral services in refugee settlements (**Team B**)	IP field staff, LWF Project Manager, LWF	Adjumani town	Output 1 of SRH	Criteria 2	Implementing Partner on ambulance referral services in refugee settlements for pregnant women and GBV survivors

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
Day 48 (Tue. 19 Nov.)	14.00-18.00 **Travel from Adjumani town to Arua District via Moyo (ferry) & by road**					Evaluator in charge of SRH (**Team B**)
Day 49 Wed. 20 Nov.)	08.30-09.00 Courtesy call /brief meeting at UNFPA field office	Mr. Denis Bakomeza, Program Coordinator, Arua Cell: 0772653283/ 0702917192	Arua Town	N/A	Criteria 2	Implementing Partner at district facilitating district engagement on SRH and HIV and gender equality and women's empowerment services
	09.30-10.00 **Courtesy call /meeting** at Arua DLG authority (Team B)	Mr. Donath Eswilu Chief Admin. Officer (CAO) Cell: 0772440682	Arua Town	N/A	N/A	Overall coordination of Implementing Partners at district level for coordination of SRHR/GBV integration; gender equality and women's empowerment services;
	10.00-11.30 Orientation of research team	Research assistants (already selected)	Arua town	N/A	N/A	
	12.00-13.00 Meeting at District Community Development Office, Arua DLG (**Team B**)	District Community Development Officer	Arua Town	Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing Partner and beneficiary at district level on SRH and HIV and gender equality and women's empowerment
	14.00-15.00 Meeting at District Health Office, Arua DLG (Team B)	Dr. Paul Bishop Drarebu District Health Officer Arua	Arua Town	Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing partner and beneficiary of CB activities on protection of reproductive rights, prevention of GBV
	15.30-17.00 Group meeting on SHR and GBV prevention (**Team B**)	Community Development Officers and Primary Health Care staff	Arua Town	Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner and Beneficiary of CB activities on protection of reproductive rights, prevention of GBV
Day 50 Thu. 21 Nov.)	09.00-10.00 Meeting with CSO Implementing Partner on skilling and empowerment activities and social norm change (**Team B**)	IP field staff, CARE Int. Project Manager, CARE Int.	Arua own	PN5924 Output 1 of GEWE	Criteria 2	Implementing partner and beneficiary on CB on skilling and empowerment activities and social norm change.
	10.30-11.30 Meeting with CSO Implementing Partner on Maternal Health in Emergencies (**Team B**)	IP field staff, IRC Project Manager, IRC	Arua town	Output 1 of SRH	Criteria 2	Implementing partner on maternal health (MH) in emergencies: MH among refugees (Omugo settlement) including capacity building, community mobilisation, pregnancy mapping, MDSR, midwives and ambulance services.
	12.00-13.00 Meeting with CSO implementing Partner on Learning & Innovations; : District Engagement and Coordination	IP field staff, Reach A Hand Uganda (RAHU) Programme Manager, RAHU	Arua town	PN6577 Output 1 of AYSR Output 1 of GEWE	Criteria 2	Implementing partner on Learning & Innovations; District Engagement and Coordination (WAY programme)

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	(WAY programme) (**Team B**)					
	14.00-16.00 Meeting with religious leaders on prevention of violence against women and girls (VAW/G)	Representatives of Religious leaders under the Inter-Religious Council of Uganda (IRCU) -(Ug. Muslim Supreme C.) -(Church of Uganda) -(Seventh Day Adventist) -(Born Again Fellowship)	Arua town	PN6584 Output 1 of GEWE Output 1 of SRH	Criteria 2	Implementing partners and beneficiaries of CB for capacity for prevention of VAW/G and SRHR: Strengthening capacity of religious institutions to develop policy and program tools and conduct community social mobilisation to prevent VAWG and HP and promote SRHR
Day 51 (Fri. 22 Nov.)	09.00-11.00 FGD session on SRHR and GBV issues (**Team B**)	Women refugees	Omugo refugee settlement (Arua District)	Output 1 and 2 of SRH; Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV in emergencies
	11.30-14.00 FGD session on VAWG/HP (**Team B**)	Adolescents/Youths beneficiaries (Arua District)	Omugo refugee settlement (Arua District)	Output 1 of GEWE Output 1 of SRH	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV in emergencies
	14.00-16.00 **Travel from Omugo to Arua town**	N/A	N/A	N/A	N/A	
Day 52 (Sat. 23 Nov.)	09.00-18.00 Further documents review; compiling /arranging notes from various interviews and FGDs	Evaluation Team	Respective district towns	N/A	N/A	To ensure data is of good quality and is kept safely
Day 53 (Sun. 24 Nov)	09.00-18.00 Further documents review; compiling /arranging notes from various interviews and FGDs	Evaluation Team	Respective district towns	N/A	N/A	To ensure data is of good quality and is kept safely
	07.00-18.00 **Travel from Arua to Kyegegwa (via Kampala) by road**					Evaluator in charge of SRH (**Team B**)
Day 54 (Mon. 25 Nov.)	08.30-09.00 Courtesy call /meeting at UNFPA field staff	Mr. Ssekyewa Desmond, Program Analyst SRHR, Kyegegwa; Cell: 0789762948 Emorut Erongot Judi, Program Analyst GBV; Cell: 0772463806/ 0706600436	Kyegegwa town	N/A	N/A	Implementing partner for district engagement on SRHR and beneficiary on capacity building activities to deliver high quality maternal health, FP and GBV prevention services
	09.00-09.30 Courtesy call /meeting at Kyegegwa DLG authority (Team B)	Mr. Oloya Stephen, Chief Admin. Officer Cell: 0772592231	Kyegegwa town	N/A	N/A	Overall coordination of Implementing Partners at district level for coordination of SRHR/GBV integration; gender equality and

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
						women's empowerment services;
	10.00-11.30 Orientation of research team	Research assistants (already selected)	Arua town	N/A	N/A	Support to the evaluator while in Kyegegwa District
	10.00-11.00 Meeting at District Community Development Office, Kyegegwa DLG (Team B)	Mr. Kasaija Kalya, DCDO Cell: 0772669806	Kyegegwa town	Output 1 of SRH Output 1 of GEWE	Criteria 2	Implementing partner on SRHR and beneficiary on capacity building activities to deliver high quality maternal health, FP and GBV prevention
	11.30-12.30 Meeting at District Health Office, Kyegegwa DLG (Team B)	Xxxxx, District Health Officer	Kyegegwa town	Outputs 1, 2 and 3 of SRH; Output 1 of GEWE	Criteria 2	Implementing partner on SRHR and beneficiary on capacity building activities to deliver high quality maternal health, FP and GBV prevention
	12.00-13.30 Meeting at District Planning Office	Mr. Muhumuza Edward, District Planner Cell: 0772084740	Kyegegwa town	Output 1 of PD	Criteria 2	Implementing partner on planning for SRHR and beneficiary on capacity building activities to deliver high quality maternal health, FP and GBV prevention services
	14.00-1600 Focus Group meeting on SRH and GBV prevention	Men beneficiaries (Kyegegwa District)	Kabweza Kyegegwa sub-county (Kyaka South County)	Output 1 of SRH; Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of sexual reproductive rights, prevention of GBV
Day 55 (Tue. 26 Nov.)	10.00-10.30 Courtesy call /meeting at Kyaka II Refugee Camp Commandant (Team B)	Camp Commandant, Kyaka II refugee settlement	Kyaka II, Refugee settlement, Kyegegwa	N/A	Criteria 2	Beneficiary at district level on SRH and HIV and gender equality and women's empowerment
	11.00-12.00 Meeting with CSO Implementing Partner on GBV (Team B)	IP field staff, ACORD Project Manager, ACORD	Kyaka II, Refugee settlement, Kyegegwa	PN5991 Output 1 of GEWE	Criteria 2	Implementing partner and final beneficiaries on protection of reproductive rights, prevention of GBV
	12.30-14.30 FGD session on SRH /HIV issues (Team A)	Women beneficiaries (refugees) (Kyegegwa District)	Kyaka II, Refugee settlement, Kyegegwa	Output 1 of GEWE	Criteria 2	Final beneficiaries on protection of reproductive rights, prevention of GBV
	15.00-17.00 FGD session on adolescent SRH (Team A)	Adolescents/Youths beneficiaries (refugees) (Kyegegwa District)	Kyaka II, Refugee settlement, Kyegegwa	Output 1 of AYSR	Criteria 2	Final beneficiaries on adolescent SR health and empowerment & prevention of GBV
Day 56 (Wed. 27 Nov.)	09.00-10.30 Meeting with CSO Implementing Partner on GBV (Team B)	IP field staff, CARE Int. Project Manager, CARE	Kyegegwa town	PN5924 Output 1 of GEWE	Criteria 2	Implementing partner and final beneficiaries on protection of reproductive rights, prevention of GBV
	11.00-13.00	Representatives of Religious	Kyegegwa town	PN6584	Criteria 2	Implementing partners and

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
	Meeting with religious leaders on prevention of violence against women and girls (VAW/G)	leaders under the Inter-Religious Council of Uganda (IRCU) -(Ug. Muslim Supreme C.) -(Church of Uganda) -(Seventh Day Adventist) -(Born Again Fellowship)		Output of GEWE Output of SRH		beneficiaries of CB for capacity for prevention of VAW/G and SRHR: Strengthening capacity of religious institutions to develop policy and program tools and conduct community social mobilisation to prevent VAWG and HP and promote SRHR
	14.00-18.00 **Travel from Kyegegwa town to Kampala city**					Evaluator in charge of SRH (**Team B**)

Date	Activity/ institution	People to meet	Location	Location Link with the CP	Selection criteria	Justification
	REPORTING PHASE					
Day 57 (Thu. 28 Nov.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Evaluator team members work individually in data analysis and preparation of their individual findings to the team the next day
Day 58 (Fri. 29 Nov.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Same as above
Day 59 (Sat. 30 Nov.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Same as above
Day 60 (Sun. 1st Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Evaluator team members work individually in data analysis and preparation of their individual findings to the team the next day
Day 61 (Mon. 2 Dec.)	09.00-18.00 Presentation of preliminary findings to CO	Evaluation team	Country Office	N/A	N/A	Internal team meeting. Internal presentation of preliminary results by each evaluator and preparation of a joint presentation
Day 62 (Tue. 3 Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Evaluator team members work individually in data analysis and preparation of their individual findings to the team the next day
Day 63 (Wed. 4t Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Same as above
Day 64 (Thu. 5 Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Same as above
	08.00-18.00 Drafting first evaluation report	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Synthesis of the evaluation findings
Day 65	09.00-18.00	Evaluation team internal	Metropole Hotel	N/A	N/A	Evaluator team members work

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
(Fri. 6 Dec.)	Data Analysis	work	Kampala			individually in data analysis and preparation of their individual findings to the team the next day
	08.00-18.00 Drafting first evaluation report	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Synthesis of the evaluation findings
Day 66 (Sat. 7 Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	To produce useable information /results from raw data to inform the draft evaluation report
	08.00-18.00 Compilation of the different parts of drafting evaluation report	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Internal presentation of preliminary results by each evaluator and preparation of a joint presentation
Day 67 (Sun. 8 Dec.)	09.00-18.00 Data Analysis	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	To produce useable information /results from raw data to inform the draft evaluation report
	08.00-18.00 Finalise first drafting evaluation report	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Synthesis of the evaluation findings
Day 68 (Mon. 9 Dec.)	08.00-18.00 Finalise first drafting evaluation report	Evaluation team internal work	Metropole Hotel Kampala	N/A	N/A	Synthesis of the evaluation findings
Day 69 (Tue. 10 Dec.)	10.00 Draft CPE Report submitted to UNFPA for review	Team Leader	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	
Day 70 (Wed. 11 Dec.)	09.00-12.00 Morning: debriefing session and plenary discussion	All country office staff and members of the ERG	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Presentation of the CPE preliminary findings and recommendations; open discussions (workshop) with country office staff and ERG members
	14.00-15.00 Afternoon: evaluation team internal wrap-up meeting	Evaluation Team CO staff ERG members				Analysis of the outcome of the workshop; distribution of tasks; next steps
Day 71 (Thu. 12 Dec.)	08.00-18.00 Incorporation of comments from ERG and prepare presentation	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG members
Day 72 (Fri. 13 Dec.)	08.00-18.00 Incorporation of comments from ERG and prepare presentation	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG members
Day 73 (Sat. 14 Dec.)	08.00-18.00 Incorporation of comments from ERG and prepare presentation	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG members
Day 74 (Sun. 15 Dec.)	08.00-18.00 Incorporation of comments from ERG and prepare presentation	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG members

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
Day 75 (Mon. 16 Dec.)	08.00-18.00 Submit second draft CPE Report to CO and ERG	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	
Day 76 (Tue. 17 Dec.)	08.00-18.00 Incorporation of final comments from ERG &draft final CPE Report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG members
Day 77 (Wed. 18 Dec.)	09.00-14.00 Presentations of CPE report to stakeholders for validation (IPs, UN agencies, Govt, NGOs)	Evaluation team	(tbd), Kampala	N/A	N/A	Presentation of the CPE preliminary findings and recommendations; open discussions (workshop) with country office staff and ERG members
Day 78 (Thu. 19 Dec.)	09.00-18.00 Finalising the CPE Report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from stakeholders & ERG
Day 79 (Fri. 20 Dec.)	09.00-18.00 Finalising the CPE Report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from stakeholders & ERG
Day 80 (Sat. 21 Dec.)	09.00-18.00 Finalising the CPE Report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from stakeholders & ERG
Day 81 (Sun. 22 Dec.)	10.00 Submit Draft Final CPE Report to UNFPA by COB	Team Leader	Metropole Hotel Kampala	N/A	N/A	
Day 82 (Mon. 23 Dec.)	10.00 Submit Final CPE Report to Regional Office and HQ	EM		N/A	N/A	
Day 83 (Tue. 24 Dec.)	09.00-18.00 Internal work and meeting	Evaluation Team	Metropole Hotel Kampala	N/A	N/A	
Day 84 (Wed. 25 Dec)	Christmas Holiday					
Day 85 (Thu. 26 Dec.)	Christmas Holiday					
	09.00-18.00 Finalising the CPE Report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from stakeholders & ERG
Day 86 (Fri. 27 Dec.)	10.00 Comments received from Regional Office and HQ (plus further comments as received from CO)	Evaluation team		N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG, regional office
	08.00-18.00 Address the comments and finalise CPE report	Evaluation team	Metropole Hotel Kampala	N/A	N/A	Ensuring a high quality CPE Report which has addressed all comments and input from ERG, regional office

Date	Activity/ institution	People to meet	Location	Link with the CP	Selection criteria	Justification
Day 87 (Sat. 28th Dec.)	08.00-18.00 Address the comments and finalise CPE report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Same as above
Day 88 (Sun. 29 Dec)	08.00-18.00 Address the comments and finalise CPE report	Evaluation team	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	Same as above
Day 89 (Mon. 30 Dec.)	10.00 Submit Final CPE Report to RO and HQ	Team Leader	Country Office, 12A Baskerville Ave, Kampala	N/A	N/A	
Day 90 (Tue. 31 Dec.)						

Annex 8: FGD Analysis - Summaries

FGD Analysis - Summaries (Sample from 7 districts)

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
Moroto District Tapac Sub-county **Team A:** Moderator - PB Translator - LA Notetaker - AH	Adult women (7 including 1 PLWD) Age range (26-45 years)	1. The women and men were consulted by IRC about their needs and how IRC could help address their needs.	1. The women have been empowered to talk in village meetings on issues concerning peace, health and alcoholism; this something which never used to happen years ago 2. As result of the work of SASA activists, there a noticeable reduction of forced early marriages, rape, female genital mutilation (FGM), GBV and over drinking. 3. Through the use of FP, the women have learnt to manage the number of their children whom they can look after very well.	1. IRC services were provided regularly. 2. The other organisations that provided support to the women include: community development officers (CDOs) and BRAC; the latter which focuses on FP, prevention of HIV (avoiding use of sharp instruments on their bodies) and prevention of alcoholism.	We are mostly engaged and supervised by the sub-county CDO. He invites us to participate in several projects initiated from the sub-county related to community development.	IRC has involved various structures such as LC Is, elders, police and the courts of law especially during village meetings.	1. Male involvement should be increased in all SASA activities since there is some interest by men to learn. 2. IRC should take SASA activities to hard-to-reach places which are distant from Moroto (Naut and Natumkale) and where there is a continuation of FGM practice. 3. SASA activists should establish local FGM monitors embedded into the communities to report any case of FGM practice.
Moroto District Tapac Sub-county **Team A:** Moderator - PB Translator - LA Notetaker - AH	Adult men (7) Age range (25-45 years)	1. The men and women in Tapac sub-county were consulted by IRC about their needs and how IRC could help address their needs.	1. The community members now know the dangers of early marriages GBV and rape. 2. The community members now know the complications brought about by FGM among girls (eg. difficulties in childbirth, excessive bleeding after FGM which can lead to	1. IRC services were provided regularly. 2. The other organisations that provided support to the area: CDOs and BRAC; the latter which focuses on FP, prevention of HIV (avoiding use of sharp	The trained SASA activist in the sub-county will be able to continue their work even when funding comes to a stop	We are supervised by CDOs and this helps us to learn about other activities in the sub-county	1. IRC should consider increasing the number of SASA activities so that all parts of Tapac sub-county are covered. 2. IRC should ensure should regular supervision visits and follow-up of activities.

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
			death) 3. Some men have learnt the value of sharing domestic roles, taking children to school through SASA activities. 4. There is increased involvement of men in peace coordination among community members	instruments on their bodies) and prevention of alcoholism.			3. Conduct exchange visits for community members to go to places such as Abim and Kampala to learn new things.
Moroto District Tapac Sub-county **Team A:** Moderator - PB Translator - LA Notetaker - AH	SASA activists (10 including 2 PLWD) Age range (25-45 years)	1. The men and women in Tapac sub-county were consulted by IRC about their needs and how IRC could help address their needs.	1. Since the introduction of SASA activities, there has been a noticeable reduction in cases of GBV (eg. beating of wives, quarelling); FGM practice. 2. The community members know the dangers of GBV and the complications brought about by FGM among girls. The communities are aware about the law on prevention of FGM. 3. There has been a reduction of cross-border FGM that is girls crossing into Kenya for 'cutting'.	1. IRC services were provided regularly. 2. The other organisations that provided support to the area: CDOs and BRAC; the latter which focuses on FP, prevention of HIV (avoiding use of sharp instruments on their bodies) and prevention of alcoholism.	The trained SASA activist in the sub-county will be able to continue their work even when funding comes to a stop	In order to improve coordination, some local councilors have become SASA activists themselves.	1. IRC should train more SASA activists to improve geographical coverage of services. 2. Given the sedentary life style of people in Karamoja, IRC should consider outreaches in cattle camps. 3. IRC should consider transport facilitation of SASA activists by providing bicycles.
Moroto District Acholi Inn Moroto Town	Adolescent girls (9) – BRAC Empowerment	1. The community members were first consulted about their	1. The ELA club members have been empowered with knowledge about income	Some of the expectations in terms of vocational skills were experienced	The ELA clubs have established IGAs which they plan to continue with	There is good liaison between ELA clubs and	1. The ELA clubs requested further training in hair dressing and setting up of poultry

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
Council **Team A:** Moderator - PB Translator - LA Notetaker - AH	and Livelihoods for Adolescents (ELA) club members Age range (16-21 years)	needs by BRAC. 2. The members of the ELA club were consulted by BRAC about their needs as adolescent needs.	generating activities (eg. bakery, goat rearing, beads); saving within groups, good customer care. 2. The community members now know the value of FP, menstrual hygiene and prevention of HIV; dangers of rape and GBV and their prevention.	some delays.	even after BRAC goes away.	other structures such as LCs and local police	business 2. Provision of uniform for ELA club members to improve their recognition within their localities
Amudat District **Team A:** Moderator - PB Translator & Notetaker - CN	Mentors for ELA (12) Age range (20-25 years)	1. All members in the different ELA club were consulted by BRAC about their needs	1. The ELA members have got knowledge about financial literacy which has improved their handling of money within homes. 2. ELA members reported reduction of cases of early and forced marriages and GBV. 3. The life skills about health life style has helped girls to avoid FGM, HIV infections, alcohol and substance abuse. 4. Improved knowledge on FP and child spacing.	1. BRAC services were provided regularly. 2. The other organisations that provided support to community members include: CDOs and IRC.	Knowledge gained from the trainings to will stay in homes and community	ELA clubs have worked with CDOs and IRC; the latter has focused on male involvement in SRH and other domestic areas.	1. BRAC should arrange exchange or exposure visits to other places eg. Kapchorwa. 2. There is need to set up cross-border meetings between Amudat and the neighbouring place in Kenya to address FGM. In addition, there should be continuous sensitisation on FGM, GBV. 3. Increase members in a group or increase number of groups in order to expand coverage of services.
Iganga District Nabirye village **Team A:** Moderator - PB Translator - DN	Adult women (12 including 1 PLWD) - Nabirye Club Nabirye village	1. The club members were consulted on their needs by BRAC through various meetings.	1. The club members have been empowered with knowledge on ELA+ as the project name, social and economic development, banking and components of	Delays in meeting expectations especially related to vocational skills	The club activities will continue since members have got the knowledge and skills for making the books and selling them.	There are no other organisations supporting activities previously provided by BRAC	1. The members want to get skills in making sanitary pads for menstrual hygiene; the sale of pads will contributes to club's and personal income.

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
Notetaker - AN	Age range (25-45 years)		BRAC mother's forums. 2. Members know value of FP and the different FP types which has helped them in child spacing.				2. BRAC should provide training in skills bakery, hair dressing, poultry farming, shoe making in order to diversify income generation

Key to team: PB = Paul Bukuluki; LA = Aramathan Lomongin; AH = Hildegard Asio; CN = Christine Naroo; DN = Druscilla Nabulumba; AD = Aloysious Nnyombi

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
Adjumani District Mireiyi Refugee Camp, Ofua Sub-county **Team B:** Moderator -JMM Translator - ER Notetaker - RA	Adult women (12) Age range (26-40 years)	1. Groups were consulted briefly by CARE about their needs in in August 2018 and then they had a training that lasted 3 days in Dec. 2018. 2. CARE delayed to address their needs though they were informed that the poor	1. The women have been empowered with knowledge about their rights and can relate well with their spouses; the cases of forced sex among spouses has reduced. 2. They have learnt counseling skills. This has consequently helped in resolving conflicts among neighbours in the community. 3. They have done counselling	1. Some services were provided but not regularly. 2. The other organisations that provided support to the group includes: Danish Refugee Council (DRC); UN Women; OPM (Office of the Prime Minister); UNHCR; Uganda Red Cross; Save	1. The other organisations that provided support to the group includes: DRC (Danish Refugee Council); UN Women; OPM; UNHCR; Uganda Red Cross; Save the Children, Roman Catholic Church, Mosques and Episcopal Church talk about the dangers of GBV during the sermons.	The sub-county office communicates through the local councils (LCs) who mobilize the groups when partners come.	1. CARE should always respond to us in a positive way and in real time. 2. CARE should continue training the women regarding the different activities but also to continuously inquire about their needs. 3. CARE should create safe spaces for women in the refugee camp.

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
		coordination between CARE and them was as a result of poor network connectivity.	of people in the community especially people who prepare alcohol and those who consume it and as a result the production of alcohol has reduced significantly. 4. The behavior and attitude towards other people has significantly changed such that there is peaceful co-existence regardless of the differences in tribes.	the Children. The Roman Catholic Church, Mosques and Episcopal Church talk about the dangers of GBV during the sermons.	2. The women emphatically stated that they would be able to continue with what they have learnt even if funding stops to the organisations supporting them.		
Arua District Omugo Sub-county **Team B:** Moderator -JMM Translator - DA Notetaker - MG	Adult women (8 including 1 PLWD) Odulugo United Women Group Age range (30-50 years)	1. CARE made contact with the group in June 2019 having gone through the sub-county office and there was some consultations about the groups' needs. 2. CARE first did a training of trainers and has supported the group on FP, prevention of early marriages, teenage pregnancies and GBV; IGA; school drop outs and construction of energy saving stoves 3. The group's needs were being addressed by CARE activities.	1. Group has a five year vision document. 2. Women are empowered with knowledge about GBV, how to deal with adolescents, girl-child education; proper agricultural planting methods; planting trees; proper food preparation. 3. Adult literacy classes (2015-2016) enabled women to write their names and be able to borrow money from the local micro-finance organisations. 4. Women have learnt their rights on land ownership and also gained knowledge on building permanent houses using bricks and iron sheets.	1. The services provided so far have been training in FP, prevention of early marriages and teenage pregnancies, GBV, IGAs. However, CARE has delayed in getting back to them since the training ended.	1. The group has been supported by one NGO called Community Empowerment for Rural Development (CEFORD) which has provided health services and also pointed out their rights to demand services from providers such as health facilities. The women stated that they would be able to continue with what they have learnt even if funding stops to the organisations supporting them.	1. Other NGOs dealing with the group on SRH and GBV issues include CEFORD which addresses FP, STIs such as candidiasis, syphilis and HIV/AIDS. 2. The locally based health facility (Omugo HC IV) provides information on FP, GBV and STIs through the facility staff and VHTs; however the medical treatment is not adequate due to drug stock outs.	1. CARE should consider provision of assistance to orphans to go to school so as to avoid early marriages 2. CARE consider provision of vocational skills for school drop-outs (eg. tailoring, plumbing, brick laying, charcoal stove making, hair dressing) 3. CARE should address poverty among communities through income generating activities

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
Arua District Omugo Sub-county **Team B:** Moderator -JMM Translator - DA Notetaker - MG	Young girls (8) Age range (20-24 years	1. CARE consulted girls about their needs and they trained some trainers of trainers who taught them about early pregnancies, early marriages, school drop outs, how to avoid STIs and engage with Village Saving and Loan Associations (VSLAs).	1. They have been empowered with knowledge on family planning and are aware of the traditional FP methods (abstinence, breastfeeding) and modern methods (pills, condoms, implants, intra-uterine device) and making good diets. 2. Those who have never got pregnant are able to delay getting pregnant and able to say NO to sex when approached. Those who have had children are able to space their children (space of three years) using implants.	1. The other organisations that provided support to the group includes: Rural Initiative for Community Empowerment (RICE) on health, environment, livelihood, vocational studies; CEFORD; Dan Church Aid (DCA). 2. The Health Centre IV at Omugo does outreaches in the villages and there are VHTs who visit the homes regularly.		1. The sub-county communicates through the LCs mobilize the groups when Partners come.	1. The FP items such as condoms should be freely available at health facilities 1. CARE should consider vocational training in tailoring, hair dressing, bakery etc to allow members generate income 1. CARE should consider provision of school fees for dropouts
Kitgum District Layamo Sub-county **Team B:** Moderator -JMM Translator - JA Notetaker - IO	Adult women mentors (7) Age range (26-50 years)	1. There was some consultation about the groups' needs but the area counsellor brought the issues concerning the programme to the community where women were selected to participate in the CARE programme. 2. In some cases, there has been some resistance from some women who are not willing to be enrolled in the counselling	1. The programme has changed lives in the communities since cases of GBV are now being handled and the number is reducing.	1. The services provided so far has been training in mentorship. No follow up monitoring of training has been conducted yet. 2. The mentors were promised reporting tools/materials such as files and books but these have not been provided yet	1. CARE mentors are expected to work for 2 years on contractual terms after which one's contract can be renewed depending on the ability of the mentor to continue with the activities. The mentors plan to continue working in their community even if the programme ends since people have already known them as educators in the community. 2. The other NGO that did similar work in their community was Food for	1. CARE collaborates with the sub-county CDOs and names of women mentors and their mentees were given to the CDOs. 2. The locally based health facilities provides SRH, GBV services and at times there are health facility outreaches in different	1. There is urgent need for follow-up of mentors since it will motivate and boost morale of mentors and make the community to appreciate them without doubts. 2. CARE should consider the provision of following: • IEC materials and reporting tools to mentors • Refresher training for the mentors in future • Giving certificates of attendance on mentorship course to boost morale of mentors • T--shirts to the mentors to

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
		even when there were obvious signs of need; the mentors have had to continue talking to those women to participate because they are victims of GBV.			the Hungary but it stopped work in July 2019 (they were dealing with GBV issues). 3. The Loborom Health Centre III offers SRH services such as FP, ANC and HIV/AIDS prevention	communities. 3. Reach A Hand Uganda (RAHU) also coordinates some activities with CARE	differentiate them form the mentees and other community members • CARE should consider helping school drop-out girls to re-join schools
Kitgum District Layamo Sub-county **Team B:** Moderator -JMM Translator - JA Notetaker - IO	Young girls (10 including 2 PLWD) under BRAC from 3 clubs - Faith in Action from Pagen Parish; Struggles Never End from Ocettoki Parish and Dii Cwinyi from Pamolo Parish. Age range (20-24 years)	1. The participants mentioned that they had been consulted about the activities of BRAC in their localities. 2. Following consultations, BRAC conducted training on the following things: • FP • ways of reducing GBV in their homes through drama skits • prevention of early marriage, HIV/AIDS • survival skills, hygiene practices and skills on music, dance and drama (MDD) and poems as a	1. Influencing other girls to join BRAC groups and they have accepted willingly. 2. For those who have not yet gotten pregnant before, they have been able to postpone getting pregnant until when they need it; use of FP methods such as abstinence, implants, female condoms have helped alot. 3. For those who have already children, they are now empowered enough to make choices about child spacing or to talk to their boyfriends or husbands when to have the next child 4. Obtained skills in income generating activities such as bakery and goat rearing which have helped to make them earn some money for their upkeep and family members. 5. Acquisition of skills in traditional dancing, playing	1. In most circumstances, the services are being provided well through the sub-county based field staff but sometimes there are few delays in getting feedback from CARE head office in Kitgum.	1. There are no other groups or NGO involved in the above activities in the localities.	1. Right from the start up to now, the BRAC programme liaises with the local council (LC) members in particular LC I councilors for women and youth affairs. 2. Coordination of the groups is through the sub-county leader.	1. BRAC to make follow up of the ongoing activities in the communities 2. Formation of music, dance and drama (MDD) activities to broaden the activities base which gather people together 3. Provision of T-shirts to members which would make the group to be recognised in the local communities

District/ Location/ Research Team	FGD Category	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Recommendations
		How well were you consulted about your needs? Possible probes: How were you involved in the development of the programme?	**What changes has this programme brought about in your lives?**	**Were you receiving services in a timely manner/whenever you needed them? Did the group receive any other support in connection with UNFPA work and who provided this support?**	**Are you engaged in gender equality and women empowerment activities by other agencies or individuals?**	**How well has the programme been able to work within existing community structures?**	**What recommendations would you like to give to improve the programme?**
		means of passing out information • goat rearing and poultry management	netball, making personal sanitary pads				
Kyegegwa District Ruyonza Sub-county **Team B:** Moderator -JMM Translator - AM Notetaker - IK	Adult male mentors (6) under ACORD Age range (25-45 years)	1. ACORD consulted the communities on their needs first - the representatives requested for health/medical services and they were granted e.g. FP, testing HIV/AIDS and cancer screening. 2. Communities identified GBV as a serious problem and ACORD trained them how to handle it	1. Men have learnt to be careful and able to listen to their family members thereby being exemplary to rest of families. 2. Learnt the value of education and therefore keeping children in school. 3. Men have learnt to control their anger (GBV) while at home and how to approach wife and children in a friendly way. 4. People are requesting advice from mentors on how to solve issues. 5. With their reflector jackets, the men are able to attract positive attention.	1. ACORD provides the services regularly; the only constraint is the bad roads in area which hamper the speed of various activities. 2. There are no other NGOs working of GBV.	1. The male mentors feel confident to continue their work of advising communities on dangers of GBV even if ACORD goes away.	1. ACORD ensured that male mentors are introduced to the LCs, police and local security officers 2. There are no other NGOs working on GBV in area; the sub-county CDOs also handle GBV. .	1. There should be more involvement of LCs on the ACORD programme so that male mentors can be recognized in the community. 2. Male mentors want more training on GBV. 3. ACORD should ensure that regular supervisory support from higher level. 4. Provide incentives (bicycles) to the male mentors to boost morale.

Key to team: JMM = John Mark Mwesigwa; RA = Richard Agani; ER = Edwin Rwothomiyo; DA = Dalil Asiku; MG = Mercy Guzu; JA = James Acaye; IO = Irene Owot; AM = Alfred Masereka; IK = Irene Karungi