



Republic of Uganda



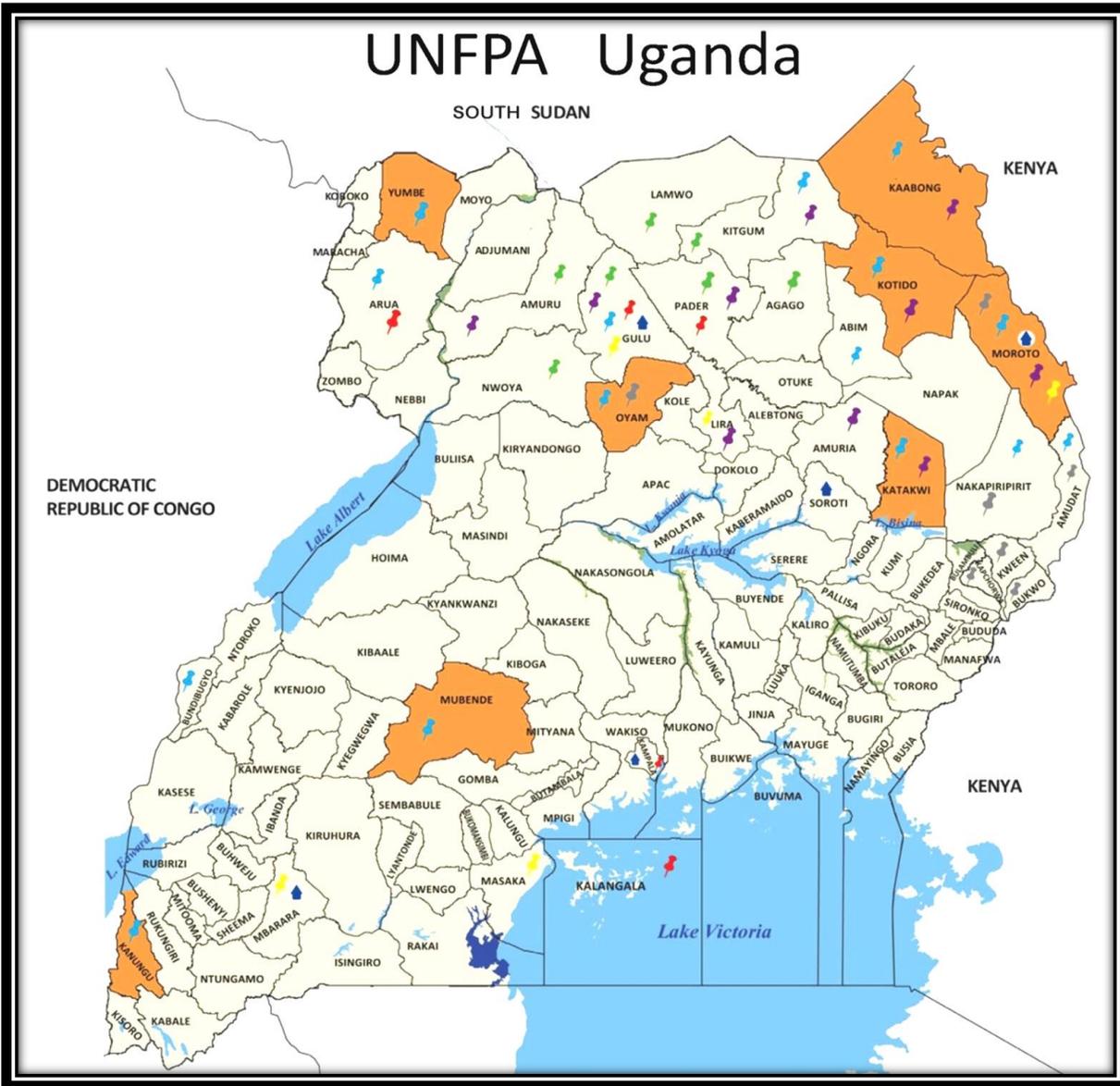
United Nations Population Fund

# Country Programme Evaluation 2010- 2014 Uganda



Final Report March 20, 2014

# UNFPA Uganda



**KEY**

-  UNFPA Supported Districts
-  Joint Programme on HIV/AIDS  
5 Districts
-  UNFPA Offices

-  Joint Programme on Gender Based  
Violence (10 Districts)
-  Joint Programme on Gender  
(5 Districts)
-  Joint Programme on Population  
(15 Districts)

-  UN Peace Building Fund  
Programme (7 Districts)

-  Joint Programme on Female Genital  
Mutilation (6 Districts)

**Table 1: The Evaluation Team**

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**Table 2: Key Facts Table: Uganda**

<b>Land</b>	
Geographical location	East Africa, West of Kenya, East of the DRC, North of Tanzania, South of Southern Sudan
Land area	241,039 square kilometers including water bodies
Terrain	Mostly Plateau with rim of mountains
<b>People</b>	
Population	Total Population 35,357,000 Million; Male=49%:Female=51% (UBOS , 2012). Urban Population: 6,419, 400 (18.15%) Rural Population: 28,937,600 (81.85%)
Population Growth Rate	3.2%(UBOS, 2012)
<b>Government</b>	
Government	Republican 1995 constitution, amended in 2005
Key Political events	1962: Independence from British colonial rule; 1971 – 1979: Military takeover/government characterized 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 – todate: Current National Resistance Government under multiparty dispensation.
Seats held by women National Parliament	40% (2012, Government of UgandaParliament Scorecard Report)
<b>Economy</b>	
GDP per capita	\$1,400 (2012 est.)
GDP growth rate	Average 6.7% (2006 – 2010), 3.4% (2011), 5.1% (2012), 5.8% GoU/MFPED, 2013)
Structure of the economy	Agriculture, forestry and fishing, transport, communication and real estate services, construction industry(GoU/MFPED, 2013). Discovery of oil will influence the structure of the economy in the Medium and Long Term.
<b>Social indicators</b>	
Human Development Index Rank	0.456: 161 out of 187countries (UNDP, 2013)
Unemployment	Unemployment rate is 23% and only 14% is employed in the formal employment. The labor force is growing at a rate of 6.5% per annum (National Population Policy/GoU, 2008)
Life expectancy at birth	53.98 years (UBOS,2012)
Under-5 mortality (per 1000 live births)	90(DHS, 2011)
Maternal Mortality Rate (deaths of women per 100,000 live births)	438 maternal deaths per 100,000 live births(UBOS, 2012)

Health expenditure % of GDP	9% of GDP (2010) 45 <sup>th</sup> in the world
Births attended by skilled health personnel, %	58 (DHS 2011)
Adolescent fertility rate (births per 1000 women aged 15-19)	134.5(DHS 2011)
Condom use to overall contraceptive use among currently married women, 15-49 years of old, %	(2.7/26)% (DHS 2011)
Contraceptive prevalence rate(Use of Modern Methods)	26% (DHS 2011)
Unmet need for family planning	34.3% of women in relationship unable to access FP;(UBOS , 2012)
Total Fertility Rate	6.2 children born/woman (2011 UDHS)
PLHIV, 15-49 years, %	7.3 %(UAIS 2011)

## **Box 1:Structure of the Uganda Country Programme Evaluation Report:**

The present report comprises an executive summary, seven chapters, and seven annexes and follows the structure recommended in the DOS evaluation handbook, version March 2012.

Chapter 1, the **Introduction**, provides the background to the evaluation, objectives and scope, the methodology used including limitations encountered and the evaluation process. **The second chapter** describes Uganda country context including the development challenges it faces in the three UNFPA mandate areas as identified in national strategic documents produced by the Government of Uganda. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by Uganda in population and development, reproductive health, and gender equality and reproductive rights; the fourth chapter presents the findings of the evaluation for each of the 3 program components; **chapter five** discusses UNFPA's strategic positioning in Uganda (the fourth and the fifth chapters are structured on the basis of the evaluation questions); **chapter six** encompasses an assessment of the monitoring and evaluation system of the Country Office as well as the support to national partners in their M&E system and capacity. Conclusions and recommendations follow in **chapter seven**.

Finally, the annexes (presented as a standalone document) **annex 1-5** present the evaluation terms of reference, evaluation matrix and work plan; list of persons met, documents reviewed, **annex 6-7** present tables related to country context, and the evaluation tools (interviews were conducted between June and August 2013).

Adult literacy (% aged 15 and above)	66% for Women and 78% for men (UDHS 2011)
Total net enrollment ration in primary education, both sexes	81.0 (2011 UDHS)

## List of Acronyms and Abbreviations:

ACFODE	Action for Development	EM	Evaluation Manager
ACP	AIDS Control Programme	EmONC	Emergency Obstetric and Neonatal Care
AIS	AIDS Indicator Survey		
AIC	AIDS Information Centre	EMTCT	Elimination of Mother to Child Transmission
ANC	Antenatal Care		
APRM	African Peer Review Mechanism (APRM)	ERG	Evaluation Reference Group
AfDB	African Development Bank	ET	Evaluation Team
AMISOM	African Union Mission in Somalia	FACE	Funding Authorization and Certificate of Expenditure
ARC	American Refugee Committee	FAO	Food and Agricultural Organization
ARO	African Regional Office	FBOs	Faith Based Organizations
ART	Anti-Retro Viral Therapy	FC	Female Condom
ASRH	Adolescent Sexual and Reproductive Health	FDC	Forum for Democratic Change
ASB	Arbeiter-Samariter-Bund (ASB)	FGDs	Focus Group Discussions
AWP	Annual Work Plans	FGM/C	Female genital Mutilation /Cutting
BRAC	An NGO based in Bangladesh	FP	Family Planning
BSB	Biennial support budget	FIDA	International Federation of Women Lawyers
		FIGO	International Federation of Gynecology and Obstetrics
CACX	Cancer of the Cervix	FOWODE	Forum for Women in Democracy
CAO	Chief Administrative Officer	FSW	Female Sex Workers
CARMMA	Campaign on Accelerated Reduction for Maternal Mortality	FTWG	Fistula Technical Working Group
CBSD	Cassava Brown Streak Disease	GAVI	Global Alliance Vaccine Initiative
CDFU	Communication for Development Foundation Uganda	GBV	Gender Based Violence
CEDAW	The Convention on the Elimination of All Forms of Discrimination against Women	GDP	Gross Domestic Product
		GEM	Girl Education Movement
CEWIGO	Centre For Women in Governance	GoU	Government of Uganda
CO	UNFPA Country Office	GSRR	Gender Sexual and Reproductive Rights
CAO	Chief Administrative Officer	HC	Health Centre
COARs	Country Office Annual Reports	HCIV	Health Centre level IV
CP	Country Programme	HDI	Human Development Index
CPAP	Country Programme Action Plan	HIV/AIDS	Human Immune Virus /Acquired Immune Deficiency Syndrome
CPD	Country Programme Document	HMIS	Health Management Information system
CPE	Country Programme Evaluation	HPV	Human Papilloma Virus
CPMEP	Country Programme Monitoring and Evaluation Plan	HRH	Human Research for Health
CSO	Civil Society Organization	HSSP	Health Sector Strategic Plan
CSWs	Commercial Sex Worker	HTS	Health Training Schools
DANIDA	Danish International Development Agency	JP	Joint Programme
DaO	Delivering as One	IASC	Inter Agency Standing Committee
DFID	Department for International Development	ICM	International Council of Midwifery
		ICPD-PoA	International Conference on Population and Development Programme of Action
DLG	District Local Government	ICW ACC	Miracle Churches Women League
DHS	Demographic and Health. Survey	IDA	International Development Association
DHO	District Health Officer	IDI	In-depth-Interviews
DO	Development Officer	IDPs	Internally Displaced People
DOS	Department of oversight	IGA	Income Generating Activity
DP	Development Partners	IEC	Information Education Materials
DPO	District Population Officer	IMIS	Integrated Management Information System
DV	Domestic Violence	IMR	Infant Mortality Rate

INGO	International Non-Government Organization	NHP	National Health Policy
IP	Implementing partners	NMS	National Medical Stores
IRC	International Rescue Committee	NPA	National Planning Authority
JICA	Japan International Cooperation Agency	NPC	National Population Council
JLOS	Justice Law and Order Sector	NPP	National Population Policy
JMS	Joint Medical Stores	NPPAPP	National Population Policy Action Plan
KCCA	Kampala Capital City Authority	NRM	National Resistance Movement
KI	Key Informant	NSP	National Strategic Plan
KII	Key Informant Interviews	ODA	Official Development Assistance
KMCC	Knowledge Management and Communications Centre	OECD/DAC	Principles for the Evaluation of Development Assistance
LAPM	Long acting and permanent Methods	OMP	Office Management Plan
LG	Local Government	OPM	Office of the Prime Minister
LGBTI	Lesbian, Gay, Bisexual, Transgender	PAC	Post Abortion Care
LGDP	Local Government Development Programme	PACE	Program for Accessible Health, Communication and Education.
LoU	Letters of Understanding	PAM	Permanent Acting Methods
MAG	Men Action Groups	PCM	Programme Component Managers
MARPS	Most At-risk Populations	PEAP	Poverty Eradication Action Plan
MCH TWG	Maternal and Child Health Technical Working Group	PEP	Post-Exposure Prophylaxis
MH	Maternal Health	P&D	Population and Development
MIFUMI	An NGO that fights GBV & promotes Maternal Health	PLHIV	People Living with HIV
MIS	Management Information System	PMP	Performance Monitoring Plan
M&D	Marriage & Divorce Bill	PMTCT	Prevention of Mother to Child Transmission
MDGs	Millennium Development Goals	PO	Programme Officers
MDB	Marriage and Divorce Bill	POPSEC	Population Secretariat
M&E	Monitoring and Evaluation	POZIDEP	Pokot Zonal Integrated Development Programme
MFPED	Ministry of Finance Planning and Economic Development	PRDP	Peace Recovery and Development Plan
MISP	Minimum Initial Service Package	PSA	Population Situation Analysis
MMR	Maternal Mortality Rate	PSI	Population Services International
MGLSD	Ministry of Gender Labor and Social Development	PWDS	People with Disability
MPDR	Maternal and Perinatal Death Review	RBM	Results Based Management
MoES	Ministry Of Education and Sports	REACH	Reproductive, Educative, and Community Health Programme
MoH	Ministry of Health	RESCUER	Rural Extended Service for Care and Ultimate Emergency Relief
MoLG	Ministry of Local Government	RH	Reproductive Health
MoJ	Ministry of Justice	RHU	Reproductive Health Uganda
MoWE	Ministry of Water and Environment	RRH	Regional Referral Hospitals
MSU	Marie Stopes Uganda	SASA	Code name for an initiative to combat domestic violence
MSM	Men who have Sex with Men	SD	Social Development
MTCT	Mother to Child Transmission	SDA	Seventh-day Adventist
MTR	Mid Term Review	SDF	Social Development Fund
NAWUJU	National Association of Women Judges	SEAPCOH	Southern and Eastern Parliamentary Committee on Health
NCDC	National Curriculum Development Center	SGBV	Sexual and Gender Based Violence
NDP	National Development Plan	SIDA	Swedish International DevelopmentCooperation Agency
NEX	National Execution	SOPs	Standard Operating Procedures
NGO	Non Governmental Organization	SMAG	Small Men Action Groups
NGP	National Gender Policy	SPR	Standard Progress Reports
NHA	National Health Accounts	SRH	Sexual and Reproductive Health
		STD	Sexually Transmitted Diseases

STI	Sexually Transmitted Infections	UNDP	United Nations Development Programme
SUPRE	State of Uganda Population Report	UNFPA	United Nations Population Fund
SWAP	Sector Wide Approach	UNHS	United National Health Survey
TPO	Trans Psychosocial organization	UNICEF	United Nations Children's Fund
ToR	Terms of Reference	UOC	Uganda Orthodox Church
ToT	Trainer of Trainers	UPDF	Uganda Peoples Defense Forces
UAC	Uganda AIDS Commission	UPE	Universal Primary Education
UBOS	Uganda Bureau of statistics	UPF	Uganda Police Force
UDHS	Uganda Demographic and Health Survey	UPPA	Uganda Participatory Poverty Assessment
UHMG	Uganda Health Marketing Group	USAID	United States Agency for International Development
UHRC	Uganda Human Rights Commission	URCS	Uganda Red Cross Society
UKAid	United Kingdom Department of International Development	USE	Universal Secondary Education
ULGA	Uganda Local Governments' Association	UWONET	Uganda Women's Network
UMSC	Uganda Muslim Supreme Council	UWOPA	Women Parliamentarian Association
UN	United Nations	VCT	Voluntary Counseling and Testing
UNAIDS	Joint United Nations Programme on HIV/AIDS	YFC	Youth Friendly Centers
UNCT	United Nations Country Team	YFS	Youth Friendly Services
UNDAF	United Nations Development Assistance Framework	VHT	Village Health Teams
		WB	World Bank
		WFP	World Food Programme
		WHO	World Health Organization

# Executive Summary

## Introduction

This report presents the results of the Uganda UNFPA Country Programme Evaluation (CPE) conducted by an independent evaluation team from June to August 2013. With a total budget of USD 45 million, the Seventh Country Programme Cycle (CP7) focuses on population and development (P&D), reproductive health (RH), and gender equality (GE). The Country Programme (CP) supporting the government at upstream (national level support with advocacy and policy support) level and downstream at programme level in the districts. Although the main programme focus is in eight districts, UNFPA also participates in several joint programmes with other UN agencies extending the coverage beyond the eight districts.

## Objectives

The main objectives of this CPE is to provide evidence of programme performance and achievement of planned results and to inform the development of the eighth country programme (CP8) support to the GoU through feedback of lessons learned. The specific objectives are to (a) assess GoU/UNFPA CP7 achievement of expected results as indicated in the CPAP; (b) assess the extent to which the implementation framework (Partnership Strategy; Execution/Implementation arrangements; Human Resources; Resource Mobilization; and Monitoring & Evaluation) enabled or hindered achievement of the results chain, and (c) assess the extent to which the country programme is aligned to the Government priorities stipulated in the National Development Plans and relevant sector plans, the UNDAF and UNFPA Strategic Plan and priorities.

## Methodology

The evaluation covered the CP7 period from 2010 to 2014, and conclusions on whether the programme would attain the results for the entire period were made based on the progress by end of July 2013, the time of the evaluation. The evaluation focused on two components:

- I) Assessment of UNFPA three focus areas based on OECD/DAC evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability.
- II) Assessment of UNFPA strategic positioning in the country with a focus on Corporate Dimension, Systemic Dimension, Responsiveness and Added Value.

Evaluation findings are based on a mix of quantitative and qualitative evidence bringing out viewpoints of the stakeholders by triangulating multiple sources of data. Through a consultative process, ET prepared design matrices that included: evaluation questions, data collection methods, data sources, and analysis plan, following DAC evaluation criteria and DOS evaluation guidelines. Primary data was collected using Key Informant Interviews (KII), In-depth-interviews (IDI), Focus Group Discussions (FGDs), Field Excursions and direct observations (See Table 4). Secondary data was collected through a review of program, activity, strategic documents and reports; the full list of documents reviewed is annexed to this report (Annex 3). Respondents were purposively selected depending on their level of involvement and knowledge of the program. The evaluation team paid strict attention to objectivity while adopting participatory approaches in the design, data collection, reporting including debriefing, validation of findings and dissemination stages. Detailed evaluation questions are presented in the design matrix, annexed to this report

## **Main conclusions**

### **I: Strategic level**

1. The activities of UNFPA in Uganda are well-aligned with the priorities and principles of UNFPA Strategic Plan (2008-2011, and the revised SP 2012 - 2013). There was deliberate focus on disadvantaged and vulnerable groups both in the design of the CP as well as during implementation, although there was no sufficient data to measure changes that may have happened to such population as a result of the programme. The CO and partners engaged in South to South Cooperation initiatives that yielded tangible results for the programme. Capacity building is a major part of the CPAP and while there are positive CB results on the ground, an existence of a strategic approach to capacity-building was not explicit in the results framework.
2. The Country Programme is well aligned with UNDAF both in the narrative and Results framework. There was sufficient evidence that the UNFPA CO is contributing significantly to improving the UNCT coordination mechanism including in DaO and joint programming and in most cases as a lead agency. UNFPA has used its central role in the UN Coordination mechanisms and has more often than not organized the other UN agencies to support the ICPD agenda.
3. UNFPA CO has been highly responsive to demands from partners and to changing national priorities both in humanitarian and development scenarios. There were cases of delays in provision of humanitarian response especially for Kasese flood victims. The country office established a humanitarian unit and has integrated humanitarian activities into the workplans to quicken its response in case of crisis. There is evidence of cases when the CO had to adjust the programmes to respond to request from government to address new priority focus. A case in point is FP service provision in Busoga region which was found to have poor SRH and FP indicators by the 2011 DHS.
4. The added value of UNFPA as a development partner is high, particularly where UNFPA has acted as a facilitator. Its ability and commitment for advocacy and lobbying, especially to table sensitive themes on the national agenda, such as the increased resource allocation and government focus to FP, SRH, Sexuality Education and GBV are well appreciated by the development partner community. The contribution of technical expertise and capacity building is regarded as the CO's greatest strength. In some cases UNFPA is recognized as a major player and/or lead especially in Family Planning, Data (Census) and Population Dynamics. Partners note that although UNFPA was instrumental in mobilizing partners around the ICPD agenda, this advocacy momentum need to be continued even into the Post 2015 development agenda. This is because the most of the ICPD related aspirations in the area of population and development, SRH, Adolescent Health, urbanization and Gender equality have not been realized. However, in a few cases, partners especially NGOs and districts perceive UNFPA added value from a narrow angle of providing small financial and material contributions.

### **II: Programmatic Level**

#### **a) Conclusions related to relevance of the Country Programme**

5. The CP interventions in all the components (P&D RH and Gender) were relevant and in line with National Vision 2040, National Development Plan, sectoral policies like the National Population Policy, the Health Sector Strategic Investment Plan, the Social Sector Strategic and Investment Plan and the National Gender Policy and all advanced their respective ICPD agenda. The focus of the CP is in line with the needs of the population as articulated in the different national planning frameworks as well as from the expressions of communities during this evaluation. Focusing on SRH and GBV prevention and response, as well as reproductive rights is relevant to national, regional and global protocols including the Maputo Protocol,

African bill of rights, UN Security Council resolution 1325 and 1820 and Goma declaration and CEDAW. However, the Evaluation team observed that the implementation of the UNFPA supported programmes by the partners is done in a vertical fashion with minimal integration into the IP's own programmes. Although the CP focused on geographical areas with poor service accessibility indicators, this was not followed by conscious vulnerability targeting.

## **b) Effectiveness**

### **Data and Population dynamics**

6. The P&D component interventions resulted in increasing data availability both at national and district levels key among which include the 2011 DHS, National Statistical Abstracts, for Maternal Health, Adolescent Fertility and Teenage Pregnancy, Family Planning utilization and GBV. The CP increased the appreciation and use of data for decision making. The integration of population issues has reached all government levels. The capacity for staff in the National and District planning units for integration of Population Issues was strengthened as seen from the level of integration of such issues in the National Development Plan and all the district plans. However, the framework for integration that has been established need to be effectively enforced from the strategic level of the National Planning Authority , Ministry of Local Government and Ministry of Finance Planning and Economic Development. Updated user friendly data on youth and vulnerable populations was not readily available. Areas that lagged behind and thus need accelerated attention include improving functionality of the district harmonized database, updating and ensuring access to IMIS, availing user friendly data on youth and vulnerable strengthening the youth participation mechanism under MGLSD.

### **Reproductive Health**

7. **Midwifery:**The country Programme results on strengthening the health system to improve midwifery services have been achieved. Key achievements include increased health facility deliveries in the target districts from 21% in 2010 to 35% in 2013; increasing proportion of HFs with capacity for EmOC from 43% in 2010 to 65% in 2013. Although improvement in midwifery indicators was noted, Karamoja region continues to lag behind. The number of RRH providing routine Fistula services increased from 2 to 14 while 2,215 women treated for fistula with UNFPA support. Results on policy and legislation aspects, however, remain work in progress. The downstream program work needs more investments and more time (cycles) to create significant change in indicators. Integration of Nutrition with Safe Motherhood RH services could be a game changer that contributes to reduced maternal neonatal mortality. Although humanitarian response interventions were undertaken under this output, the efficiency of the response and results were not followed through.
8. **Family Planning:** The Country Programme catalyzed concerted efforts in mobilizing institutional and social structures to facilitate increased uptake of family planning. The Family planning indicator targets that the CP sought to deliver were generally achieved. The proportion of HFs in target districts without stockouts of at least 3 FP methods increased from 65% to 72% while the number of new clients utilising modern FP methods increased from 26,800 in 2010 to 77,997 in 2013. The cumulative number of new modern FP users was 231,240 people. Proportion of Health Facilities in Target Districts with at least 2 staff that can offer both short term and long acting FP Methods increased from 60% to 85%. UNFPA secured increased government funding for Family planning. In 2012, the government committed to increase FP funding from 3 million USD to 5 million USD annually over the next 5 years. According to the budget framework paper 2013/14, government allocation for contraceptive procurement increased to USD 6.9 M in 2013/14. The alternative distribution mechanism helped avail the FP commodities to non-state actors. However, as the uptake of FP services increases, there is need to ensure the quality of services as a human rights principle.

9. **HIV/AIDS Prevention:** Results under the H/AIDS prevention which mainly aimed at creating an enabling policy environment for HIV preventions for MARPs have been achieved. Under the CP, the National HIV prevention policy includes rights for populations most at risk the HIV/AIDS and SRH integration strategy and Comprehensive Condom Programming Framework were developed and are being implemented. 100% of Health Units providing integrated RH and HIV/AIDS services in target districts. A total of 50 Youth Clubs in target districts were supported to engage in addressing SRH/HIV needs of Young People. Service delivery to MARPS increased, for example, cumulatively about 10,000 sex workers and over 30,000 clients were reached with SRH/HIV services in the five thematic districts. UNFPA contributed significantly to increasing the availability of condoms in the country. In 2012 alone, a total of 45m male and 2.5m female condoms were procured for the public sector. In 2013, out of a total of 183.991.800 male condoms and 5.400.000 female condoms procured in the country, UNFPA contributed 129.592.800 (70%) male condoms and 100% female condoms

The country programme initiated innovative ideas to increase access to HIV prevention services, within the Comprehensive Condom Framework, that are either not yet completed or scaled up. These include review of the training modules for integrated management of pregnancy and related conditions and adult illnesses (IMPAC/IMAI), adoption of option B+ as a policy for delivery of elimination of mother to child transmission of HIV, establishment of functional SRH/HIV programme in Cultural Institutions and FBOs, model approach of working with district or municipality administration to create convergence of partners, reintroduction of female condom and developing a national condom brand.

10. **ASRH:** Most of the results related to ASRH had not been adequately achieved by the time of the evaluation, as most of them take processes that require long period of time. Curriculum review materials and Teacher Resource Packs for Secondary School were developed for integration of Sexuality Education into the curriculum. Also developed and in use were the Adolescent Health Policy and Standards of Care. The Evaluation notes that the formulations of the key policies like the National Youth Policy and the School Health Policy remain an unfinished agenda for the Country Programme. Though below the CP target for 2013, the proportion of HCIVs and Hospitals in target districts that provide routine Youth Friendly Services increased from 0% to 44%, 63% and 12 for Hospitals, HC IVs and HC III respectively. There were indications of improved access to YFS by young people especially boys with the number of young people reached increasing from 45,000 in 2011 to 75,500 in 2012. However, the models initiated by the CP for delivery of Youth Friendly services have not yet been documented for subsequent scale up using the national service delivery systems.
11. **Humanitarian Response:** While the program is strong on development focused indicators, programming for emergence response with clear indicators and targets was inadequate in the CPAL although there were AWP implemented for humanitarian response interventions. There is equally a need to pay attention to emergency preparedness MISP & IASC HIV guidelines roll out, as part of emergency preparedness.
12. **General:** While UNFPA has a niche in Population SRH and Gender related upstream advocacy and policy influence work, there are tendencies of investing more attention to downstream work resulting in spreading too thin. The fact that the program implementation was in 8 districts only, and with National upstream work, means that UNFPA as an advocacy agency needs scale up advocacy, so good models and approaches are taken on by other partners, districts and ministries, to enable scale up so the ICPD agenda and MDG targets are furthered from a National perspective.

## **Gender Equality and Reproductive Rights**

13. The Gender component contributed significantly to improving the policy and legislative framework as well as strengthened public and civil society sector's capacity for GBV Prevention and Response. The policies/legislation that the programme contributed include: the Domestic Violence Act 2010, the Prohibition of FGM/C Act 2011 and the Draft National Gender Policy. All the 8 targeted districts' plans and budgets incorporate Gender-Based Violence prevention/ response and reproductive rights intervention and

the five targeted sectors (SD, JLOS, Education, Health and Security/UPDF) now implement the international instruments and national legislation for GBV prevention and management. The programme has contributed to raising awareness on gender based violence, including FGM/C and positioning GBV on the national and district agenda; created a critical mass of community and district leadership that advocate against GBV and increased uptake of GBV Services. The annual number of Gender-Based Violence survivors utilizing response services in targeted districts increased from 2,650 in 2010 to 19,051 in 2013. The cumulative number of Gender-Based Violence survivors utilizing response services was 43,500. The component contributed to humanitarian response by training 150 technical staff from government and CSOs in GBV Programming in Humanitarian and Post-conflict situations and about 200 HWs in clinical Management of rape. Regarding FGM, the programme interventions resulted in 51 communities are documented to have abandoned FGM/C. The focus on Reproductive Rights was not given adequate attention during programme implementation. Similarly implementation of the policy and legislative frameworks remains weak. The country still has more to do GBV response mechanisms, including institutionalization of shelter and protection services for survivors

### **c) Efficiency**

14. The program is rated efficient as exhibited by timely preparation of AWP's compared to the global timeline, high fund utilisation rates across components, outputs and Implementing Partners and rigorosity of the of the efficiency promotion measures instituted by the CO. The CO has adequate and skilled staff in all the programme components including in Decentralized Offices to monitor programme implementation. The evaluation noted the delays in submission of reports resulting in delayed release of funds. There were also cases where the delay in release of funds resulted from late receipt of funds by UNFPA from donors. In most cases, studies, procurements and policy formulation activities were of completed in time. The consortium arrangement compromised the efficiency of programme implementation. Low funding levels for some activities and spreading too thin also compromised programme efficiency.

### **d) Sustainability**

15. The program is considered sustainable to a greater extent. This is because: the program design and implementation addressed the priorities already identified by government high level ministries/institutions; enabled systems strengthening; worked within established government structures; included capacity building of institutions staff in their permanent mandates/roles and included beneficiary participation. While for midwifery, family planning and to some extent GBV and PD were integrated in the district programmes, the ASRH is implemented as a vertical programme with minimal district involvement. However, the sustainability is assumed and not consciously implemented. Some of the identified risks to sustainability relate to the lack of exit/phase out strategy, operation and maintenance costs for some equipment that will be passed on to the districts, heavy dependence on voluntary workers at community level and lack of plans for scaling up pilot interventions. There are risks of loss of continuity when for the next cycle (CPAP8), UNFPA decides to move out of a district, and yet initiatives like GBV prevention and response are still new and with no full uptake of response mechanisms by the duty bearers.

## **III: Transversal Aspects**

### **e) Partnership relations:**

16. The levels of UNFPA strategic partnerships are considered satisfactory to allow for advancement of the ICPD agenda in terms of joint advocacy, research and programme implementation. The partnerships span from government, Development Partners, CSOs. The structures for programme management and coordination are in place and implemented. There is observed inadequacy of effective communication between UNFPA and IPs on one hand and within IPs on the other. The innovative initiative of delivering the CP using consortium approach yielded mixed results. Knowledge management focus was apparent in the UNFPA CO, but not strong in IPs.

#### **f) Monitoring and Evaluation:**

17. The CO attaches a lot of importance to monitoring and evaluation and has as such allocation adequate human and financial resources. The Country Programme has a clear monitoring and evaluation system that revolves around a sound CP Results and Resources Framework and is in tandem with UNFPA Global M&E Guidelines. The results framework shows clear linkage of results with the UNDAF, NDP and UNFPA Strategic Plan. Multilevel (inputs, activities, outputs) monitoring is frequently undertaken including both financial as well programme results and milestones monitoring. The structure for CP monitoring is clear and adequately implemented. There is sufficient evidence of M&E coordination and ownership by the National coordinating Authority (POPSEC) as well as the IPs. The observable efforts to improve M&E capacity for UNFPA and IP staff have yielded results. However, measurement indicators of M&E capacity building (CB) initiatives are lacking. Apart from programme reports both in hard and soft copies, there is no web-based mechanism for storing monitoring information for easy access by CO staff and other stakeholders.

### **Main Recommendations**

#### **a) Strategic level**

1. While maintaining the current focus of integrated, culturally sensitive, and rights based approach, establish, where absent or lacking, data bases for vulnerable populations for monitoring and assessing change due to programme interventions.
2. Develop and implement a clear capacity development plan to support the implementation of the Country Programme. Mechanisms for measuring effects of capacity building initiatives should be put in place.
3. Strengthen and continue the current approach to working in high visibility advocacy role for advancing the ICPD agenda in the Post 2015 National Development Agenda.

#### **b) Programmatic level**

##### **i) Population and Development**

4. Reinforce, effectively, the framework for integration of population issues at the strategic level of the National Planning Authority, Ministry of Local Government and Ministry of Finance Planning and Economic Development.
5. Follow through and implement 2014 targets that are not yet attained including development of the National Planning Guidelines (for Sectors and LGs) that include integration/mainstreaming of population dynamics in the plans, functionality and use of harmonized district databases, continued Advocacy for the National Housing and Population Census; update/access to IMIS by the districts and sectors and strengthen the newly established youth coordination and participation structure in the MGLSD.

##### **ii) Reproductive Health**

6. Follow through and finalize the unmet CP7 targets, and sustain the interventions and approaches that were identified while ensuring adequate investment in quality improvement during the delivery of integrated SRH services. The targets that were not met are: revision of the national midwifery training curriculum and the processes related to amendment of the Nurses and Midwifery Act of 1996, formalization of the alternative distribution strategy for FP commodities; full implementation of the CCP with focus on MARPs; completion of the National Youth Policy, School Health Policy and integration of Sexuality Education into the National Curriculum. There is need to integrate nutrition within Maternal Health interventions supported by the Country Programme.
7. Advocate for Government of Uganda to develop and implement strategies to address the Human Resource needs for critical midwifery cadres while continuing supporting training of bonded midwives. In order to have greater impact, UNFPA should mobilize other development partners to support the training initiatives for midwives since UNFPA alone will not be able to sponsor a critical mass of midwives. A programme to train the existing and already recruited comprehensive nurses in midwifery skills for a reasonably long period could be a better option to improve delivery of midwifery services.
8. Design and implement special approaches to provision of RH services in Karamoja region making consideration of the regional context.
9. Develop and implement emergency preparedness and contingency including MISP & IASC HIV guidelines roll out. Ensure humanitarian response indicators and interventions are adequately integrated in the new UNFPA programme.
10. Conduct an in-depth assessment of the Youth Corner Delivery Model to facilitate lobby efforts with government for its scaling up. Integrate the model into the National Health and Youth related policies

### **iii) Gender Equality and Reproductive Rights**

11. Scale up initiatives that support implementation of passed bills, in selected districts, and advocate for National level scale up and enable GBV legislation implementation more so in Karamoja and areas where FGM/C is practiced
12. Advocate for improved GBV & RR resourcing (HR and funding) to scale up GBV prevention and response interventions including effective implementation of the referral pathways and operationalization of the GBV shelters

### **c) Sustainability**

13. Create conditions for sustainable programme effects, and improve on integration of phase-out strategy in programme development and implementation. The exit strategy and interventions should be designed for the remaining part of the programme especially focusing on Youth Friendly Services, continuity of community based structures established for GBV prevention and response, VHT mobilization and other FP demand generation activities. In the same vein, exit strategy should be integrated in the design and implementation of the next CP. A high level debate and consultation involving key stakeholders should be held on how to address the SRH issues of young people.

### **d) Transversal aspects**

14. Improve implementation of partnership management and coordination of CPAP by strengthening national ownership of the country programme, improving UNFPA and IP communication and address challenges related to consortium delivery modality. Undertake an in-depth analysis and documentation of the documentation the consortium arrangement with a view of determining what worked and what needs to be improved upon. This is because, in the event of UNFPA limiting the number of IPS, this approach remains a viable option.
15. Strengthen the M&E system by ensuring routine data collection for programme results M&E; establishing electronic/web-based data base for M&E to improve knowledge management and continue to improve capacity of IPs and UNFPA staff to practice/apply RBM.

## CHAPTER 1: Introduction

In line with the Paris Declaration of Aid Effectiveness, under the current GoU/UNFPA Seventh Country Programme Action Plan (2010 – 2014), UNFPA has continued to closely work with the Government of Uganda and other implementing partners supporting attainment of government development priorities. Under the Country Programme, UNFPA has also continued to support the furthering of the International Conference on Population and Development (ICPD) agenda, and contributed to the attainment of Millennium Development Goals (MDGs) in Uganda. The Country Programme was built on the achievements and lessons from previous country programmes, and was focused on building capacity of national systems, strengthening results-based management, lightening business processes, and linking to National plans and policies, especially the National Development Plan (NDP), Sectoral Plans and Policies and the United Nations Development Assistance Framework (UNDAF) 2010-2014.

The focus of the Country Programme is in line with the UNFPA Strategic Plan (2008 – 2013) defined organizational priorities of a) Population and Development focusing on ensuring systematic use of population dynamics to guide planning and increased investment in reproductive health, HIV/AIDS prevention, gender equality and youth development; b) Reproductive Health focusing on improving the quality of life through universal access to reproductive life and reduction in maternal mortality; c) Gender Equality – advancement of gender equality and empowerment of women and adolescent girls to exercise their human rights particularly their reproductive rights and live free of discrimination and violence.

The UNFPA programme management guidelines stress the need to conduct a final evaluation of the country program to highlight lessons learned and thereby contribute to the development of the next Country Programme. As such, the evaluation of the Seventh CPAP (CPAP 7) was conducted in July – September 2013 following the process and guidance articulated in the UNFPA Evaluation Policy and the Handbook on “How to Design and Conduct a Country Programme Evaluation at UNFPA, March 2012”.

### 1.1 Purpose and Objectives of the Country Programme Evaluation

The main objective of this CPE is to provide evidence of programme performance and achievement of planned results, provide accountability to stakeholders, and to inform the development of the Eighth UNFPA programme support to the GoU through feedback of lessons learned.

#### Specific objectives

- a) To assess GoU/UNFPA Seventh Country Programme performance in achieving the programme outputs and the programme contribution to the CP outcomes as indicated in the UNDAF.
- b) To assess the extent to which the implementation framework (Partnership Strategy; Execution/Implementation arrangements; Human Resources; Resource Mobilization; and Monitoring & Evaluation) enabled or hindered achievement of the results chain i.e. what worked well and what did not work well.
- c) To assess the extent to which the country programme is aligned to the Government priorities stipulated in the National Development Plans and relevant sector plans, the UNDAF and UNFPA Strategic Plan.
- d) To draw key the lessons learnt in programme implementation and management and provide clear recommendations for the next programme cycle.

## 1.2 Scope of the Evaluation

The evaluation covered the CP7 period from 2010 to 2014, and conclusions on whether the programme would attain the results for the entire period were made based on the progress by end of September 2013, the time of the evaluation. The evaluation focused on two components:

### I) The analyses of UNFPA focus

- a) Population and development covering the availability and use of Population, RH and Gender data for decision making; and integration of population dynamics into national development frameworks
- b) Reproductive Health focusing on Maternal Health, Family Planning, HIV prevention and Adolescents Sexual Reproductive Health
- c) Gender Based Violence and reproductive rights

For the analysis of the UNFPA focus area, the OECD/DAC evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability were used.

### II) The analysis of UNFPA strategic positioning. This focused on two areas

- a) Strategic alignment covering the corporate dimension (Alignment with UNFPA Strategic Plan and the Systemic Dimension that covered alignment with the UN Development Assistance Framework
- b) The external dimension focusing on responsiveness towards changes in country's needs and priorities as well as an UNFPA's value added vis-à-vis other development partners

## 1.3 Methodology and Process

### 1.3.1 Methodology

#### a) Evaluation criteria and evaluation questions

As indicated in the scope above, the evaluation criteria of relevance, effectiveness, efficiency and sustainability were used for the analysis of the focus areas under Population and Development, Reproductive Health and Gender Equality. The focus of the evaluation criteria in the context of the country programme evaluation is as described below.

**Relevance:** The extent to which the objectives of the Country Programme are aligned to national priorities as articulated in the National Development Frameworks, policies and strategies as well as to the needs of the population, in particular vulnerable groups. This reflects an indication of the usefulness of the country programme in addressing national needs.

**Effectiveness:** The degree of achievement of the country programme outputs and the extent to which outputs have contributed to the achievement of the CPAP/UNDAF outcomes. Challenges and lessons learned in achieving programme results are also examined.

**Efficiency:** examined how CP resources/inputs (funds, expertise, time, etc.) are converted into results and the extent to which outputs are achieved with the appropriate amount of resources/inputs (funds, expertise, time, administrative costs, etc.).

**Sustainability:** Sought to determine the degree of continuation of benefits from the country programme interventions even after its termination with special focus on the degree of integration of CP interventions and capacity building of the implementing partners

Analysis of UNFPA Strategic positioning was assessed using the evaluation criteria covering strategic alignment both corporate and systemic, responsiveness and value added as described below.

**Strategic Alignment (Corporate Dimension):** examined the extent to which the country programme is aligned with the UNFPA Strategic Plan.

**Strategic Alignment (Systemic Dimension):** assessed the extent to which the GOU/UNFPA Country Programme is aligned with the UN strategy (UNDAF) in the country.

**Responsiveness:** examined the ability of the CO to respond to: (i) changes and/or additional requests from national counterparts e.g., natural disasters, conflicts etc.), and (ii) shifts caused by external factors in an evolving country context

**Added Value:** examined the extent to which the UNFPA country programme adds benefit to the results from other development actors' interventions including the stakeholder's perception about UNFPA in the Country

The Evaluation team, together with the Evaluation Reference Group, developed the Evaluation Matrix that guided conduct of the evaluation with regard to data collection and analysis. The evaluation matrix contained the evaluation questions under the two components of the evaluation. Details of what to check, data sources and data collection methods for each of the evaluation questions were included in the evaluation matrix (Annex 5).

The evaluation team also assessed the transversal issues including partnerships and implementation arrangements, Country Office Monitoring and Evaluation System and support to national partners' capacity in terms of M&E systems.

### c) **Methods for data collection and analysis**

A multiple method approach was used in this evaluation and the methods included review of documents, individual interviews, group discussions and field visits. The methodological choice was informed by the evaluation questions including what to check and source of data as identified development of the evaluation matrix at the design stage. To ensure credibility, robustness and evidence based approaches; both qualitative and quantitative data collection methods were applied. Primary data was collected using Key Informant Interviews (KII), In-depth-interviews (IDI), Focus Group Discussions (FGDs), Field Excursions and direct observations (See Table 3). Secondary data was collected through a review of program, activity, strategic documents and reports; the full list of documents reviewed is annexed to this report (See Annex3).

For validation of findings, judgments and conclusions, the approaches used included triangulation of data sources, data types, and data collection methods. The triangulation approach was adopted through the application of three criteria: Perceptions, Validation, and Documentation. Perceptions were elicited through interviews with internal and external stakeholders and key informants. Further validation was done through to and fro consultations with stakeholders at field and national level and through debriefing meetings with UNFPA staff and with the ERG.

Data analysis: Data was recorded on to the CPE Handbook template 6 and 8, whereas other data was manually filled onto the District Checklist tool (annexed to the report). All data was submitted for analysis as hardcopies or electronically and was subjected to cleaning for completeness and coding. Coding of qualitative data closely

followed the main evaluation themes; codes were selected in such a way that they are mutually exclusive, exhaustive and representative. The text segments with similar codes were grouped together and themes were developed to build the report presentation. A sheet with a summary of codes per theme and district was created for each country program component. From the summary sheet it was easy to identify common codes. These codes highlighted key issues under each theme and they were substantiated with quotes. Quantitative data management included entering all data from observation checklists and records into the EPI-Data V3 software. The data entry screen had been fitted with range and consistent checks. The data were exported to STATA V12 for analysis. The analysis was mainly descriptive statistics. Specifically the analysis involved cross tabulations, bar graphs and line graphs where data were available by year.

**Table 3: Type and numbers of stakeholders interviewed**

<b>Institution/ Number of sites visited</b>		<b>Number of people interviewed</b>
<b>UNFPA Country Office</b>	1	28
<b>Line Ministries (Health, MGSLD, Finance and Education)</b>	4	30
<b>Strategic partners (UN agencies and Donor, Key development partners)</b>	9	21
<b>District Local Government* Kanungu, Mubende, Oyam, Yumbe, Kaabong, Kotido, Moroto and Katakwi</b>	8	42
<b>Health Facilities at RRH, HCIV &amp; III</b>	18	60
<b>Schools with Youth Friendly Corners : Teachers, Counselors/Coordinators, Peer educators</b>	12	
<b>Police posts and GBV shelters</b>	2+2	
<b>Community level volunteers and beneficiaries: GBV alliance members, Support groups, Paralegals, SMAGs, MAGs, FP champions, satisfied users, VHT, Youth Peer educators)</b>	8 districts	256
<b>CSOs that are Implementing Partners</b>	10	21
<b>Total</b>		<b>458</b>

### c) Selection of the sample of stakeholders

Respondents were purposively selected depending on their level of involvement and knowledge of the program. The snowball method was also adapted albeit to a limited extent. The sampling frame included the IP list and the stakeholder's analysis done at the design phase. Sampling of the Health Facilities and schools to consider under this evaluation was done from intervention sites using random sampling technique. In all, 458 stakeholders have contributed to this CPE as presented in the Table 4, and they include UNFPA CO staff, strategic level partners, national IPs (ministries and NGOS), district local governments, service providers, and community volunteers and beneficiaries. Participatory approaches to the evaluation were adapted, with stakeholders and the ERG contributing to the design, and reporting phases, including debriefing, validation of findings and dissemination stages. Nonetheless the evaluation team paid strict attention to objectivity and independent judgment.

### d) Ethics and quality control

Informed consent an approval was sought from all respondents. Ethical principles of respect, beneficence, confidentiality and justice were applied in the selection of the respondents.

For quality assurance:

- Experienced research assistants were recruited and oriented to the evaluation design and tools. Research assistants were attached to ET members for supervision and mentorship to improve quality of data collected.
- Regular evaluation team meetings were held, face to face or electronically to share experience, clarity and ensure quality.
- Selected performance indicators were agreed on based on document reviews (CPAP RRF, M&E Plan, DHS, MDG reports, and various progress reports for comparison when assessing effectiveness of the programme interventions) and in consultation with the CO.
- The CO availed all documents pertaining to UN evaluation guidelines and standards and the ET reviewed and applied the guidelines, with guidance from the EM & the ERG.

#### e) Limitations and constraints

The implementation of the country programme had covered only three and a half years out of its five-year cycle. All of the desired outcomes had not been realized for the ET to compare with the expected outcome indicators. The evaluation focused on outputs, with limited mention on emerging outcomes. The probability of achieving long-term outcomes was assessed using proxy measures where feasible. Cost effectiveness measures were not conducted, efficiency was thus measured through document review and interviewing relevant stakeholders.

#### 1.3.2 The Evaluation Process

Evaluation Planning/Design Phase: included desk review of key documents, stakeholder mapping, and preparation of the design matrix and presentation of the design report.

The Implementation Phase/ Data collection and Analysis Phase: Field site visits were conducted in 8 districts as elaborated under Table 4, this enabled ET interactions with the various stakeholders involved in the implementations of the program and beneficiary representatives. At the national level, data was collected from lead GoU ministries, CSOs, IPs, Sub-Grantees, UNFPA staff and other strategic partners (UN agencies).

Reporting Phase: After the field work, upon cross-checking and preliminary analysis of data collected, a debriefing of preliminary findings was held with the CO and the ERG. The purpose was to receive initial comments and to validate findings. The draft report was then reviewed by CO staff, ERG and ESARO M&E Advisor for quality assurance. The evaluation report was presented to the national stakeholders (government officials, civil society organizations, UN agencies, main donors and CO staff) for validation. Finalization of the CPE report was then done based on feedback. A management response to the recommendations was prepared.

## CHAPTER 2: Country Context

### 2.1 Development Challenges and National Strategies

The Republic of Uganda is located in East Africa astride the equator. It is landlocked and borders Kenya to the east, Tanzania to the south, Rwanda to the southwest, the Democratic Republic of Congo to the west, and South Sudan to the north. Being in the Great Lakes region where a number of countries (Rwanda, DRC, South Sudan) have faced political instability, Uganda has had effects especially the high refugee influx.

Uganda has a relatively high altitude, rainfall levels decrease in the North, with just one rainy season a year. Soils are generally fertile in the Central and Western regions; less fertile in the East and North. The topography ranges from tropical rain forest vegetation in the South to savannah woodlands and semi-arid vegetation in the North. Climate determines the agricultural potential and thus the land's capacity to sustain human population; population densities are high in the Central and Western regions and decline towards the North.

Uganda gained independence in 1962. Post-independence, Uganda went through periods of relative economic progress, and was at par with countries like Malaysia and Kenya by the early 1970s. After the 1971 military coup, Uganda faced more than 15 years of political turmoil and economic slowdown<sup>1</sup>. Since 1986 the country has had relative peace in most of the country; however the 20 year civil war in the North ended only in 2006. There have been insurgent groups on and off in the Southwestern Rwenzori region and the Karamoja region faced conflicts due to cattle rustling.

Uganda has a decentralized system of governance and has 112 Districts Local Governments. However, the central Government retains the role of formulating policy, setting and supervising standards and providing national security.

Uganda's economic structure is the result of its heavy reliance on agriculture, coffee being the most important export commodity. The country is adequately endowed with natural resources as well, such as fertile soils, sufficient rain and adequate mineral deposits of copper, gold and cobalt. The recently discovered oil resource will make a significant contribution to the economy. From 1992 to 2010, the Ugandan economy grew on average rate of around 7%, halving poverty levels from 56% in 1992 to 24% in 2010 (UBOS - National Household Survey, 2013). The economy growth slowed down to 3.5% on 2011/12. An analysis of developments in the first half of 2013 shows it may grow to 4.5% by end of the year.

The agricultural sector shows a marked disparity when the work force involved is compared to the sector's contribution to the GDP. The sector employs 82% of the labor force but contributes only 22.2% of the GDP growth. On the contrary, the industrial sector recruits only 5% of labor but adds 25.1% to the annual GDP. The service sector of the Ugandan economy is in a transitional phase of development. The sector employs 13% of the working population and contributes 52.8% to the GDP growth.

Uganda is a low income country with a Human Development Index of 0.458 in 2013 up from 0.306 in 1990, and currently ranks 161th out of 186 countries. The 2013 HDI of Sub-Saharan Africa is 0.475 placing Uganda below the regional average (2013 HDI report).

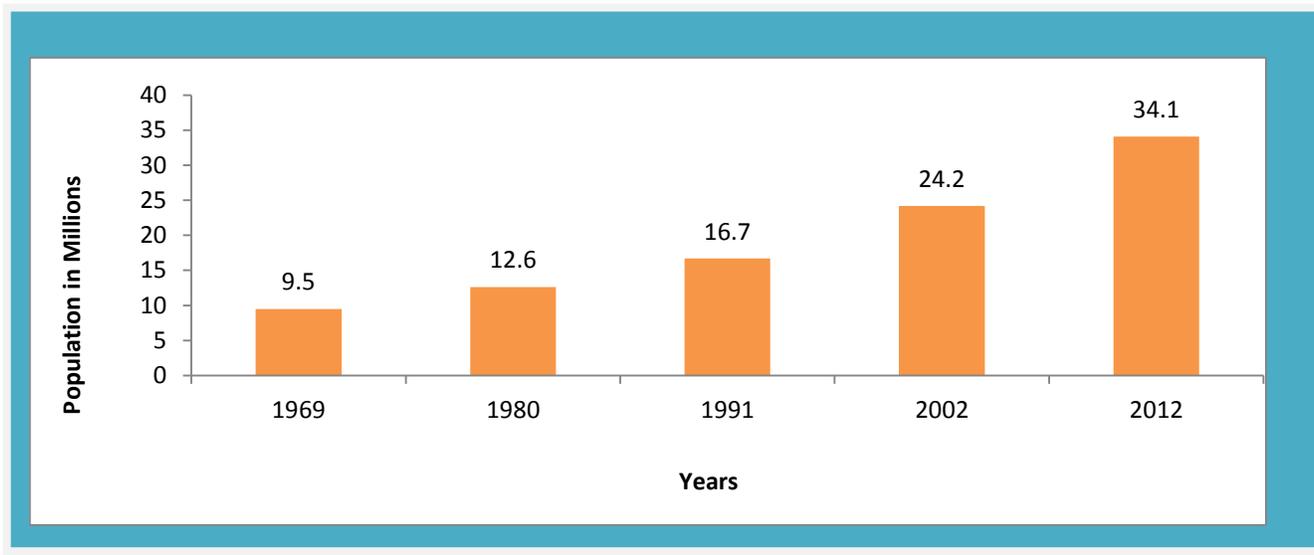
<sup>1</sup> Uganda national development Plan (2010/11-2014/15)

## 2.1.1 Population and Development Issues

### a) Socio-economic and demographic status

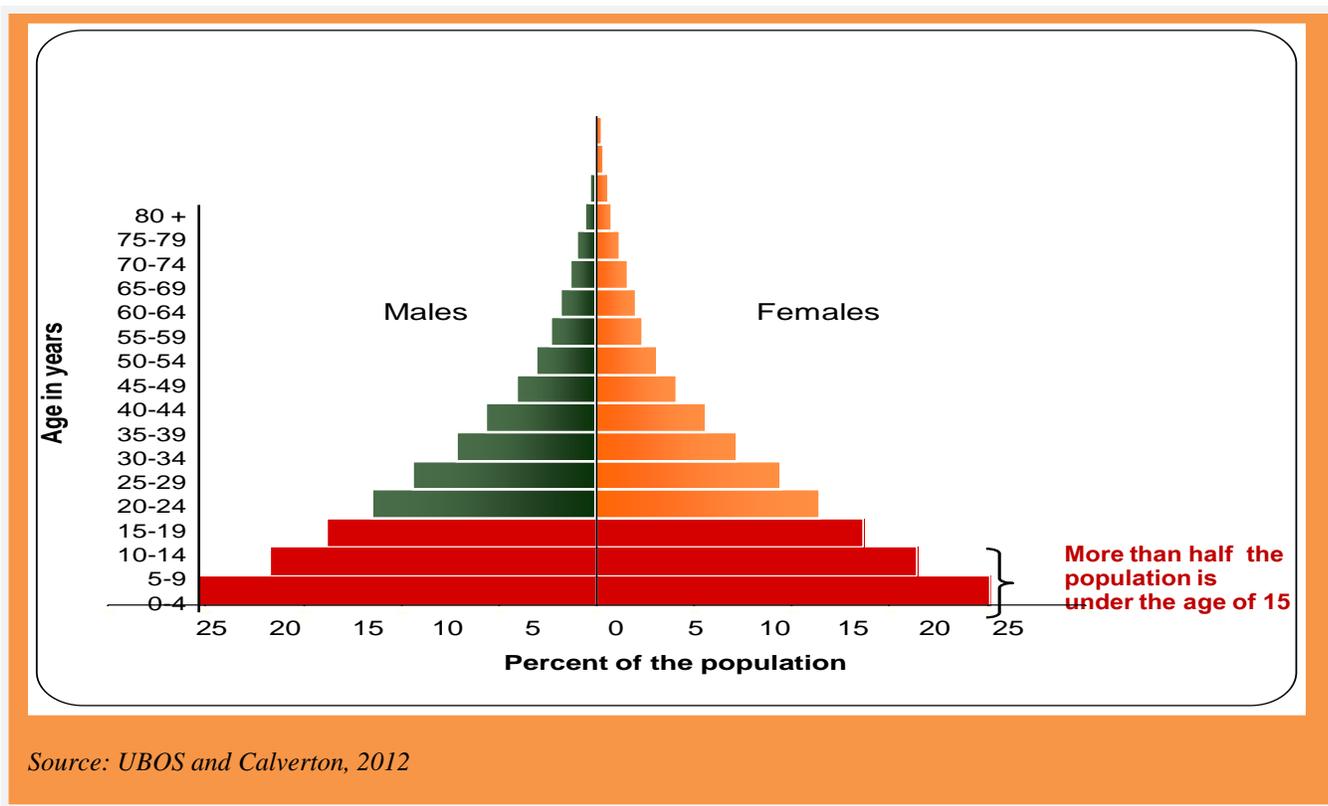
Figure 1 demonstrates that the population has been growing rapidly from 16 million in 1991 to 24.2 million in 2002 and estimated 34.1 million in 2012, and 35.4 in 2013 (GoU/MFPED, 2013). The high growth rate is attributed to high fertility rate of 6.2 children per woman (UBOS, 2012).

**Figure 1: Population growth in Uganda 1969-2012**



Uganda's population is among the youngest in the world with 56% of the population below 15 years of age (See Figure 2). A very young population presents a major challenge for Uganda in the short and medium term as a result of the high rates of dependents. It also creates pressure to provide the adequate social services required for building the capacity of the youth as well as to create employment opportunities. Positively, the under 5 mortality rate has reduced from 152 in 2000/1 to 90 in 2011. Similar reductions have been observed for infant, neonatal, post-neonatal and child (1-4 years) mortality rates. This has been attributed to high immunization coverage, improved health services and other preventive measures.

**Figure 2: Age and Sex structure**



**b) Poverty levels**

Uganda faces large disparity in poverty levels among regions (See Table4). For example the poverty levels in the Northern region and Karamoja sub-region are twice as much as for the central region (GoU/NPA, 2010). Poverty rates are also higher in the rural areas as compared to urban areas because of the slightly superior infrastructure development in the urban areas (GoU, Uganda Poverty Status Report, 2010).

**Table 4: Trends in poverty rates for rural and urban population in Uganda**

	1999	2002	2006	2009
Proportion of population living in poverty in Rural areas	37.4%	42.7%	34.2%	27.2%
Proportion of population living in poverty in Urban areas	9.6%	14.4%	13.7%	9.1%

(Source: GoU, Uganda Poverty Status Report, 2010)

**c) Key policy frameworks on population and development**

Uganda has a number of policy and development frameworks that recognize the need to address the challenges of a rapidly growing population in order to benefit from a demographic dividend. The policies also prioritize the use of population data to inform investment decisions in Sector Strategic and Investment plans. Key among the policies and plans are:

- ✓ National Population Policy (2008) and Population Action Plan: Uganda's first explicit National Population Policy was promulgated by the government in 1995 and revised in 2008. The policy elaborates clear strategies with an overall goal of contributing to the improvement of the quality of life of the people of Uganda. The revised policy is a clarion call to plan for and invest in the increasing population; so that the country's human capital develops to its full potential. Only then can Ugandans hope to benefit from an increasing population as a demographic 'bonus' instead of a demographic 'burden' (POPSEC, 2008). A National Population Action Plan was also developed and rolled out at the sub-national level.
- ✓ The National Vision 2040: The National Vision is "A transformed Ugandan society from a peasant to a modern and prosperous country within 30 years". This involves changing from a predominantly low income to a competitive upper middle income country within 30 years. It is envisaged that the country will graduate to the middle income segment by 2017. The Vision further recognizes the importance of addressing the population challenges in order to harness the development opportunities to achieve faster socio-economic transformation as indicated in chapter 4. Specifically more attention is given to the need to harness the demographic dividend.
- ✓ The NDP is a medium term development strategy for the period 2010/11 to 2014/15. The theme of the NDP is "Growth, Employment and Prosperity for Socio-Economic Transformation". The NDP identifies promotion of sustainable population and use of environment and natural resources as one of its objectives.
- ✓ Passing of an Act creating the National Population Council (NPC). The council will be the supreme advisory body to the government for coordination, implementation, and promotion of all population programs,
- ✓ Establishment of Parliamentary forum on Food Security, Population and Development that has helped to strengthen lobbying and networking with other stakeholders, to champion the integration of population concerns into national development planning.

## 2.1.2 Reproductive Health Issues

### a) Status on safe motherhood and maternal mortality

In spite of efforts by the government and development partners to improve the health status of women in Uganda, maternal mortality rates in Uganda remain unacceptably high. This is due to weak health systems resulting into lack of universally accessible Antenatal Care (ANC), Emergency Obstetric Care (EmOC), Postpartum Care, satisfactory post-abortion care, the provision of Family Planning and STI/HIV/AIDS comprehensive services. Other barriers to improved maternal health include poor geographical access (poor terrain, bad roads, long distances) to health facilities, gender inequalities that give pregnant women limited decision making at the household level, negative traditions and cultural practices, restrictions based on religious beliefs, low education status, and inadequate resources (*Annual Health Sector Performance Reports 2011, 2012*).

**Table 5: Trends in Safe Motherhood indicators**

Indicator	2001	2006	2011	MDG target 2015
Maternal mortality rate (per 100,000 live birth)	505	435	438	131
Percentage of births attended by skilled health personnel	39	41.1	57	90
Postpartum attendance within two days (%)	-	26	33	
Percentage of pregnant women attending ANC at least 4 times	42	46	48	60*

*Source: UDHS 2001, 2006 & 2011*

### b) Management of obstetric complications

Obstetric complications remain a big challenge for women in Uganda. A Fistula Situation Analysis conducted by the Ministry of Health in 2010 with Support from UNFPA indicates that the number of women suffering from obstetric fistula in Uganda is estimated at 200,000 with about 1,900 new cases per year, reflecting on the poor obstetric care services. Obstetric fistula mostly affects young, poor, illiterate, rural girls and women who are economically disadvantaged. Illiteracy and early marriage make women more vulnerable to teenage pregnancy which is the main predisposing factor for fistula. On top of having few skilled practitioners who can correct this defect, women with obstetric fistula rarely seek treatment due to stigma.

### c) Fertility rates and contraception

Fertility rates in Uganda remain very high. The current Total Fertility Rate is 6.2 which is a decline from 6.7 children in 2006. Childbearing begins early in Uganda. More than one-third (39 percent) of women age 20-49 gave birth by age 18, and more than half (63 percent) by age 20. High teenage pregnancy and low use of modern contraception are the main drivers of high fertility rates in Uganda.

The use of modern contraceptives in Uganda has remained very low although awareness of at least one method of contraception in Uganda is nearly universal. Three in ten currently married women are using a method of contraception. The use of modern methods of family planning has consistently increased over the past decade, growing from 14 percent of currently married women in 2000-01 to 26 percent in 2011.

About one-third (34 percent) of currently married women have an unmet need for family planning services, with 21 percent in need of spacing and 14 percent in need of limiting. Forty-three percent of family planning users in Uganda discontinue use of a method within 12 months of starting its use. Fear of side effects is the main reason for discontinuation (16 percent).

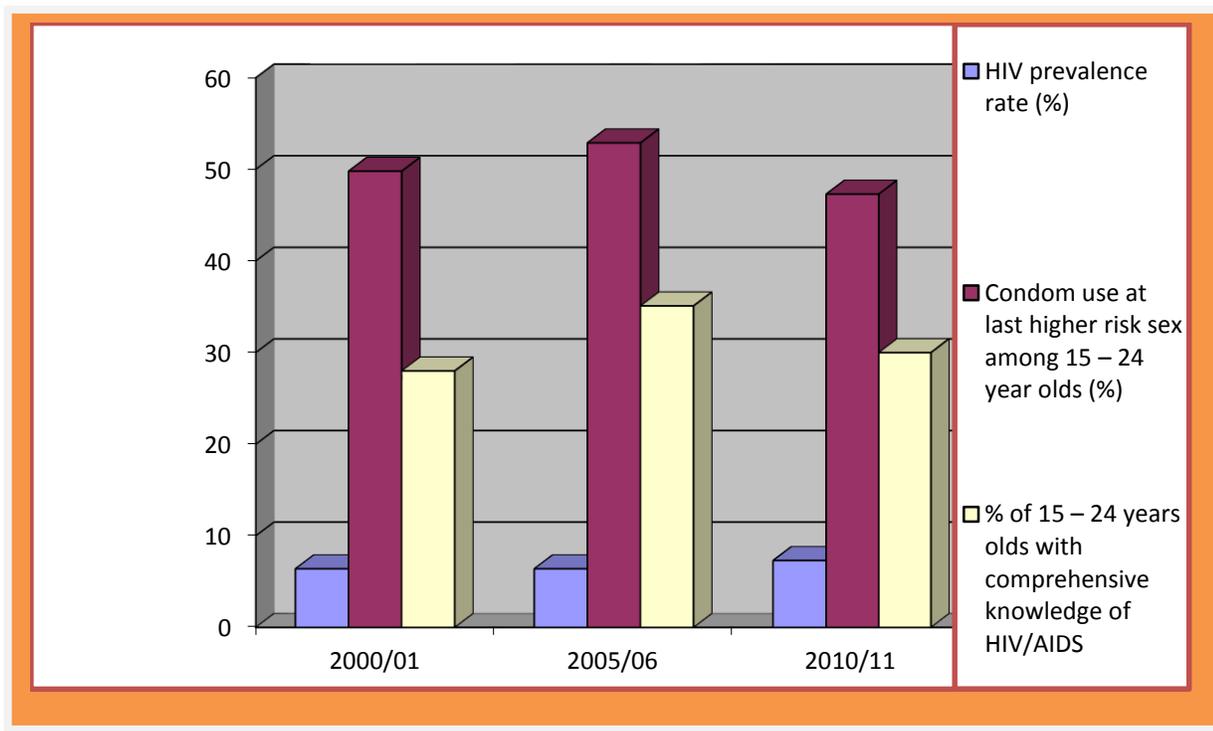
#### d) Teenage Pregnancy and Adolescent sexual reproductive health

Teenage pregnancy and motherhood has remained a major health and social concern in Uganda because of its association with higher morbidity and mortality for both the mother and child. In addition to the physiological risks, there is a negative effect on the socioeconomic status of the mother, and hence the child, because current school policy is to have pregnant girls terminate their education. The majority of teenage pregnancies are unplanned. Although still high, Teenage Pregnancy in Uganda has reduced from 43% in 1995, to 25% in 2006 and 24% in 2011 (UDHS 1995, 2006 and 2011). About 55% of abortions are among girls aged 15-20 years (UDHS, 2011). The utilization of antenatal, delivery and postnatal care service is lower among adolescents than the adult group, yet adolescents are at a greater risk of obstetric complications. About 44% of maternal mortality occurs among 15-24 years and mortality is 2-5 times higher among girls below 18 years than in women over 18 years (WHO, 2011). The contraceptive prevalence rate among the 15-24 age-group is 10%.

#### e) HIV and AIDS

Overall HIV prevalence among women and men age 15-49 has increased from 6.4% in the 2004-05 to 7.3% in the 2011 (MOH, UAIS 2012). HIV prevalence is higher among women (8.3%) than among men (6.1%). Among women, HIV prevalence is higher in urban areas (10.7%) than in rural areas (7.7%). In contrast, HIV prevalence is the same (6.1%) for men living in urban and rural areas. About 3.7% of young women and men age 15-24 are HIV-positive.

Figure 3: HIV/AIDS Indicator Trends 2000/01, 2005/06 & 2010/11 (So UDHS 2006 and 2011)



Enga

gement in risky sexual behaviour, condom use and HIV testing are key elements in HIV prevention. About 36% of young women and 49% of young men engaged in risky sexual behaviors. Condom use remains very low. Sixteen percent of women and 15% of men who had multiple sexual partners in the past 12 months reported using a condom at last sexual intercourse. HIV testing in Uganda has increased dramatically over the past seven years. Since the 2004-05 the proportion of women age 15-49 who have ever been tested for HIV and received

their results has increased more than five-fold. Similarly, HIV testing among men age 15-49 has increased from 11% in the 2004-05 to its current level of 45% of men who have ever been tested and received their results

The level of comprehensive knowledge about HIV among youth is declining among the Most-At-Risk Populations (MARPs). In Uganda, MARPs are identified as female sex workers (FSW), fishing communities, uniformed services, mobile populations and migrant workers as well as persons living with disability (UAC, 2011). Most MARPs face structural inequalities and have less access to both preventive and curative services because, among other reasons, there is uneven distribution, and poorly linked care, treatment and referral services in most of the MARPs' programs (UNAIDS, 2012).

#### **f) Reproductive Health priorities and strategies**

Reducing maternal mortality has consistently been and is a Government priority. Government investments are guided by its policies, plans and implementation modalities. The most relevant policy is the National Health Policy with implementation strategies expanded in the Health Sector Strategic Plans. The Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2007-2015), together with the Reproductive Health Commodity Security Strategy, provide the implementation modalities.

In the National Health Policy the Government re-affirmed its commitment to Primary Health Care (PHC) as its basic philosophy and strategy for national health development. Within the Primary Health Care approach, interventions to reduce maternal mortality and improve maternal health were integrated in a Minimum Health Care Package, which formed the primary focus of the health care delivery. In this Package, maternal health formed one of the four clusters, with emphasis on safe motherhood, newborn care and child survival.

The core interventions under the cluster were: expanding emergency obstetric care; strengthening community capacity to identify and refer high-risk pregnancies; and scaling up antenatal care.

In 2010, recognising the inability to meet the MDG 5 target, the Government developed the MDG 5 Acceleration Framework. The framework elaborates key bottlenecks to reducing maternal mortality in the areas of inadequate quantity and quality of health staff, inadequate management of supply chain system, insufficient stocks of blood, Poor basic infrastructure: space, electricity, water and inadequate demand generation interventions. Consequently, Uganda has prioritized four interventions that should significantly improve maternal health. These interventions, which focus on the direct and indirect causes of highest impact on maternal health, are: a) Access to emergency obstetric care b) Skilled attendance at birth c) Universal access to family planning and c) increasing access to Antenatal and Postnatal care

#### **g) Policy frameworks**

Uganda has adequate policy framework for advancement of reproductive health. The RH related policies and guidelines include:

- ✓ The second National Health Policy (2010/11 to 2019/20). The government of Uganda, with the stewardship of the Ministry of Health (MOH), developed the second National Health Policy (NHP II) to cover a ten-year period from 2010/11 to 2019/20. Its major aim is to contribute towards the overall development goal of the government of Uganda by improving the Health status of Ugandans thus increasing and improving on the Human Capital Development.
- ✓ The first Health Sector Strategic Plan (HSSP I) for Uganda covered the period 2000/01 to 2004/05. The plan helped to guide the government of Uganda in its health sector investments. Continuous monitoring through quarterly and mid-term reviews helped to assess key achievements and challenges during the implementation of HSSP I and formed the basis for the development of HSSP II for the period 2005/06 to 2009/10. The current third Health Sector Strategic Plan (HSSP III) was developed to operationalize the NHP II and the health sector component of the National Development Plan (NDP) 2010/11-2014/15, which is the overall development plan for Uganda. The HSSP III provides an overall framework for the health sector.
- ✓ The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda 2006-2015 (GoU/MoH)

- ✓ National Obstetric Fistula strategy
- ✓ Guidelines on adolescent youth friendly services
- ✓ National Strategy and Operational Plan for Sexual Reproductive Health and Rights and HIV/AIDS Linkages and Integration
- ✓ Uganda Reproductive Health Commodity Security Strategic Plan

Specific for adolescents:

- ✓ The National Youth Policy of 2001 and which has been revised in 2012.
- ✓ National adolescent sexual and reproductive health strategy
- ✓ The Adolescent Health Policy Guidelines and Service standards, 2012.
- ✓ The School health policy (2012)

These policies provide a conducive environment for addressing Reproductive Health issues in the country. However, they are yet to translate into significant improvement in reproductive health indicators.

### 2.1.3 Gender equality and reproductive rights issues

Articles 1 and 2 of the UN General Assembly Declaration on the Elimination of Violence against Women (1993) and Recommendation 19, paragraph 6, of the 11<sup>th</sup> Session of the CEDAW Committee define GBV as: "... violence that is directed against a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other/him deprivations of liberty.... While women, men, boys and girls can be survivors of gender-based violence, women and girls are the main survivors." Additionally, the Uganda MoH definition of Reproductive Rights includes the rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, the right to – access health services, information regarding sexual and reproductive health, attain the highest standard of sexual and reproductive health, and make decisions concerning reproduction, free of discrimination, coercion and violence (RH Division, 2012). Gender Based Violence (GBV) is a criminal offence under the Laws of Uganda and the constitution; the NDP and National Vision 2040 provide for equality between women and men.

Furthermore, Uganda is signatory to several international protocols on gender rights and equity including: CEDAW (Convention for the Elimination of all forms of Discrimination against Women), The Maputo Protocol (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa – 2003) and The Goma Declaration on Eradicating Sexual Violence and Ending Impunity in the Great Lakes Region.

#### a) Gender inequality and social vulnerabilities

Although, Uganda has seen improvements in Gender related indicators, gender inequalities and social vulnerabilities remain. Table 7 below provides information on the status of key gender equality indicators.

**Table 6: Selected indicators on GBV, gender and vulnerability issues in Uganda**

Gender, age and vulnerability issue	Magnitude of problem
Proportions ever experienced GBV	68% for females, and 20% for males (UBOS, 2006)
Proportions ever experienced sexual violence	28% of women compared to 9% men (UDHS 2011)
Proportion of women believing that wife beating is justifiable	58% UDHS 2011, compared to 70% of UDHS 2006 (UBOS, 2012)
Incident of rape and other forms of SGBV before the age of 15	Up to one in five women reports being sexually abused before the age of 15 ( <i>Moroto District, 2011</i> )
Estimated annual incident of FGM/C	More than 1000 girls subjected to FGM/C annually ( <i>Moroto District, 2011</i> )
Participation in cash only economy	Women 49% in 2011, compared to 20% in 2006 (UDHS, 2011); Men 62% in 2011 compared to 34% in 2006 (UDHS, 2011)
Magnitude of a woman's cash earnings relative to those of her husband or partner	76% women have cash earnings less than those of their husbands/partners;

Retention in primary education	53% for boys, and 42% for girls (UDHS, 2006)
Enrollment figures for secondary education/continuing in school to the age 18	33% for girls compared to 50% for boys that enrolled in primary school (UDHS, 2006)
Adult illiteracy rates	50% women, 23% men
Proportion of people employed in lowest wage sectors	50% women, 33% men (UNHS, 2002/03 and 2005/06).
Registered land ownership	Women own only at 20%, the rest by men (MLHUD data)
Currently married women reporting participation in household decision	Only 38% (UDHS, 2011), lower than status UDHS 2006
Currently married employed women who make independent decision on how to spend their income	53% (UDHS, 2011)

While National commitments to prevent and respond to GBV, and to strengthen reproductive rights are secured through Maternal Health, Family Planning, ASRH and favourable Gender policies, GBV and violation of reproductive rights remain rampant (UDHS, 2011). Moreover, vulnerabilities are generally associated with demographic characteristics such as age, gender, disability, unemployment, ethnic minorities and other characteristics such as poverty and disasters. The rampant discrimination against women is a result of the patriarchy system and traditional rules and practices that explicitly exclude women or give preference to men, which serves as a key constraint on women's empowerment and economic progress (GoU/NPA, 2010). Women have low incomes, inequitable access to land and resources, and are more illiterate when compared to men, and less likely to complete primary education.

Efforts to eliminate Female Genital Mutilation (FGM) focused on campaigns to change attitudes and social acceptability in some cultural groups (Karamoja and Sabiny). To date, reports imply that some communities have denounced FGM/C. In Karamoja, FGM culture had been unrecognized by the Government and other leaders until recently. Besides, with the enforcement of the anti-FGM act, there are fears that FGM continues, as underground highly protected cultural movement (MGLSD/GoU, 2010; French Embassy, 2012).

Ugandan women are further oppressed with regard to cultural practice of bride price payment. Reproductive rights are violated on account of the bride price paid and in some situation they are unable to get out of the marriage especially where culture demands so (MGLSD/GoU, 2010). It is important to note that women's vulnerability to GBV worsens in conflict and post conflict settings. Women in such settings suffer from negative psychological effects of abductions, life in camps, physical injury, AIDS, and fistula (CEWIGO, 2012). In an attempt to improve access to justice, Police forms 3, 3A, 24A have been revised, to make them more responsive for use in handling cases of rape and defilement. The new forms were gazette and guidelines for its implementation were produced in 2012.

#### **b) Institutional Policy and legislative framework for advancement of Gender equality**

Uganda has a clearly established framework for advancing gender equality and women empowerment. The Ministry of Gender Labor and Social Development (MGLSD) has overall responsibility for overseeing all gender programs within the country and that sectoral ministries and districts mainstream gender. The Uganda Human Rights Commission (1995) and the Equal Opportunity Commission (2007) contribute significantly to the implementation of gender programs. At the local government level, the Probation Officers and Community Development Officers are responsible for sensitising communities and monitoring enforcement of the various laws and policies. At each Local Council Committee, the Vice Chairperson is designated in charge of gender and children affairs and deals with cases that affect the rights and wellbeing of the girl child (GoU/UNFPA, 2013). The Local Government Development Program (LGDP), an innovative fund disbursement modality, assesses gender as one of the district performance measures. This initiative has helped make women's voices heard at national and sub-national planning processes and has resulted into prioritizing gender issues in national and district plans (MoLG/GoU, 2011/2012).

The key policy, legal and programming frameworks that guide and provide strategies to advancing gender equality and women empowerment include:

- ✓ The National Gender Policy (NGP), written in 1997 and revised in 2007 has the purpose to ensure that all Government policies and programs, in all areas and at all levels, are consistent with the long-term goal of eliminating gender inequalities. It provides a framework for redressing gender imbalances as well as mainstreaming gender in planning, resource allocation and implementation of development programs.
- ✓ The National Action Plan for Women, 2008 is a guiding document for each sector, government bodies and ministries as well as for non-state actors on how to formulate actions that support and promote women's empowerment and advancement in order to improve the status and quality of life for all women in all spheres of life.
- ✓ The National plan on UNSCR 1325, 1820 (2008) and Goma Declaration (2011)
- ✓ The Domestic Violence Act (2010) and the Domestic Violence regulations (2011)
- ✓ The prohibition of Female Genital Mutilation Act 2010
- ✓ The prevention of trafficking in persons Act (2009)
- ✓ The Penal Code Act (Cap 120, Chapter 4 on offences against immorality)<sup>2</sup>
- ✓ The draft National Policy on Sexual and Gender Based Violence (SGBV) 2011
- ✓ Legislation on women's access to land and family property, revision: The Constitution of Uganda (1995) Articles 273 (3) accords men and women equal rights to own land in accordance with various land tenure systems; The Land Act (1998) amended in 2004 (section 39) provides the legal framework through which the fundamental rights of women are protected as a mechanism to redress gender disparity to access and control over economically significant resources and benefits. It provides for consent of a spouse in the event of any transaction on family land.
- ✓ Policies for free access to basic (primary) and secondary education for boys and girls- Universal Primary Education (UPE) & Universal Secondary Education (USE).
- ✓ GBV guidelines for establishment of safety shelters (2013)
- ✓ The checklist on mainstreaming gender and human rights in legislation has been shared as the first parliamentary concern and the Ministry of Justice and will help in the future in the drafting of legislations.

## 2.2 Progress towards attainment of MDGs

Uganda has already met two of its seventeen MDG targets ie halving the number of people living in absolute poverty and achieving debt sustainability and is on track to achieve another eight. Despite this success, there are a number of areas where progress remains slow, has stagnated or has experienced a reversal. Progress has been particularly strong in reducing the share of the population that lives in poverty and the country has already halved the poverty i.e. 21% compared to 56% in 1990; Gender quality and empowerment of women.

**Table 7: 2013 Progress towards attainment MDGs**

Goal/Target	Status
<b>Goal 1: Eradicate extreme poverty and hunger</b>	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	ACHIEVED
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	NO TARGET
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	ON TRACK
<b>Goal 2: Achieve universal primary education</b>	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	SLOW
<b>Goal 3: Promote gender equality and empower women</b>	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	ON TRACK

<sup>2</sup> Guidelines for establishment and management of GBV shelters in Uganda, MGLSD- June 2013

Goal/Target	Status
<b>Goal 4: Reduce child mortality</b>	
Target 4.A: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	ON TRACK
<b>Goal 5: Improve maternal health</b>	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	STAGNANT
Target 5.B: Achieve, by 2015, universal access to reproductive health	SLOW
<b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	REVERSAL
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	ON TRACK
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	ON TRACK
<b>Goal 7: Ensure environmental sustainability</b>	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	SLOW
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	SLOW
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	ON TRACK
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	NO TARGET
<b>Goal 8: Develop a global partnership for development</b>	
Target 8.B: Address the special needs of the least developed countries	SLOW
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	ACHIEVED
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	ON TRACK
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	ON TRACK

**Source: MFPED, MDG Report 2013.**

The target of gender parity between boys and girls in primary education has been achieved and is on track to achieve access to HIV/AIDS treatment and access to safe water. There is also commendable progress in areas related to global partnership for development, notably in ensuring debt relief and sustainability as well as expanding access to information and communication technology.

There are areas where progress to meet the MDG targets has been slow. While access to primary education has improved with introduction of the Universal Primary Education programme, the rates of completion of the full cycle of primary education are still low and have stagnated in recent years. Several health targets including those related to child and maternal mortality, access to Reproductive Health and the incidence of malaria have seen very slow progress. The same is true for environmental management and diversity loss. In the area of HIV/AIDS, there has been challenges in sustaining past gains as the recent data indicate an increase in new HIV infections and prevalence rates. The detailed and specific progress on the MDGs including indications of which targets are on truck or not is shown in Fig 3

## 2.3 The Role of External Assistance

Even though inadequate funding was found to be a major challenge to achievement of ICPD objectives, Uganda has enjoyed tremendous support from development partners in form of direct funding and technical assistance (GoU/UNFPA, 2013). The donor support despite its irrefutable benefits has persistently left Uganda to be heavily dependent on foreign support for example in the health sector. Aid to Uganda's national budget has contributed substantially to the government's resource envelope during the last two and a half decades. Between 1991/92 and 2003/04 ODA to government remained fairly constant at approximately 50% of total expenditure and 10% of GDP. More recently, however, the contribution of ODA relative to GDP has experienced a decline from 9.6% in 2004/05 to 4.5% in 2011/12. This decline is largely on account of a reduction in budget support, which has fallen from 5.2% in 2004/05 to less than 1% of GDP in 2012/13. By contrast, the decline in project aid disbursements has been much more moderate from 4.4% to 3.7% over the same period. In

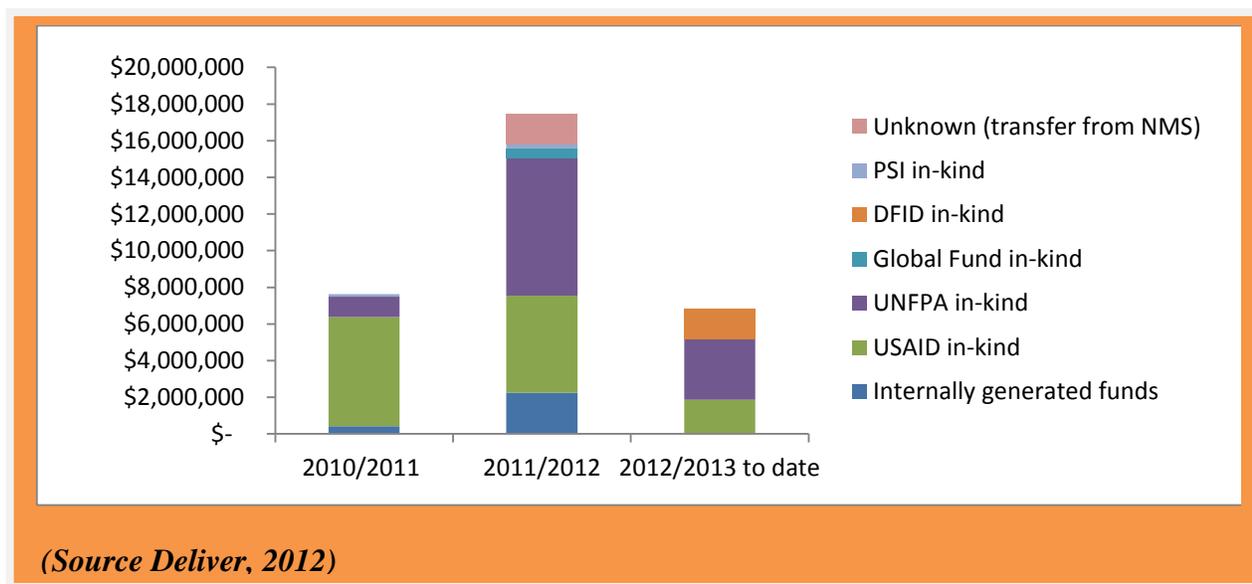
absolute terms, there was a substantial increase in ODA during 2011/12. This was largely in account of high project aid disbursements. Figure 4 demonstrates trends in ODA support to the health sector.

**Figure 4: Expenditure on FP/RH Commodities in Uganda by funding source.**

Projections for FY2013/14 the total Midterm Expenditure Framework contribution, which will add to the government’s domestic resource envelope, are expected to total 913.5 millionUSD. GoU works together with Development Partners to reduce the overall share of off-budget aid, while it continues to collect yearly data from donors on off-budget projects to facilitate macroeconomic management and inform strategic allocation of resources.

While the Government of Uganda is vigorously working its way out of aid dependence, it still acknowledges the vital role that aid has to play in financing and technical assistance especially to support productive sectors. Government is therefore keen to see more of its development partners direct large amounts of their ODA to sectors that are critical for its ability to address its strategic objectives of employment creation and socio-economic transformation. In FY2013/14 the majority of assistance is planned for the Health sector (24%), followed by Works and Transport sector (20%), and Energy and Minerals (15%), and will thus continue to be used for major infrastructure investment programmes.

One should note that the effect of donor support to the health sector is that the total government budget



allocation was in the range of 9.6% in 2009/10 to 8.3% in 2011/12 and falls short of the Abuja target of 15% of the total budget.

Key development partners have included bilateral like USAID, IDA, UKaid, Ireland, SIDA, DANIDA, JICA, the Netherlands, Belgium and Global Fund, AfDB, GAVI, and the UN agencies. The United Nations System is well represented in Uganda with national and sub-national interventions. These include UNDP, UNFPA, UNICEF, UNWOMEN, FAO, WFP, IOM, ILO, UNESCO, UNAIDS, IFAD, UNCDF, UNIDO, UNEP, WHO, UNHCR and UNCHR. The Ministry of Finance, Planning and Economic development has put in place a mechanism to ensure aid transparency. Each quarter, the development partners submit their aid amounts to the ministry. This has improved on tracking the aid support to government for both budget and project support.

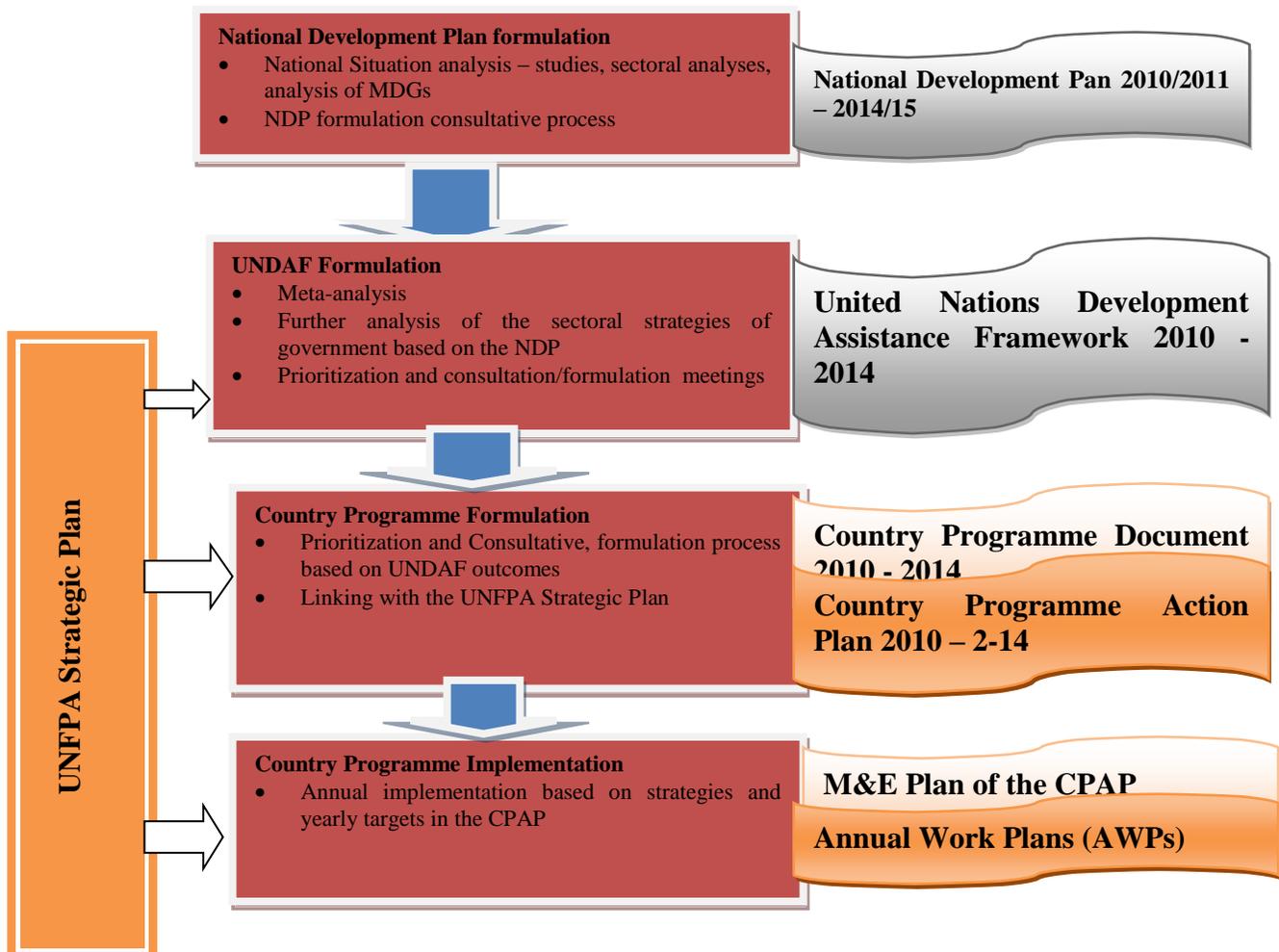
# CHAPTER 3: UN/UNFPA Strategic Response and Programme

## 3.1 UN and UNFPA Response

### 3.1.1 Programme development flow

The UN programme development in Uganda was anchored on the process of formulating the National Development Plan (2010/11 – 2014/15). The UNCT actively participated in the NDP formulation processes including the national and sectoral situation analysis. The UNCT conducted a meta-analysis that provided an avenue for identification of national priorities for the United Nations in Uganda to focus on. Based on these priorities, the United Nations Development Assistance Framework (UNDAF) 2010 – 2014 was formulated. The outcomes outlined in the UNDAF and the UNFPA Strategic Plan informed the formulation of the UNFPA Country Programme and the subsequent action plan (CPAP). The CPAP (2010-2014) elaborates the results to be achieved over the five year period disaggregated into annual year targets. Based on the CPAP, a Monitoring and Evaluation Plan was developed. At implementation level, Annual Work Plans are developed to operationalize the CPAP. Figure 5, below presents process and logical flow that was followed in formulating the GoU/UNFPA Country Programme.

Figure 3: UN/UNFPA Programming flow



### 3.1.2 UNFPA Strategic Response

The UNFPA supported programmes in Uganda have always been aligned to the National Development Priorities; in the past to the Poverty eradication Action Plans and currently to the National Development Plan 2010/11- 2014/15 as well as priorities for the United Nations System stipulated in the Uganda United Nations Development Assistance Framework (UNDAF) 2010-2014. The UNDAF vision is to support the capacity of Uganda to achieve the national development plan, with a focus on equity and inclusion, peace and recovery, population and sustainable growth.

The country programme supports two of the UNDAF outcomes namely a) the Government and civil society have improved capacity for governance and accountability in order to reduce geographic, economic and demographic disparities in attaining the MDGs; and b) vulnerable populations in Uganda, especially in the North, have increased access to and use of sustainable and quality basic social services by 2014. It is also equally important that the country programme creates a partnership with other United Nations agencies to pursue the principle of Delivering as One (DaO) especially through Joint Programming. The CP was also developed in line with the UNFPA Global Strategic Plan for the period 2008 to 2011, which has since been revised and extended to 2013 and took into account the Millennium Development Goals (MDGs) and the 1994 International Conference on Population and Development Programme of Action (ICPD-PoA).

## 3.2 UNFPA Response through the Country Programme

### 3.2.1 UNFPA previous cycle strategy, goals and achievements

UNFPA's support to Uganda started in 1975 through the project approach. Cooperation through a programme approach began in 1985. Currently implementing its 7<sup>th</sup> CP, the first CP (1985-1988) aimed at building necessary institutional capacities in identified sectors, and laying groundwork for a more comprehensive programme at a later stage.

*The second CP* (1989-1992) focused on assisting the Government of Uganda (GoU) in improving maternal health, achieving a better balanced population growth through an explicit national population policy, integration of population parameters into development planning, and promotion of the socio-economic status of women.

*The third CP* (1993-1996) was a continuation of the second CP. However, following the International Conference on Population and Development in 1994, it was amended to support GoU to incorporate the ICPD Programme of Action; recommendations emanating from the conference. Adolescent reproductive health was hence included as a critical component for assistance.

*In the fourth CP* (1997-2000), special emphasis was placed on reproductive health services for all including adolescents and young people, strengthening capacity of planning units to integrate population and reproductive health factors when planning. Focus was also put on establishment of modern maternal health referral system, referred to as Rural Extended Service for Care and Ultimate Emergency Relief (RESCUER); reducing harmful traditional practices, especially female genital mutilation in Kapchorwa through the Reproductive, Educative and Community Health Programme (REACH).

For *the fifth CP* (2001 – 2005) support broadened to help address the Plan of Action of the ICPD, Convention on Elimination of all forms of Discrimination Against Women (CEDAW) and the Millennium Declaration. The

focus was on better quality of life for Ugandans through improved reproductive health, sustainable population growth and development, enhanced gender equity and equality, and the empowerment of women.

*The sixth CP(2006 – 2009)* was designed to respond to national priorities, as articulated in the Poverty Eradication Action Plan (PEAP), especially under pillar 5 (Human Development), and UN priorities as defined in UNDAF. The focus of the CP6 was gender mainstreaming; prevention and response to Gender-Based Violence; improving availability of disaggregated data, integration of population dimensions into development frameworks, and increased commitment and support to ICPD agenda; improving midwifery services, family planning and HIV/AIDS prevention.

### **3.2.2 The current Country Programme 2010 – 2014**

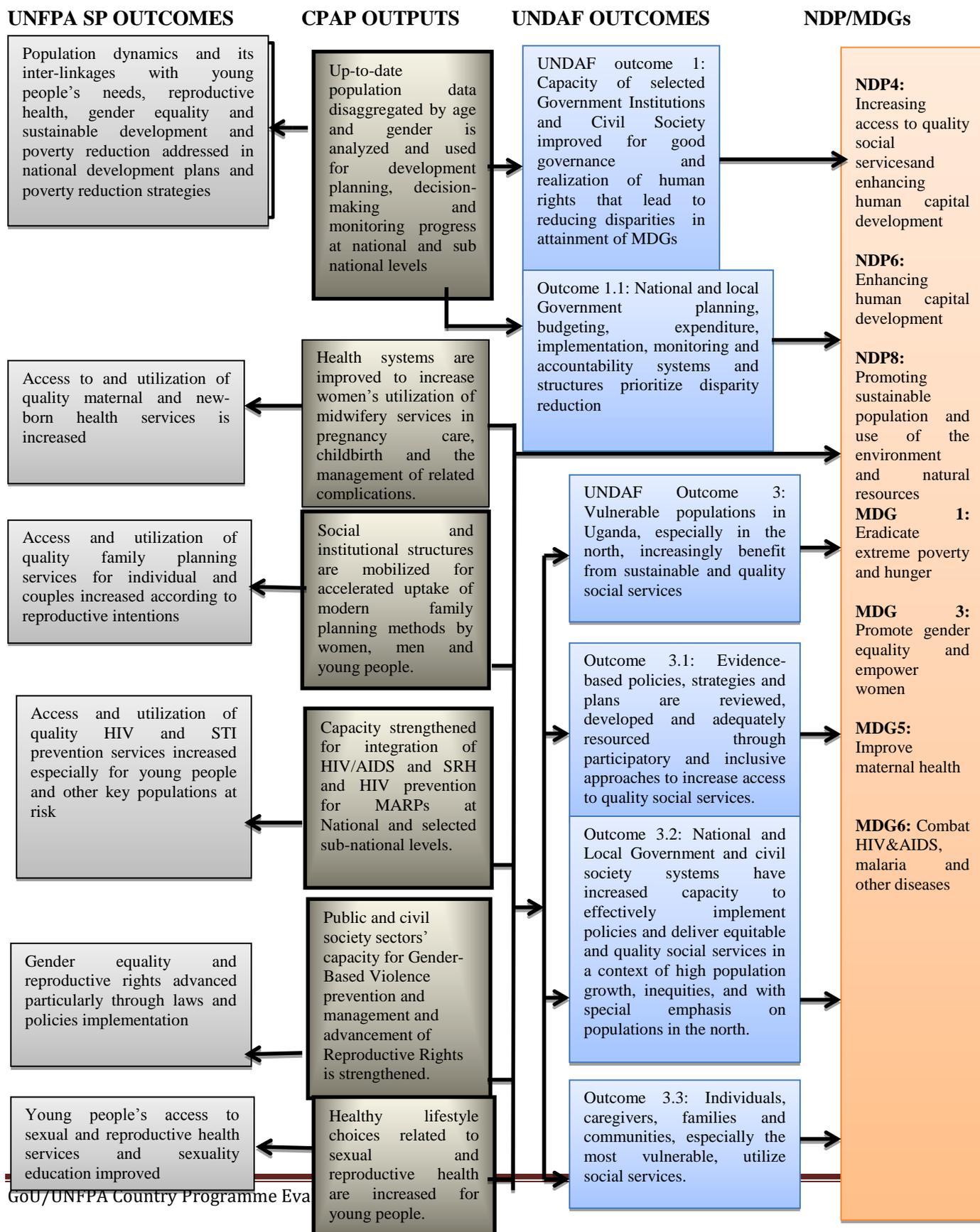
The orientation of the CPAP is to address the current context of Uganda especially in addressing the mounting challenges of rapid population growth. This called for social mobilization and championing of leadership in various fora to advocate for population, reproductive health and gender issues and rights firmly in the public domain supported with the necessary policy and institutional backing. The Country Programme employed the main strategies of capacity building, building/promoting the use of knowledge base, reinforcing advocacy and policy dialogue, strengthening partnerships as well as developing systems for improved performance.

In terms of programmatic focus, the Country Programme 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 and 2011.

In 2011, a Mid Term Review of the UNFPA Global Strategic Plan was conducted. UNFPA adopted a refined strategic focus, which is designed to direct its work on sexual and reproductive health and reproductive rights, on supporting greater progress towards MDG 5 and towards the ICPD agenda. Consequently, the GoU/UNFPA Country Programme was revised to align with the revised UNFPA Global Strategic Plan. However, the alignment of the Country Programme to the UNFPA Strategic Plan did not substantially change the focus of the Country Programme.

Figure 6 below indicates the linkage of the CP results to the results of the UNFPA Strategic Plan, The UNDAF and the National Development Plan as well as the MDGs. The CP contributes to all the outcomes of the UNFPA Strategic plan, to outcome 1 and outcome 3 of the UNDAF, to objectives 3, 4 and 5 of the NDP and directly to MDGs 3, 4, 5 and 6.

**Figure 6: Results' Linkages – UNFPA Strategic Plan, CP Outputs, UNDAF outcomes, NDP objectives and MDGs**



## **Current Programme focus**

### **a) Population and development component**

For the years 2010-2011, the P&D component had two outputs that were later merged into one key output with the 2012 strategic re-alignment. The output and focus of P&D component is:

**Output 01:** Up-to-date population data disaggregated by age and gender is analyzed and used for development planning, decision-making and monitoring progress at national and sub national levels. The focus of the output was to ensure:

- Existence of new national Survey Reports supported by UNFPA (DHS, Census, National Panel Survey)
- Availability of in-depth analytical reports (on MH, FP, Young People, GBV and Reproductive Right) and district profiles from Census, DHS and Panel Survey
- Sectors and target districts are able to access data on UBOS Integrated Management Information System.
- Availability of National Planning Guidelines (for Sectors and LGs) that include integration of population dynamics in the plans
- National, Sectoral and district Plans fully integrate population dynamics
- Existence of a functional Youth coordination structure /network for engaging young people in planning/policy dialogue and programme.

### **b) Reproductive Health component**

The RH component aligns to UNDAF and links to NDP fourth objective of increasing access to quality social services and enhancing human capital development and contributes to UNFPA's Global Strategic Plan outcome 2.1, 2.2 and 2.3. The re-aligned RH component has four outputs and is designed to respond to health sector priorities as articulated in the National Health Policy II (2010 – 2020) and as would be translated in the subsequent Health Sector Strategic Plan III (2010 – 2014). Through the RH component, UNFPA contributed to strategies outlined in the 'Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, 2007–2013', and the 2009 AU Campaign on Accelerated Reduction for Maternal Mortality (CARMMA). Below are the outputs and focus for the RH Component.

**Output 02:** Health systems are improved to increase women's utilization of midwifery services in pregnancy care, childbirth and the management of related complications focusing on

- Increasing Health Facility deliveries in target districts
- Supporting revision of national midwifery training curriculum
- Existence of amended Nurses and Midwifery Act, Handbook and Midwifery Implementation Plan
- Improving capacity of Health facilities (Hospitals, HC IVs and HC IIIs) in target districts for EmONC
- Increasing the capacity of Regional Referral Hospitals to offer Fistula repair services on routine basis
- Increasing the number of women treated for Fistula with UNFPA Support

**Output 03:** Social and institutional structures are mobilized for accelerated uptake of modern family planning methods by women, men and young people.

- Eliminating contraceptive stockouts at national and health facilities in target districts
- Increasing the capacity of Health Facilities in Target Districts to can offer both short term and long acting FP Methods
- Increasing the number of new clients utilizing modern family planning methods in targeted districts
- Advocacy for increased government share in budget allocation for, and expenditure on contraceptives

**Output 04:** Capacity strengthened for integration of HIV/AIDS and SRH and HIV prevention for MARPs at National and selected sub-national levels.

- Supporting the putting in place a conducive policy environment for HIV prevention specifically the National HIV prevention policy includes rights for populations most at risk and the HIV/AIDS and SRH integration strategy
- Building capacity of districts and Health Units (HC IIIs, HC IVs and Hospitals) to provide integrated RH and HIV/AIDS services
- Comprehensive Condom Programming Framework

**Output 06:** Healthy lifestyle choices related to sexual and reproductive health are increased for young people.

- Supporting the review of Secondary School curriculum to integrate Sexuality Education
- Supporting review and development of Youth Specific policies, guidelines and standards focusing on National Youth Policy and Action Plan, National Youth Coordination Framework, School Health Policy and Action Plan, Adolescent Health Policy and Standards of Care, Guidelines for management of Sexual Reproductive Health issues in School setting
- Building capacity of districts and selected Health Units and schools to provide Youth Friendly ASRH services

### c) **Gender equality and reproductive rights component**

The gender equality component links up primarily with objective 4 of the NDP and UNDAF outcome 3. The gender component links with the third goal of the UNFPA global strategic plan 2008-2011. The period 2010-2011, Gender outputs focused on strengthening the capacity of public and civil society sectors capacity for Gender-Based Violence prevention and management. Also enabled women's and men's groups advance reproductive rights and gender equality, creating a critical mass for social transformation. The realigned component focuses on Gender-Based Violence prevention and response, build capacity for legal and protection systems and medical care for survivors, particularly in conflict affected and recovery settings; and strengthening Government co-ordination mechanisms. The gender output and focus areas are presented.

**Output 05:** Public and civil society sectors' capacity for Gender-Based Violence prevention and management and advancement of Reproductive Rights is strengthened.

- Building the capacity of targeted districts to incorporate Gender-Based Violence prevention/ response and reproductive rights interventions in plans and budgets.
- Providing response services to Gender-Based Violence survivors utilizing s in targeted districts
- Supporting sectors to implement the international instruments and national legislation for GBV prevention and management
- Supporting establishment of a functional system in place to regularly record GBV incidence at national and district level
- Supporting government to develop GBV related policies and legislation focusing on Domestic Violence Act, FGM/C, Marriage and Divorce Bill, and Sexual Offences Bill
- Training in GBV Programming in Humanitarian and Post-conflict situations
- Supporting communities to declare the abandonment of FGM/C

#### d) Partnership strategy, programme management, monitoring and evaluation

CPAP7 refocused its partnerships and support to new strategic alliances within the context of country ownership and leadership; alignment to government priorities, systems and processes and harmonization within the UN and the wider Development Partners' arrangement, while promoting active involvement of Civil Society Organizations (CSOs) and the private sector. UNFPA together with other partners participate in Sector Wide Approaches (SWAPS).

Program Management arrangements are that the Ministry of Finance, Planning and Economic Development through the Population Secretariat provides the overall programme coordination, with the Ministry of Health coordinating the reproductive health component, the Population Secretariat coordinating the population and development component, and the Ministry of Gender, Labor and Social Development coordinating the gender component. UNFPA Government implements the programme in partnership with government institutions, United Nations and civil society organizations, and various coalitions and alliances. The implementation of the Programme at the district level is within the decentralized government framework.

Monitoring and evaluation function is aligned with the UNDAF and harmonized with national sectoral coordination mechanisms. The Country Programme Action Plan (CPAP) and the Annual Work Plans (AWPs) provide a crucial guide for implementation and monitoring of the Country Programme.

UNFPA Uganda Country Office has established three decentralized offices to monitor its programme interventions over in the region. Initially the Decentralized Offices were established for emergency response in displaced settings and GBV prevention and response, but are gradually shifting to cover aspects of development programme in recovery and post recovery period. The Decentralized Offices provide integrated programme and technical support to implementing partners as well as act as the technical hub for knowledge transfer between implementing and non-implementing districts.

#### 3.2.3 The Financial Structure of the Programme

##### a) Country Programme resources anticipated at the CP formulation

According to the Country Programme Document for the Seventh GoU/UNFPA Country Programme (2010 – 2014), a total of \$45 million was expected to finance the CP; \$30 million from regular resources and \$15 million mobilized from other sources. Reproductive health was expected to take 40% (\$18 million) of the total resources, Gender Equality 33% (\$15 million), Population and Development 25% (\$11 million) and Programme Coordination Assistance 2% (\$ 1 million). This proportionate allocation was in line with the revised UNFPA Strategic Plan whose focus is on Sexual and Reproductive Health. The planned distribution of the UNFPA financial commitments for the Seventh GoU/UNFPA Country Programme is indicated in the table below

**Table8: UNFPA Financial commitments projections as per CPAP 7**

Programme Area	Amount of projected resources (million \$)		
	Regular resources	Other	Total
Reproductive health and rights	14	4	18
Population and development	6	5	11
Gender Equality	9	6	15
Programme Coordination and assistance	1	-	1
<b>Total</b>	<b>30</b>	<b>15</b>	<b>45</b>

##### b) Overall Country Programme Resources: 2010 to 2013

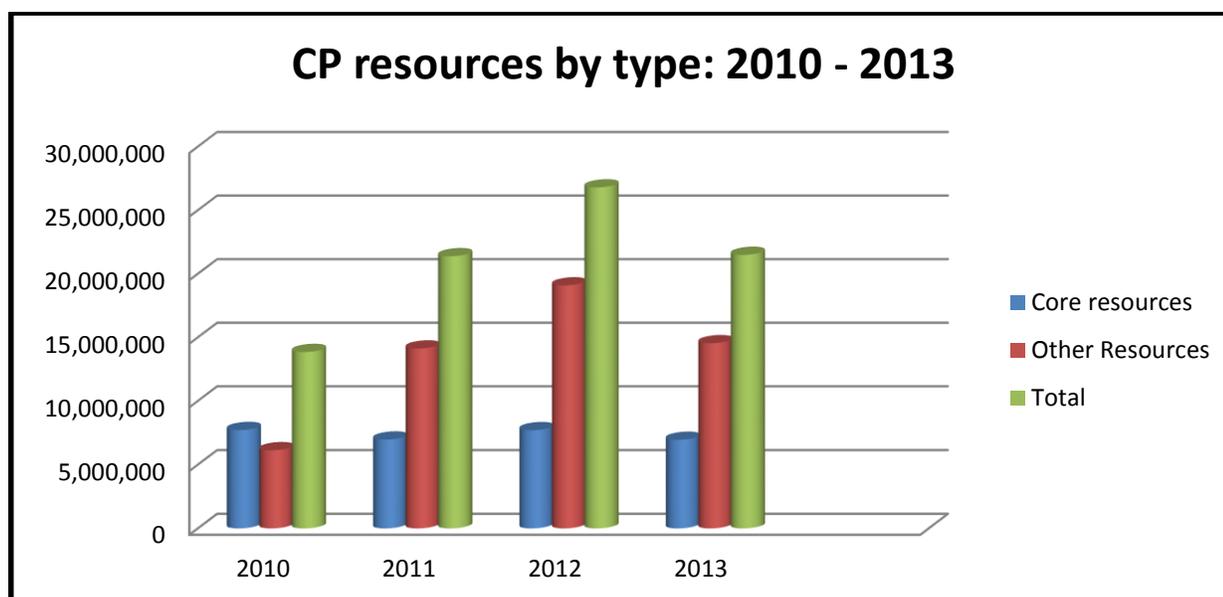
Resources mobilised for CPAP7 have been increasing since 2010. The increase in the resources was mainly due to increase in other/mobilised resources which more than trippled from \$6.1m to \$19.1m in 2012. The regular remained almost the same over the four years. Overall, for the first four years of the CP, \$83.5 million have been mobilised compared to the \$45 million expected over the entire CPAP period (2010 – 2014).

**Table 9:Trends in CP resources (US \$): 2010-2013**

Type of resources	2010	2011	2012	2013	Total
Core resources	7,715,858	6,967,808	7,705,364	6,946,875	29,335,905
Other Resources	6,132,651	14,124,462	19,085,269	14,538,533	53,880,915
<b>Total</b>	<b>13,848,509</b>	<b>21,380,270</b>	<b>26,790,633</b>	<b>21,485,408</b>	<b>83,504,820</b>

Apart from 2010 wheret the regular resources were more than the other resources, for the remaining years other resources were almost double the regular resources.

**Figure 7: Comparison of CP resources: 2010 – 2013**



**c) CP Resources by CP Output Areas 2010 – 2013**

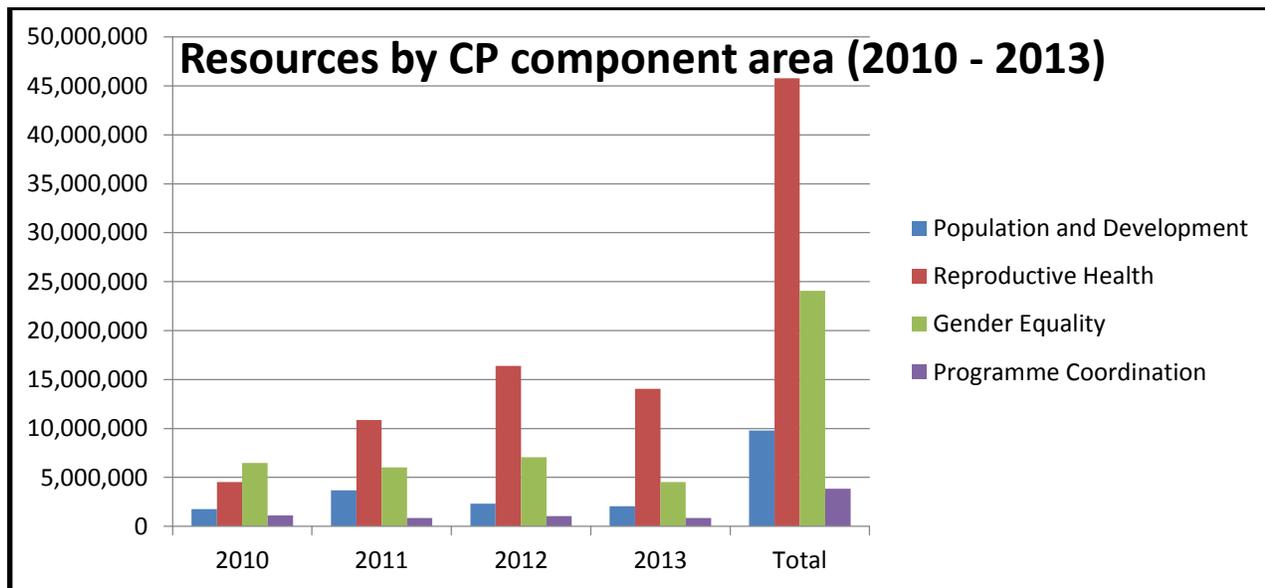
Assessment of CP resources by output from 2010 - 2013 reveals that Family Planning has attracted most resources (\$24.5m representing 30%) followed by GBV and advancement of Reproductive Rights (\$24.0m which translates to 28% of all resources). The table below indicates the amount of resources that were available for each output from 2010 to 2013.

**Table 10: Amount of resources for the CP from 2010 – 2013**

Output	2010	2011	2012	2013	Total	% of overall resources
Output 1: Data availability and use	1,753,512	3,670,063	2,298,852	2,066,096	<b>9,788,523</b>	12
Output 2: Midwifery Services	1,812,672	3,172,153	2,564,677	1,944,704	<b>9,494,206</b>	11
Output 3: Family Planning	1,727,080	5,242,459	9,492,476	8,118,152	<b>24,580,167</b>	30
Output 4: HIV/AIDS prevention	713,315	1,563,582	2,245,491	2,138,305	<b>6,660,693</b>	8
Output 5: GBV and Reproductive Rights	6,465,111	6,025,758	7,062,487	4,512,837	<b>24,066,193</b>	28
Output 6: ASRH	259,971	870,501	2,081,353	1,846,298	<b>5,058,123</b>	6
PCA	1,116,648	835,754	1,045,297	859,241	<b>3,856,940</b>	5
<b>Total</b>	<b>13,848,509</b>	<b>21,380,270</b>	<b>26,790,633</b>	<b>21,485,633</b>	<b>83,505,045</b>	100

When analysed by component, Reproductive Health had most of the resources each year and over the four years. Overall, RH was allocated \$45.8m representing 56% of all CP resources, followed by Gender Equality with \$24.0 m (28%), Population and Development with \$9.8m (12%) and Programme Coordination with \$3.9 (5%).

**Figure8: CP resources by component area**



**d) Overall fund utilisation (2010 – 2012)**

Although the annual resource envelope has been increasing since 2010, the overall resource utilisation rate (though high) has been declining from 93% in 2010 to 88% in 2011 and 85% in 2012 as indicated in Table 12. For all the completed three years of the CP, fund utilisation rate has been very high for core resources (regular and BSB) and lower for other resources. For regular resources and BSB the utilisation rate has been high (98% on average), while for other resource the utilisation rate declined from 86% in 2010 and 2012 to 79% in 2012. The main reasons for low fund utilisation rates for other/mobilised resources are late release of resources from

donors to UNFPA as well as delayed transfer of funds that are meant to be used in the subsequent years. Other reasons relate to programming challenges faced in the Joint Programme implementation.

**Table 11: Annual comparison of CP resources' utilisation (2010 – 2012)**

Type of resources	2010			2011			2012		
	Budget	Expense	Impl rate	Budget	Expense	Impl rate	Budget	Expense	Impl rate
Core resources	6,799,210	6,629,899	98	6,332,054	6,020,123	95	6,939,784	7,015,416	101
BSB	916,648	937,786	102	635,754	631,334	99	765,580	727,936	95
Other Resources	6,132,651	5,275,346	86	14,124,462	12,107,317	86	19,085,269	15,016,614	79
<b>Total</b>	<b>13,848,509</b>	<b>12,843,031</b>	<b>93</b>	<b>21,380,270</b>	<b>18,758,774</b>	<b>88</b>	<b>26,790,633</b>	<b>22,759,966</b>	<b>85</b>

### Fund utilisation by CP Component

The expenditure rates by CP component area for the three completed years (from 2010 to 2012) are indicated in the table below.

**Table 12: Fund utilisation by Component (2010 - 2012)**

CP Component	Total Resources	Total Expense	Fund Utilisation Rate
PD	7,722,427	7,092,266	91.8
RH	31,745,730	27,254,168	85.9
Gender	19,553,356	17,235,446	88.1
PCA	2,997,699	2,890,012	96.4
Total	62,019,212	54,471,892	87.8

Generally fund utilisation rate was high at 88%. Population and Development had the highest utilisation rate at 92%, followed by Gender (88%) and RH (85%).

### SUMMARY OF FINANCIAL STRUCTURE

The CP programme financial structure indicated a high level of resources mobilization. For the first four years of the programme resources amounted to \$83m compared to the \$45m expected for the entire CP duration. Sixty five (65) percent of the total resources came from other sources while 35% were from the UNFPA core resources. In terms of proportionate allocation of resources to programme components, Reproductive Health had 56% of all the CP resources. The fund utilisation rates were generally high over the three completed years of the CP. Overall the fund utilisation rate was 88%.

## CHAPTER 4: Analysis of the Programmatic Areas

This chapter presents results based on a rigorous analysis of the collected data related to the evaluation questions for the programmatic focus under the OECD/DAC criteria of Relevance, Effectiveness, Efficiency and Sustainability. Under each criterion, the findings are presented for the three programme focus areas of Population and Development, Reproductive Health and Gender equality. The findings presented in here are based on evidence and reasoned judgments.

### 4.1 Relevance

**Evaluation Question:** To what extent is UNFPA support to Uganda aligned to the objectives in the National Vision 2040, National Development Plan 2010/11 – 2014/15 and other sector policy frameworks responding to the national priorities? To what extent is the UNFPA support in the field of Reproductive Health, Gender and Population and Development adapted (i) to the needs of the population (ii) capacity and systematic needs of government institutions (iii) and in line with the priorities set by the international and national policy frameworks?

The evaluation process focused on verifying the relevance and alignment of the CP to the national needs/priorities and national context that are described in Chapter 2 (The Country Context) as stated under the evaluation question.

#### 4.1.1 Population and Development

##### a) Alignment with national and international policy frameworks

The evaluation confirms that CPAP7 focus under P&D was fully aligned to Government policies and contributes to the advancement of the ICPD agenda (defined in Chapter 2). The population and development objectives that the CP was designed to address are well articulated in the Vision 2040, National Population Policy (NPP) and National Population Action Plan (NPAP) and the National development Plan (2010/11 – 2014/15). There was evidence that the Population and Development Component was designed in consultation with national stakeholders and took into account the national needs related to data availability and use for improving evidence based and population centered decision making.

The P&D component is also anchored on the ICPD PoA particularly Principle 2 that stipulates that the human beings are at the centre of sustainable development; Chapter 2 on integration of population and development strategies. To this end the component was designed to promote integration of population concerns into development strategies, planning and decision making in order to achieve social justice and eradicate poverty.

##### b) Addressing the needs of the stakeholders

The component was relevant in that it helped bridge gaps of inadequacy of data for decision making, which was cited by a number of respondents (both at national and district levels); the capacity gaps in evidence based planning and use of data to influence decision making and the lack of appreciation of statistics among the decision makers. Moreover, key respondents asserted that the aspiration and plans to use data in development frameworks had been in existence long before the CP7, although districts and sectors lacked technical and financial resources (see Box 2).

At national level, UBOS and Population Secretariat focused on the integration process aimed at ensuring use of census data and data from other sources. Unquestionably, CPAP7 brought in new ideas in the integration process by adding on vulnerable populations, that included children under 18, child and female headed households, adolescents in and out of school (10-24 years), youth in and out of school (18-30) and other marginalized populations, making sure that every person counts.

#### **Box 2: Stakeholders' voices on the Program Relevance**

*"The need to integrate population factors in development frameworks has been seen as critical since it promotes a comprehensive and robust approach in identifying specific needs of the people in a specific locality"*

*"..Our district has one of the highest fertility rates at 7.1, above national average so FP support is very pertinent and we need continuous support in this area"*

*"Yes....the program enhanced GoU to implement Reproductive Health Rights, Human Rights anchored within the National Gender Policy, action plan on women focusing on ending Violence against Women; CPAP7 is anchored in the 1995 constitution on rights issues, the NDP, Social Development Sector*

#### **Summary of findings on relevance of P&D component**

Based on evidence from triangulated data; field level, review of the National P&D policy frameworks and requirements of a highly decentralized system of governance, the evaluation team concurs that the P&D component of the Country Programme is relevant nationally and in addressing the areas stipulated in the ICPD PoA. The decision to undertake P&D interventions at the national and district level was reasonable and helped advance the ICPD agenda.

#### **4.1.2 Reproductive Health**

##### **a) Alignment with national and international policy frameworks and agenda.**

The UNFPA/GoU RH component contributed to the provision of the maternal health component of the Uganda National Minimum Health Care Package as defined in the National Development Plan, National Health Policy, Health Sector Strategic Investment Plan 2010/11 to 2014/15 (GoU/MOH, 2010). The training and bonding of midwives was a well thought through intervention to address gaps and the scarcity of midwives in the underserved districts. Equipping skills laboratories in training schools was very needed for quality midwifery services (Miheala, 2011; MoH, 2009& 2010). Additionally, the baseline study had identified that facilities lacked EmONC and PAC equipment, making strategies to equip health facilities relevant. Similarly fistula initiatives responded to a need of more than 200,000 poor women, (National Fistula Strategy, 2008).

The focus on reducing FP commodities stock-outs, training of service providers and increasing funding for RH commodities were very significant as Uganda's fertility rates remain high, yet the contraceptive rates for modern methods were only at 26% culminating to unacceptable MMR. All these RH needs were articulated in the National Development Plan, National Health Policy and Health Sector Strategic Investment Plan.

Targeting the reduction of Ugandan HIV prevalence rates through services to MARPs (CSW, LGBTI, fishing/migrant communities), is the new National Strategic direction to curb the epidemic. Revitalization of comprehensive condom programming was needed to increase access and utilization of both female and male condoms (MoH-3, 2010; MoH, 2013).

For adolescent health, the output on increasing the healthy lifestyle choices related to sexual and reproductive health for young people is in line with the MoH Guidelines on Adolescent health (RH Division, 2012). The focus on building GoU capacity for an enabling policy environment remains relevant and the integration of GBV prevention and response to RH activities are in line with CEDAW, CARMMA and the Maputo Plan.

The alignment of the RH component to the ICPD PoA was found to be very strong. The component focus responds Chapter 7 of the PoA: Reproductive Rights and Reproductive Health. As elaborated in the PoA, the CP focuses on meeting the RH needs of the target population using the human rights principles with particular focus on Maternal Health, Family Planning, HIV/AIDS, and Adolescent Health.

#### **b) Meeting the needs of the population**

The RH component alignment to the needs of the population can be explained by the CP focus in Northern Uganda and other districts that very low SRH indicators. The identification of districts focus of was based on the composite methodology. The methodology helped identify districts that had very low indicators. The indicators that formed the composite include Total Fertility Rate, Population Growth Rate, Proportion of Deliveries in Health Facilities, HIV Service availability and Adolescent birth rate. The data for these indicators was extracted from the 2006 DHS, the 2009 Annual Health Sector Performance Report and the 2009 Statistical Abstract. The use of such a methodology ensured that the programme focused in district with the population with highest SRH/HIV needs. This is how the districts of Kanungu, Mubende, Yumbe, Oyam, Katakwi, Kotido, Moroto and Kaabong came be identified as the main focus districts.

Other districts were targeted based on their unique population needed. For example the districts of Kalangala, Gulu, Pader, Arua and Kampala were identified as focus areas for downstream HIV prevention activities due to presence of large number of Most At Risk Population like Commercial Sex Workers, long distance truck drivers and fishing communities. The need to address FGM led to programme focus in Kapchorwa, Kween, Bukwo, Amudat and Moroto Districts. Most of the programme interventions were concentrated in the rural areas is an indication that the programme targeted a section of the population that was in most need of the services since the statistics indicated that rural areas had poor indicators than urban areas.

#### **Summary of findings under relevance-RH**

There was sufficient evidence that the RH component was aligned and relevant to the National Development Priorities enshrined into the Uganda National Minimum Health Care Package as defined in the Health Sector Strategic Investment Plan 2010/11 to 2014/15, and was in line with ICPD PoA. Interventions on midwifery services and fistula care, FP commodities provision, targeting MARPS for HIV prevention, Revitalization of comprehensive condom programming was needed to increase access and utilization of both female and male condoms and establishment of Adolescent friendly reproductive services were in line with national and local priorities. The programme focused in the districts that had very low SRH/HIV indicators thus addressing the actual needs of the population.

### **4.1.3 Gender Equality**

#### **a) Alignment to National and international policy frameworks**

The evaluation reaffirms that the component design was aligned to the 2007 National Gender Policy and that had been informed by the needs of local Ugandan women, girls, men and boys, as discussed under chapter 2. Respondents asserted that CPAP7 was opportune to bridge gaps in gender policies, laws and plans. Moreover the program enabled national and local government implement priorities on gender equality and reproductive rights, as per chapter 4 of the Uganda constitution. CPAP7 was in harmony with regional instruments, international protocols, charter; the African bill of rights, the UN Security Council resolution 1325 and 1820 and the Goma declaration.

It further enhanced the implementation and follow through of the ICPD agenda on delivery of gender equality, and empowerment of women, eliminating all forms of practices that discriminate against women and girls as well as eliminate all forms of violence and harmful practices against women as presented in Chapter 4 of the PoA. The Country Programme also focused on MDG 3, while contributing directly/indirectly to MDGs 1,2,4,5

&6; contributed to section 656 of the NDP and the links to global frameworks was demonstrated under the Country Context Chapter 3 of this report.

### **b) Addressing the needs of the population**

The focus of the gender component of the country programme was in line with the poor gender related indicators observed in the country. Some of the indicators are 68% for females, and 20% for males have ever experienced GBV; 28% of women compared to 9% men ever experienced sexual violence; 58% of women believing that wife beating is justifiable; high incident of rape and other forms of SGBV before the age of 15 (up to one in five women reports being sexually abused before the age of 15 (*Moroto District, 2011*); More than 1000 girls subjected to FGM/C annually(*Moroto District, 2011*)

The identification of districts of focus also took into consideration of the gender related indicators namely GBV incidence, Female Net School Enrollment Rate as indicated in the National Statistical reports like the 2006 DHS and the 2009 Statistical Abstract. For example, the Joint Programme on GBV focused on districts that had high incidence of GBV especially those that were recovering from conflict. These districts are Kitgum, Gulu, Pader, Amruru, Lamwo, Lira, Dokolo, and Amuria all from Northern Uganda

The evaluation of the sixth country programme made a number of recommendations regarding the need to focus the programme on the needs of the population. Key recommendations were: Complete, pilot Model GBV Recovery Centers and build lessons for expansion to other district; Engage more with the justice system at local and national levels to handle GBV cases; partner with traditional and religious institutions at national and district levels make them allies for GBV prevention and response other than opponents; foster partnerships with policy makers, parliamentarians, FBOs, Community Based Organizations (CBOs), NGOs and the private sector; educate the rights holder on their fundamental human rights in line with existing laws that protect the rights of women and the girl child; and strengthen capacity of CSOs, women groups to participate in the formulation of national and district anti-GBV policies and funding frameworks:

Review of the Seventh Country Programme documents and workplans clearly indicate that the above recommendations have been addressed. GBV Shelters (recovery centers) have been established in Masaka, Mbarara, Moroto, Gulu and Lira; at National level JLOS sector is a key stakeholder, at local level paralegal structures strengthened to handle the GBV cases, Communities have been engaged in GBV prevention activities eg the GBV Male Action Groups and Women Alliances. There has been increased engagement of Faith Based Organizations (the Church of Uganda, Muslims Supreme Council, SDAs, Orthodox, Born Again Association) in addressing GBV. Key partners like Uganda Women's Network, Uganda Women Parliamentary Association have been organized in form of consortia to address GBV issues in the country.

### **Summary of findings on relevance- Gender Equality & Reproductive Rights**

The Gender Equality and Reproductive Rights component was rated highly relevant and based on National Development Plan, National Gender Policy and planning frameworks; acknowledged as enabling national and local government implement priorities on gender equality and reproductive rights (MGLSD/GoU, 2010); and in harmony with regional instruments, international protocols, charter, African bill of rights, UN Security Council resolution 1325 and 1820 and Goma declaration and focused on MDG 3, while contributing directly/indirectly to MDGs 1,2,4,5 &6. The Gender Component also addresses the fundamental elements regarding discrimination against women, male involvement, Gender Based Violence and FGM in line with the ICPD PoA. The focus of the component strongly addresses the GBV and Reproductive Health needs of the population.

## 4.2 Effectiveness

### 4.2.1 Population and Development

**Evaluation question:** *To what extent were the expected outputs related to Population and Development of the CPAP achieved or are likely to be achieved regarding Data generation/availability and Data use to integrate population dynamics in national and sub national policies, plans and programmes, What were the facilitating factors for the realization of CPAP results? What are the challenge/limiting factors that may have affected the achievement and implementation of the CP?*

The section presents an elaboration on results, factors that enabled or hindered the attainment of these results. The Population and Development component of the Country Programme focused on one output with six indicators. Key Implementing Partners for this output were the Population Secretariat, Uganda Bureau of Statistics, the District local Governments/

#### a) Summary performance

Table 13 below presents the evaluation findings on the CP performance on the P&D component indicators.

**Table 13: Summary of Performance P&D Output by indicator**

CP Output 01: Up-to-date population data disaggregated by age and gender is analyzed and used for development planning, decision-making and monitoring progress at national and sub national levels				
Output Indicators	Baseline (2010)	Value	Target (2014)	Performance at Evaluation July 2013
1.1 Existence of national Survey Reports supported by UNFPA (DHS, Census, National Panel Survey)	0		1 Census (detailed) 1 DHS 2 NPS	<ul style="list-style-type: none"> <li>• 2011 DHS done, data widely used</li> <li>• National Panel Survey reports available</li> <li>• 2011 and 2012 Statistical Abstracts available</li> <li>• Census not on course, has been postponed twice</li> </ul>
1.2 Availability of in-depth analytical reports (on MH, FP, Young People, GBV and Reproductive Right) and district profiles from Census, DHS and Panel Survey, HIV/AIDS Sero-behavioral Survey	0 (none existed for the program districts)		<ul style="list-style-type: none"> <li>• 5 further analysis reports from DHS</li> <li>• 8 Census Based district profiles</li> </ul>	<ul style="list-style-type: none"> <li>• Drafts DHS further analysis reports available for Maternal Health, Adolescent Fertility and Teenage Pregnancy, Family Planning Utilization, GBV.</li> <li>• Census not conducted; with UNFPA support UBOS has capacity for undertaking census using the state of the art scanning technology.</li> </ul>
1.3 Number of sectors and target districts that are able to access UBOS Integrated Management Information System.	Districts: 0 Sectors: 0	0	Districts: 8 Sectors: 5	No district and sector reported accessing IMIS. IMIS is functional, some data available (for some variables) for the 1991, 2002 Censuses and the 2003 Agricultural Census.
1.4 Availability of National Planning Guidelines (for Sectors and LGs) that	Not Available		Available and in use	Not available. What is available are Draft guidelines for integration of

<b>CP Output 01: Up-to-date population data disaggregated by age and gender is analyzed and used for development planning, decision-making and monitoring progress at national and sub national levels</b>			
<b>Output Indicators</b>	<b>Baseline Value (2010)</b>	<b>Target (2014)</b>	<b>Performance at Evaluation July 2013</b>
include integration of population dynamics in the plans			population variables in plans
1.5 Number of National, Sectoral and district Plans that integrate population dynamics	0 (None of the plans that existed before had fully integrated population dynamics to current extent)	1 National 5 Sectoral 15 District	<ul style="list-style-type: none"> <li>National plans ie the NDP and the Vision 2040. The two plans clearly articulate the need to address population dynamics</li> <li>Sectors (education and Health)</li> <li>9 Districts – Kanungu, Katakwi, Yumbe, Oyam, Mubende, Moroto, Kotido, Kaabong, Arua, Gulu</li> </ul>
1.6 Existence of a functional Youth coordination structure /network for engaging young people in planning/policy dialogue and programme.	Not functional	Functional	Structure established in MGLSD. Guideline for Youth Coordination Mechanism available

#### **b) Support for data generation and availability**

From the field data collection, there was evidence that new national survey reports were produced including the 2011 UDHS, 2 National Panel Survey reports and statistical abstracts. There were also 5 in-depth analytical reports (on MH, FP, Young People, GBV and Reproductive Rights) and some districts presented abstracts. The Web-based Integrated Management Information System (IMIS) though available was not easily accessible to all, and was not updated. Gender statistics were available more so on disaggregation for sex, and however the sectoral analysis on gender is a new practice. MoH through its ASRH policy presents social determinants of health including GBV, and consequences of ill health. JLOS, Education, NPA had implemented a gender audit to inform strategy and policies; however this is work at its onset and requires more time. Some districts like in Karamoja region, the statistical abstracts were available and data is used to inform development of Annual Workplans and the Budget Framework Papers. The program has done a lot for district and national level implementing partners; key among these benefits include capacity enhancement of implementing partners, establishing district data bases, integration of population issues in district and national plans.

The further analysis of the 2011 DHS was achieved under the Country Programme. Through UNFPA support, UBOS and Makerere University produced 7 analytical reports on: The Contribution of Contraception, Marriage, and Postpartum susceptibility to fertility in Uganda; Correlates associated with uptake of maternal health seeking behavior in Uganda (2001-2011); Factors associated with teenage pregnancy in Uganda; Predictors of postpartum Family Planning (PPFP) in Uganda; Risk factors associated with Obstetric fistula in Uganda; Association between Sexual Violence, Un-intended pregnancy and STIs in Uganda; Utilization of Reproductive Health Services by women with disability in Uganda. These reports provided an important input to the National Planning Authority during the Mid-term review of the National Development Plan.

Under the programme, a total of 158 technical staff at National and district level were trained in various aspects of data generation and analysis including on Integrated Information Management Systems (REDATAM+SP (REtrival of DAta for Small Areas by Microcomputers) package for data entry, analysis and dissemination, data analysis using the Harmonized District Local Government Data base, scanning technology for the upcoming census. This has created a pull of technical staff and will go a long way in improving data availability.

The valuation established that UNFPA played a vital role in advocating and supporting the preparatory activities for the National Population and Housing Census. The Uganda Bureau of Statistics singled out the UNFPA as the sole organization that consistently provided significant technical and financial support during the census preparatory phase. However, while preparations for the census including procurement of equipment were done, the census at the time of the evaluation had not yet been implemented due to lack of appropriate budget allocation on the Government side. UNFPA support to census then had development of the Census Master Plan, design of census data collection tools, census mapping, pilot census, procurement of census equipment to build capacity for use of scanning technology and technical support for census workflow. The evaluators noted that the delays of execution of census were precarious, as it might necessitate a repeat of process, and with cost implications. Positively, as at the time of the evaluation, the country resumed plans for the delivery of the census due in 2014. (Source: CPE7 data-Triangulation KIs, FGDs and Observation)

### **c) Capacity enhancement for Data use for integration of population dynamics in relevant national and sub-national plans and programmes**

The PD component had an inbuilt capacity building strategy and made a number of strides in promoting the integration of population issues in the national and sub-national development framework. These include

- ✓ Training 78 National and District planning staff on integration of population dynamics with focus on the production, utilization and dissemination of quality statistical data on population dynamics, youth, gender equality and sexual and reproductive health.
- ✓ Establishment of the National Taskforce for population integration
- ✓ Guidelines for integration of population dynamics into national and district level development planning
- ✓ Identification capacity building and engagement of 140 Champions [national and district level] to advocate for ICPD and MDGs
- ✓ Capacity building for generation of data/information for use in decision making including Gender statistics, districts profiles, IMIS, further analysis of 2011 UDHS
- ✓ Advocacy and policy dialogue for the incorporation of population dynamics issues in relevant national plans and programmes
- ✓ Young people (including adolescents) participation in policy dialogue and programming

### **d) The establishment of district harmonized databases**

One of the key achievements of the P&D component is the increased appreciation of the need for data use for decision making as well as increased availability of data at district level. In all 8 districts, statistical committees were functional and the database was set though at different levels of functionality. Only Kanungu, Yumbe, Katakwi and Kotido had database that were fully functional. The departmental databases like education, health, and Agriculture were also available in all districts but they are not updated regularly. In 5 of the 8 districts there was evidence of use of data for decision making. Five of the districts reported that the data were available all year round.

### e) Integration of population issues into district development plans and budgets

The National Population Secretariat had integration of population dynamics as a major intervention for all the CP years. Guidelines for integration of population issues in the district plans and budgets were developed. Working with the Ministry of Local Government, the indicators to assess the level of integration of population issues in the development plans were developed and incorporated into the District Assessment Manual as part of the district performance measures that determine access to district conditional grants. This is a key achievement in that even when the programme ends, the district local government will still be obliged to integrate population issues in the plans. The areas for assessment are:

The areas for assessment are:

i) Evidence that population focal person or district population officers has participated and facilitated medium term and annual planning process,

ii) The local government has taken deliberate steps to implement the national population policy and identified mechanisms of addressing national and local population issues,

iii) The local government has integrated the population action plan into the development plan and provides sound analysis of population issues;

iv) The sector plans consider population and development variables in assessing needs and coverage of their services;

v) Local government capacity building needs for population sustainable development mainstreaming have been identified and planned for;

vi) Skills enhancement training on population and development for district technical planning committee (DTPC) members was undertaken in the previous financial year

#### **Box 3: Approaches used that enabled success**

- ✓ The strategy of working with champions resulted into more focus on use of data on population issues during planning.
- ✓ Empowering Village Health team. VHTs are primary data collector on health of people especially children and women. Training these VHTs in record keeping improves quality of data and timeliness of reporting
- ✓ Setting up statistical committees enabled the periodic discussions and update of data at district level for use in planning.
- ✓ Teamwork with stakeholders in P&D. including Population secretariat, UBOS, District Planning Units enabled consistent technical support for data generation and integration of population dynamics

**Source: CPE7 data-Triangulation KIs, FGDs and Observation**

With support from the Country Programme, six (6) of the 8 districts had developed the district Population Action Plans that contain values for demographic, social and economic indicators to guide the integration of population issues. All districts have budget lines for population activities and the annual work plans have population issues too. However, the allocated funds for population is usually very small, except in Kanungu where a good practice on mainstreaming population budgets across all sectors is emerging resulting into good resource mobilization.

### f) Advocacy for population issues

Over the period under review, the program supported advocacy efforts that resulted in, among other things, the development of laws & policies, including the National Population Council Act passed in July 2013. This NPC Act creates a National Population Council as an autonomous body and further strengthens the positioning of population issues in national development processes and fund base. Through advocacy, the inclusion of population dynamics into climate change Policy was realized. Influential persons including the Uganda First Lady and the Nabagereka (Queen) of Buganda Kingdom were used as champions for population issues. The

program also supported the Parliamentary Forums to advocate on Population issues, inclusion of critical population issues into Local Government plans and there was direct support towards the implementation of National Population Policy Action Plan. Through the programme a number of advocacy materials were produced and available for use. These include the National Advocacy Strategy for Population issues in Uganda, the State of Uganda's Population (2010, 2011, 2012 and 2013), materials and briefs for population champions and the RAPID Model. As part of the 2010 Uganda MDG report, an Acceleration Framework for MDG 5 was developed as a special theme for the report as a result of the CP advocacy efforts.

In 2012, the champions in parliament mobilized for increased budgetary allocation for reproductive health resulting in allocation of Ushs. 49.5 billion to MoH for recruitment and remuneration of health workers for FY 2012/2013; advocated for allocation of funds for the Population and housing census which had been postponed twice due to lack of funds. The government allocated Uganda Shillings 50 billion in the 2013/14 budget and another Ushs 39 billion to be allocated in 2014/15 for the census.

UNFPA sustained advocacy with government for integration of Population Issues in the National Development Frameworks. One of the key national documents that take into consideration the population dynamics is the Uganda Vision 2040. The Vision recognizes the current population profile as one of the challenges to Uganda's Development; the importance of addressing the population challenges in order to harness the development opportunities to achieve faster socio-economic transformation and specifically more attention is given to the need to harness the demographic dividend. The vision recognizes population factors have to be taken into consideration as part of the development equation if social transformation is to be achieved. The Vision sets targets that take into consideration the population factors particularly seeking to reduce fertility from 6.2 to 4 and population growth rate from the current 3.2 to 2.4.

The CP also addressed the issue of youthful population in decision making. This was based on the fact that the majority Ugandan population (70%) is under 35 years, and that the majority of this population is independent or under employed. The CP supported the Ministry of Gender Labour and Social Development to establish a Youth Coordination Structure and Network for engaging young people in planning/policy dialogue and programme. The bill to enable the establishment of a National Youth Fund to promote youth entrepreneurship and job creation has been developed and awaits presentation to parliament. Related to this an Enterprise Model Programme is being piloted by UNFPA in Kampala and Mubende districts. The project "Youth Enterprise Model" aims at increasing access to SRH information and services to young people within an enterprise set up under the Government Youth Venture Capital and Catalytic Action Fund programme. To strengthen advocacy for youth issues, the CP supported the establishment of the Parliamentary Forum on Youth. By the time of the evaluation, the forum was instrumental in advocating to the passing of the National Youth Policy and Action Plan. In addition, UNFPA supported the Ministry of Health to establish a Multi-sectoral Adolescent Health Technical Working Group to coordinate provide guidance in the provision of adolescent health across the various sectors especially Health, Education, Social Development as well as the Civil Society Organizations

**Conclusion:** The P&D component interventions resulted in increasing data availability both at national and district levels. At National level the DHS and National Panel Survey reports were produced, in-depth analysis reports are also available to inform the ongoing review of the National Development Plan. At district level, district harmonized databases have been established to provide data for district planning. UNFPA Capacity development efforts saw a number of districts integrate of population dynamics into plans. However, the areas that still need attention include Advocacy to Government on resource allocation for the National Population and Housing Census, improving accessibility to IMIS, functionality of the district databases and strengthening the functionality of the youth coordination structure at Ministry of Gender, Labour and Social Development.

## 4.2.2 Reproductive Health

The RH Component of the Country Programme has four indicators. The analysis of the component effectiveness is therefore done output by output.

### **CP output 02: Health systems are improved to increase women's utilization of midwifery services in pregnancy care, childbirth and the management of related complications.**

**Evaluation Question:** To what extent has the CP achieved results related to improved health systems strengthening for increased women's utilization of midwifery services in pregnancy care, child birth and management of related complications? What were the facilitating factors for the realization of CPAP results? What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?

#### **a) Summary output focus, implementers and performance**

The first output under RH Component focused on improving the utilization of midwifery services in order create an enabling environment for addressing the poor Maternal Health Indicators at national level and in the focus districts. The output strategies included: strengthening midwifery education and training; midwifery practice and regulation through the midwifery association and councils; and the management of delivery and pregnancy complications including post abortion care and fistula. Key Implementing Partners were Ministry of Health with its partners; Ministry of Health and related departments including Nursing and Midwifery Council, National Referral Hospitals, Nursing Division, Uganda Nurses and Midwifery Union; Ministry of Education and Sports and District Local Governments.

The effectiveness of the output has been assessed based on the level of achievement of the targets set for the six output indicators, a summary of which is indicated in table 14 below.

**Table 14: Summary on Performance Midwifery Services' Output**

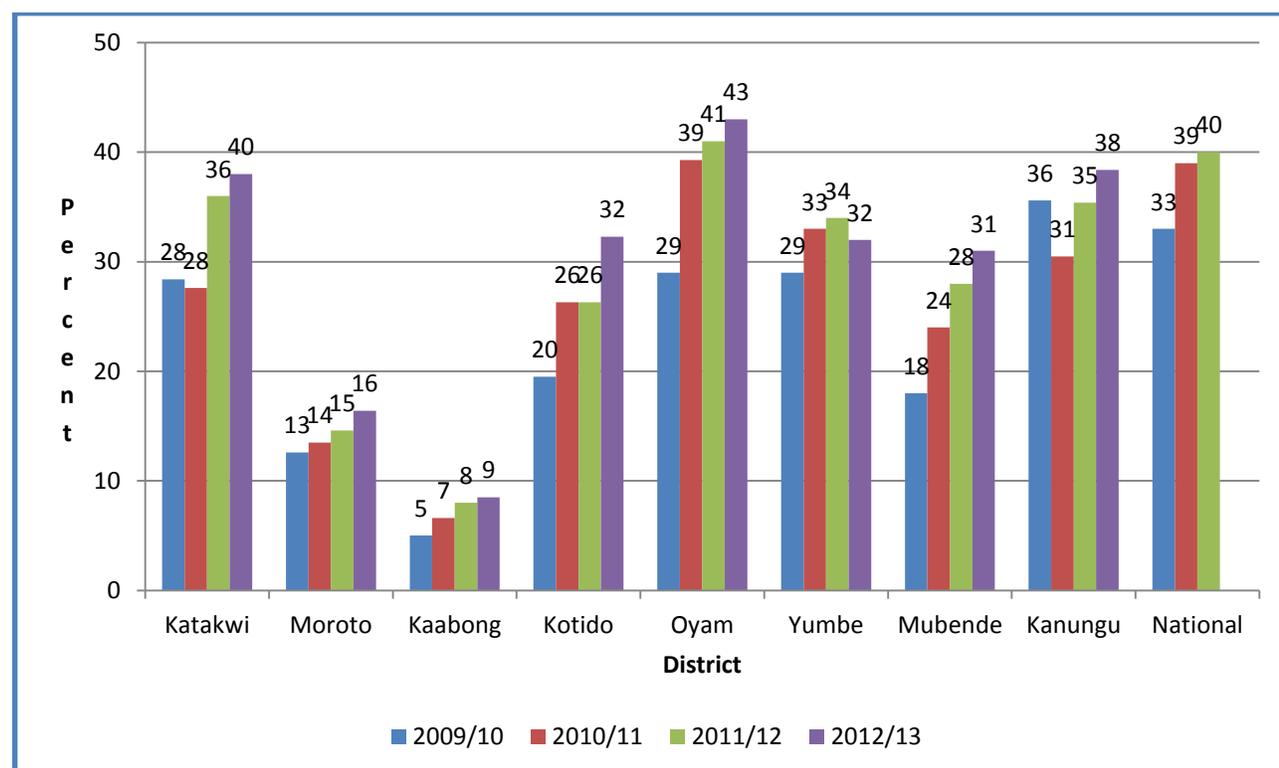
<b>Output Indicators</b>	<b>Baseline Value (2010)</b>	<b>Target (2014)</b>	<b>Performance at Evaluation July 2013 (All info is based on CPE7 data)</b>
% of Health Facility deliveries in target districts	21% (Average for 8 focus districts)	50%	35% <sup>3</sup> Average for 8 focus districts
Availability and use of revised national midwifery training curriculum	Not available	Available and used	Not available. The process for the curriculum review was initiated.
Existence of amended Nurses and Midwifery Act, Handbook and Midwifery Implementation Plan	None	Midwifery Act, Handbook, Implementation plan exist and in use	<ul style="list-style-type: none"> <li>Handbook and implementation plan are available and in use</li> <li>Work on amending the Midwifery Act was initiated.</li> </ul>
% of Health facilities (Hospitals, HC IVs and HC IIIs) in target districts with capacity for EmONC	43%	100%	65% of the facilities have full capacity and deliver EmONC. However, 100% targeted facilities were fully equipped with EmONC equipment
Number of Regional Referral Hospitals (RRH) offering Fistula repair services on routine basis	2	13	On track, 11 RRH offer routine fistula repair services. The remaining two will offer routine fistula repair services by end of 2014.
Number of women treated for Fistula with UNFPA Support	0	3,000	5,215. This is in the supported districts but the national figure is likely to be higher than this as Mulago hospital, with UNFPA support, established a fistula clinic that runs on daily basis.

<sup>3</sup>We note that data variation HMIS and CPE data

## b) Deliveries in Health Facilities

The country programme increased the percentage of facility based deliveries in each of 8 target districts as indicated in figure 7. On average for the 8 districts increased from 21% in 2009/10 to 35% in 2012/2013. This represents fast increment in deliveries in the 8 supported districts compared to national level progress that increased from 33% in 2010 to 40% in 2011/13 (MoH-5, 2013). These results were attributed to factors listed in Box 5. As evaluators, we note the data variation HMIS and CPE data and for the future, strengthening routine data collection and harmonization can help address this gap. High improvement in facility based delivery is noted for district of Oyam, Kotido, Katakwi and Mubende. The districts of Moroto, Kanunu and Kaabong showed less improvement while there was marginal improvement for Yumbe District.

**Figure 9: Trend of facility based deliveries**



Key milestones that may have resulted in the observed improved facility based deliveries include:

- **Improved focus on midwifery human resources in the target districts.**

Field data demonstrates that the number of midwives positions filled at district level averaged at 55% (ranging from 53% in Kaabong to 100% in Mubende). UNFPA supported pre-service training of bonded midwives. By July 2013, the number of midwife students bonded under UNFPA programme was 306, of whom 44 had completed and 84%(37/44) recruited by their respective districts. The re-introduction of vertical midwifery training programmes, advocated for by the Country Programme, was a robust strategy that will improve the quality of midwives compared to when midwifery was taught as part of the comprehensive nurse programme.

- **Improved Maternal and Perinatal Death Review.**

All districts reported conducting Maternal Peri-natal Death Reviews or Audits (MPDR), a significant improvement from zero at baseline. Establishment of and training and training of MPDR committees at District, Hospital and Health Centre IVs was singled out as having been very beneficial. The evaluation team observed

that district prepare and implement MPDR Action Plans to implement the Maternal Death causes identified during the MPD.

- **Improved HF capacity to provide EmOC.**

All Hospitals, HCIV and HC111s were equipped to offer EmONC. Important to note is that not all facilities that received EmONC equipment are able to provide the EmOC related services. Sixty five percent of the facilities visited during evaluation were able to offer EmONC services. 120 health workers from the 8 focused districts were trained on Emergency Obstetric Care service delivery including post-abortion care. Despite, training in EmOC under the CP, staff in facilities not offering EmONC said that they lacked skills e.g. did not know how to operate vacuum extractor.

- **Strengthened and multifaceted community mobilization for MH Services uptake.**

The country programme supported pregnancy mapping by the VHTs. Discussions with HF staff revealed that the pregnancy mapping facilitated targeted ANC outreaches and follow up by midwives as well as improving the participation of husbands in ensuring that the pregnant mothers deliver at HFs. The Healthy Choices Communication Project implemented by Communication for Development Foundation Uganda with UNFPA support was a major mobilization radio programme. For three years, communities in the target districts were mobilized through pre-recorded as well as live call-in programmes for uptake of MH services. Review of Annual Assessment reports for the radio programmes as well as focus group discussions at HFs indicated that radio programmes were a main source of information for the MH services clients. Rigorous mobilization was also done through the Faith Based Organizations through their routine programmes.

- **Improved referral through provision of ambulance services**

Through the Country Programme, districts were provided with ambulances for Health Facilities in the hard to reach areas. A total of 11 low cost and easy to maintain ambulances were provided to the districts. In order to ensure continued functionality of the ambulances, some districts established ambulance committees to manage the operations of the ambulances. Districts of Yumbe, Kotido, Kanungu and Katakwi had provided budgets from own resources to run the ambulance referral system.

### **c) Strengthening capacity for Midwifery Education and regulation**

The CP supported strategic interventions to strengthen midwifery education in Uganda. These included creating conducive environment for midwifery education, reviewing the midwifery education curriculum in line with international standards, strengthening midwifery regulation and improving the capacity of midwifery training institutions.

By the time of the evaluation, the Midwifery Handbook and Midwifery Implementation Plan were developed and in use. The handbook serve the purpose of quick reference, keeping midwives abreast with new developments, maintain standards and scope of midwifery practice and deliver evidence based care to the community.

The national midwifery training curriculum had not yet been revised, and the Nurses and Midwifery Act of 1996 was not amended as was the plan, to incorporate International Council of Midwifery (ICM) standards, task shifting and the current Ugandan context. However, there are noticeable milestones towards revision of the said instruments. The evaluation team established that, in Uganda, the revision of a curriculum as well as legislation usually takes a long time and thus could not be achieved in the period under review.

The evaluation found out that the CP improved the capacity of training schools to offer midwifery education. Eighteen (18) Midwifery Training Schools were equipped with skills laboratories and EmONC equipment for practicum sites to contribute towards improved quality of training. Twenty two (22) midwifery tutors also were sponsored for Bachelors of Medical Education. However, it is too early to assess the impact of equipping of training on improving skills acquired by trainees.

In an attempt to improve the registration and supervision of midwives in Uganda, the Country Programme supported the Nurses and Midwives Council to prepare a 5-Year Strategic Plan and review of Accreditation Standards for assessment and licensing of health training schools. UNFPA supported Midwifery Needs

Assessment and Evaluation of the Comprehensive Nurse Training programs which were used to advocate for reinstating vertical midwifery training into public health training colleges that had dropped the programme and were training only comprehensive nurses. This led to three (3) public Health Training Institutions reinstating vertical midwifery training.

In the same light, the council was supported to establish and equip 12 regional centres centers to ease the registration, licensing and supervision of Midwives and Nurses. Although this strategy is believed to improve midwife performance, by the time of the evaluation the centres were not yet functional.

#### **d) Strengthened Capacity for Fistula Repair**

The Country Programme improved the capacity of the Regional Referral Hospitals to offer routine Fistula Repair Services. This was by providing Fistula repair equipment and training fistula repair teams. As a result, the number of RRH offering fistula repair services on routine basis increased from 2 in 2010 to 11 by the time of the evaluation. By end of the programme, the remaining two hospitals will be equipped to provide routine services. Three surgeons have been trained in Ethiopia through South-South cooperation, in addition to other fistula teams (23Surgeon, 54nurses and 11anaesthetists) trained locally.Fistula repairs were also performed during the camps organized at the RRFs that also acted as training practicum for fistula surgeons. The CPE finding is that 5,215women had fistulae repaired under UNFPA support, a figure above the targeted 3,000.The country has a total of 200,000 women waiting for fistula repairs (MOH Fistula Assessment Report, 2009), making the achieved target to be like a ‘drop in the ocean’. However, the programme does not support interventions aiming at re-integration of women with repaired fistulas back into the community in terms of psychosocial and income support.

#### **Box 4: Factors enabling or hindering midwifery and obstetric care success**

##### **List of enabling factors**

- ✓ Availability of EmONC equipment supplied by UNFPA, for midwifery service and equipment for fistula repair
- ✓ Equipping and training of tutors for training schools has improved quality of knowledge and skills passed on midwives (KII, MoES)
- ✓ Support from health facility administration and teams for midwifery and fistula repair
- ✓ Multi faceted community mobilization strategies through: radio, TV, Newspaper, VHTs, cultural and FBO leadership
- ✓ Synergies from other partners not supported by UNFPA in fistula services like EngenderHealth, Terrowode, AMREF/White Ribbon Alliance, women at work international on community mobilization and fistula repair

##### **List of hindering factors**

- Understaffing, delayed recruitment, staff attrition including the trained fistula surgeons leaving for greener pastures, creating skills drain.
- Non-use of equipment due to lack of adequate space, and users’ lack skills to operate machines e.g. vacuum extractors
- The MPDRs do not include community maternal death autopsies yet many mothers are still delivering outside health facilities.
- Maintenance costs for the ambulance in terms of paying for driver and fuel is a challenge in many districts.
- Distribution of mama kits during 4<sup>th</sup>ANC visit is deterring mothers from delivering from health facilities in Karamoja region.
- The reintegration of women who have undergone fistula repair into community is not adequately done.
- The implementation plan for the National Fistula strategy was not yet developed.
- Procurement delays GoU procedures: it has taken over 12 months to recruit a consultant for midwifery curriculum review

**Source: CPE7 data-Triangulation KIs, FGDs and Observation**

#### ***Good Practice:Creation of Waiting Room for Pregnant Women in Remote Health Centres in Kanungu District***

*Kanungu health center is one of the level four (administrative level between district and sub county) health centers found in Kanungu district. Its catchment population is found in the hard to reach areas of the district with a poor road network. This has limited the accessibility of pregnant mothers to attend antenatal services and to deliver at health facilities. Deliveries attended by supervised health workers stood at 42% in 2010 and antenatal attendance of four visits at 27%.*

The level IV district health center has a Maternal and Perinatal Deaths Review (MPDR) committee that regularly reviews cases of maternal and perinatal deaths that occur in the community around the health center. Through the maternal death audit in 2010 the committee noticed a high maternal death rate among women from remote areas of Kanungu district.

**“My village is far away. The advantage of having a waiting room is that you don’t have to stay in the village where you suffer and meet problems”**

Pregnant woman in the IV health center of Kanungu

When the health professionals themselves went to those remote areas for house visits and outreach services they noticed how impenetrable and hard to reach that region is. When pregnant women would arrive at the health center in critical condition they would often be exhausted and some would even die. Health center staff also noticed that the dropout rates in terms of antenatal visits was high as well as mothers and children not finishing their immunizations. Next to the inaccessibility of the mountainous areas the lack of adequate information was identified as one of the reasons for the high maternal mortality rate.

Taking the above into account, the Kanungu health center IV developed a strategy to increase antenatal attendances and supervised deliveries by creating a waiting room for pregnant women from hard to reach areas inside the health center

#### **Objectives**

The overall objective of the Kanungu health center IV programme is to reduce maternal and peri-natal deaths occurring in the community and health facilities. More specific 1) to encourage all pregnant mothers to attend

antenatal visits four times and to deliver under the supervision of skilled health personnel, 2) to encourage mothers from hard to reach areas to come and wait in the health center waiting room and 3) to build capacity of all midwives so as to identify mothers at risk for timely referral.

#### **Strategy and Implementation**

The strategy adopted by Kanungu health center IV comprised of increasing antenatal attendances and supervised deliveries by creating a waiting room for women from hard to reach areas inside the health center to encourage expecting mothers to already be at the health center between the 8<sup>th</sup> and 9<sup>th</sup> month of their pregnancy. In addition health center staffs, in particular midwives, were trained to strengthen their knowledge and skills. The proposal was presented to the district health management committee and approved by the standing council. The health center created space for five beds in a separate room and identified professional health workers and supportive staff. The newly created waiting room for pregnant women from remote areas was promoted on the radio, through community dialogues, community health workers and community leaders.

#### **Key challenges**

One of the challenges faced by this program was the fact that some pregnant women would delay seeking medical attention and many women lacked the support of their husbands. Furthermore, according to the IV health center, traditional birth attendants in the remote areas tend to discourage mothers from attending antenatal visits at the health center and myths and misconceptions about health services and reproductive health are common in these areas. In addition women are faced with difficulties regarding transport to the health center. The procurement of an ambulance has helped to partially overcome this challenge. Because the health center four is the only one in the district with a waiting room the other health facilities refer pregnant women there. The popularity of the waiting room has increased the number of patients at the health center and staff members are now faced with an increased workload for the same number of staff. Finally there are only five beds available at the moment and there have been situations where there was no space for pregnant women who came to the health center. According to one of the nurses: “If you send women away there is a risk that they don’t come back for the delivery”.

#### **Progress and Results**

The result of the creation of the waiting room for pregnant women has been remarkable. The antenatal care attendance in the IV health center now stands at 87 % (compared to the 2010 district rate of 27%) and family planning utilization has increased from 37% in 2010 to 41% in 2011. Deliveries at the health center have increased from 17 to 35 per month (50%). In 2011 5% of the mothers were being escorted to the health facilities for antenatal care by their husbands compared to only 1% in 2010.

*Pregnant women staying at the waiting room expressed their appreciation for the created waiting room. One of the expecting mothers explained: “I decided to come to the waiting room to wait here for my delivery in order to have a quick service in case I go into labor, since there is no transport in my village. I feel comfortable here”. Another pregnant woman stated: “This is going to be my second child. I had the first one in the district hospital. I choose to have my second baby here in the health center, because it is closer and the service is better since there is a waiting room here and good antenatal care. Also the health workers here discuss issues with me if they find anything and the services are free”. The women heard about the waiting room on the radio, from community leaders and health workers who came to the communities for home visits and community dialogues.*

*Midwives and other health staff members increased their knowledge and skills through the training component of the programme. Health center staff noticed an increase in patients because of the creation of the waiting room as well as general improvements in other departments influenced by the success of the programme. Moreover the increase in men visiting their wives in the waiting room also contributed to an increase in the use of medical services by men, such as HIV testing and vasectomies during the time their wives stayed in the waiting room. The programme also resulted in community members actively seeking medical services and an improved referral system because of the procurement of the ambulance.*

### **Conclusion and Lessons Learned**

*The creation of the waiting room for pregnant women from remote and hard to reach areas has increased the number of deliveries at the health center and reduced the number of maternal and peri-natal deaths. According to the district health officer one of the factors that contributed to the success of the programme was the comprehensive community approach to reproductive health education down to the household level. The concept is simple and only requires for the health center to create space in a separate room and to ensure that the essentials, such as beds, mosquito nets, soap and support staff, are made available. In addition the health center explained the importance of having electricity “We are lucky that we have solar electricity; other health facilities in the area are not that lucky and are forced to treat their patients in the dark at night time”. Finally the involvement of district leadership and integration of the programme into the district development plan has been fundamental in the achieved results.*

In summary, most of the indicators under Output 2: Strengthening the health system to improve midwifery services have been achieved, or are on track except for revision of the midwifery training curriculum and the Nurses and Midwifery act of 1996. The strategies employed i.e. advocacy and capacity building and the respective activities were rightly employed to facilitate achievement of results. Technical support supervision and monitoring should be regular to ensure quality delivery of midwifery services.

**Output 03: Improved social and institutional structures for accelerated uptake of FP methods by women, men and young people**

**Evaluation Question for Output 03:** To what extent has the CP contributed to: improved social and institutional structures for accelerated uptake of FP methods by women, men and young people? What were the facilitating factors for the realization of CPAP results? What are some of the challenges/limiting factors that may have affected the achievement and implementation of the programme?

**a) Summary output focus, implementers and performance**

The second output under RH Component focused on improving the capacity of HFs to provide FP by ensuring availability of FP stocks, training the service providers in FP methods; creating demand for FP through community mobilization and provision of FP Services. Interventions were on Advocacy, Social Mobilization and commodities' supply and FP service provision.

The implementation of interventions under this output was undertaken by a number of Implementing Partners (IPs). These are Reproductive Health Uganda with its consortium members (Marie Stopes Uganda and Uganda Health Marketing Group), Communication for Development Foundation Uganda, District Local Governments, Faith Based Organizations (Catholic Secretariat, Church of Uganda, Muslim Supreme Council, Association of Born Again Churches, Orthodox Church and Seventh Day Adventist Church); Cultural Institutions (Acholi, Lango, Karamoja, Bunyoro) and Ministry of Health. The performance of the indicators under the output is summarized in the table below.

**Table 15: Summary of Performance Family Planning**

Family Planning Output Indicators	Baseline Value (2010)	Target (2014)	Performance at Evaluation July 2013
% health facilities in target districts without stock-outs of at least 3 FP methods	65%	100%	<ul style="list-style-type: none"> <li>72% of the facilities had no stock outs</li> <li>While district HMIS indicates zero stock outs, facility level analysis during the CPE showed 28% (6/23) had suffered stock outs</li> </ul>
Number of new clients utilizing family planning methods in targeted districts	26,800	100,000	<ul style="list-style-type: none"> <li>77,997 clients were served in by July 2013, On track to achieving target according to data collected from districts during evaluation.</li> <li>Cumulatively, 231,240 new FP clients were served from 2010 to July 2013</li> <li>The intensification of FP provision through camps greatly improved access to FP in the target districts.</li> </ul>
% of budget allocation for, and expenditure on contraceptives	4.2%	50%	
Proportion of Health Facilities in Target Districts with at least 2 staff that can offer both short term and long acting FP Methods	60%	90%	85%. The indicator target had reached 100% but due to recent recruitment, some staff moved out of the districts and the newly recruited have not been provided with appropriate training.

**b) Improving the availability of contraceptive commodities at the HFs**

The CP achieved both upstream and downstream results regarding availability of contraceptive stocks. At national level, the UNFPA procured contraceptives reduced national contraceptive stock outs to zero. Contraceptives worth USD 8 million annual (on average) were procured by UNFPA and put into the National Contraceptive supply chain. Stock out levels at the HFs reduced with 72% of HFs reporting no stock outs in 2013 compared to 65% in 2010. Establishment of medicine and therapeutic committees at district and Health Sub District levels helped to improve contraceptive logistics management. UNFPA supported government to prepared and implement a Reverse Logistics Strategy that facilitated redistribution FP commodities within and between districts that minimized stock outs and drugs expiring on shelves.

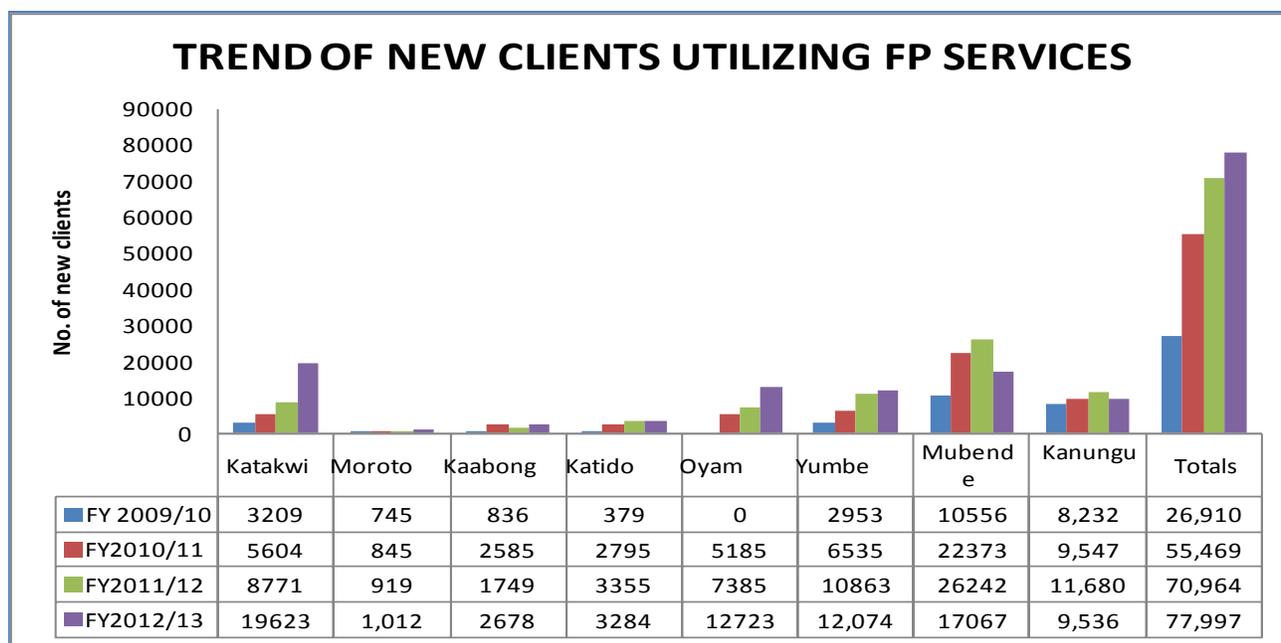
**c) Family Planning Service Provision**

The CO supported the partners to provide FP services through FP outreaches, conducting outreach camps in the hard to reach areas and at static clinics at Health Facilities. This combination of approaches resulted in increased FP service provision as shown by the number of new FP clients served over the completed CP period. As demonstrated in Figure 8 below, the new clients utilizing FP services increased from 26,910 in 2009/2010 to 77,997 close to the targeted 100,000 in 2014. Cumulatively, 231,340 new FP clients had been served with FP Services by the time of the evaluation. Notable increase in the New Clients is observed in the districts of Katakwi, Oyam, Yumbe and Mubende. However, it is important to note that the number of new users is still modest in Karamoja region (Kaabong, Kotido and Moroto districts).

All (100%) Health Units offer three or more modern contraceptive methods and family planning counseling. Use of FP camp modality for provision of FP services has been found to be a good strategy for reaching out to many FP clients. There was evidence that integrated service provision was undertaken. For example in 2012 clients served with other services included 19,663 for STI treatment, 66,494 for VCT, and 53,620 for Cancer of the Cervix is a confirmation of integration of services.

To improve and standardize the quality of service provision, UNFPA supported MoH and Reproductive Health Uganda to develop guidelines for government facilities and NGOs to conduct family planning outreaches. The guidelines are now being used and have enabled partners to collect data during camps and feed this into the HMIS.

**Figure 10: Trends of new clients using modern Family Planning methods**



#### d) Support to advocacy for increased government resource allocation to FP

UNFPA invested in advocacy efforts towards ensuring increased government allocation and expenditure on FP. Through these advocacy and policy dialogue efforts, government funding for procurement and implementation of modern FP interventions increased. In 2012, the government committed to increase FP funding from 3 million USD to 5 million USD annually over the next 5 years. UNFPA supported advocacy efforts by the Partners in Population and Development-Africa Regional Office (PPD ARO) and Uganda Family Planning consortium and the Reproductive Health division of Ministry of Health to increase budget allocation for procurement of contraceptives. According to the budget framework paper 2013/14, government allocation for contraceptive procurement increased to USD 6.9 M in 2013/14.

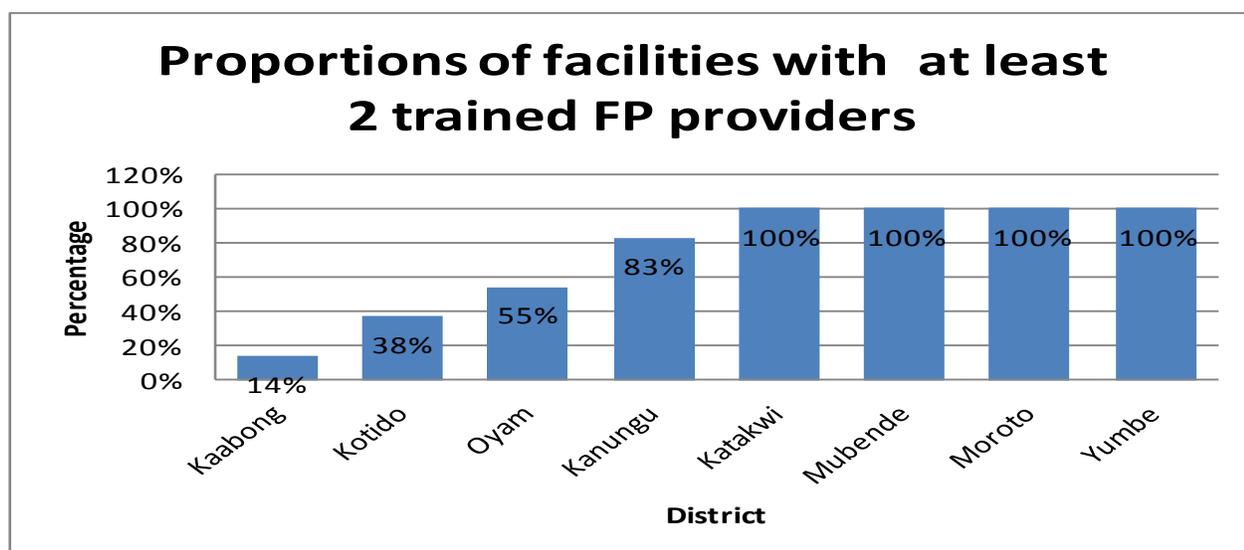
As a tool of improving tracking expenditure on RH commodities, UNFPA is appreciated for supporting compilation of the National Health Accounts (NHA) which includes a separate RH sub account. At national level the CP supported the development of policies, regulations, norms and guidelines that promote FP and availability of reproductive health commodities especially the Reproductive Health Commodity Strategy and Contraceptive Procurement Plan including forecasts all of which have continued to guide the country in addressing the RHCS needs. The advocacy efforts also saw the revitalization of the FP Technical Working Group in Ministry of Health than discussed and proposed policy direction regarding family planning.

In order to improve access to RH/contraceptive commodities by non-state actors, the CP supported the development and implementation of the Alternative Distribution Strategy. Under this mechanism, the Government procured RH/contraceptive commodities are given to Uganda Health Marketing Group from where the NGOs and other non-government actors in the field of FP can access the commodities. This has increased access to FP services under the NGO programmes.

#### e) Support for capacity building of Service Providers of FP Methods

The CP provided training of HF staff in provision of FP methods. As a result of the training, the proportion of health facilities with at least two staff that can offer two FP methods (short term and long acting method) has increased from an average of 60% to 85% in 2013. The indicator had reached 100% but due to recent recruitment, some staff moved out of the districts and the newly recruited have not been provided with appropriate training. Like many other indicators, Karamoja region (especially Kaabong and Kotido) have very few facilities that have adequate staffing to provide a range of FP methods. Review of partner reports reveal that a total of 213 Health Workers had had in service training in provision of FP Services under the Country Programme.

Figure 11: Proportion of facilities with at least 2 trained FP staff



### e) Strengthened community mobilization for FP uptake

The UNFPA Country Programme was very active in mobilizing communities through undertaking interventions that increased demand generation for FP services. Communities were mobilized through supporting the radio programs under the Healthy Choices Project. Six radio stations were identified and their capacity built to produce and broadcast MH/FP programmes. Communities were supported to form village listener's groups about the radio programme using the low cost solar radios provided under the programme. The discussions by the listeners' groups were facilitated by a Village Health Team member who provided more information on FP and encouraged community members to seek for services at the HFs. This radio programme played a key role in mobilizing communities for services by providing information FP service availability, countering wrong information regarding FP side effects etc.

The strategy of door-to-door mobilization of communities for FP service utilization by Village Health Team (VHT) was also effective providing information to eligible household members regarding FP services either at FP outreach camps or at FP clinics at the health facilities. In addition, the VHTs provided off-the counter contraceptives commodities to the community. All (1005) of the Health Facilities in the target districts has a functional VHT structure for community mobilization. The CP also supported FBOs to conduct community dialogues on FP at church/mosque, supported development of IEC/BCC and advocacy materials for FP, dissemination of appropriate messages for FP by the community level health workers, advocacy on FP at the community levels to involve the formal and informal leaders, sensitization and awareness creation through community radio, television, drama and satisfied users. Sensitization activities were conducted targeting special groups including male motivation & youth involvement in FP promotions. Promotion of condom use for both FP and HIV prevention and social marketing of modern contraceptives were conducted.

#### **Box 5: Enabling and hindering factors for FP Program**

##### **List of enabling Factors**

- ✓ Revitalization of FP TWG at MoH for stewardship and coordination of family planning activities
- ✓ Improving the RHCS logistics management system
- ✓ Training of health providers including VHTs to offer FP services
- ✓ Increased access to FP services through alternative distribution strategy for RH commodities to private providers as well as using different modes of SDPs including outreaches, camps and static units
- ✓ Massive mobilization through VHTs, champions and radio messages

##### **List of hindering Factors**

- Program is focusing on increasing number of new clients but less on quality assurance yet there are many providers ranging from Public health facilities, NGOs such as Marie Stopes and RHU to VHTs
- Inadequate capacity at facilities to offer permanent methods. Providers lack both skills and equipment for vasectomy and Tubal ligations
- VHTs voiced lack of adequate knowledge on how to handle FP side effects
- Failure to contextualize FP program to Karamoja context where there is chronic food insecurity and development programs being tagged to food incentives

Source: CPE7 data- triangulation FGDs, KIs and Document review

In summary, CP7 catalyzed concerted efforts in mobilizing institutional and social structures to facilitate increased uptake of family planning. Both health workers and community volunteers were trained to strengthen capacity to offer and increase access to utilization of FP services. The multi-faceted mobilization strategy was effective in reaching communities with FP services thus increasing more than three times the annual number of new FP clients between 2010 and 2013. In addition, integration of FP and HIV service delivery was a very useful strategy in increasing uptake. However, as the uptake of FP services increases, there is need to ensure the quality of services as a human rights principle.

**Output 04: Capacity strengthened for integration of HIV/AIDS and SRH and HIV prevention for MARPs at National and selected district levels.**

**Evaluation Question output 04:** To what extent has the CP contributed to capacity strengthening for integration of HIV/AIDS, SRH and HIV prevention for MARPs in Uganda? What were the facilitating factors for the realization of CPAP results? What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?

**a) Summary output focus, implementers and performance**

Based on the UN Division of Labor, UNFPA is the lead agency for HIV prevention. Under HIV/AIDS, UNFPA support focused on capacity strengthening for integration of HIV prevention and SRH and HIV prevention for MARPs at national and selected districts. The main partners involved in implementing the activities for this output were Ministry of Health (AIDS Control Programme), the Uganda AIDS Commission, Ministry of Gender Labor and Social Development, Uganda Police Force, Ministry of Defense (Uganda Peoples Defense Forces), AIDS Information Centre, UHMG and Uganda Catholic Secretariat. The performance of the indicators under the output is summarized in the table below.

**Table 16: Summary of output performance**

Output Indicators	Baseline Value (2010)	Target (2014)	Performance at Evaluation July 2013
Existence of a National HIV prevention policy includes rights for populations most at risk	Was not available	Yes	The policy is available and integrates MARPS rights of access to service and provides the strategy to lower prevalence among MARPS
Existence of HIV/AIDS and SRH integration strategy	Was not available	Exists and used	The strategy is in place and in use at National level. It was also used to guide development of SRH/HIV integration plans at district level.
% of Health Units providing integrated RH and HIV/AIDS services in target districts	0 (None was known to offer integrated services)	80% (HC IIIs, HC IVs and Hospitals)	100% HC IIIs, HC IVs and Hospitals visited offer integrated RH, HIV & AIDS service, though not necessarily trained for integration. Shortage of personnel mean multi-tasking at facility level, and HMIS registers already integrate FP & HIV/AIDS. Guidelines.
Number of Youth Clubs in target districts engaged in addressing SRH/HIV needs of Young People	0 (none were officially known)	180 (18 per district)	50 Youth Clubs serving 18 Youth Corners. This is below the set target, more attention to this indicator is needed if target is to be attained by 2014.
Existence of Comprehensive Condom Programming Framework	None (none documented)	Exists and operational	Condom Programming Framework has been developed and will be disseminated by the end of 2013.

## **b) Support to HIV policy framework including integration of HIV and SRH (including STI prevention) services**

Table 16 above demonstrates success in attaining the planned results. UNFPA advocated for and supported the development of the National HIV Prevention Strategy and revision of the National HIV Strategic Plan 2012 - 2015, to include focus on young people and SRH/HIV integration. Advocacy efforts secured the development of the National RH/HIV linkages and Integration Strategy by MoH; as well as development of the National Condom Strategy and finalization of the Operational Plan for Sex Workers. UNFPA supported legal audits on SRH/HIV, sex work and other sexual minorities.

UNFPA supported a systematic review of SRH and HIV training, service delivery and data collection tools the outcomes of which informed review of the training modules for integrated management of pregnancy and related conditions and adult illnesses (IMPAC/IMAI). The CP contributed to efforts that resulted in the country Adoption of option B+ as a policy for delivery of elimination of mother to child transmission of HIV. Policy guidance reflected in the EMTCT Action Plan provides strong emphasis on primary prevention of HIV in women of reproductive age group and prevention of un-intended pregnancies among HIV infected women. Intensified leadership mobilization efforts for EMTCT resulted in the First Lady of the Republic of Uganda accepting to serve as national champion for EMTCT and safe motherhood and resources for rolling out option B+ to all districts by end of 2013 have been mobilized including \$25m from the American Government. At total of 300 health sector leaders in 5 target districts were trained Ministry of Health adapted model on leadership management and stewardship with a focus on SRH/HIV integration and combination prevention.

Other programme achievements regarding HIV/AIDS integration realized under the CP include:

- Establishment of functional SRH/HIV programme in 17 cultural institutions in the country where socio-cultural factors that impact on HIV, maternal health and GBV have been documented; cultural leaders trained in community dialogue skills and supported to conduct community dialogue sessions; and support provided to implement generated action plans targeting positive social and individual behaviour change.
- Establishment of functional SRH/HIV programmes in 5 major faiths of Roman Catholic Church, Church of Uganda, Moslem, Seventh Day Adventist, and Orthodox where leadership manuals on HIV/SRH/GBV have been developed and training of religious and lay leaders from community to national levels done; communication materials developed; community dialogues sessions linked to service delivery outreaches conducted, and community mobilization expanded.
- Development of human resource capacity for SRH/HIV integrated service delivery including training of 150 health workers from 4 target districts trained on provision of integrated services including to the MARPs.

## **c) Support for increased access to HIV and STI prevention services for MARPs**

UNFPA supported the National STD Clinic under the Ministry of Health as the major entry point for supporting SRH/HIV information and services access for the key population groups from a public health perspective. Cumulatively about 10,000 sex workers and over 30,000 clients were reached with SRH/HIV services in the five thematic districts and 800 members of LGBTI communities supported with regular ARH/HIV services at static public health facilities. Over 500 peer educators for the SW are supported in the 5 target districts to support condom distribution and organize community dialogue sessions linked to service delivery outreaches. Through the CP, there is now an expanded focus on SW as a driving force of the HIV epidemic in the country with many programmes running in the various parts of the country but largely fragmented with poor central coordination that impact on national reporting. The development of the national Action Plan on SRH/HIV in sex work

settings, the service delivery tools and the planned development of a common framework for working with all key population groups is anticipated to address this challenge. The UNFPA developed a model approach of working with district or municipality administration to create convergence of partners and working with the community groups to define the problem, develop targets and agree on implementation frameworks to address fragmentation constraints

#### **d) Implementation of the strategic approach to comprehensive condom programming**

UNFPA supported the MOH and Uganda AIDS commission to develop and implement the 10 step Comprehensive Condom Framework resulting into the development of the National Comprehensive Condom Strategy by MOH, revitalization of the Nation Condom Coordination Committee to address bottlenecks in condom supply, development of the 5-year operation plan for the female condom, strengthening the quantification of male and female condom needs for HIV prevention as part of was developing Contraceptive Procurement Tables. In 2012 alone, a total of 45m male and 2.5m female condoms were procured for the public sector. In 2013, out of a total of 183.991.800 male condoms and 5.400.000 female condoms procured in the country, UNFPA contributed 129.592.800 (70%) male condoms and 100% female condoms (Source: AccessRH). The position of district condom coordinator was revitalized and coordinators oriented on condom programming; about 300 have been trained on FC2 service delivery and demonstration aides and IEC materials were developed and procured. UNFPA successfully advocated for the condom as a pillar for combination prevention and dual protection highlighting focus on removing barriers to access as a major national undertaking for 2012/2013. With UNFPA support, MOH had started on the processes for branding public sector male condoms and for social marketing but were not finalization by the time of the evaluation.

With the CP support, the female condom (FC2) that had failed before has been reintroduced after a situation analysis that was supported by UNFPA. Lessons from the analysis implied a need to put more emphasis on training of service providers and education of users before distribution of FC2. This principle of training of H/W before distribution of female condoms has been followed by most partners involved in distribution of FC2 except at public health facility level. Thus it was no surprise that the CPE found low absorption capacity of female condoms at public health facilities. The condom situation analysis and mapping (MoH, 2011-3) was done in the UNFPA supported districts. From the mapping innovative outlets were identified such as peer led initiatives like Bodaboda, self-dispensing options, market vendors association, taxi operators, youth groups, video & disco halls, the uniformed personnel, slum based drinking joints, mobile /transient population meeting points and village health teams (VHTs). These have been effective alternative distribution channels to increase access to condoms especially to youth and MARPS.

By the time of the Evaluation, a UNFPA-supported national multimedia campaign promoting male and female condom ongoing. Discussions with stakeholders established that the campaign was well received among development partners, including USAID which expressed interest in joining the campaign.

The enabling and constraining factors under the HIV prevention output are indicated in Box 8 below.

#### **Box 6: Factors enabling or hindering the HIV Prevention Program**

##### **List of enabling factors**

- ✓ Supportive policy environment created
- ✓ Training of health workers on how to deliver services to MARPS in a non-judgmental way and training of National Trainers also for FC2 Service providers.
- ✓ Alternative distribution mechanism that increased access to condoms
- ✓ Synergies from cultural and FBO institutions in mobilizing communities to access health services
- ✓ The Advocacy team through mobilization of Parliamentarians to support condom use (male & female) and awareness creation by implementing partners on FC2 has led to increased demand.

##### **List of hindering factors**

- ✓ The MoH is understaffed and there have been staff transfers, loss of institutional memory and low stewardship at national level, and there is a lack of integration of RH and HIV/AIDS programs at MoH level
- ✓ MARPI clinic, the only public facility supported by UNFPA to offer services to MARPS is understaffed with only 2 counselors, one doctor and one nurse
- ✓ Inadequate staffing at HF constrains delivery of integrated SRH and HIV/AIDS services
- ✓ Inadequate commodities condoms, pregnancy testing kits and HIV testing kits especially during outreaches. Stock outs of condoms were registered in 2012 due to delays in paying post-shipment testing costs, a GoU role.
- ✓ MARPs face higher levels of community discrimination and stigma,
- ✓ Ugandan legislation out-laws CSW and LGBTI and this constrains access and delivery of services.
- ✓ Widespread homophobia from cultural and religious communities, duty bearers including untrained health workers...*“There is a high demand for health care by MARPs but the health system is not adequately strengthened to handle them. There are few clinics exclusive for MARPs. Integrating MARPs into general health facilities is still a challenge”*

**Source: CPE7 data-Triangulation of KIs, FGDs and Document Reviews**

In summary, the output mainly targeted upstream aimed at creating a conducive policy environment for HIV preventions for MARPs and this has been achieved. Under the output, a number of initiatives were designed for scale up. These include review of the training modules for integrated management of pregnancy and related conditions and adult illnesses (IMPAC/IMAI), adoption of option B+ as a policy for delivery of elimination of mother to child transmission of HIV, establishment of functional SRH/HIV programme in Cultural Institutions and FBOs, model approach of working with district or municipality administration to create convergence of partners, reintroduction of female condom and developing a national condom brand. Nonetheless, it has been difficult to deliver results at grassroots within the anticipated timeframes especially with government policy, strategy starting to take effect. Three years was a short time to support policy translation to action or fully strengthened systems. CPAP 8 should focus on advocating for implementation of the developed policies as well as operationalizing the Comprehensive Condom Programming Framework.

**Output 06: improvement of health lifestyle choices for young people related to sexual and reproductive health in Uganda**

**Evaluation Question output 06:** To what extent has the CP contributed to improvement of health lifestyle choices for young people related to sexual and reproductive health in Uganda. What were the facilitating factors for the realization of CPAP results? What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?

**a) Summary output focus, implementers and performance**

Under this output the focus was to increase healthy lifestyle choices related to sexual and reproductive health for young people. The main areas of investment were:

- i. Comprehensive, age appropriate and culturally sensitive sexuality education
- ii. Youth friendly services provision; and
- iii. Youth participation, networking and policy making.

Partners for Output 6 were the Uganda Red Cross in partnership with the Naguru Teenage Information and Health Centre and RHU; Ministry of Education and Sports /National Curriculum Development Centre; Ministry of Gender, Labor and Social Development (Youth Department), Ministry of Health. POPSEC through FBOs, Uganda Muslim Supreme Council, Seventh day Adventist, 8 districts, Uganda catholic Secretariat, Church of Uganda and Straight Talk Foundation. Table 17 presents the summary of performance under ASRH output.

**Table 17: Summary of performance –ASRH Output**

<b>Output Indicators</b>	<b>Baseline Value (2010)</b>	<b>Target (2014)</b>	<b>Performance at Evaluation July 2013 (All info is based on CPE7 data)</b>
Availability of curriculum review materials and Teacher Resource Packs for Secondary School Curriculum	Not available for latest review	Materials available and used	Achieved, Materials were developed, copies available and in use in secondary schools
Number of Youth Specific policies, guidelines and standards developed	None existed at baseline	5 including -National Youth Policy and Action Plan, - National Youth Coordination Framework, -School Health Policy and Action Plan, - Adolescent Health Policy and Standards of Care, & Guidelines for management of Sexual Reproductive Health issues in School setting	<ul style="list-style-type: none"> <li>• The Adolescent Health Policy and Standards of Care in place,</li> <li>• The School Health Policy and the National Youth Policy are still in draft forms</li> </ul>
Proportion of HCIVs and Hospitals in target districts that provide routine Youth Friendly Services	0 (None provided routine services)	100% Hospitals  100% HC IVs 50% HC IIIs	<ul style="list-style-type: none"> <li>• 44% Hospitals (4/9),</li> <li>• 63% (5/8) HC IV ,</li> <li>• 12%(7/60) HC III, providing Routine YFS</li> </ul>

**b) Support to development of policy and programme frameworks for promotion of adolescent Sexual Reproductive Health**

The CP evaluation established evidence of national capacity development for the incorporation of comprehensive age-appropriate sexuality education in policies and curricula. With UNFPA technical and financial support to the National Curriculum Development Centre (NCDC) of Ministry of Education and Sports, the curriculum review materials and Teacher Resource Packs for Secondary School Curriculum was reviewed, updated and were in use. These materials provide for integration of Sexuality Education in some Secondary School teaching subjects like Biology, English, and Religious Education). A team of 21 experts from the NCDC and 51 teachers were trained in integrating Comprehensive Sexuality Education in the Secondary School Curriculum.

Under support to policy formulation, the Adolescent Health Policy and Standards of Care were developed and put to use as the guide for the provision of Adolescent Sexual Reproductive Health Services. Three policies and guidelines are in final draft forms awaiting approval from Parliament including:

- I. National Youth Policy and Action Plan, the National Youth Policy had been approved by cabinet.
- II. National Youth Coordination Framework and School Health Policy and Action Plan;
- III. Guidelines for management of Sexual Reproductive Health issues in School setting.

Responses from key stakeholders from Government indicate that the non-finalization of these policies/guidelines can be attributed to the long policy making process in the country which on average takes five years.

### **c) Support for the provision of essential sexual and reproductive health services and information to young people**

There was evidence that CP7 built capacity of national implementing partners to provide Youth Friendly Services, using the ‘Three-point Access Model’. Under the model, YFS are provided at Health Facility, in selected Secondary Schools and under Youth Groups in the Community. Each Youth Corner at a Health Facility is served by a network of community Youth Groups. The evaluation established that this model provides opportunity for reaching both in school and out of school youth and enables youth mobilization for ASRH services Under the CP, a total of 36 Youth Friendly Corners were established at health facilities and in the schools implementing the school health/nurse programme. Out of these 36 youth friendly corners (14 are at health facilities and 22 are in schools), thirteen (13) were established through Faith Based Organizations including the Catholic, Anglican, Orthodox and Muslim. Through the Youth Corners approach, the number of young people reached increased from 45,000 in 2011 to 75,500 in 2012. Figure 10 shows the number of health facilities with functional YFC.

**Table 18: Proportion HF with functional Youth Corners in 8 districts**

<b>Facilities</b>	<b>HC111</b>	<b>HC1V</b>	<b>Hospital</b>	<b>Total</b>
Existing facilities	60	8	9	77
Facilities with YFS	7	5	4	16
Proportion of HFs with functional Youth Conner (%)	12	63	44	21

The evaluation established that the proportion of targeted Hospitals HCIVs and HC IIIs in target districts that provide routine Youth Friendly Services has increased from 0 to 44% (5/8) hospital , 63% (5/8) HCIVs. Although HC IIIs were not initially targeted under the programme, monitoring visits revealed that targeting them will be more productive if the programme is to reach the rural underserved youth, this culminated in support to the 12% (7/60) HCIIIs that offer YFS. Evaluators note that the YFCs under the FBO Health Facilities

partially conform to the MoH YFS standards and guidelines due to rigidity of the different faith regarding provision of FP methods and distribution of condoms. Nonetheless, the contribution of FBO interventions to ASRH remains commendable.

“Citations from schools” on reduction of teenage pregnancy were reported in schools as a result of the programme for example at Ngai Secondary school in Oyam District the numbers of pregnancies reported reduced from 5 in 2009, 3 in 2010, 2 in 2012 and 0 in 2012 (KII, Patron, Ngai S,S).

At Mubende Light Secondary School, under the SDA church, teenage pregnancies were reported to have dropped from 16 per term to 4 per term in the first year of project implementation (KI, Coordinator SDA FBO), a 75% decline. Similarly, trends in reduction in teenage pregnancies were reported in Kotido Secondary School. The School Administration staff interviewed indicated that the programme improved communication between the students and teachers and this has improved on students’ discipline and reduced the occurrence of strikes (manifestations) in schools. Evaluators note that it was not within the mandate of the evaluation to establish the association between the programme inputs and reduced school strikes. Box 9 presents enabling and hindering factors for ASRH component success.

Unintended findings related to ASRH were that the programme, under the youth output, targeted marginalized girls. The distribution of 4,800 girl kits in 24 schools to vulnerable girls was reported to have boosted the confidence of the girls and reduced absenteeism from class. The “Girl kits” was a package that contained two (2) sanitary packs (2 pieces re-usable or 8 pieces single use), two (2) panties and one (1) piece of cleaning soap; this is noted as a good practice that needs be replicated, more so in poor underserved communities.

Additionally as evaluators, our impression was that while the RH component through Outputs 2, 3, 4 and 6 delivered positively on interventions related to RH, the program impact on MDGs, could have more long-term effects if strengthening health systems for RH, and related interventions, had a holistic approach that integrated improved maternal nutrition as a part of outputs contributing to the RH component. Integration of Nutrition with Safe Motherhood RH services could be a game changer that contributes to reduced maternal neonatal mortality.

Summary for output 6: Strategically, UNFPA has maintained its strong presence in all policy and key decision related functions of the Education sector/ National Curriculum Development Centre (NCDC) that culminated into a decision to include sexuality education as a single non elective unit to be taught in lower secondary classes against the original plan to spread it into various units as a topic. In terms of ASRH Service provision, the Youth Corner model provides potential for improved mobilization of young people for SRH service uptake. For this model to be sustainable and scaled up, it should be fully integrated into the mainstream service delivery in the districts and health facility. UNFPA has demonstrated many good practices that need scale up. The Evaluation notes that the formulation of the key policies like the National Youth Policy and the School Health Policy remain an unfinished agenda for the Country Programme.

### 4.2.3 Gender Equality and Reproductive Rights

#### CP Output 05: Public and civil society sectors' capacity for Gender-Based Violence prevention and management and advancement of Reproductive Rights is strengthened

**Evaluation Question:** To what extent were the expected outputs related to Gender and reproductive rights of the CPAP achieved To what extent have the interventions in gender contributed to (i) raising awareness on gender based violence and (ii) positioning this theme on the national and district agenda? To what extent did the outputs contribute to the UNDAF outcomes? What were the facilitating factors for the realization of CPAP results? What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?

#### a) Summary output focus, implementers and performance

Delivery of the Gender Equality and Reproductive Rights related output was through core UNFPA funding, and

#### Box 7: Factors enabling or hindering ASRH program

##### List of enabling factors

- ✓ Equipping of 36 youth friendly corners at Health facilities and schools with training, games, IEC materials, furniture
- ✓ Existence of already formed youth clubs attached to youth friendly corners to offer an opportunity for youth to learn different entrepreneurship skills
- ✓ All schools visited, the parent teachers associations and boards had passed resolutions to support establishment of YF centers
- ✓ Proximity of health facilities to youth corners facilitated the referral system

##### List of hindering factors

- Low capacity at national level to respond to vulnerable youth especially girls although at the community the program responded to needs of these girls by distributing girl kits
- HMIS does not capture ASRH data but resource center is updating the database to include data for adolescents
- Low involvement of neither duty bearers (DLG) nor society gate keepers (the adults and elders), URCS is the main driver in management of the youth friendly centers with minimal district leadership. This affects ownership of the YC.
- Youth (10-15yrs) in primary schools were not reached by the program.
- High turnover and transfer of trained staff to areas where there are no facilities for YFS
- YFS in FBO institutions do not provide a full range of services
- Infrastructure issues some corners do not offer both visual and audio, where these are available, in some instances there was no access to electricity to operate them. The needed privacy for youths was not guaranteed fully as YFS were located within adult out-patient units
- Lack of access to affordable medicines, means poor youth with ailments suffer more
- Inadequate outreaches for YFS.

*So: CPE7 data triangulation*

also through the UN Joint Programs (JP) on GBV, FGM and Gender Equality, a demonstration of the program success in delivering as one, mobilizing partnership and financial support from French Embassy (FGM), UK-Aid (Gender Equality) and Norway (GBV) for GBV prevention & response and the advancement of Reproductive Rights in Uganda. The output results were delivered in partnership with a number of organizations including Ministry of Gender Labour and Social Development, Uganda Women's Network, District Local Governments, Uganda Bureau of Statistics, FBOs (Catholic Secretariat, Church of Uganda, Muslim Supreme Council, SDA, Orthodox), American Refugee Committee, ASB, IRC, RLP, COOPI, WCC, WC UK, and CARE.

**Table19: Summary of performance GBV and Reproductive Right Output**

Indicators assessed as per evaluation matrix	Baseline Value (2010)	2014 Target	Performance at Evaluation July 2013 (All info is based on CPE7 data)
1. Number of targeted districts' plans and budgets that incorporate Gender-Based Violence prevention/ response and reproductive rights interventions.	0 (none was known at baseline)	8 (100%)	100%, On track, though necessitates more local budget allocation
2. Number of Gender-Based Violence survivors utilizing response services in targeted districts	2,650	4,521	<ul style="list-style-type: none"> <li>• 19,051 for 2013</li> <li>• 43,500 cumulative</li> <li>• . The implementation of the JP on GBV resulted in an increased number of GBV Service utilisation.</li> </ul>
3. Number of sectors implementing the international instruments and national legislation for GBV prevention and management (SD, JLOS, Education, Health & Security/UPDF)	1	5	All the 5 sectors have been reached, work is at initial phase with training, gender audits done&designingsectoral gender policies
4. Number of target districts that have a functional system in place to regularly record GBV incidence at overall district level	0 (None had system for regular recording)	3 of 8	Only 3 districts (Kanungu, Oyam, Katakwi) had systems in place. Generally, there was no harmonized GBV IMIS centrally, some districts were equipped and not trained
5. Number of selected GBV related policies/legislation passed into law by Parliament (DV, FGM/C, MDB, Sexual Offences, Khaddi's Bill)	1 of 5	5 of 5	3/5 (DVAct, FGM/C Act, Trafficking in Persons Act)
6. Number of persons trained in GBV Programming in Humanitarian and Post-conflict situations	0 (None for humanitarian & post conflict situation)	300	150 technical staff from (MoH, MoES, MoJCA, MGLSD, Police and UPDF).
7. Number of communities that declare the abandonment of FGM/C	0 (applies where FGM is practiced. None had publicly declared)	50	51 communities are documented to have abandoned FGM/C

Table 18 demonstrates that the CO successfully attained the set results for output 5. All the indicators were on target, or even over, other than targets that had been set around the establishment of functional GBV data

management systems and training in GBV programming in humanitarian and post conflict situations. Nonetheless, it was noted that the AWP for 2013 and the focus areas for 2014 have included trainings on GBV in humanitarian settings, as well as training in the clinical management of rape. The results related to the influence of creation of a gender equality enabling environment were on track, save for the Marriage and Divorce Bill (MDB). The CP contributed to the formulation of the Domestic Violence Act (2010) and The Prohibition of FGM/C Act 2011. The CPE found that the MDB was tabled in parliament, subjected to broad community consultations, and put on hold (shelved). In the section below further analysis on the effectiveness of the GBV prevention/response and reproductive rights component is presented.

## **b) Awareness raising and social mobilization for GBV prevention and response and on reproductive rights**

The analysis of triangulated CPE data demonstrates that through CP7, GoU made commendable progress on raising awareness and societal mobilization for GBV prevention, and response, as well as reproductive rights using multiple strategies including strengthening institutional capacities for FBOs, cultural leaders, utilization of champions and mobilization of high level national leadership support, in addition to initiatives at district level. Another success for CP7 was the creation of strong partnership for GBV prevention and response that involved religious bodies. The Church of Uganda was a stand-alone Implementing Partner and other religious bodies like the Seventh Day Adventists (SDAs), Uganda Muslim Supreme Council, the Orthodox, Fellowship of Born Again, and Miracle Centre Churches were sub-grantees under POPSEC (the 5 FBOs).

These FBOs have played a significant role in community mobilization on GBV, ASRH and other population issues. The Church of Uganda had passed a resolution on promotion of FP, prevention and response to GBV and prevention of HIV and management of AIDS that was signed off by top church leadership and was operationalized through the church structures. Additionally, the top leadership from the 5 FBOs had also commenced on integrating GBV and SRH into institutional strategies, which had been rolled out through FBO structures to grass-root levels. UNFPA through POPSEC supported all 5 FBOs to develop handbooks that integrate GBV, FP, and ASRH with religious messages. The dissemination of these handbooks and the training of community level religious leaders had commenced. This then would enable integrate the new knowledge into religious teachings. Nonetheless, the pastoral outreach structures still require strengthening through training and empowerment of grass root level religious leaders. In summary, the indicator on GBV social mobilization and awareness creation was on track and was very likely to be fully achieved by 2014. The good practices and lessons linked to CPE7 will need to be carried forward into CPAP8, to continue harnessing powers of FBOs community mobilization abilities for GBV prevention and response.

### **Box8: High Level Commitment UPDF**

*'Gender Equality is a command driven- the Chief of Defense Forces leads on this, commanders are held accountable on GBV issues'.*

**Source: Sector KI discussions**

On the participation of cultural and traditional leaders for Gender Equality and Reproductive Rights, there was evidence that work with cultural leaders included partnership with the Queen of Buganda<sup>4</sup> as a goodwill ambassador and the mobilization of leaders in FGM/C vulnerable communities to change attitude and lead the mobilization of their communities for the abandonment of FGM. The attainment of targets on FGM/C was enhanced by the enactment of the Prohibition of FGM/C Act in 2010. Subsequently UNFPA and other partners supported the MGLSD to develop FGM/C prohibition policy guidelines and draft the FGM/C prohibition regulations. A review of documents indicated that these instruments were used to help galvanize efforts against FGM/C. Linked to this, the UNFPA 2012 donor reports<sup>5</sup> indicate that through community dialogues, media, and community theatre; close to 61,000 women, girls, boy and men among the Sabinu and

<sup>4</sup>Data collection was done at the period when Buganda Kingdom commemorated 20 years of the King's coronation, thus evaluators were unable to meet with the Queen as she had tight schedules

<sup>5</sup> Standard Progress report January- December 2012, Annual review meetings 2012 and Annual reports

Karamajong communities were reached with messages on the existence of the laws prohibiting FGM/C. It was reported that by the time of the evaluation, 51 communities had declared abandonment of FGM/C; including 100 groups of community leaders, political and religious leaders, and villages, mutilators, and youth and women groups. Other communities abandoning FGMC included; 13 villages (Moroto), 31 villages (Amudat), 6 villages (Nakapiripirit); 11 sub counties (Kapchorwa), 2 sub counties (Kween), 8 sub counties (Bukwo). Similar results were noted by the Social Development Fundevaluation report that indicated FGM/C reduction in Kapchorwa region to below 10% (French Embassy, 2012).

High level national political commitment was recognized as the key enabling factor for success on GBV awareness creation, and social mobilization. This political goodwill had enabled the formulation of policy and its implementation. Moreover, the hosting of the Great Lakes summit on elimination of SGBV by GoU, that resulted in the 2011 Kampala declaration further demonstrated the presence of political goodwill. A triangulation of data from the review of documents, KIs and group discussions re-affirmed that UNFPA/GoU program engaged the Uganda Women Parliamentarian Association (UWOPA) and specifically collaborated with the speaker of parliament on GBV issues including the abuse of women and children, the exploitation of women and harassment in workplaces. Additionally, the National Association of Women Judges of Uganda (NAWUJU) was a key stakeholder. NAWUJU supported the simplification of the DV Act. Moreover, key National leaders including the; Chief Justice, Inspector General of Police, Director of Gender/ MGLSD and Director General of Health made declarations of commitment to address GBV through the public media channels. Other high level leadership commitments were exhibited through the interreligious council that crafted resolutions to address GBV, which bound Christian and Muslim leaders to follow the resolution. The forum of cultural leaders had earlier on adapted approaches to reduce GBV, promote maternal health and integrate with HIV/AIDS messages. Cross border engagement included being party to the East African Community gender policy development processes. Additionally, the Uganda Security forces deployed to Somalia, (AMISOM) was trained on GBV in armed conflicts, see Box 10.

### c) Positioning GBV prevention and response on the national and district agenda

**Policy & Legal Frameworks:** Results related to policy legislative were attained through upstream work and necessitated GoU/UNFPA and partners' capacities to successfully lobby, advocate and influence legislators and policy makers. This also included formation of strategic partnership with UWOPA, NAWUJU, Sectoral leaders as was previously mentioned. Additionally, the UWONET consortia of CSOs monitored CEDAW implementation, and engaged in advocacy actions on CEDAW compliance in Uganda. Additional results included publishing the Uganda progress report on the implementation of CEDAW in 2010, with sectoral recommendations, that were used to enrich the Gender and Reproductive Health agenda (ASRH Policy, MoH).

KIs and FGDs asserted that the penal code, the Defilement Act and the Children's Act all have provisions to protect against child marriage or forced marriage and thus protect the rights of the girl child. Additionally, the Trafficking and Smuggling in Persons Act of 2009 helped in protection of girls and women. Close to 80% of the content in the draft sexual offences bill had been incorporated into the penal code. However, some key policy bills remain to be passed or enacted, including the MDB and the draft National Policy on Sexual and Gender Based Violence (SGBV) 2011 wait to be passed. It was noted that there were plans to re-table the marriage and divorce bill, and the sexual offences bill as a private members bill, **(So- KIs, FGD and document review- CPE7)**. Such delays had a negative trickle down effect that affected program progress and the attainment of set targets.

Despite the stated progress, a review of documents points out gaps in the quality of these legislation tools that necessitate sustained efforts. For example, literature criticized the Penal Code for classifying acts of sexual violence against women as crimes against morality or honor, and not as crimes against physical and mental integrity of women/ girls. The penal code is further criticized for its definition of rape, defilement, prostitution, and other sexual offences under the morality law. The basis of this criticism is that, the focus on notions of "moral versus immoral" sex, further discriminated women and girls who have been defiled or forced into sexual acts. Under section 129, of the aggravated defilement bill, death penalty was mentioned as a punishment, yet this

is strongly opposed by the international human rights watch body -Amnesty International. Additionally, critics noted that the guidance around HIV post-exposure prophylaxis (PEP), fell short of international standards; PEP should be offered irrespective of the test results of the alleged perpetrator (CEWIGO, 2012; ACFODE, 2012). On FGM among the Pokot and Sabiny, literature revealed that most of the girls who cherish the practice cross over the border to Kenya for FGM where enforcement of the law is weak; such a gap calls for cross-border collaboration on FGM/C, (Moroto District, 2011).

#### **d) Strengthening Sectoral Capacities**

There was ample evidence of program interventions to strengthen sectoral capacities for GBV/prevention and response, the Justice Law Order Sector (JLOS) which brings together 17 institutions, (the Police, Prisons, Law reform center, Judiciary Service Commission, Ministry of Justice, MGLSD, Directorate of Public Prosecutions, Legal Reform Council, Judicial Services Commission, Local Government through the Local Council Courts, Law Society, Law Development Centre, Tax appeals tribunal, Uganda human rights commission) was on board. Nevertheless, evaluators noted that the strengthening of key GBV sectors is work in progress and should be prioritized through 2014, and CPAP8. Resourcing and investments vary from sector to sector, creating a need for further research, synthesis and documentation of the resourcing through sectoral responses. Factors that hindered functionality are presented in Box 11.

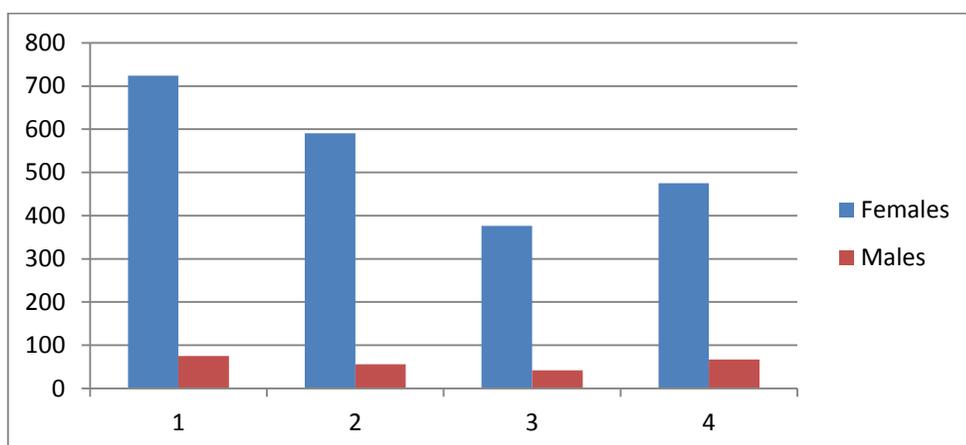
#### **e) Integration of GBV in District Plans, Data Management and provision of GBV Services**

While GBV prevention and response is integrated in all district plans, just 50% of the 8 districts could easily avail data on numbers of GBV survivors utilizing services, limiting access to the full picture on number of GBV survivors utilizing response services. Even so, at the baseline in 2010, the number of GBV survivors using response services was 2,650 survivors and the 2012 UNFPA reports (SPR & COAR) indicated a cumulative number of 19,051, close to 5 times the 2014 target; the data source was reported as the GBV Information Management System (IMS), a system that is operated by certain International NGOs and was inaccessible to the evaluators/public.

On functionality, it was found that the 8 core districts did not have a fully functional system (trained staff at district level who, are equipped with computers and standardized software package to enable collation of data, analysis and transmission) to regularly record GBV incidence and case management. Functional harmonized data systems generates needed evidence for decision making and resource allocation, helps define GBV magnitude, cause, response mechanisms, and define various types of GBV to inform prevention programs. While, districts like Kanungu, Yumbe, Mubende and Katakwi had a rudimentary GBV data management system, the rest of the districts have no records, some reported to be in the process of developing one.

In Kanungu, IMS innovations included use of Microsoft office access & excel programs to enter and analyze data, an example of which is presented above in Figure 11. Kanungu district GBV data demonstrates the vulnerability of females (girls and women). Kanungu trends show a decline of GBV in 2010-2012 which was attributed to program interventions, a finding that was echoed by Kanungu paralegals-the Small Male Action Groups against GBV (SMAGS/MAGS).

**Figure 42: Gender disaggregated GBV service utilisation, Kanungu District**



Yumbe district has established community support systems from the district up to the parish level, comprising 115 MAGS groups, and had recorded that 425 GBV survivors used response services in 2012. In Kaabong, Moroto and Kotido districts, the CSOs, and Government actors had different reporting lines on the numbers of GBV services in the district, implying that the stakeholder coordination meetings had not been utilized for harmonization. This gap implies a need for stronger coordination and the clarity on ultimate ownership of data & results; the role of the duty bearers in government institutions, visa vie the role of institutions supporting GoU service delivery. In Yumbe 72 police officers, 22 health officers and 15 CBSD staff had been trained in manual management of the data base; they had no computer/software.

This gap in functional IMS was of no big surprise to national level actors: The Joint Program on GBV arrangements are that data management task is with INGOs. Evaluators learnt that JP-GBV and MGLSD each had separate IMS. The JP-GBV IMS would not easily be replicated in districts that are in none conflict settings (development work). Positively, evaluators learnt of the efforts to harmonize the two systems: the design of ToRs, for creation of a harmonized data base and fundraising initiatives were underway (So: Triangulation CPE7 field data).

**Results on preparedness for humanitarian crises:** The evaluation established that the partners carried out trainings and invested in rolling out of IASC (Inter Agency Standing Committee) Guidelines on GBV in emergency settings. Only 150 people were trained GBV in emergency settings and these included personnel from MoH, MoES, MoJ, MGLSD, Police and UPDF. UNFPA should invest in building a critical mass of staff, from UN agencies and development partners, IPs, duty bearers and CSOs with the knowledge on GBV programming in humanitarian and post conflict settings, integrated with prevention/response to HIV in emergency settings, as part of Reproductive Rights.

To enable FGM/C survivors' access quality services; the program trained 20 health-workers from affected communities on: FGM/C case management, provisions of FGM/C law/guidelines and regulations. Integration of FGM/C services into all existing healthcare services in the selected health-centers has been initiated. Data management systems on FGM/C were established in some sites. Direct support to FGM/C survivors included access to medical treatment, psychosocial support, and corrective surgery.

**f) Community mobilisation for GBV prevention and management**

The Country Programme invested in creating a critical mass of people to address the GBV vice in communities. All districts have anti-GBV groups at community level, as shown in Table 19. The CPE found that district community support systems ranged from gender technical working group comprising the Health, Education, Gender officers at district level. On the presence of gender action groups, the anti-violence groups for example in Oyam. Mubende has district and sub-district GBV alliances that comprise NGOs, CSOs and the paralegals, child protection committees. Paralegals were generally classified as Small/SGBV Male action groups (SMAGs) or

Male Action Groups (MAGs) or Alliance members (Katakwi, Kanungu, Mubende, Yumbe). These GBV structures were acknowledged as a good practice that enabled program sustainability mechanisms.

**Table 20: Availability of GBV reference and community mechanisms**

District	Anti GBV groups available	Group meeting records indicate a focus on GBV prevention/response	Total Group Membership	Average Members/ Male Action Group
Kaabong	YES	Yes	60	50
Kanungu	YES	Yes	405	27
Katakwi	YES	Yes	80	20
Kotido	YES	Yes	60	20
Moroto	YES	Yes	40	20
Mubende	YES	Yes	40	20
Oyam	YES	Yes	60	20
Yumbe	YES	Yes	120	20

In addition, districts and sub-districts have passed by laws and ordinances against GBV. Examples from Kanungu where all 5 sub-counties have resolutions on GBV prevention, an example is on control of alcoholism, promotion of girl child education and on domestic relations. All districts reported to have GBV Standing Operation Procedures (SOPs) and defined GBV referral pathways, except for Oyam. The SOP from Moroto district is commendable as a well written document, it is noted that this quality document was a result of joint efforts from UNOHCHR, Moroto DLG, UHRC, ASB, Refugee Law Project, Uganda Police, UPDF, Uganda Prisons Service, and Magistrates court-Moroto, KDDS, UNFPA, URCS, BRAC and IRC. This is a lesson for other districts on the importance of ensuring technical quality through collaboration with other stakeholders.

**GBV psycho-social support guidelines:** Only 3 out of 8 districts (Kanungu, Katakwi and Yumbe) indicated availability and use of guidelines on psychosocial support to GBV survivors. TPO is an NGO that was commended for support in Katakwi. At National level, MGLSD had just commenced the process of developing GBV response psychosocial support guidelines. The Ministry noted the challenge on quality and appropriate guidelines, as the MoH guidelines were considered to be more focused on psychiatry other than psychosocial support. Evaluators note that MGLSD should explore partnership with private counseling firms or the Uganda Counseling Association to produce quality psychosocial support guides. This however should not block the two line ministries; Health and Gender continue to work together, to leverage synergies and expertise. Other areas of mutual learning and synergies include: male involvement as it addresses GBV, quality RH-FP, Maternal health, HIV prevention, including EMTCT and GBV medical and shelter service delivery.

To enable **access to medical legal services**, the police form 3 was revised to enable other categories of health workers other than the police surgeon to fill the form, thus supporting increased access to GBV response services and justice. However the Form 3 utilization is marred by a number of hindrances. Safety for the GBV survivors is another issue requiring attention. Only 2 out of the 8 districts visited had shelters. In Moroto the shelter set up by MIFUMI, with support from UNFPA and in Mubende, a shelter by ActionAid with funding from UKAid, more information on shelters is presented under the section on lessons learnt.

### **Box 9: Factors facilitating or hindering gender and reproductive rights output results**

#### **List of factors that facilitated results**

- ✓ Presence of high level political goodwill and conducive environment the ratification of regional and international gender agreements
- ✓ UNFPA technical assistance to MGLSD & CSOs resulted in drafting policies, and guidelines
- ✓ Partnership with UNWOMEN, the Joint Programs on GBV, Gender Equity bringing on board other actors, & flexibility for innovation.
- ✓ GBV prevention and response a real community need, the investment in community mobilization activities, creating response structures and the training of CSOs on the SASA methodology
- ✓ FBOs and cultural leaders have constituencies, are key community educators with established structures

#### **List of Factors that hindered results**

- District Gender Focal Persons are not strong technically, not trained; GBV role is as an 'Added role'
- Inconsistency in political goodwill can become a hindrance, as cited for the delays in enacting the M&D bills
- FGM/C perpetrators were never prosecuted, Cultural leader voices in Kotido, Kaabong and Moroto, remain stronger than the national judicial system and can be permissive of practices like courtship rape, a culturally acceptable practice
- The church norms of 'goodness' obscure and create silence around GBV more so when respected leaders are involved
- Connivance with legal systems and failure to prosecute or convict perpetrators of GBV, the case of lost files
- Moroto, Kotido and Kaabong districts had no substantive judge, creating a backlog of GBV cases
- The program had a limited media engagement, this led to negative reporting, & stigmatization of GBV
- Social mobilization in activities falls short of emphasis on prevention that addresses the systematic factors of male dominance, women powerlessness and lack of access to resources that drive GBV.
- Non availability of police form 3 at police post, creating practices of demanding moneys from survivors to enable photocopying of forms ; Health workers reluctance to fill in the form 3 for fear of taking on 'time consuming' additional role of state witness, and some health workers in public health units charge a consultation fee to survivors
- In Karamoja GBV survivors abused the form 3 after reporting the case to the police and having the form filled by the police and the health worker, they take the form to the perpetrators to ask for compensation
- The concept of the integrated GBV shelter model is new to Uganda, and is yet to be fully understood and operational zed by the different stakeholders. Limited ownership of the GBV shelter programme at the national level (MGLSD)

*(Source: Triangulation of KI, FGD, Observations, document reviews)*

### **Good Practice: Comprehensive approaches aimed at increasing awareness among all community members, including elders and youth, works best to allay this harmful practice. A Violent – Sometimes Deadly – Rite of Passage Undergoes Public Scrutiny in Uganda**

**Background:** The Tepeth are mountain people of North-eastern Uganda. They reside in conical huts made of sticks, thatch and mud in the semi-arid savannahs and scrubby forests of Moroto district. This generation and generations before them herd animals and grow crops for subsistence. If the harvest has been a good one, and food is plentiful, village elders will grant permission for a 'cutting' ceremony, in which girls 11 to 14 years of age undergo a rite of passage to womanhood by having all or a portion of their external genitalia removed with a blunt knife.

Female genital mutilation/cutting, as it is known, is now illegal in Uganda and has been publically condemned. Yet it persists among an estimated 1 per cent of the population – mostly the polygamous Tepeth, Sebei and Pokot ethnic groups living in districts bordering Kenya. A multi-pronged effort by the UNFPA-UNICEF Joint Programme on FGM/C is showing that laws are only a first step in rolling back deeply rooted traditions held firmly in place by vested interests and shrouded in secrecy.

#### **FGM/C: A carefully guarded secret**

Once the girls have been cut, they retreat even further into remote mountainous areas to recover for up to three months. The parents are asked to bring them food, but no one other than the cutter herself is allowed to see them. Additional ceremonies are held over this period to prepare the girls for marriage and to have children. The end of the healing period is marked by yet another ceremony, after which the girls are reunited with their families.

The girls are officially available for marriage offers at this time, which are expected to be accompanied by a 'bride price' – essentially a dowry given to the bride's family, usually in the form of many head of cattle. Typically, it is the older men in the village who can afford a bride price, which increases in value if the girls are cut.

When the social dynamics of FGM/C and other harmful practices such as bride price and child marriage are considered, it is not surprising that they persist. The bride price tends to give older men exclusive access to new young wives. The act of performing female mutilation provides income and prestige to the cutters themselves, who receive large payments from

parents and tokens of appreciation throughout the year. Parents receive gifts in exchange for their daughter's hand in marriage. And village elders, who confer their blessings on the ceremony, preserve their power and the status quo. Seemingly, the only ones to suffer are the girls themselves. Yet until recently, the considerable risks accompanying FGM/C remained a carefully guarded secret among elders

### **Strategies: a) Opening the practice to public scrutiny**

What appears to be working is combining the force of the law with the will of the people: letting villagers themselves, girls included, decide what is best for them, based on sound information. Since those who deviate from social norms are often ostracized in these traditional communities, it is important that abandonment of the practice be a collective decision. Tapping the influence of village elders – the gatekeepers and custodians of local culture – is key.



Dialogue sessions are conducted separately with youth and elders, who are asked to explore how the practice is carried out and its positive and negative effects. The two groups are then brought together for further conversations about the issues raised. At the end of the sessions, a facilitator explains the Prohibition of Female Genital Mutilation Act, 2010, which makes FGM/C a crime, punishable by up to ten years in prison or for life imprisonment for aggravated female genital mutilation (*Aggravated mutilation included if death occurs, a victim suffers disability, the victim is infected with HIV as a result, if the act is done by a medical worker, if the offender is a person with authority or control over the victim*), if a girl dies.

### **Strategies: b) Children and elders as agents of change**

Working with children in and out of school not only as potential FGM/candidates but as agents of change has been a fruitful intervention. Awareness-raising on the dangers of FGM/C are conducted through a video documentary. By mid-2012, 20 shows had been screened in primary schools and in informal learning centres, reaching 1,000 children in Moroto district.

Pupils report that, before watching the videos, they only knew the exiting stories and advantages associated with FGM/C as told by peers and elders including the celebrations, being showered with gifts for being brave, increased social status after being cut, initiation into adulthood, social acceptability and the high dowry and gifts at marriage especially if one was found to be a virgin at the time of being cut. This however changed afterward the documentary shows as the children are able to articulate the negative side of FGM/C, they relayed information about the dangers of the practice to their parents and peers and told them about the new law. The sessions gave the girls confidence to speak out against the practice. Some of the boys reported that they would now feel comfortable marrying an uncut girl, especially since it would be easier for them to give birth.

### **Results:**

#### **a) Increased awareness about the dangers of FGM**

Before the project began, youth within the Tepeth communities were largely unaware of the negatives consequences of FGM/C, according to one community leader. It was not widely understood, for example, that in addition to excruciating

pain, cutting can cause girls to bleed to death or to contract HIV or other infections, since the same unsterilized knife is used for all the girls being cut. Other risks include pain or loss of feeling during intercourse, infertility and complications during childbirth. In some cases, parents had to wait for months, until the final ceremonies had concluded, only to find out their daughters had died of the consequences of FGM/C or were permanently disabled. The practice also contributes to illiteracy, since girls that undergo FGM/C typically marry and drop out of school soon afterwards.

#### **b) Community participation in FGM abandonment**

One key to the success of the dialogues is a high level of participation, including, most importantly, local leaders. Another is to let community come up with their own solutions. “Nothing is imposed on the community,” she says. “Instead you allow the community to talk and dialogue and as a result, they own the process.”

Through the dialogue sessions, it has become clear that, once they (community) understand the possible consequences, the majority of them favour abandonment of the practice. The challenge however is although many have come to appreciate the negative effects of FGM/C and are in for abandonment, they still fear to come out openly to denounce the practice for fear of being shunned or punished for their beliefs. This is due to the fact that the FGM/C has been practised for long and is deeply rooted in people’s beliefs and traditions of the communities as an acceptable norm with negative reinforcements/punishments for going against. Nevertheless, the Tepeth community in Moroto has demanded that the police in their sub-county do a better job of enforcing the anti-FGM/C law. In 2011, the year the dialogues got under way, no cases of FGM/C were reported by the community, which is now keeping data on the practice for the first time.

#### **c) Solutions from deep inside a community**

While UNFPA and UNICEF were strong backers of the law prohibiting FGM/C, they also understood that the legal ban would have to be accompanied by a grassroots approach to change people’s minds through education. Not surprisingly, as a result of the law, the practice went underground: Instead of openly celebrating FGM/C, communities now practise it in secret, in hard-to-reach locations or across the border in Kenya. But things are changing in that country, too. Following passage of the ban on FGM/C in Uganda, Kenya passed a similar law, and police forces in both countries are now working jointly to discourage the practice in border communities. Opponents of the practice in Uganda are advocating for the creation of boarding schools and safe spaces for girls who escape early marriage and FGM/C and cannot return to their communities – an approach being used successfully in Kenya.

“When the attitudes of some members of the society have changed, then the complacency has been disturbed for almost everyone in that society,” according to POZIDEP, the faith-based organization promoting public declarations against the practice. “FGM/C abandonment needs to be a collective effort; all actors need to come together and deliver that message from deep inside the community.”

Summary, the GBV and reproductive rights output attained most of the set indicator targets. Nationally, policy frameworks have been established and national commitment secured. The programme has created a critical mass of community and district leadership that advocate against GBV in form of functional GBV reference groups, NGO coalitions and Community based Anti GBV groups. Male involvement in GBV prevention and response is a key strategy that the programme employed in all the districts. The referral pathways still face challenges related to resourcing, the shelters are a new phenomenon, and continued support for institutionalization and scale up is needed in the coming cycle. GBV data management remains a challenge.

### **4.3 Efficiency**

**Evaluation Questions:** How adequately were the available resources (funds and staff) used to carry out activities? To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs? To what extent were the activities managed in a manner that would ensure the delivery of high quality results?

This sections analyses the process and timeliness in developing Annual Work Plans and its effects in timely commencement of annual implementation, the quarterly release of funds to IPs, implementation rates for the country programme resources and the efficiency check mechanisms used in the country programme. The

analysis of effectiveness has been done generally ie not segmented under Population and Development, Reproductive Health and Gender Equality.

**a) Annual Workplans: development and signing:**

Save for 2010, the Country Office finalized the Workplans in January and by the end of February all workplans were signed. This means that the Country Office always met the end of February deadlines for completing AWP's set by the UNFPA HQ usually in the Executive Director's communication about organizational Annual Priorities. The year 2010 being the first year of the Country Programme, the delays were caused by the processes related to finalization of identification and assessment of partners and signing the Letters of Understanding.

**b) Submission of quarterly reports and release of funds**

The CO follows the quarterly schedule for release of funds to the partners. Funds are released to partners upon submission of quality and complete reports of the ending quarter and requests for the new quarter. The reports required in each quarter are:

- Quarterly Progress report: Workplan Monitoring Tool (Cover all activities in the ending Quarterly Workplan)
- Summary Activity reports (for all completed and partially completed activities)
- Field monitoring reports (for each of the visits made)
- FACE – Expenditure for ending t Quarter and request for new Quarter
- Bank statement for ending quarter
- Bank Reconciliation Statement –ending quarter
- Quarterly Workplan for new quarter (Activities including monitoring and coordination) and detailed budgets
- Quarterly Monitoring Plan for new quarter

The CO, in a Programme Coordination Meeting of April 25, 2010, agreed with the Partners on the reports to be submitted and the timeline of 5<sup>th</sup> of the first month of the new quarter as the deadline for submission of the reports for the ending quarter.

From the review of a sample of reports, the evaluation team established the almost all the partners submitted the required reports. However, this improved gradually from 2010 to 2013. In 2010, the a few partners were submitting the Bank Statements and Reconciliation Statements and a few activity reports but all submitted the rest of the reports. As the programme implementation progressed through 2011, 2012 and 2013, the partners submitted complete reports.

The main issue identified in the review of reports was the delay in submission of reports. Whereas the agreed deadline for reporting was 5<sup>th</sup>, very few Partners met the deadline. The table below shows the adherence to the agreed upon timeline for submission of report taking a second quarter reports for all the years as an example.

**Table 21: Timeliness in submission of reports (Second quarter 2010 – 2013)**

Year	% IPs submitting on time (by 5 July)	IPs that submitted in time	Remarks
2010	65% (13 IPs out of 19)	Ministry of Health (RH), Reproductive Health Uganda, Kanungu District, Mubende District, Yumbe District, Oyam district, Katakwi District, Kotido District, Kaabong District, Ministry of Health	The IPs were submitting second quarter request since there was no releases in first quarter.

		(ACP), UWONET, CoU, CDFU	
2011	40% (8 out of 20 IPs)	UBOS, RHU, Mubende, Yumbe, Katakwi, Kotido, ARC, CoU	
2012	40% (8 out of 20 IPs)	UBOS, RHU, Mubende, Yumbe, Katakwi, ARC, CoU, Kotido	
2013	30% (9 out of 30 IPs)	Yumbe, Katakwi, Kaabong, MGLSD, CDFU, MoES, Kotido, Mubende, Catholic Secretariat	Due to the breakup of the ARC consortium, the number of IPs increased to 30. All the new IPs therefore had to undergo the IP engagement process hence late submissions.

*Source: CP Second Quarterly Analysis Reports*

The review presented in the table above, indicates that save for 2010, less than 50% of the IPs submitted the reports late. It is important to note that although most of the IPs under the CP submit reports beyond the CO set deadline, almost all of them meet the UN Global deadline of 15<sup>th</sup> day of the new quarter as stipulated in the Letters of Understanding template.

Other issues noted in the review of reports include:

- Low implementation rates especially for the first quarter and second quarter. This leaves implementation of most of the activities for third and fourth quarter
- Over expenditure on activities without prior authorization
- Delayed implementation of the Policy, advocacy and research/study related activities
- Difficulties in management of contractees: Evidence of poor coordination and supervision of contractees especially for ARC, POPSEC, MGLSDS, RHU and UWONET

Regarding release of funds, the CO set a deadline for release of funds on the 15<sup>th</sup> day of the quarter of request. Review of reports indicate that due to delays in submission of reports as in the above table, the release of funds does not meet the set deadlines for most of the IPs. On average, only 20% of the IPs received funds by the 15<sup>th</sup>. The processing of funds on average takes 3 to 7 days, if the report does not have any issues that lead to failure of budget acceptance in the UNFPA financial system. However, the evaluation team noted delays at payment level with UNDP sometimes taking long to release funds to partners' accounts especially when large sums of money are requested.

### c) AWP implementation

The evaluation team also analyzed the implementation of the workplans with view of establishing whether the partners adhered to the AWP activities and delivery of results. The analysis reveals that all the IPs adhered to implementation of the activities stated in the AWP. In case of changes and adjustments, the IP usually discussed them with UNFPA. The letters of authorizing such changes and adjustments were seen by the Evaluation Team. Although for all workplans, the results to deliver were very clear, the review of reports indicated that for a number of partners reporting results remained a challenge. However, for activities related to service delivery, the results achieved were clearly reported.

Major delays were noted in advocacy and policy related activities as well as procurements and studies. A few cases noted include:

- Formulation and finalization of the National Youth Policy by the MGLSD and the School Health Policy by MoES

- Procurement of EmOC equipment that span over 2011 and 2012
- Delays in procurement of consultancies for the review of Midwifery Curriculum and the Nurses and Midwifery Act by MOH and UNFPA
- Delays in establishment of the District Harmonized Database by UBOS, POPSEC and Districts
- Delayed undertaking of the National Population and Housing Census
- Delays in establishing the GBV IMIS by MGLSD

#### d) Country programme resources and utilisation rates

The Evaluation established that the fund utilisation rate for the CP resources were generally high as indicated in table 23 below. Output 1 (Data availability and use), Output 3 (Family Planning) and Output 2 (Midwifery) have on average had high fund utilisation rate over the three years (93%, 92% and 92% respectively). Output 5 (GBV and Reproductive Rights) comes fourth with an average fund utilisation rate of 88% while Output 6 (ASRH) and Output 4 (HIV/AIDS) comes fifth and sixth with average fund utilisation rates of 85% and 72% respectively. Thus performance in relation to fund utilisation rates was good.

**Table 22: Fund allocation and expenditure by output from 2010 to 2012**

Output	2010			2011			2012		
	Budget	Expense	Imp rate	Budget	Expense	Imp rate	Budget	Expense	Imp rate
1-Data availability and use	1,753,512	1,637,793	93	3,670,063	3,304,522	90	2,298,852	2,149,951	94
2-Midwifery Services	1,812,672	1,813,881	100	3,172,153	2,771,586	87	2,564,677	2,257,471	88
3-Family Planning	1,727,080	1,617,475	94	5,242,459	5,094,164	97	9,492,476	7,930,192	84
4-HIV/AIDS prevention	713,315	678,991	95	1,563,582	759,201	49	2,245,491	1,606,077	72
5-GBV and Reproductive Rights	6,465,111	5,764,897	89	6,025,758	5,509,142	91	7,062,487	5,961,407	84
6-ASRH	259,971	242,217	93	870,501	631,222	73	2,081,353	1,851,691	89
Program Coordination and BSB	1,116,648	1,137,783	102	835,754	749,022	90	1,045,297	1,003,207	96
<b>Total</b>	<b>13,848,509</b>	<b>12,893,037</b>	<b>93</b>	<b>21,380,270</b>	<b>18,818,859</b>	<b>88</b>	<b>26,790,633</b>	<b>22,759,996</b>	<b>85</b>

Regarding fund utilisation rates by implementing partners, the analysis also reveals that the rates are generally high. The partners whose fund utilisation rate is 95% and above are Katakwi, Kotido, Yumbe, Moroto, Kaabong, ARC and UONET. Those with 90 – 94% are MOH, UBO, RHU, Kanungu, Mubende and Oyam. POPSEC, MGLSD, Catholic Secretariat and UNFPA (Direct Execution) have implementation rates of between 80 – 89%. The partners that had low utilisation rate are CoU, CDFU and MoES with 70%, 71% and 53% respectively. The low implementation rate for MoES was a result in delays to recruit consultants to undertake the Curriculum review as well as delays in finalization of the School Health Policy.

**Table 23: Total amounts (budgets and expense) and utilisation rates by IPs 2010 – 2012**

IP Name	Total (2010 – 2012)		
	Budget	Expense	Impl rate
Population Secretariat	3,507,912	3,025,691	86

IP Name	Total (2010 – 2012)		
	Budget	Expense	Impl rate
Ministry of Health	2,570,298	2,337,823	91
Ministry of Gender Labour and Social Development	2,396,762	2,026,105	85
Uganda Bureau of Statistics	2,431,301	2,290,501	94
Kanungu District Local Government	301,775	283,394	94
Moroto District Local Government	177,374	175,491	99
Kotido District Local Government	248,466	244,897	99
Katakwi District Local Government	477,844	482,409	100
Yumbe District Local Government	311,184	308,990	99
Mubende District Local Government	185,296	173,867	94
Oyam District Local Government	204,587	190,534	93
Kaabong District Local Government	337,942	331,934	98
Ministry of Education and Sports	474,673	250,972	53
Reproductive Health Uganda	3,722,604	3,334,083	90
American Refugee Committee	8,153,239	7,882,145	97
Uganda Red Cross	1,500,831	1,468,444	98
Uganda Women's Network	2,197,509	1,648,523	75
Program for Accessible Health, Communication and Education.	343,655	328,889	96
Church of Uganda	548,560	433,296	79
Communication Development Uganda	1,440,762	1,026,696	71
Catholic Secretariat	741,640	623,267	84
UNFPA	9,745,185	25,487,499	86
<b>Total</b>	<b>62,019,398</b>	<b>54,355,451</b>	<b>88</b>

e) **Measures put in place to ensure efficient implementation of the AWP's and fund utilisation**

- **Development of workplans with clear activity and results linkage and detailed budgets.** The CO and Partners engage in a rigorous process of developing the AWP's and this takes almost 3 months usually from September to December/January. The clarity of results in the AWP's and the detailed activity based budgets developed makes it if relatively easy for the partners to implement the workplans and use the resources within the agreed upon activity costs.  
The CPE triangulated the above data with qualitative data mostly from IPs through KIIs and FGDs. From these methods, the findings were that IPs agreed that the budgeting and planning process was transparent, jointly discussed and agreed between staff at UNFPA and IPs. Yet many more IPs and sub-contractees were *dissatisfied* that after the initial consultative planning meetings, few persons were engaged to finalize the planning. The result was that some of the previously agreed on key priority interventions were dropped. Such approach in a few cases resulted in lack of ownership of some of the activities in the AWP. Respondents' voices, gave an impression that resources/funding levels were quite low, partners implemented under tight non flexible constrained budgets. Besides, as evaluators we consider that while leveraging resources is very good; the above voices imply inadequacy of funding and spreading thin and this could be a risk to the delivery of high quality results.
- **Implementation Planning:** The evaluation team realized that from 2011, the IP and UNFPA IM Manager undertakes implementation planning once the Quarterly Workplans have been approved. This involves review of the QWP by all persons involved in its implementation and developing the concept notes for each

of the activities in the workplan. This makes it easy for the persons implementing the activity to adhere to the required quality standards. However, not all IPs consistently prepare the concept notes.

- **Continuous IP follow up, monitoring and technical support:** UNFPA CO has staff designated as IP managers who on continuous basis provide and/or mobilize technical support to the IP during implementation of the workplan.
- **Quarterly review of Partner Financial and Programme reports:** On a quarterly basis, the IP manager and UNFPA M&E team review the reports submitted by the IPs. The reports are reviewed mainly for completeness, quality of reporting especially results' reporting, fund utilisation rates. The Evaluation Team saw these quarterly analyses and evidence of feedback to the IPs. However, it was also noted that the Issues identified in the IP reports reoccur in the subsequent quarter, hence the need for UNFPA to always follow up to ensure the issues are addressed.
- **Field monitoring:** UNFPA and Partners conduct regular monitoring of the AWP implementation. The monitoring reports reviewed indicate the monitoring focuses on assessing progress in implementation of the workplans, assessment of progress in achieving the AWP results, supporting partners in preparation of reports, monitoring fund utilisation and accountability and supporting the partners to document good practices.

#### f) Decentralized Offices(DOs)

UNFPA has three decentralized Offices, in Moroto, Gulu and Mbarara. These DOs play a very vital role in ensuring greater efficiency of the CP implementation. The DO staff support and supervise the implementation of the programme activities (for both district and national based IPs) in their area of jurisdiction. The staffs act as contact between UNFPA and the Local Government and the beneficiary populations. This ensures faster information flow between UNFPA and other national level line ministries. The DOs also represent UNFPA in the various district and regional working groups like the Karamoja Development Working Group, PRDP Working Groups, UN Inter Agency Groups and other UNDAF related working groups. However, the evaluation team noted that whereas the DOs have close collaboration with the districts, the information gap on the activities of the national level IPs makes it difficult for them to monitor and provide necessary support. Secondly the funding mechanism for DO activities makes it difficult for them to implement their activities in a timely manner.

#### g) Other voices from partners regarding efficiency of implementation.

The Evaluation team recorded some voices from the respondents voices on efficiency and adequacy of funding, fund management mechanism some of which are presented below.

- *'The consultative nature of developing the AWP is a good approach, but the final review sometimes is done by few people who end up removing some key priority activities'*
- *'Funds transfer was sometimes late even up to one month and this affected implementation. and created gaps in follow up'*
- *'..Delayed reporting resulted in delays in release of funds ....pressure & this comprised quality and reflection on strategic intervention. ----- 6 monthly fund releases are recommended to create reflection time'*
- *Inadequate consultations during prioritization of activities...in planning'*
- *'... There is a need to avoid the centralized workshop model, for example UGX 23m, was used for training 15 participants, On site trainings could be more cost beneficial'*
- *'Managing UGX 6 billion that was transferred to a contractees, and yet coordination costs were not catered for, is an institution nightmare, not cost-beneficial to us as partners and yet presents institutional risks on being disqualified if sub-contractees audits are poor, partnership and coalition processes should be reviewed'*

- *“The new program must be well thought through around consortia arrangements, coordination costs should be included, funds transfer every 6 months, and with quarterly reporting, rethink funding levels”*
- *‘..... there should be a ceiling around funding levels for sub-contractees, if they have huge budgets then they become IPs that receive direct funding’*
- *“There were also challenges in accomplishing the program targets due to the late finalization of AWP and budgets that delayed the implementation by one quarter the year and as such the first quarter activities were often delayed or cancelled’ This was mainly from the Partners that broke from the ARC Consortium.*
- *“The expectation of IPs to keep up with the implementation and fund absorption rate standards was judged as prime when compared to addressing quality and sustainability of the process in achieving results. This was because on one hand, the implementation rate and fund absorption rate determine the performance of the implementers of the programme’.*

**In Summary,** the efficiency enhancement aspects that characterized the CP implementation across all the Programme Components were: timely formulation of results based AWPs and detailed budgets compared to the UNFPA Global timeline; high fund utilisation rates; institution of innovative measures by the CO to ensure efficient programme delivery. The role of UNFPA Decentralized Offices in contributing to greater programme efficiency cannot be over emphasized. The available resources (funds and staff) were adequately used to carry out activities, and there was evidence of leveraging of resources. However, there were issues that may have compromised the efficiency of the CP and these include delayed quarterly reporting and release of funds; implementation of most of the activities in the third and fourth quarters; delayed implementation of Policy, Studies and Procurement related activities and the difficulties faced in management of IPs in a consortium arrangement. While the CO team emphasized fund utilization rates and the attainment of most targets, the IPs expressed strong concerns that the fund management mechanisms put pressure on the implementation process, with expectations of speedy delivery of results and utilization of funds, which was deemed a compromise to the learning from the process and the focus on quality.

## 4.4 Sustainability

**Evaluation questions:** To what extent has Country Programme been able to support partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects? To what extent were activities designed in a manner that ensured a reasonable handover to local partners? To what extent has national capacity been developed so that UNFPA may realistically plan progressive disengagement?

The analysis of sustainability has been done in a way that reflects key programme elements that will ensure durability of programme interventions and results as well as threats to sustainability across the programme themes.

### **a) Programme elements that indicate ownership and durability of programme interventions and results**

The main element of the Country Programme that will ensure sustainability of UNFPA support rests in the relevance of the PD, RH and Gender interventions that the CP focuses on. All the component programme focus are aligned to the National Priorities and the needs of the population. The fact that the CP focus is in tandem with the national needs has created an environment of national ownership of the UNFPA supported programme. These views were echoed by the Executive Directors of the Uganda Bureau of Statistics and Population Secretariat. The two share the view that UNFPA support is only a contribution to the mandate of the two organizations and therefore even if UNFPA sopped funding, the programmes would continue.

The second element is areas of UNFPA support were arrived at through extensive consultative process both at formulation of the Country Programme as well as during the development of the Annual Workplans. These two have also secured high level of ownership of the programme.

The support to strategic high level government institutions like Ministry of Health, Ministry of Gender Labour and Social Development, Ministry of Education and Sports, Population Secretariat, national Planning Authority, Uganda Bureau of Statistics means that UNFPA support is strategically positioned in the long term government strategies. This approach is important in that some of the key areas of UNFPA support became Government policy direction that will stay for over a long time. Such cases include the integration of Population dynamics into national development frameworks that is already taken up an a principle in development of plans as spelt out on the National Vision 2040 and the National Development Plan. Integrated Management Information System has been taken up as a major product by the Uganda Bureau of Statistics. The Ministry of Education has developed the School Health Policy and is integrating Sexuality education in the Secondary School curriculum both of which will provide durable solutions to addressing issues related to SRH in the school setting. The Enactment of Domestic Violence Act and Prohibition FGM Act as well as their regulations, the National Gender Policyetc will definitely ensure the continuity of interventions to address GBV and FGM/C.

Other programme elements that show that the CP7 programs, interventions were considered durable include:

- ✓ **The program was implemented through existing national structures and mandates:** Governments, FBOs, cultural institutions, some CSO coalitions already had established mandates and systems and the Country Programme only built on these mandates and systems. By strengthening existing structures it is most likely that the ownership of the programmes is assured. UNFPA took the mainstreaming strategy eg mainstreaming gender into plans and budgets of districts will enhance/ensure sustainability. In schools, integration of activities into already existing school systems, ASRH services were traditionally embedded in

the school calendar such as interschool game competitions, school clubs like the health clubs, debating clubs and many others. These clubs have created ownership of the services for both school administration and the students. FBO's & cultural institutions have functional SRH/HIV programme even before UNFPA/GoU funding. The location of youth friendly centers within government owned health facilities is a step towards continuity.

- ✓ **Providing the necessary and durable capacity building solutions:** Examples in this area include equipping public and private health training institutions will ensure continuity of the midwifery diploma and degree programs for instance the 18 midwifery training schools provided with delivery and demonstration based equipment. The provision of durable Maternal Health and Fistula repair equipment to the HFs will ensure continuity of the services at least in the medium term. The training conducted under the CP including training government planners in data and planning, Health Workers in delivery of RH and FP services, training Fistula surgeons for routine fistula repair, training UBOS staff in IMIS and other data analysis skills etc targeted the staff already in public service. This implies that these technical staff will still apply the skills they gained even with the end of UNFPA support.
- ✓ **System strengthening:** The country programme also used the approach of systems strengthening which is key to ensuring sustainability. Examples in this case include: Strengthening the Uganda Nurses and Midwifery Council decentralize its operations to regional referral hospital levels will ease the regulation and registration of midwives. The developed midwifery Scope of Practice is a durable solution to improving midwifery services. The strengthened supply chain system using both routes (alternative and NMS/JMS) will enhance delivery of commodities and hence increase availability of commodities in health facilities for instance the established alternative contraceptive distribution mechanism. The programme also focused on strengthening the already existing technical working groups like the FP Working Groups Condom Committee in MOH; the National GBV Reference Group in MGLSD. Such groups are already part of the government system and will continue even if UNFPA support ends
- ✓ **A critical mass of human resource across the three themes built:** to carry on the achievements of the programme for example midwives, fistula surgeons, nurses for FP services, peer educators, VHTs and DLG staff at the different levels including police officers. This critical mass of skilled staff will ensure that services continue to accrue to the target beneficiaries but not necessarily at the current scale with UNFPA support.

#### b) Threats to sustainability

- **No explicit phase-out strategy** within the program design. Ownership of the program benefits was not imbedded in the programme design though it was embarked on during the course of implementation. A case in point is the implementation of the YFS project that was initially led by Uganda Red Cross Society. From 2013 onwards to 2014, the programme will be handed over to the district and will be part and parcel of the District Health Office responsibilities. This case is likely to face sustainability problems given that most districts have not been prepared to handle the YFS. Another case is where the programme provided equipment that have operation and maintenance cost implications eg Ambulances which may be difficult to meet by the beneficiary institutions. Although districts have put in place mechanisms for ensuring continuous operation of the ambulances, they may need donor support to supplement their efforts.
- **Limited reach or coverage through pilots or model projects:** The coverage for the programme was limited to small geographical locations even in the target districts YFC in two schools per districts,

and selected sub-counties for GBV. The evaluation team established that documentation of the pilots was poor and this may compromise efforts to advocate for scale up.

- **GoU continues to be donor dependent for essential services:** The national HIV/AIDS response is 68% externally funded. GBV response remains a new process and mostly donor funded with limited GoU allocation.
- **Donor dependent CSO strategies:** NGO IPs can only sustain action if receiving financial support for operational costs from other sources and strategies can be determined by funding availability.
- ✓ **Partner institution interests:** For example, religious institutions will largely sustain those aspects that will make their way into liturgical guidance (or ways of work) where the leaders do not need extra funds to deliver a message to the congregation. Though currently receiving minimal funds to make their systems work, it is unlikely to sustain the programmes when the small funds are no more.
- ✓ **Volunteer based community structures:** The delivery of some programme interventions depends on voluntary community groups like the SMAGs, VHT and peer educators. Continuing their work when the programme ends will be difficult. ,

#### **Summary findings on sustainability:**

While donor funding remains crucial, CP7 programs, interventions were considered durable because: the program is aligned to and addresses the national priorities and population needs; was tailored to existing structures and mandates without creating parallel systems; focus on mainstreaming approaches; investment in systems strengthening; rigorous capacity building targeting staffing in mainstream public service; strategic engagement with national institutions and ministries for long term policy and legislation; equipping public and private health training institutions that would ensure continuity; beneficiary participation in programming and implementation of activities. On the other hand the lack of consideration of phase out in the design and taking it as an afterthought may affect the sustainability of the programme. Lack of exit strategy, dependence on the community volunteer groups, the general donor overdependence by both government and NGOs and lack of scale up strategy for pilots are the other factors that threaten sustainability.

## **4.5 Lessons Learnt**

**Evaluation questions:** What was the most and least successful approach in the delivery of CP outputs? What do you consider the most innovative approach in delivering program approaches? What are the good practices that should be continued and/or replicated elsewhere?

### **4.5.1 Lessons Learnt**

- ✓ Population dynamics & Data integration issues need be communicated in simplified approaches, to increase its understanding and application at national and District Local Government levels and by non- experts.
- ✓ Using the strategy of champions can achieve a lot in reinforcing government efforts to advance SRH and GBV programmes.
- ✓ Acknowledging the expanding young unemployed population, there should have been a stronger integration of youth development/livelihoods in the SRH programmes
- ✓ Across the components, key program staff and IPs need trainings in collaboration, coordination, and advocacy.
- ✓ Training and mentoring of teams at hospitals motivates the providers to offer quality services. Moreover, using local surgeons for mentoring and coaching of upcoming fistula surgeons is rewarding and less costly.
- ✓ MoH leadership and ownership is essential for success & sustainability, the FistulaTWG and MCH TWG are doing a lot to coordinate activities including holding regular meetings and dialogue among partners.

- ✓ Harnessing synergies through coalitions and partnership building is the way to go, for coordination and implementation success. The case of: Private –Public collaboration for the promotion of midwifery profession in secondary schools in underserved areas; Intra ministerial cooperation like in the development of the School Health Policy, MoH and MoES collaborated with each articulating their mandates in the policy.
- ✓ Support to midwifery bodies, the council and training institutions, was empowering and potentially improves quality and access to midwifery services.
- ✓ Camps, mobile vans: Increasing access to and utilization of modern Family Planning methods especially the LAPMs is possible by targeting those in underserved areas through the use of comprehensive outreach camps.
- ✓ MARPs (CSWs, LGBTI) are willing to come for services provided the environment is conducive with health workers who are non- judgmental and where privacy is assured.
- ✓ Integration of Nutrition with Safe Motherhood RH services, could be a game changer, that contributes to reduced maternal and neonatal mortality
- ✓ While the set MDG targets on women empowerment were attained as per data, there is still much more that needs to be done for gender equality, the prevention and response to GBV.

## CHAPTER 5: Strategic Positioning

The strategic positioning has two dimensions, an internal and external. The internal dimension refers to the CO alignment with the UNFPA Strategic Plan (viewed as corporate dimension) and the wider UN strategic frameworks, i.e. alignment with UNDAF (viewed as Systemic dimension). The external dimension designates the CO position among the country development partners in view of responding to country needs (“responsiveness” and “added value”).<sup>6</sup>This chapter assesses the all the elements of strategic positioning and the findings are based on relevant document reviews and interviews with UN agency officials and donors available at the time of the evaluation, UNFPA CO staff members, IPs and selected beneficiaries.

### 5.1 Corporate Dimension of Strategic Positioning

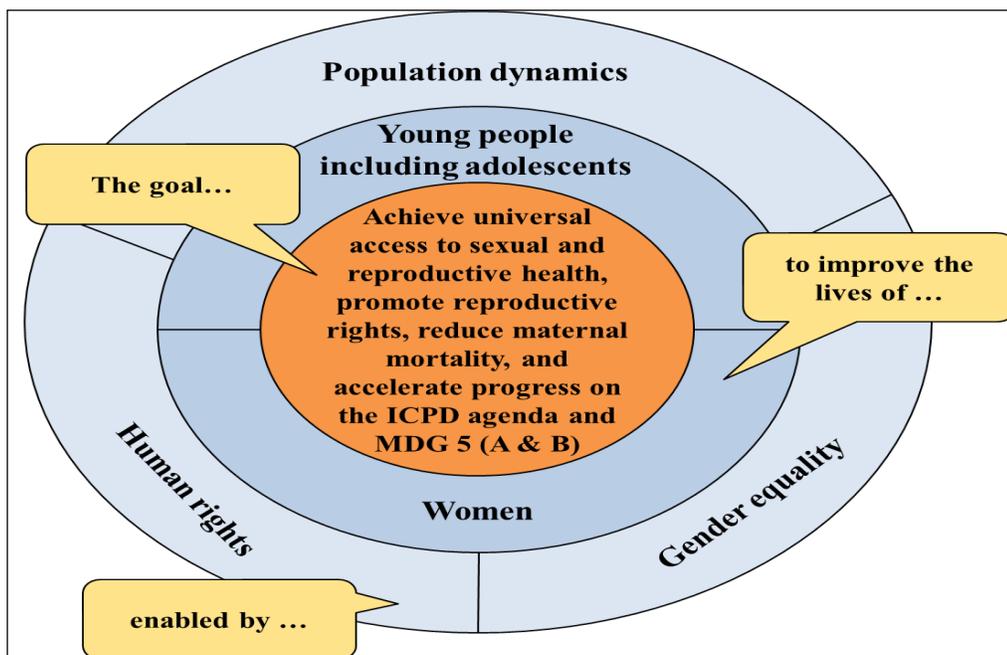
**Evaluation questions:** To what extent is the CP and its implementation aligned to the UNFPA corporate mandate as set out in the Strategic Plan and to what extent has the CO positioned ICPD goals and issues within governmental processes at the national and local levels?

In this analysis, corporate dimension looks at the extent to which UNFPA support to Uganda is aligned with the UNFPA Global Strategic Plan: the extent of attention given to the most vulnerable and disadvantaged population group; capacity development; South-South cooperation and national ownership.

#### a) CP alignment to the UNFPA Strategic Plan

UNFPA Strategic Plan initially covered the period 2008- 2011 and was subsequently extended until 2013. The goal and focus of the revised version, 2012-2013 are indicated in figure 13 below.

**Figure 13: The UNFPA’s new strategic direction: the "bull's eye"**



<sup>6</sup>Handbook “How to design and conduct a country programme evaluation at UNFPA,” Evaluation Branch, Division for Oversight Services, New York, March 2012

(Source: UNFPA Strategic Plan MTR 2012-2013)

The focus is on women's reproductive health and adolescents and youth to promote cross-functional work, and to accelerate the programme delivery.

The Evaluation notes that following the revision of the strategic plan, CO made changes in the CPAP to align the country programme to the plan. However, this did not change the CPAP drastically as the focus and interventions to accelerate MDG targets, especially to reduce maternal deaths and to achieve universal access to reproductive health, including family planning remained relatively the same as previously planned<sup>7</sup>. In the CPAP development including the 2011 alignment, the Country Programme Results and interventions were focused to deliver the UNFPA Strategic Plan. The linkages between the CP results and the SP are clearly defined.

There is explicit programme focus on ICPD POA in the CPAP under the three CP themes of PD, RH and Gender as elaborated under the Relevance section of analysis of UNFPA focus areas. Efforts to involve key stakeholders are evident in the recent ICPD review process and work plans. CO focused on ICPD review in the country with an extensive mapping exercise to identify key partners involved in the implementation of the ICPD Programme of Action. Representation in the exercise consisted of civil society organizations (24 CSOs), faith-based groups (18 participants from 9 FBOs), cultural institutions (39 leaders from 23 cultural institutions), the media (26 participants from 21 media institutions), 35 parliamentarians and young people, including individuals who are HIV-positive and teenage mothers, along with other special interest groups. Explicit mention of mainstreaming gender equality, human rights-based approaches and HIV/AIDs into CP is noteworthy. CO's clear and important mandate and its alignment with the strategy can be mentioned as a great strength, contributing positively to the CP. CO offers strong contribution to policy dialogue as well as national plans.

#### **b) Disadvantaged and vulnerable groups**

During the development of the CPAP, UNFPA CO followed a rigorous process to identify the focus districts for the 7<sup>th</sup> CP. A composite index was developed to rank the districts in the order of performance with the intention of focusing the support to interventions in areas/districts with poor indicators. The composite index included eight variables: total fertility rate (TFR), skilled attendance at birth, adolescent fertility (15- 19), women (15-49) who ever experienced physical violence, net enrollment ratio disaggregated by sex for secondary education, percentage of HIV/AIDS service availability, population growth rate and percentage of people living in poverty. The identification of districts for support was based on district ranking and the poorest districts in each of the four regions were considered to be included in the seventh. The selection criteria of identifying the focus districts itself gives attention to targeting the underserved and vulnerable populations.

Within these districts, sub-groups of vulnerable populations are identified (context specific) and targeted interventions are launched (e.g. women with fistula and women who have been victim of GBV and FGM); young girls who are forced into early marriage and sexual activity; youth including adolescents who are vulnerable to risky behaviors, MARPs, as well as refugee populations. The interventions under these and their outcomes are explained in detail under the programmatic sections in previous chapters of the report.

Evident by the findings, there is a focus on vulnerable groups by UNFPA sponsored activities in general, and this is particularly clear in the Reproductive Health and Gender components. Some of the informants who are implementing partners at the district level expressed that UNFPA is inclusive in its outreach and most segments

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<sup>7</sup>Aligned GOU/UNFPA CPAP results to the new UNFPA Global Strategic Plan, Aligned CPAP Planning and Tracking Tool: Results Matrix. Also see Table 8 of this report.

of populations that are not reached by other development partners are served by UNFPA interventions. This was evident in the districts by the presence of VHTs, SMAGs, YFCs, and interventions to support fistula repair, waiting room in the hospital for mothers who do not have easy and quick access to health facilities and support for abandonment of female genital mutilation/cutting (FGM/C) which utilizes a human rights-based approach. Various arrangements, with IPs' support, were visible in the districts to reach the needy populations. While there was conscious effort to include the disadvantaged and vulnerable populations, as they were defined within the context in which they lived, inclusion of PWDs was not very explicit in the interventions. While PD component provides required data, a systematic data base on vulnerable populations for monitoring and assessment of progress specific to these groups could not be found. Due to the limited records in data bases with regard to the vulnerable and disadvantaged populations, it is a challenge to assess changes unless close monitoring systems are in place to track these segments of populations.

Young people including adolescents are focused in interventions that are within UNFPA mandate. Although mainstreaming youth concerns in all aspects of programme interventions is not yet obvious, CO is integrating youth focused programmes strategically. Upstream advocacy supporting youth concerns, secondary school curriculum (discussions in progress to include primary schools as well), youth friendly services, and specific output dedicated to youth programmes in the CPAP are some examples of efforts taken by the CO.

### **c) South-South Cooperation**

South-South Cooperation alludes to conscious and systematic exchange of resources, technology, and knowledge between countries and institutions. The Strategic Plan of UNFPA puts emphasis on South-South Cooperation (SSC) as a means to address with more guarantees the challenges related to development. Areas of collaboration are identified and explicit in IPs Work Plan and Office Management Plans with several successful outcomes of SSC under this CP. Support to South to South initiatives are based on pre-identified priority areas and clear conceptualization. Some of the key results from the S-S initiatives include:

- The passing of the National Population Council Bill by Parliament. The Population Secretariat staff, staff from Ministry of Finance and Members of Parliament on the Parliamentary Forum on Food Security Population and Development visited Ghana to study the management of population issues. As a result of this, the parliamentarians mobilized for the passing of the NPC Bill that had been on the parliamentary agenda for more than 4 years.
- Undertaking the scanning technology for surveys and Census data capture and analysis. With UNFPA support, the staff from UBOS undertook study tours to various countries including Lesotho, Egypt, Ghana, Kenya and India to understand the new scanning technology for data capture and analysis. After the visits, UBOS adopted the technology which has so far been applied for the National House Hold Survey and the Pilot Census.
- With UNFPA support, Uganda hosted the South Sudan delegation to study how to improve provision of midwifery services in their country. Through this exchange, Uganda provided scholarships for South Sudan Students to study midwifery courses in Uganda.
- There was evidence that the Uganda CO acts as a hub for support to other UNFPA country Offices. CO staff supported other country offices like Humanitarian support to South Sudan and Madagascar/Seychelles, Programme support to Zambia, NY, Zimbabwe and ESARO. The CO together with ESARO hosted the East and Southern Africa Region Communications officers/focal points networking meeting.
- Building a team of Fistula Surgeons: UNFPA supported Ugandan doctors to undertake skills training in Addis Ababa. As a result a pool of TOT has been created in Uganda and this has enabled improve the capacity of the Regional Referral Hospitals to provide routine fistula repair.

While there are conscious efforts to promote S-S cooperation within the CP and has shown valuable policy outcomes as well as enhanced national capacities, mainstreaming SSC into the programme design and instituting a systematic way to measure it in the results framework was not apparent.

#### **d) National Ownership**

The delivery of country programme utilizes the national, sectoral and decentralized channels to achieve programme results. Using partnership approach, CP has been able to build strategic alliances within the context of national ownership and leadership, aligning with government priorities, while promoting active involvement of Civil Society Organizations (CSOs). Development and coordination of implementation of the CP has been done by government departments, as explained with evidence under the three focus programme areas

National Execution (NEX) is the main modality of CP delivery. While this has given an opportunity to build in-country capacity, feedback indicated challenges related to the timely reporting by IPs, late disbursements of funds and inflexibility of procedures. Corporate requirements call for high accountability for results. CO's role in supervision and monitoring creates pressure for high quality products and services from IPs and this need has been viewed as 'policing' as some IPs. There are apparent communication gaps although regular coordination meetings have been able to minimize these. Voices from IPs indicate that although the development of the CPAP (2010 – 2014) was done in a consultative manner, the 2011 re-alignment exercise did not seem to be clear to those at the implementation level, causing some misunderstanding with regard to the decisions for the changes that were made to the CPAP in response to corporate level requirements. Although it was brought to ET's attention that the changes were made by CO without consulting the coordinating agency, there had been formal exchange of communication with regard to the needed change in the CPAP and the work programme.<sup>8</sup> There is an apparent lack of communication within the staff members of implementing agencies which affects the relationship between the agencies.

Also observed was the inadequate information flow between UNFPA and IPs on one hand and within the IPs on the other. Sharing of information among the IPs and within their staff members was found to be weak resulting in only one or two key people in an organization holding most of the information. The staffs that eventually have the implementation responsibility may not have been part of the discussion and decisions made at higher levels. To a certain extent, this has affected the programme ownership and harmonious working relationship within some IPs. Several IPs lack leadership qualities, posing challenges to successful coordination and implementation of the programme

Due to the need for strengthening accountability, and the requirement to adhere to global regulations and rules, CO applies agency specific financial and reporting systems. CO is constantly engaged in supervision and monitors IPs closely in order to maintain accountability and quality assurance of the products and services supported by CO. As such the involvement of the CO in supervision and monitoring is seen as "too much control" by IPs.

To the contrary to what is said above, it was also noted that CO works within the government systems avoiding establishing parallel systems when working with government institutions. While this has slowed down the (according to feedback from respondents) process of implementation, the situation is understood/unavoidable and accepted. The use of existing government procedures and systems are seen as enhancing ownership and sustainability. CO's engagement in upstream advocacy role with the national counterparts had brought several successful results and there is strong national ownership at policy level. The capacity to build networks and work collaboratively with partners – specifically, government counterparts and civil society in the area of sexual and reproductive health outcomes has been seen as strength for the country programme.

#### **e) Capacity Development**

At the national institutional level, and throughout the eight districts covered by the programme capacity development is achieved mainly through training and providing the necessary logistics. This includes technical

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<sup>8</sup>Documents relating to the meetings organized by POPSEC to discuss the changes (Note to file on alignment).

training of staff at ministries, midwifery training, IPs and training of trainers (ToTs), which is an important factor to create spill-over effects and sustainability. Advocacy and upstream work have resulted in realization of several policies, laws and Acts. This capacity-building has shown results, as described in detail under the three programme areas.

Training is also provided at district and sub-district level for community resource persons like the VHTs, to peer-educators and GBV Action groups. This capacity development is also achieved at the more general level of the population through the sensitization and communication for behavior change. Penetrating to the village level, CO supports promoting and communicating key messages, via radio, to address the difficult and sensitive issues where stigma, pre-conceived ideas, prejudice and harmful habits/practices are common. Information provided through VHTs, peer educators, CSOs, and other channels allows the empowerment of beneficiaries and, more particularly, of women. They can better negotiate their sexual and reproductive life, advocate their rights, and become financially more self-sufficient.

In general, all the programme outputs in the CP include explicit strategy for capacity building. However, a noted weak area is the follow up of the outcomes of capacity building interventions. The number of trainees and number of workshops held are reported, but the expected outcome indicators were not very clear. Exceptions exist, for example in midwifery training, some South-South collaborations, where outcomes are measured with expected results. There is explicit focus on peer educators, and community capacity development via VHTs, capacity development of FBOs and myriads of CSOs, but how the investments in capacity building have translated to results on the ground is hard to measure.

In summary, the activities of UNFPA in Uganda are well-aligned with the principles of UNFPA Strategic Plan as realigned in 2011. Evidence from the design through implementation of the Country Programme indicates explicit focus on the various disadvantaged and vulnerable populations though there was limited evidence of strategic inclusion of PWDs. Support in terms of national capacity building of IPs, NGOs, is evident with positive results<sup>9</sup>. Despite success stories in outreach via IP consortium mechanism, there are weak areas related to building synergy among the IPs, specifically those in consortium arrangements. Explicit in the CPAP and OMP, South to South cooperation is thought out in the planning stage and there are good examples and success stories from South-South cooperation. Capacity building is a major part of the CP, while there are many positive results of individual capacity enhancement, linking it to specific sustainable capacity development at institutional level or programmes on the ground is not yet clear. Although mechanisms to strengthen national ownership and clearly embedded in the programme design and implementation modalities, the apparent gaps in communication between UNFPA and IPs and with IPs may undermine the gains realized in this area. No clear exit strategies included in the work plans.

## 5.2 Systemic Dimension of Strategic Positioning

**Evaluation questions:** To what extent is the GOU/UNFPA CP aligned with the UN strategy (UNDAF) in the country and to what extent is UNFPA CO coordinate with other UN agencies in the country?

The **systemic dimension** looks at the extent to which the GOU/UNFPA CP is aligned with the UN strategy (UNDAF) in the country. Comparative assessment of the plans and to some extent the alignment in implementation was assessed via document review and interviews with CO staff and a selected UN agency staff. The focus was on issues such as if elements of the CPD/CPAP are in line with UNDAF, if UNDAF reflects the interest and priorities and mandate of UNFPA, and the degree of coordination between UNFPA and other UN agencies.

<sup>9</sup> Progress reports, KI interview feedback, and IP feedback

The Evaluation found out that the UNFPA country programme is highly aligned to the UNDAF from the strategic outcome level, through the output results to the key interventions. “UNDAF Action Plan 2013-2014: Priorities for Strategic Change” specifies that the UN Strategy for change to include *coordination* as the priority. The UN should be operating in a coordinated manner to provide services to, protect the interests of, and engage with youth – with each agency bringing its comparative advantage to the comprehensive package. Identified roles for UNFPA are stated in the report as: “*evidence based advocacy for development, investment, and implementation; promotion of sexuality education; building capacity for sexual and reproductive health service delivery including HIV prevention, treatment and care and promotion of youth leadership and participation.*”

The UN agencies are brought together in the UNDAF implementation process. The UN in Uganda has 11 resident and 9 non-resident UN agencies in the early stages of “Deliver as One”. The recent existence of UN joint programming in Uganda has brought the UNCT closer and planning and implementation more aligned to UNDAF. Evident in the respondents’ feedback, and evaluators’ observation, were the willingness of UN agencies to work closer for more efficient and effective delivery. At the national level, there are several committees that bring UN agencies together and joint programming has been successful in building synergy in cases where UNFPA is participating. According to the feedback from almost all respondents, UNFPA has played an active role in coordinating and implementing key initiatives. UNFPA participates in 6 Joint Programmes ie HIV/AIDS (Chair of prevention); JP on Population (lead), JP on FGM (lead), JP on Gender Equality, JP on GBV (Lead) and JP on Climate Change.

UNFPA CO is represented in several technical groups and committees that contribute to the better coordination mechanisms of the UNCT including UNDAF outcome working groups. At the time of the evaluation, UNFPA was Chair of the Programme Management Team (PMT), and the Operations Management Team (OMT); co-chair of the United Nations Communications Team (UNCG) and the Joint UN M&E Team. At regional level, UNFPA chaired the United Nations Area Coordination (UNAC) in Moroto and Mbarara.

The evaluation also established the UNFPA has organized the UN around key activities including the CARMMA –U campaign, the National ICPD beyond 2014 Review that provided input to the National dialogue on the Post 2-15 agenda.

In summary, CP (and CPAP) is well aligned with UNDAF and reflects the UNFPA mandate and results. Evident from the respondents’ feedback, and observation of ET, coordination with other UN agencies is satisfactory. Joint programming was well aligned during UNDAF preparation and UNFPA is a key player in UN Joint Programmes and coordination mechanisms and in general, CO coordination role is well appreciated by other UN agencies. UNFPA is contributing positively to the UNCT, especially in joint programming; technical cooperation through coordinated programmes. Some UN agencies would like to see more symbiotic interventions (e.g. UNICEF, UNHCR) with UNFPA. There is more room for coordination, specifically in the interventions leading to similar objectives by UN agencies.

## 5.3 Responsiveness

**Evaluation questions:** To what extent has CO been able to respond to changes in national needs and priorities or shifts caused by crisis or major national disasters? What was the quality of the response?

Responsiveness refers to the ability to respond to changes and/or additional requests from national counterparts and CO’s position among the country development partners in view of responding to the country needs. This evaluation, via document review and interviews with relevant UN agencies, donor agencies, and CO staff, assesses the response capacity of UNFPA in terms of speed, timeliness, and quality of response.

The UNFPA's responsiveness in emergency situations is much appreciated by the UN agencies, particularly, UNHCR. UNFPA had been quick in its response to the emergency situation in the humanitarian field. The quality of contribution was not assessed as the activity occurred in emergency situation and all those contributing offer their input in the areas of their comparative advantage and competency. UNFPA has been flexible, adapting to evolving national needs and priorities. Humanitarian Response interventions were undertaken for the Kasese Floods victims, DRC refugees in Bundibugyo and Nyakabande Transit Centres and Rwamwanja refugee settlement. In general, UNFPA leaves the area once the emergency situation becomes normal, but due to the value and the quality of technical input, more regular and continued interventions in the area of SRH is expected of UNFPA, by other agencies on humanitarian grounds, even after the emergency situation.

CO has a designated person to coordinate humanitarian disaster preparedness and response. However, according to the interview feedback, CO has experienced delays in responding due to financial delays from HQ. This has caused some difficulty as timely input was not possible. Based on this, CO is setting up contingency plans for emergency situations to avoid non-response resulting from these gaps.

CO has been able to respond constructively to the country needs other than in emergency situations. Examples are CO's response to a national priority area based on an evaluation outcome where midwifery education was found to be needed. As a result a strong contribution to the midwifery training is supported by UNFPA to GoU. Supporting the MoH to develop the Reverse Logistics Strategy facilitating the redistribution of contraceptives between HCs within districts and National Medical Stores, setting up of FP Working group (FPWG) at MoH, and establishment of a waiting room for mothers in Kanungu are some of the examples CO responses in non-emergency setting at the request of government. The support to the establishment of the Alternative Distribution Mechanism for RH commodities is another case where UNFPA responded to the emerging need to improve access to Government procured commodities by the non-state actors. The evaluation team also noted that UNFPA expansion to Busoga Region for FP services was a result of government request after the 2011 DHS revealed that fertility levels as well as Contraceptive use were real issues in the region.

In most cases, the response of UNFPA is well-aligned with the priorities and objectives set in its strategic plan as well as in the CPAP. CO is highly responsive to demands from partners and to changing priorities in emergency as well as non-emergency situations. Evident from above examples, CO had been able to respond to changing national needs and had taken the opportunities to develop new initiatives within its mandated areas.

## 5.4 UNFPA's Added Value

**Evaluation question:** To what extent does UNFPA CO adds benefit to the results from other development actors' interventions (stakeholders' perception about UNFPA in the Country)?

Added value measures the extent to which the UNFPA Country Programme (CP) adds benefit to the results from other development partners' interventions. It is the added value of UNFPA within the country development framework. This framework is composed of the government, donors, CSOs, national and international NGOs, UN agencies and other agencies and organizations that work on RH, gender, and PD in the country.

Evident from the long list of added value mentioned, UNFPA CO has high recognition for its added value from other development partners. This stems from comparative strength resulting from generic corporate features of UNFPA (those characteristics of UNFPA as an agency) as well as country specific comparative strength. Some common themes that emerged from respondents on added value strengthen the observations made by the evaluators and what is documented in the CO reports. Some relevant comment summaries are as follows:

- ✓ Long experience in the field of RH and FP services and commodities (*“changed the face of FP in Uganda”*). Increase in FP usage on top of Uganda’s development agenda. This has enabled UNFPA to make progress on complex agendas. The added value of UNFPA lies in the fact that it is the only development partner active in some areas.
- ✓ Well established systems (guidelines, policies, accountability systems) that can be replicated; Great and clear mandate and keeping to it; Wealth of experience – long years of experience in the field; Partnership and collaboration. Some of the country specific comparative strengths are in the area of midwifery training, Joint programming experience – bringing the development partners together (good coordination and leadership role)
- ✓ Advocacy (upstream) role, very strong partner in advocacy area.
- ✓ Inclusive approach in outreach, Supply chain system (inbuilt system and involved the staff -sustainable one)
- ✓ Capacity of DHOs (in some focus districts) increased as a result of CP; Very Resilient (does not give up!)
- ✓ In each of CP three focus areas, UNFPA has made good use of its comparative strengths, thus bringing added value to the country. One of those comparative strengths consists in the UNFPA recognized technical expertise. It allows the CO to act as a facilitator, mostly in the field of Reproductive Health. The UN joint programmes have entrusted UNFPA with the implementation and management of the funds. CO is an active partner, harmonized approach performing strong and taking a lead in most of the joint programmes.
- ✓ UNFPA proved to have a specific ability in policy dialogue, and particularly in placing sensitive themes on the national agenda. According to all development partners, the advocacy and dialogue (upstream) at national level has been one of UNFPA’s important added value (eg. increased government support to FP).
- ✓ UNFPA is the main organization addressing the data question especially supporting UBOS regarding preparatory activities for the National Housing and Population Census

In sum, the added value of UNFPA as a development partner is high, particularly where UNFPA has acted as a facilitator. Its ability and commitment to be engaged in upstream policy and advocacy and specifically to table sensitive themes on the national agenda, such as the increased services in FP, SRH and GBV; and the contribution of technical expertise are regarded as CO’s greatest strengths. In some cases UNFPA is recognized as the major player and/or lead especially in Family Planning, Data (Census) and Population Dynamics.

## CHAPTER 6: Transversal issues and assessment of the Monitoring and Evaluation System

UNFPA is increasingly attaching a lot of importance to improving partnerships and monitoring and evaluation system in delivery of development programmes across all organizational units. The UNFPA strategic plan clearly spells out the need for strengthening partnerships especially focusing on strategic partners as well as establishing strong M&E systems in order to address the issue of programme measurability identified in the MTR of the Strategic Plan. This section analyses the partnership and implementation mechanisms and the CO M&E system.

### 6.1 Partnerships and implementation arrangements

UNFPA partners include UN Agencies, Government (National Ministries, Autonomous Agencies), District Local Governments, Local and International NGOs, Faith Based Organizations and Cultural Institutions. This diversity of partnerships is a result of the uniqueness of the UNFPA mandate that touches the centre of human existence ie Population, Sexual Reproductive Health and Gender. The partnerships are centred around common objectives including

- Partnerships to advance a common agenda: This is mainly with the UN Agencies especially UNICEF, WHO, World Bank in advancing the Maternal and Neonatal Health in Uganda. One case where this partnership was brought into action was during the CARMMA campaign where UNFPA partnered with Un Agencies and major NGOs like Save the Children, World Vision, Family Health International to conduct a campaign to raise the profile of maternal and neonatal mortality in Uganda. The second case of such partnership was in 2010 when UNFPA, WHO, UNDP, UNICEF worked with Ministry of Finance Planning and Economic Development and Ministry of Health to advocate for the focus on MDG 5 in the 2010 MDG report. AS a result, the MDG report included a Framework for Accelerating Achievement of MDG 5.
- Research partnerships especially with research institutions like Makerere University (Department of Population Studies and School of Public Health), the Uganda Bureau of Statistics, the National Planning Authority mainly to generate evidence to inform the advocacy efforts and for evidence based decision making. However, the research partnership was not well developed.
- Programme Implementing Partnerships where UNFPA partnered with different organizations to implement the GoU/UNFPA Seventh Country Programme. This is the most common and known form of UNFPA partnership with other organizations.

Under the programme implementation partnerships, by the time of the evaluation, UNFPA Country Programme had 30 implementing Partners comprising of 5 National Government Departments, District 8 local Governments and 17 Civil Society Organizations. The guiding instruments for this partnership were the Letter of Understanding and Annual Workplan signed between UNFPA and the IP. Most of these organizations were standalone implementing partners while in other cases the Implementing partner had contractees with which it delivers the AWP in a consortium arrangement.

As discussed under efficiency, although there were mechanisms to guide the programme implementation partnerships, some IPs voices pointed to hindrances related to administrative regulatory framework. On the other hand GoU procurement systems were noted as very slow, and contributed to none expenditure on budgets and the return of funds to UNFPA, some stop gap measures included delivery through CSOs for Government

activities. Funds absorption challenges at IP level curtail efficient planning for resources to the extent that funds that would have benefitted the country in other areas are returned to HQ. Some IPs, however, attributed funds transfer delays to own reporting delays and believed that it is not easy to meet the set deadline.

The consortia arrangement was a common mechanism especially to partners that had big budgets and these included

- Reproductive Health Uganda Consortium comprising of RHU (IP), AIC, Marie Stopes Uganda, and Uganda Health Marketing Group implementing Family Planning, HIV/AIDS prevention interventions
- The UUNET Consortium comprising of UWONET (IP), ACFODE, FOWODE, ACTION AID, MIFUMI, and FIDA implementing GBV and Gender Equality interventions
- The MGLSD consortium comprising of MGLSD (IP) and 9 District Local Governments, Law Reform Uganda, Association of Women Judges, REACH, POZIDEP and MAZIDEP implementing GBV and FGM/C prevention and response interventions
- The POPSEC consortium comprising of POPSEC (IP), 7 District Local Governments, FBOs (UMSC, SDA, Orthodox) implementing Data, FP, GBV and MH interventions
- The Red Cross Consortium comprising of URCS (IP) and Naguru Teenage and Information Centre implementing ASRH interventions.
- The ARC consortium comprising of ARC (IP) and IRC, WCC, WC UK, CARE, RLP, ASB and COOPI implementing the JP on GBV.

The challenges faced under the programme implementation partnerships varied from partner to partner. The IPs in the consortium arrangement raised major implementation, coordination and management issues compared to the standalone IPs. On one side, UNFPA sought to leverage partner technical comparative advantage through consortia arrangements, among IPs for with a view of creating networks and strengthening synergies for better results. In cases where the consortium arrangement worked, major results were achieved eg regarding high number of new FP users served in case of RHU and MSU; and creating a critical mass of community activists against GBV using the SASA methodology in case of the ARC consortium; successful advocacy for passing of GBV related laws in case of the UWONET consortium.

**Box 10: Evaluative assessment coordination, consortia challenges**

- In reference to UNFPA CO's internal document on DOL to strengthen IP coordination, our judgment is that UNFPA program staff were mentored for success and delivery of the program, while the participating IP staff were not equally prepared, UNFPA staff thus deliver their roles and create demands at a faster pace than IPs. This creates a need to empower IPs on coordination role to strengthen synergies and harmony.
- Similarly UNFPA staff and Partner staff in program leadership role would benefit from leadership and management training modules. Such empowerment should have the mutual benefit of strengthened partnership, and management of partnership relations.
- Equally important is that UNFPA partnership standards are reflected on annually, staff and partners should do joint self-assessment around partnership, what works and what does not work, lessons learnt and commit to joint implementation of remedies, mutual accountability & respect for program quality and stronger harmony.
- The feedback and technical support from UNFPA to IP need to be improved and done in time for IPs to be able to learn and act on the feedback and technical assistance.

**Source: CPE7 field data – a triangulation KIs, FGDs**

However 2/3 of NGOs, that played the role of lead IP for consortia at the time of the evaluation felt managing and coordinating the consortium was an added responsibility and the formation of the consortia was poorly perceived. Furthermore at the time of the evaluation, the ARC led consortia that had 9 NGOs working together had just been disbanded due complications in managing the consortium members. The splitting of the ARC consortia was a red flag (an awakening) on consortia management weaknesses and a threat to implementation

continuity. Other challenges cited were around communication and information exchange between the lead IP, UNFPA and consortia members; often consortia members had key program information from UNFPA that the lead IP was unaware of. Another issue was that sometimes new consortia members were brought on board without sufficient discussions with the lead and this undermined the IP contract relationships.

Although the consortia arrangement, is well managed, has the potential to yield greater results, the these challenges identified need to be addressed immediately, and be taken as lessons around participatory consortia management, district IP coordination and leveraging synergies.

In summary, UNFPA has productive and strategic partnerships that have the potential to advance UNFPA mandate. The programme implementation partnership is constituted of a variety of partners drawn from Government, Civil Society, Faith Based and Cultural Institutions and this is ideal given the components of UNFPA country Programme. The consortium arrangement was an innovative approach to rally partners with similar objectives to deliver together around key UNFPA outputs. Although this approach delivered tangible results, it also is faced with a number of challenges related to consortia formation, coordination and management. UNFPA should pay immediate attention to emerging partnership and consortia challenges for better program quality and results. Addressing this as an organizational development challenge will necessitate mutual learning, accountability and change.

## **6.2 The Country Office Monitoring and Evaluation (M&E) System**

The effectiveness of monitoring, evaluation and reporting was assessed through documents review. The documents reviewed were the CPAP (2010 - 2014), the M&E Framework (2010), Monitoring reports and Programme progress reports. The assessment focused on the following issues:

- Existence of a clear framework for M&E and Coherence of the programme logic.
- Partnerships and linkages with national M&E institutions and frameworks;
- Extent to which performance monitoring was undertaken ie monitoring inputs, activities and outputs;
- Extent of utilization of results from the M&E system for programme and project management;
- Existence of capacity enhancement measures for results based monitoring;

The CPAP Results and Resources Framework, the CPAP Planning and Tracking Tool and the CPAP M&E Calendar were assessed for adequacy in measuring programme results. The M&E Framework was assessed for appropriateness of content to guide the programme in achieving and measuring results. It was also assessed for achievement of intended M&E processes.

### **6.2.1 Framework for Monitoring and Evaluation**

The Monitoring and Evaluation Framework enables IPs and the CO to collect required data for decision making and programme delivery. The baseline estimates for national level indicators were estimated using a baseline study conducted at the end of 2009 as part of finalization of the CPAP. This was a good practice that enabled the CO to establish baseline values and set indicator targets before the start of implantation.

#### **a) The CPAP ‘Results and Resources Framework’ and ‘Planning and Tracking Tool’**

The CP M&E system is set around the CPAP results at output and sub-output levels with a detailed M&E Plan. The results chain is clear with CPAP outputs/results contributing to the outcomes of UNDAF and larger objectives of the National Development Plan. CP outputs were further broken down to Sub-Outputs to address the issue of the programme logic. Each output and sub-output has clear indicators to measure achievement and/or make it feasible for monitoring and to assess if the implementation is in the correct path and direction.

The CPAP Results and Resources Framework was complete. Indicators in both the CPAP and M&E Framework were sufficient to facilitate measurement of results.

- The CPAP Planning and Tracking Tool have all the baseline data and annualized targets. This makes it easy for programme managers to focus on yearly targets.
- Indicators are similarly stated in the CPAP Results and Resources Framework, and the CPAP Planning and Tracking Tool as well as the M&E Framework.
- Most of the indicators are adequately stated to guarantee common understanding by the implementation stakeholders. The few that were not clear at the beginning were modified during the alignment of the CP to the revised SP at the end of 2011.

The programme logic presented through the CPAP was robust. There is a clear linkage between resources, activities, outputs and outcomes. The program design logically contributed to four UNDAF outcomes as well as the UNFPA strategic plan as already outlined. The CP took into consideration the delivery systems particularly decentralization, by emphasizing a district specific approach as evidenced by local governments that were IPs..Within the mandate of UNFPA, the strategic actions in the three programme areas had a synergistic effect on achieving national development outputs and outcomes. It was further noted that the input, output and outcome relationship in the three thematic areas of Reproductive Health, Population and Development and Gender were logical. However, the allocation of resources to the outputs in the results and resources framework seemed to have been arbitrarily done.

#### **b) The CPAP Monitoring and Evaluation Calendar**

The CPAP M&E Calendar was complete. . There was sufficient evidence that most activities in the calendar were undertaken. These include the annual panel survey, DHS 2011, further analysis of the DHS data, CP quarterly and annual review meeting, UNDAF Annual reviews, Routine field monitoring visits and M&E capacity building for partners. However, some activities especially those related to census undertaking and CP midterm review were not done.

#### **c) Monitoring and Evaluation Framework**

The Country Office (CO) has a guiding M&E Framework developed in 2010 and revised in early 2012 to cater for the alignment to the revised strategic plan. The M&E plan restates the CPAP results framework (outputs, indicators with baselines and annualized targets) and the M&E Calendar. Also included are the M&E activities; roles and responsibilities; mechanisms for programme coordination; tools /templates and indicators definition/reference sheets. One key feature of the M&E plan is that it reflects the Key Performance Indicators (KPI) to be tracked periodically quarterly and annually. These KPIs in assessment of the likelihood of achieved of intended results at either activity or output levels.

### **6.2.2 Extent of performance monitoring – inputs, activities and outputs.**

The CO effectively engaged in performance monitoring over the course of the 7<sup>th</sup> CP. Performance monitoring was guided by the CPAP M&E calendar and quarterly monitoring plans developed during the course of AWP implementation. The M&E Unit developed a matrix to monitor submission of these plans, and a reporting format to monitor compliance with these plans. The CO also ensured consistent use of the Field Monitoring Report as stated in the UNFPA M&E Guide. In some instances, implementation decisions were taken based on these facts, for example, change of priority areas and diverting resources to such emergency issues under RH component. To enhance management decision making, the CO produced quarterly and annual reports. Monitoring of performance was done at two levels a) monitoring inputs and activities and b) monitoring outputs. The monitoring visits were structured in a way that they provide for assessing progress in implementation of the AWP activities, assessment of utilisation of funds including appropriateness of financial accountability and management mechanisms. In other words, there was integrated programme and financial monitoring. The monitoring teams comprised of programme and finance staff. The visits also looked at the progress in achieving the annual output and sub-output targets as stated in the AWP. The fact that most of the output indicators derive their data from the existing national systems for collection of routine administrative data makes it easy for the CO to monitor the output indicators. The regular programme review meetings also provide another avenue to monitor and discuss the programme activities as well as progress in achieving results. The Evaluation team saw the IP reports, field monitoring reports and quarterly/annual review reports that provided evidence of input, activities and output monitoring.

Overall, the monitoring of the inputs, activities and outputs can be considered satisfactory. The Evaluation team was able to get sufficient information from the existing reports like the Annual Programme review reports, Standard Progress reports, Field Monitoring Reports and the Country Programme Annual reports to inform the evaluation. However, there is need to establish an electronic or web-based M&E database to ease access to programme performance information.

### **6.2.3 Extent of utilization of results from the M&E system for programme and project management**

There was evidence of utilization of monitoring and evaluation results (including supervision reports, quarterly, annual and ad hoc reports). To a great extent, M&E results were used to highlight and address implementation challenges during programme coordination meetings. Bottlenecks and best practices identified from joint field visits were discussed during those meetings. The existing M&E framework enabled management to use M&E information for decision making. There are cases where M&E information has resulted in changes in modalities of engagement with partners. A notable case is the suspension of funding to Oyam district when the monitoring visits established that there was no value for money in programme implementation in the district. Also, when monitoring visits found out that the FP outreaches were conducted in diverse manner, management took a decision to develop guidelines for conducting FP outreaches which were being used at the time of the evaluation. In addition, there was a clear evidence of feedback from CO to IPs on the reports that they submit and monitoring visits.

The M&E Unit also used M&E information to follow up implementation challenges (both programme and financial) with IPs. However, utilization of products from the M&E framework was limited by lack of a clear follow-up strategy of constraining factors observed during the previous quarter.

#### **6.2.4 M&E coordination**

The Population Secretariat, Ministry of Finance Planning and Economic Development, is the government institution responsible for coordinating the M&E function. The CP's M&E function is managed by a multi-stakeholder coordination committee. Each of the implementing partners has staff that performs the M&E functions. CO has one dedicated M&E person at a senior level and another M&E officer specially recruited for joint population programme. The M&E function at CO is positioned under the policy and oversight unit, and regularly feeds/updates the information needed for management decisions and guidance on Programme Design & Implementation.

Under the leadership of the Population Secretariat, Quarterly Programme Coordination Meetings are held to examine progress in implementation of quarterly work plans. Programme outcome managers present and submit quarterly progress reports at this meeting where progress towards achieving quarterly and annual targets is discussed and actions for addressing identified issues and fund allocations are decided in a team. At the end of each year an annual review and a planning meeting are held to review progress towards achieving annual results and to develop annual work plans and budgets for the following year.

The Work Plan Monitoring Tools are completed for each work plan to enable assess quarterly and annual progress in implementation of the work plans and the Standard Progress Reports (SPRs) provide information to assess progress in achieving annual results as stipulated in the CPAP. On reviewing the documents, M&E plans, progress reports, and interviews with KIs and CO relevant staff, there is evidence that M&E results are utilized for decision making, planning and guiding implementation.

#### **6.2.5 Existence of capacity enhancement measures (for UNFPA and IP Staff) on results based monitoring and evaluation**

Annually, the CO had a specific resources to train IPs in results based management and M&E. A budget line for capacity enhancement for results based monitoring should be maintained under the P&D programme, to train more staff from IPs on results based monitoring and results based management. In addition each IP has M&E resources in the Annual Workplans. The evaluation team was able to establish that M&E/RBM training for IP and UNFPA staff was conducted in 2010, 2011 and 2012 with an average of 60 staff trained each year. The focus on training is mainly on Planning for results/formulating results and indicators, implementing for results, monitoring results and reporting results. 15 UNFPA staff have also undertook the online RBM course in 2012. An internal assessment report observed improved reporting of results from IPs.

UNFPA together with POPSEC orient IPs on coordination mechanisms, reporting, M&E data management & reporting during the regular meetings such as Joint Quarterly Programme Coordination Meetings (JQPCM), Annual Review and Planning Meetings (ARPM), Joint Field Monitoring Trips, and M&E Technical Committee Meetings.

Measurement indicators of M&E capacity building (CB) initiatives are lacking. There is evidence of needs analysis, pre and post-tests (as per progress reports post-test are generally not done systematically) designed for learning events at individual level. Results-focused capacity development is a strategic and country-led approach and it should extend beyond individuals

Strengthening institutional capacity in support of the development goal is planned; however results measurement of the CB at institutional level was not explicit.

Observation of the contents in the progress reporting over the years show improvement in results' reporting and show evidence of change in understanding M&E issues. This has been achieved through continuous training, mentoring and "on the job" training on reporting results and progress monitoring. However, more follow up is necessary to assess if the CB has produced results as planned at implementation for results. Attrition also mentioned to be an issue hindering any impact at application level and repetitive training is expensive and not feasible under the given circumstances in the districts.

#### **6.2.6 Good Practices:**

- The CO has adequate resources dedicated for M&E. There was a dedicated M&E unit in the CO, which ensured effectiveness of M&E processes. The dedicated M&E team in the CO diligently followed-up on both financial and programme documentations. In terms of financial resources, the CO allocated resources under ACTIVITY60 to facilitate monitoring. Each IP AWP has financial allocation for M&E.
- Frequent and consistent monitoring visits that focused on both financial and administrative issues as well as results were observed. This strengthened the fact that monitoring should not only be programmatic but also financial, which is a major CP input. Systematic financial monitoring reduces CO OFA.
- A report indicating, "Status of submission of AWPs, Quarterly Work Plans/Requests and Quarterly Reports" was also a good practice and should be maintained in the next CP.
- The activity reports submitted by IPs were good practices as they provided information to project managers on what to include in their quarterly and annual reports.
- Quarterly review and analysis of IP reports by the M&E Unit helps identify the performance of the IP in terms of timeliness of reporting, completeness of reporting, quality of results reporting, fund utilisation rates. Quarterly results produced by the IP are captured at this point. A report for each IP is produced that forms basis for quarterly advance. The feedback provided to the IPs based on this analysis is key to improving IP performance.
- The frequent discussion of issues from field monitoring reports and IP quarterly reports in programme and senior management meetings provides adequate information for management to use in making informed decisions.

In Sum, CPAP has a robust results framework that shows linkages between CPAP, UNDAF, NDP and UNFPA Strategic Plan results. All the indicators have baselines and annualized targets that make easy to assess annual performance. KPI that enable assess milestones are clearly spelt out the M&E Plan, that also has the indicator definitions as well as M&E tools. Monitoring performance (inputs, activities and outputs) is categorized as satisfactory. The monitoring information for both activities and results is readily available at the Country Office. There is sufficient evidence of M&E coordination and ownership by the National coordinating Authority (POPSEC) as well as the IPs. The CO office attaches a lot of importance to M&E and has thus allocated sufficient resources for the purpose. There have been a concerted effort by UNFPA and POPSEC to strengthen the national partners' capacity to do M&E function better by providing an on the job as well as formal M&E training. The observable efforts to improve M&E capacity for UNFPA and IP staff have yielded results. However, measurement indicators of M&E capacity building (CB) initiatives are lacking. There is a need for easy access to monitoring data by the users. What are currently available are the quarterly and annual programme as well as project reports that have all the needed information. There is a need to establish a database including a web-based one which will enable the users' easy access to relevant data at any given time.

## CHAPTER 7: Conclusions and Recommendations

The conclusions and recommendations of this evaluation and are arranged into three main sections: Strategic Level, Programmatic Level and Transversal (Partnerships and M&E system) taking into account the Evaluation Criteria under each section.

### 7.1 Main conclusions

#### 7.1.1 Strategic level

**Conclusion 1: The activities of UNFPA in Uganda are well-aligned with the priorities and principles of UNFPA Strategic Plan (2008-2011, and the revised SP 2012 - 2013). There was deliberate focus on disadvantaged and vulnerable groups both in the design of the CP as well as during implementation, although there was no sufficient data to measure changes that may have happened to such population as a result of the programme. The CO and partners engaged in South to South Cooperation initiatives that yielded tangible results for the programme. Capacity building is a major part of the CPAP, while there are positive results on the ground, an existence of a strategic approach to capacity-building was not explicit in the results framework.**

The activities of UNFPA in Uganda are well-aligned with the principles of UNFPA Strategic Plan as realigned in 2011. Evidence from the design through implementation of the Country Programme indicates explicit focus on the various disadvantaged and vulnerable populations though there was limited evidence of strategic inclusion of PWDs. Support in terms of national capacity building of IPs, NGOs, is evident with positive results. Despite success stories in outreach via IP consortium mechanism, there are weak areas related to building synergy among the IPs, specifically those in consortium arrangements. Explicit in the CPAP and OMP, South to South cooperation is thought out in the planning stage and there are good examples and success stories from South-South cooperation. Capacity building is a major part of the CP as observed in the CPAP, AWP and OMP, while there are many positive results of individual capacity enhancement, linking it to specific sustainable capacity development at institutional level or programmes on the ground is not yet clear. Although mechanisms to strengthen national ownership and clearly embedded in the programme design and implementation modalities, the apparent gaps in communication between UNFPA and IPs and with IPs may undermine the gains realized in this area. No clear exit strategies included in the work plans.

**Conclusion 2: The Country Programme is well aligned with UNDAF and UNDAF reflects the UNFPA mandate and results. UNFPA CO is contributing significantly to improving the UNCT coordination mechanism, especially in joint programming and in most cases as a lead agency. UNFPA has used its central role in the UN Coordination mechanisms to organize the other UN agencies to support the ICPD agenda.**

The coordination with other UN agencies is satisfactory, and Joint programming was well aligned during UNDAF preparation and UNFPA is a key player in UN Joint Programmes and coordination mechanisms like the PMT, OMT, UASC and UNDAF Outcome TWG. In general, CO coordination role is well appreciated by other UN agencies and some UN agencies would like to see more symbiotic interventions (e.g. UNICEF, UNHCR) with UNFPA. In Joint programming cohesion has been a challenge when working with several agencies that have their own mandate, work plans, and priorities. With the emphasis on Delivering as One (DAO), there is

room for synergy if more time could be invested at planning stages –DAO is not in effectively implemented yet. The evaluation also established the UNFPA has organized the UN around key activities including the CARMMA –U campaign, the National ICPD beyond 2014 Review that provided input to the National dialogue on the Post 2-15 agenda.

**Conclusion 3: CO has been highly responsive to demands from partners and to changing national priorities both in humanitarian and development scenarios. There were cases of delays in provision of humanitarian response especially for Kasese flood victims. The country office established a humanitarian unit and has integrated humanitarian activities into the workplans to quicken its response in case of crisis. It also takes advantage of opportunities to develop new initiatives within its mandate areas.**

The UNFPA's responsiveness in emergency situations is much appreciated by the UN agencies, particularly; UNHCR/UNFPA had been quick in its response to the emergency situation in the humanitarian field including refugee and natural disaster crises particularly in the areas of SRH and GBV. In terms of development programme responsiveness, there is evidence that the CP made adjustments to respond to the changes from government especially in FP Commodity distribution to non state actors, Reversal logistics to address stock outs and FP service provision in Busoga region which was found to have poor SRH and FP indicators by the 2011 DHS.

**Conclusion 4: The added value of UNFPA as a development partner is high, particularly where UNFPA has acted as a facilitator. Its ability and commitment for advocacy and lobbying, especially to table sensitive themes on the national agenda, such as the increased services in FP, SRH, and GBV are well appreciated by the development community. The contribution of technical expertise and capacity building is regarded as the CO's greatest strength. In some cases UNFPA is recognized as a major player and/or lead especially in Family Planning, Data (Census) and Population Dynamics. The stakeholders note that the advocacy agenda for the ICPD is not yet over.**

The CO's added value in the three programme areas are clearly appreciated by other partners. Key role played by UNFPA CO in upstream advocacy, well established financial and procurement systems, high technical expertise in the mandated areas, networks and relationship with the Government institutions have been identified as added value. Specifically for being a forerunner in sensitive issues/ areas such as FP, HIV/AIDS prevention, sexual and reproductive health, GBV, have been identified as positive contributions. Technical expertise in the country office is appreciated by the development community and confirmed that UNFPA uses its competitive and comparative advantage "to get things done well." Long experience in the field of sexual and reproductive health; commodity procurement systems; CO's technical expertise, and the ability of CO to call on outside expertise (from other UNFPA countries and HQ); the cordial relationship with the government and the established networks have been regarded as positive contributions to the CP. However, in a few cases, partners especially NGOs and districts perceive UNFPA added value from a narrow angle of providing small financial and material contributions.

Partners note that although UNFPA was instrumental in mobilizing partners around the ICPD agenda, this advocacy momentum need to be continued even into the Post 2015 development agenda. This is because the most of the ICPD related aspirations in the area of population and development, SRH, Adolescent Health, urbanization and Gender equality have not been realized.

### 7.1.1 Programmatic Level

#### 7.1.2.1 Conclusions related to relevance of Relevance of P&D, RH and Gender

**Conclusion 5: There is evidence that P&D RH and Gender interventions were relevant, in line with NDP, Vision 2040, sectoral policies line the national Population Policy, the Health Sector Strategic Investment Plan, the Social Sector Strategic and Investment Plan and the National Gender Policy and all advanced their respective ICPD agenda. The focus of the CP in line with the needs of the population as articulated in the different national planning frameworks as well as from the expressions of communities during this evaluation. Focusing on SRH and GBV prevention and response, as well as reproductive rights is relevant to national, regional and global protocols. However, the Evaluation team observed that the implementation of the UNFPA supported programmes by the partners of done in a vertical fashion with minimal integration into the IP's own programmes.**

Based on the data and evidence from the planning needs expressed both at National and Sub national levels, and review of the P&D related objectives of the national development frameworks and requirements of a highly decentralized system of governance, the evaluation team considers that the P&D component of the Country Programme is relevant and the decision to undertake P&D interventions at the national and district level was reasonable and advanced the ICPD agenda. However, much attention still needs to be given to Youth in development agenda.

There was evidence that the RH component was aligned and relevant to the Uganda National Minimum Health Care Package as defined in the Health Sector Strategic Investment Plan 2010/11 to 2014/15, was in line with ICPD plan of action, CARMMA and Maputo plan of action. Interventions on midwifery services and fistula care, FP commodities provision, targeting MARPS for HIV prevention, Revitalization of comprehensive condom programming was needed to increase access and utilization of both female and male condoms and establishment of Adolescent friendly reproductive services were in line with national and local priorities. The programme focused in the districts that had very low SRH/HIV indicators thus addressing the actual needs of the population.

Similarly the Gender Equality and Reproductive Rights component was rated highly relevant and based on National Gender Policy and planning frameworks, was acknowledged as enabling national and local government implement priorities on gender equality and reproductive rights. Was in harmony with regional instruments, international protocols, charter, African bill of rights, UN Security Council resolution 1325 and 1820 and Goma declaration and focused on MDG 3, while contributing directly/indirectly to MDGs 1,2,4,5 &6. The Gender Component also addresses the fundamental elements regarding discrimination against women, male involvement, Gender Based Violence and FGM in line with the ICPD PoA. The focus of the component strongly addresses the GBV and Reproductive Health needs of the population.

#### 7.1.2.4 Effectiveness-: Population dynamics &Data integration

**Conclusion 6: The P&D component interventions resulted in increasing data availability both at national and district levels, and increased the appreciation and use of data for decision making. The integration of population issues has reached all government levels. The capacity for staff in the National and District planning units for integration of Population Issues was strengthened as seen from the level of integration of such issues in the National and district plans. However, the framework for integration that has been established need to be effectively enforced from the strategic level of the National Planning Authority , Ministry of Local Government and Ministry of Finance Planning and Economic Development. Updated user friendly data on youth and vulnerable populations was not readily available.**

At National level the DHS and National Panel Survey reports were produced, in-depth analysis reports are also available to inform the ongoing review of the National Development Plan. At district level, district harmonized databases have been established to provide data for district planning. UNFPA Capacity development efforts saw a number of districts integrate of population dynamics into plans. However, the areas that still need attention include Advocacy to Government on resource allocation for the National Population and Housing Census, improving accessibility to IMIS, functionality of the district databases and strengthening the functionality of the youth coordination structure at Ministry of Gender, Labour and Social Development.

The IMIS database although accessible continues to use the 1991 and 2002 census data. The implementation of census has delayed. The data on youth and vulnerable population is not readily available in a user friendly form. GBV survivor information is not readily accessible at districts.

#### 7.1.2.5 Effectiveness Midwifery services, Family Planning, HIV/AIDS prevention and ASRH

**Conclusion 7 - Midwifery: The country Programme results on strengthening the health system to improve midwifery services have been achieved. Results on policy and legislation aspects, however, remain work in progress. The downstream program work needs more investments and more time (cycles) to create significant change in indicators. Integration of Nutrition with Safe Motherhood RH services could be a game changer that contributes to reduced maternal neonatal mortality. Although humanitarian response interventions were undertaken under this output, the efficiency of the response and results were not followed through.**

Most of the service delivery targets including deliveries in HFs, HF capacity for EmOC and Fistula repair have or on track. The revision of the midwifery training curriculum and the Nurses and Midwifery act of 1996 has not been concluded. The strategies employed i.e. advocacy and capacity building and the respective activities were rightly employed to facilitate achievement of results.

Although improvement in RH indicators was noted, Karamoja region continues to lag behind national averages, it was noted that Karamoja region participates more where interventions are integrated with food aid. Equipping health facilities was novel; however service providers at facility level were not fully skilled for EmONC, did not know how to use the machines and some of the machines had broken down. Coverage of initiatives like YFC, ASRH remains low, with few pilot sites in targeted districts.

**Conclusion 8 – Family Planning: The Country Programme catalyzed concerted efforts in mobilizing institutional and social structures to facilitate increased uptake of family planning. The Family planning indicator targets that the CP sought to delivery were generally achieved. The alternative distribution mechanism helped avail the FP commodities to non state actors. However, as the uptake of FP services increases, there is need to ensure the quality of services as a human rights principle.**

The multi-faceted mobilization strategy employed by the CP was effective in reaching communities with FP services thus increasing, more than three times, the annual number of new FP clients between 2010 and 2013. Both health workers and community volunteers were trained to strengthen capacity to offer and increase access to utilization of FP services. Innovative ways of taking commodities to service delivery points for non state actors (although not yet formalized) and ensuring reduced stockouts in government facilities were employed by the CP. In addition, integration of FP and HIV service delivery was a very useful strategy in increasing uptake. Reports from the field point to the fact that the programme focused more on improving access, by way of increasing numbers of FP users, without necessarily giving the similar attention to the quality of service provision especially during FP camps that attracted large numbers

**Conclusion 9 HIV/AIDS Prevention: Results under the H/AIDS prevention which mainly aimed at creating a conducive policy environment for HIV preventions for MARPs have been achieved. The country programme initiated innovative ideas to increase access to HIV prevention services, within the Comprehensive Condom Framework, that are either not yet completed or scaled up.**

The targeted policy and strategy frameworks for improving MARPs' access to HIV/AIDS prevention services were developed notably the SRH/HIV/AIDS integration strategy, National HIV Prevention strategy and the Action Plan for HIV prevention among sex workers. A number of initiatives that were designed for scale up include review of the training modules for integrated management of pregnancy and related conditions and adult illnesses (IMPAC/IMAI), adoption of option B+ as a policy for delivery of elimination of mother to child transmission of HIV, establishment of functional SRH/HIV programme in Cultural Institutions and FBOs, model approach of working with district or municipality administration to create convergence of partners, reintroduction of female condom and developing a national condom brand. Nonetheless, it has been difficult to deliver results at grassroots within the anticipated timeframes especially with government policy, strategy starting to take effect. Three years was a short time to support policy translation to action or fully strengthened systems.

**Conclusion 10 - ASRH: Most of the results related to ASRH were not adequately achieved, as most of them take processes that require long period of time. Although there were indications of improved access to YFS by young people especially boys, the models initiated by the CP the for delivery of Youth Friendly services have not yet been documented for subsequent scale up using the national service delivery systems.**

Strategically, UNFPA has maintained its strong presence in all policy and key decision related functions of the Education sector/ National Curriculum Development Centre (NCDC) that culminated into a decision to include sexuality education as a single non elective unit to be taught in lower secondary classes against the original plan to spread it into various units as a topic. In terms of ASRH Service provision, the Youth Corner model provides potential for improved mobilization of young people for SRH service uptake. For this model to be sustainable

and scaled up, it should be fully integrated into the mainstream service delivery in the districts and health facility. The Evaluation notes that the formulation of the key policies like the National Youth Policy and the School Health Policy remain an unfinished agenda for the Country Programme.

**Conclusion 11: For all RH focus areas, use of community structures such as champions, and VHTs etc. is strategic in strengthening access to services however lack of adequate supervision and retaining them as volunteers is a threat to program quality and sustainability.**

While use of community volunteers is a good practice that requires regular technical supervision to ensure quality, the Joint program monitoring approach does not provide ample time for technical supervision of service providers including community volunteers. For example, during joint monitoring missions, some health workers were supervised by leaders/managers that do not have adequate capacity or time for technical support supervision. This is coupled with the question on how the operational needs of volunteers can be sustained and on the other hand is the question around assessing the quality of outputs from VHTs and Champions.

**Conclusion 12: Humanitarian Response: While the program is strong on development focused indicators, there is equally a need to pay attention to emergency preparedness MISP & IASC HIV guidelines roll out, as part of emergency preparedness.**

MISP for conflict and post conflict settings, use of IASC guidelines did not have due required attention to enable preparedness. Moreover HIV in emergency training commitments was not clear.

**Conclusion 13 - General: While UNFPA has a niche in population related upstream advocacy and policy influence work, there are tendencies of investing more attention to downstream work resulting in spreading too thin.**

The fact that the program implementation was in 8 districts only, and with National upstream work, means that UNFPA as an advocacy agency needs scale up advocacy, so good models and approaches are taken on by other partners, districts and ministries, to enable scale up so the ICPD agenda and MDG targets are furthered from a National perspective.

#### 7.1.2.6 Effectiveness - Gender Equality and Reproductive Rights

**Conclusion 14: The Gender component contributed significantly to improving the policy and legislative framework as well as strengthened public and civil society sector's capacity for GBV Prevention and Response. The programme has contributed to raising awareness on gender based violence, including FGM/C and positioning GBV on the national and district agenda; created a critical mass of community and district leadership that advocate against GBV and increased uptake of GBV Services. The focus on Reproductive Rights was not given adequate attention during programme implementation. Similarly implementation of the policy and legislative frameworks remains weak. The country still has more to do GBV response mechanisms, including institutionalization of shelter and protection services for survivors**

Almost all set outputs under Gender and RR were on target except for districts' having functional GBV data management systems and training in GBV programming in humanitarian and post conflict situations.

Interventions on policy influence were on track, other than for the Marriage and Divorce Bill (MDB). There are gaps with the penal code that need be addressed. And the implementation of policy in the 8 districts and at national level remains marred with several hindrances like connivance, lack of referral mechanisms, and this means more needs to be done.

The programme has created a critical mass of community and district leadership that advocate against GBV in form of functional GBV reference groups, NGO coalitions and Community based Anti GBV groups. Male involvement in GBV prevention and response is a key strategy that the programme employed in all the districts. However, the referral pathways still face challenges related to resourcing; the shelters are a new phenomenon, and continued support for institutionalization and scale up is needed in the coming cycle. GBV data management remains a challenge.

#### 7.1.2.7 Efficiency

**Conclusion 15: The program is rated efficient as exhibited by timely preparation of AWP's compared to the global timeline, high fund utilisation rates across components, outputs and Implementing Partners and rigorousness of the of the efficiency promotion measures instituted by the CO. The CO has adequate and skilled staff in all the programme components including in Decentralized Offices to monitor programme implementation. The evaluation noted the delays in submission of reports resulting in delayed release of funds. In most cases, studies, procurements and policy formulation activities were of completed in time. The consortium arrangement compromised the efficiency of programme implementation.**

The efficiency enhancement aspects that characterized the CP implementation across all the Programme Components were: timely formulation of results based AWP's and detailed budgets compared to the UNFPA Global timeline; high fund utilisation rates; institution of innovative measures by the CO to ensure efficient programme delivery. The role of UNFPA Decentralized Offices in contributing to greater programme efficiency cannot be over emphasized. The available resources (funds and staff) were adequately used to carry out activities, and there was evidence of leveraging of resources.

However, there were issues that may have compromised the efficiency of the CP and these include delayed quarterly reporting and release of funds; implementation of most of the activities in the third and fourth quarters; delayed implementation of Policy, Studies and Procurement related activities and the difficulties faced in management of IPs in a consortium arrangement. While the CO team emphasized fund utilization rates and the attainment of most targets, the IPs expressed strong concerns that the fund management mechanisms put pressure on the implementation process, with expectations of speedy delivery of results and utilization of funds, which was deemed a compromise to the learning from the process and the focus on quality. IPs have voiced: low funding levels, pressure related to work, limited time to learn due to quarterly funding arrangements, challenges on managing coalitions and weak GoU supervision role present risk to quality. Staff attrition at IP and UNFPA in some cases affected continuity of implementation and hence efficiency.

### 7.1.2.8 Sustainability

**Conclusion 16: The program is considered sustainable to a greater extent. This is because: the program design and implementation addressed the priorities already identified by government high level ministries/institutions; enabled systems strengthening; worked within established government structures; included capacity building of institutions staff in their permanent mandates/roles and included beneficiary participation,. However, some of the identified risks to sustainability relate to the lack of exit strategy, operation and maintenance costs for some equipment, heavy dependence on voluntary workers at community level and lack of plans for scaling up pilot interventions.**

While donor funding remains crucial, CP7 programs, interventions were considered durable because: the program is aligned to and addresses the national priorities and population needs; was tailored to existing structures and mandates without creating parallel systems; focus on mainstreaming approaches; investment in systems strengthening; rigorous capacity building targeting staffing in mainstream public service; strategic engagement with national institutions and ministries for long term policy and legislation; equipping public and private health training institutions that would ensure continuity; beneficiary participation in programming and implementation of activities. Some districts like Katakwi, Kanungu and Yumbe have already integrated UNFPA supported interventions into their institutional plans and budgets using local resources.

On the other hand the lack of consideration of phase out in the design and taking it as an afterthought may affect the sustainability of the programme. Dependence on the community volunteer groups, the general donor overdependence by both government and NGOs and lack of scale up strategy for pilots are the other factors that threaten sustainability. There are risks of loss of continuity when for the next cycle (CPAP8), UNFPA decides to move out of a district, and yet initiatives like GBV prevention and response are still new and with no full uptake of response mechanisms by the duty bearers.

### 7.1.3 Transversal Aspects

**Conclusion 17: Partnership relations: The levels of UNFPA strategic partnerships are considered satisfactory to allow for advancement of the ICPD agenda in terms of joint advocacy, research and programme implementation. The partnerships span from government, Development Partners, CSOs. The structures for programme management and coordination are in place and implemented. There is observed inadequacy of effective communication between UNFPA and IPs on one hand and within IPs on the other. The innovative initiative of delivering the CP using consortium approach yielded mixed results. Knowledge management focus was apparent in the UNFPA CO, but not strong in IPs.**

UNFPA has productive and strategic partnerships that have the potential to advance UNFPA mandate. The programme implementation partnership is constituted of a variety of partners drawn from Government, Civil Society, Faith Based and Cultural Institutions and this is ideal given the components of UNFPA country Programme. The consortium arrangement was an innovative approach to rally partners with similar objectives to deliver together around key UNFPA outputs. Although this approach delivered tangible results, it also is faced with a number of challenges related to consortia formation, coordination and management. UNFPA should pay immediate attention to emerging partnership and consortia challenges for better program quality and results. Addressing this as an organizational development challenge will necessitate mutual learning, accountability and change.

Programme coordination is frequently done at output and overall programme level. KIs suggested that in the future it is beneficial to have frequent high level interaction between UNFPA and outcome coordinating ministries to discuss strategic level programme changes, if any, to Country Programme. There was also an apparent lack of information flow within IPs where information sharing was weak or absent.

**Conclusion 18: The CO attaches a lot of importance to monitoring and evaluation and has as such allocation adequate human and financial resources. The Country Programme has a clear monitoring and evaluation system that revolves around a sound CP Results and Resources Framework and is in tandem with UNFPA Global M&E Guidelines. The results framework shows clear linkage of results with the UNDAF, NDP and UNFPA Strategic Plan. Multilevel (inputs, activities, outputs) monitoring is frequently undertaken including both financial as well programme results and milestones monitoring. The structure for CP monitoring is clear and adequately implemented. Although RBM capacity strengthening initiatives have been undertaken during programme implementation, there was no central place where monitoring information was stored for easy access by CO staff and other stakeholders.**

In Sum, CPAP has a robust results framework that shows linkages between CPAP, UNDAF, NDP and UNFPA Strategic Plan results. All the indicators have baselines and annualized targets that make easy to assess annual performance. KPI that enable assess milestones are clearly spelt out the M&E Plan, that also has the indicator definitions as well as M&E tools. Monitoring performance (inputs, activities and outputs) is categorized as satisfactory. The monitoring information for both activities and results is readily available at the Country Office. There is sufficient evidence of M&E coordination and ownership by the National coordinating Authority (POPSEC) as well as the IPs. The CO office attaches a lot of importance to M&E and has thus allocated sufficient resources for the purpose. There have been a concerted effort by UNFPA and POPSEC to strengthen the national partners’ capacity to do M&E function better by providing an on the job as well as formal M&E training. The observable efforts to improve M&E capacity for UNFPA and IP staff have yielded results. However, measurement indicators of M&E capacity building (CB) initiatives are lacking. There is a need for easy access to monitoring data by the users. What is currently available are the quarterly and annual programme as well as project reports that have all the needed information. There is a need to establish a database including a web-based one which will enable the users easy access to relevant data at any given time.

## 7.2 Main Recommendations

This section presents the recommendations that need to be addressed to improve programme implementation in the remaining part of the CP as well as informing future UNFPA programming in the country. Recommendations are presented below in 2 clusters, cluster 1 is Strategic Level and cluster 2 is programs. They are presented with an indication on priority level (1: high; 2: medium; 3: low) and their respective targeted audiences.

### 7.2.1 Strategic Level

<p><b>Recommendation 1</b> (linked to Conclusion 1) While maintaining the current focus of integrated, culturally sensitive, and rights based approach, establish, where absent or lacking, data bases for vulnerable populations for monitoring and assessing change due to programme interventions.</p>	To Country Office	Priority level:1
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<p>At the time of programme design and through programme implementation, deliberate vulnerability assessments should be conducted for the vulnerable populations that the CP identifies to focus on. The geographical distribution of the populations should be determined as one of the guiding principles for programme location. Although, this was done in the current programme, it was for few populations like CSW and FGM/C prone districts. These assessments should provide baseline data upon which programme success measurements should be based. During implementation, the programme should maintain culturally sensitive, and rights based approach to working in the three programme component areas.</p>		
<p><b>Recommendation 2 (linked to conclusion 1)</b> Develop and implement a clear capacity development plan to support the implementation of the Country Programme. Mechanisms for measuring effects of capacity building initiatives should be put in place.</p>	To Country Office/ARO	Priority level:1
<p>Develop a strategic approach to capacity-building, understanding it as a long-term, staged process with built-in follow up, monitoring and technical support, addressing specific needs at particular stages (not one-off training events). While Capacity building is a major part of the CPAP and while there are positive results on the ground from capacity building initiatives, an existence of a strategic approach to capacity-building was not explicit in the CPAP and results framework. The CB building needs to be well planned and its results clearly articulated in line with reinforcing programme results in order to deliver the deliver long lasting solutions. The capacity building plan should cover different approaches including training, south to south exchanges. The CP plan should target staff from both UNFPA and other stakeholders. A follow up mechanism to ensure that the capacities built are out in place should be instituted.</p> <p>The ESARO should provide the necessary support to the CO in development and implementation of the Capacity Building Plan as part of the routine Regional Office technical programme and operations support.</p>		
<p><b>Recommendation 3 (linked to conclusion 4 and )</b> Strengthen and continue the current approach to working in high visibility advocacy role for advancing the ICPD agenda in the Post 2015 National Development Agenda.</p>	To Country Office	Priority level:1
<p>UNFPA should develop and implement a robust advocacy programme for the ICPD agenda especially for integration in the Post 2015 National Development Agenda. The partners note the added value of UNFPA in this. UNFPA should develop a partnerships strategy in order to galvanize the efforts of the partners around advancing the ICPD agenda and the Post 2015 development agenda in the UNFPA mandate areas. The advocacy efforts should target the highest national institutions and leadership. Maintain, and if possible improve the technical capacity within CO, to undertake the robust evidence based advocacy role balancing up-stream &amp; downstream work while optimizing the comparative advantage that UNFPA has in the country. Use of results from pilot interventions to advocate for scale should be core to UNFPA operations. This calls for major improvements in the design of the pilots, documentation of the processes during their implementation and measuring results.</p> <p>In cases the advocacy efforts require interventions beyond country level, the Regional Office should create conditions that promote such regional and/or inter country advocacy agendas. The contribution of the regional office would also include providing technical support to development of the required advocacy materials.</p>		

## 7.2.2 Programmatic level

### 7.2.2.1 Population and Development

<p><b>Recommendation 4 (Linked to conclusion 6)</b> Reinforce, effectively, the framework for integration of population issues at the strategic level of the National Planning Authority, Ministry of Local Government and Ministry of Finance Planning and Economic Development.</p>	To Country Office	Priority level 1
<p>UNFPA should continue to advocate for and support integration of population issues in development and budgetary</p>		

frameworks at the highest level of authority. While major achievements have been realized and capacities built in this area, a lot still needs to be done. UNFPA should design and implement an engagement plan for integration of population, SRH and Gender issues in the ongoing review of the National Development Plan I and the subsequent development of the National Development Plan II, building on the gains already achieved during the formulation of the Vision 20140. Similar attention should paid to the relevant Sector Strategic and Investment Plans as well as District Development Plans..		
<b>Recommendation 5 (Linked to conclusion 6)</b> Follow through and implement 2014 targets that are not yet attained under P&D while sustaining and carry forward the successful enabling approaches under CP7 to CPAP8	To Country Office	Priority level 1
Produce the National Planning Guidelines (for Sectors and LGs) that include integration/mainstreaming of population dynamics in the plans and the manual to integrate population dynamics, for use by the 8 sectors and districts. Ensure functionality and use of harmonized district databases.Continue Advocacy for the National Housing and Population Census. Update and ensure access to IMIS by the districts and sectors. Strengthen the newly established youth coordination and participation structure in the MGLSD.		

### 7.2.2.2 Reproductive Health

<b>Recommendation 6 (Linked to conclusions 6,7,9 and 9)</b> Follow through and finalize the unmet CP7 targets, and sustain the interventions and approaches that were identified while ensuring adequate investment in quality improvement during the delivery of integrated SRH services.	To Country Office	Priority level 1
The CP should complete the unfinished yet important agenda under all the RH outputs. Follow through initiatives on the revision of the national midwifery training curriculum and the processes related to amendment of the Nurses and Midwifery Act of 1996 to incorporate International Council of Midwifery (ICM) standards, task shifting and the current Ugandan context. Ensure continuous improvements in capacities for EmOC; formalization of the alternative distribution strategy for FP commodities; full implementation of the CCP with focus on MARPs; completion of the National Youth Policy, School Health Policy and integration of Sexuality Education into the National Curriculum. Design innovative models that integrate nutrition action within RH service scale up, and aligned to the multi-sectoral Uganda Nutrition Action Plan; as this could be the ‘gamechanger’, that contributes to reduced maternal neonatal mortality.		
<b>Recommendation 7 (Linked to conclusions 6,7, 8 and 9)</b> Advocate that GoU develops and implements strategies to address Human Resource needs for critical midwifery cadres; GoU to enhance recruitments, and deployment of midwives/t and/or other staff that can provide quality midwifery care. .	To Country Office	Priority level 1
UNFPA, in partnership with other stakeholders, should advocate with government on ensuring adequacy of midwives in HFs including at HC II. As a gap filling measure, UNFPA should continue the current support to training bonded midwives, but should follow up with government on their recruitment. In order to have greater impact, UNFPA should mobilize other development partners to support the training initiatives for midwives since UNFPA alone will not be able to sponsor a critical mass of midwives. A programme to train the existing and already recruited comprehensive nurses n midwifery skills for a reasonably long periodcould be a better option to improve delivery of midwifery services. Conduct refresher trainings, taking consideration of staff attrition, and loss of skills like vacuum extractor use/ fistula surgeons,		
<b>Recommendation 8 (Linked to conclusion 6 and 7 )</b> Design and implement special approaches to provision of RH services in Karamoja regionmaking consideration of the regional context.	To Country Office	Priority level 2
‘One size does not fit all’, Karamoja continues to have special needs and therefore needs region specific interventions. Focus on more numbers of skilled staff at facilities in Karamoja; Review the practice of distribution of mama kits during 4 <sup>th</sup> ANC visit, weigh benefits visa vie findings that it deterred mothers from delivering from health facilities in Karamoja region. Design strategies to increase FP uptake, including linking to food supply, like what is done in education and other sectors- contextualize FP program to Karamoja context where there is chronic food insecurity and development programs being tagged to food incentives. Special programme for training and recruiting midwives to work in Karamoja region should be designed.		

<b>Recommendation 9 (Linked to conclusion 6 and 12)</b> Develop and implement emergency preparedness and contingency including MISP & IASC HIV guidelines roll out	To Country Office	Priority level 2
UNFPA should finalize the contingency plan that is under development to address the need to improve national implementation of MISP for conflict and post conflict settings including use of IASC guidelines. Integration of MISP into the National Disaster Preparedness plan at the Office of the Prime Minister would be a better strategic intervention. Moreover HIV in emergency training commitments was not clear. A critical mass of technical staff from Government sectors, UNFPA and CSOs should be trained in MISP and Humanitarian programming.		
<b>Recommendation 10 (Linked to conclusion #: 6,9, and 10)</b> Conduct an in-depth assessment of the Youth Corner Delivery Model to facilitate lobby efforts with government for its scaling up. Integrate the model into the National Health and Youth related policies	To Country Office	Priority level 1
There is need to take YFC to another level, formally institutionalize within schools and facilities, taking note of sensitivity to local culture and religion. This assessment should also address the challenges related to National leadership for youth (between MOH and MGLSD) that have affected delivery of adolescent sexual reproductive health services. To get a policy backing, the programme should also be incorporated in the National Youth Policy and the School Health Policy that are still under finalization.		

### 7.2.2.3 Gender Equality and Reproductive Rights

<b>Recommendation 11 (Linked to conclusion 14)</b> Scale up initiatives that support implementation of passed bills, in selected districts, and advocate for National level scale up and enable GBV legislation implementation more so in Karamoja and areas where FGM/C is practiced	To Country Office	Priority level 1
Keep gender and reproductive rights at High Level, Enable key sectors to finalize strategies and implement priority interventions, Follow through the finalization of tabling and enacting the Marriage and Divorce Bill (MDB), - bring religious and other societal leaders on board MDB, through orientations, to garner their support. Sustain raising awareness and societal mobilization for GBV prevention, and response, as well as reproductive rights using FBOs, cultural leaders, and champions. Sustain work on FGM/C in Karamoja and Sabin areas; sustain monitoring CEDAW implementation and compliance by CSOs. Work with counsellors association to finalise guidelines on psychosocial support to GBV survivors. Finalize the harmonization of GBV IMS. Advocate for appointment of judge/judicial officers to cover Moroto, Kotido and Kaabong districts. More sensitization and education, work with cultural leaders so they become allies on GBV in this region other than opposition, as they are powerful influencers. Educate communities more around police form 3 so it is not negatively explored for exchange of goods or money.		
<b>Recommendation 12 (Linked to conclusion 14)</b> Advocate for improved GBV & RR resourcing (HR and funding) to scale up GBV prevention and response interventions including effective implementation of the referral pathways and operationalization of the GBV shelters	To Country Office	Priority level 2
Advocate for resource allocation for GBV at national and Local Government levels, Trainings, refresher and orientation for district Gender Focal Persons, districts should include Gender into job description of focal person as a deliverable so it is not perceived as an add on. Take measures to reduce connivance with legal systems and failure to prosecute- zero tolerance law. Emphasize prevention that addresses the systematic factors of male dominance, women powerlessness and lack of access to resources that drive GBV. Make police form 3 readily available, and motivate service providers to fill it in and be active in the referral pathways. The concept of the integrated GBV shelter model is new to Uganda, and is yet to be fully understood and operationalized by the different stakeholders. GoU should increasingly own and finance the GBV shelter as a basic service.		

### 7.2.2.4: Sustainability

<b>Recommendation 13 (Linked to conclusion 11 and 16)</b> Create conditions for sustainable programme effects: Improve on integration	To Country Office	Priority level 1
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of phase out strategy in programme development and implementation		
<p>UNFPA should continue with the current good practices that promote programme sustainability. These include: ensuring that the program is aligned to and addresses the national priorities and population needs; is tailored to existing structures and mandates without creating parallel systems; focus on mainstreaming approaches; invests in systems strengthening; undertakes rigorous capacity building targeting staffing in mainstream public service; ensures strategic engagement with national institutions and ministries for long term policy and legislation; and ensures beneficiary participation in programming and implementation of activities.</p> <p>The exit strategy and interventions should be designed for the remaining part of the programme especially focusing on Youth Friendly Services, continuity of community based structures established for GBV prevention and response, VHT mobilization and other FP demand generation activities. In the same vein, exit strategy should be integrated in the design and implementation of the next CP.</p>		

### 7.2.3 Transversal aspects

<p><b>Recommendation 14 (Linked to conclusion 17)</b>          Improve implementation of partnership management and coordination of CPAP by strengthening national ownership of the country programme, improving UNFPA and IP communication and address challenges related to consortium delivery modality.</p>	To Country Office	Priority level:1
<p>UNFPA and Population Secretariat should improve the quality of implementation of the programme coordination mechanisms stipulated in the CPAP and M&amp;E Plan. Ensure high level consultative meetings to address emerging issues; enable POPSEC to play its leadership role. The CO should develop and implement a communication plan to address the communication challenges identified during this evaluation including between UNFPA and IPs as well as within IPs.</p> <p>In-depth analysis and documentation of the documentation the consortium arrangement should be undertaken with a view of determining what worked and what needs to be improved upon. This is because, in the event of UNFPA limiting the number of IPS, this approach remains a viable option.</p>		
<p><b>Recommendation 15 (linked to conclusion 18)</b>          Strengthen routine data collection for programme results M&amp;E; Establish electronic/web-based data base for M&amp;E to improve knowledge management and increase capacity of IPs to practice/apply RBM.</p>	To Country office	Priority level:1
<p>To increase access to programme M&amp;E information, UNFPA design a way to make such information readily available to all programme stakeholders. Establishment of an e-database will ensure easy access to the information. Capacity building for UNFPA and IP staff should be undertaken continuously to improve planning, implementation, monitoring and evaluation for results.</p>		

## Annexes

### Annex 1: Terms of Reference for the Evaluation of the GoU / UNFPA Seventh Country Programme 2010-2014

#### 1. Introduction

The current GoU/UNFPA Seventh Country Programme (2010 – 2014), was developed and endorsed by Government in 2009 with full participation of Government institutions, UN agencies, NGOs, religious and cultural institutions and academia. The programme became operational effective January 2010. The Programme was aligned with national priorities as articulated in the National Development Plan 2010/11 – 2014/15 as well as priorities for the United Nations System stipulated in the Uganda United Nations Development Assistance Framework (UNDAF) 2010 - 2014. The programme was also developed in line with the UNFPA Global Strategic Plan for the period 2008 to 2011, which has since been revised and extended to 2013 and taking into account the Millennium Development Goals (MDGs) and the 1994 International Conference on Population and Development Programme of Action (ICPD-PoA).

The UNFPA Executive Board Decision 2009/18 and the UNFPA Evaluation Policy (DP/FPA/2009/4) require that all UNFPA Country Programmes should be evaluated at least once in the programme cycle. Given that in 2013 the current GoU/UNFPA Country Programme will be in the fourth year of implementation, a Country Programme Evaluation will be conducted. The evaluation will be used to assess the programme performance against planned targets as well as provide evidence to inform the development of the next UNFPA programme of support to Uganda.

This Country Programme Evaluation will be conducted following the process and guidance articulated in the UNFPA Evaluation Policy and the Handbook on how to design and conduct a Country Programme Evaluation at UNFPA; resulting into high quality evaluation with the highest level of objectivity and impartiality.

This ToR will be used to guide the evaluators especially regarding the design, field work and reporting aspects of the Country Programme Evaluation.

#### 2. Context

The GoU/UNFPA Country Programme Action Plan (2010 – 2014) was developed to respond to the national Priorities. The orientation of the CPAP is to address the current context of Uganda especially in addressing the mounting challenges of rapid population growth. This called for social mobilisation and championing of leadership in various fora to advocate for population, reproductive health and gender issues and rights firmly in the public domain supported with the necessary policy and institutional backing.

The Country Programme was designed to respond to national priorities by employing the main strategies of capacity building, building/promoting the use of knowledge base, reinforcing advocacy and policy dialogue, strengthening partnerships as well as developing systems for improved performance. The main National Development Plan objectives that the GoU/UNFPA Country Programme contributes to are: Increasing access to quality social services; Enhancing human capital development; Strengthening good governance; and Promoting sustainable population and use of the environment and natural resources.

The CPAP was inspired by the United Nations Development Assistance Framework (UNDAF) for 2010-2014. The UNDAF vision is to support the capacity of Uganda to achieve the national development plan, with a focus on equity and inclusion, peace and recovery, population and sustainable growth. The country programme supports two of the two UNDAF outcomes namely a) The Government and civil society have improved capacity for governance and accountability in order to reduce geographic, economic and demographic disparities in attaining the MDGs; and b) Vulnerable populations in Uganda, especially in the north, have increased access to and use of sustainable and quality basic social services by 2014. The Country Programme is delivered in partnership with key government sectors and government institutions including Ministry of Finance, Planning and Economic Development (MFPED); Population Secretariat, Ministry of Health (MOH) Reproductive Health Division and Aids Control Programme; Ministry of Gender, Labour and Social Development (MGLSD); Ministry of Education and Sports; and Ministry of Local Government. Other important national institutions for partnership include Office of the Prime Minister; the selected Committees of the Parliament of Uganda; National Planning Authority; Uganda Bureau of Statistics; National Curriculum Development Centre; Uganda AIDS Commission and Office

of the First Lady of Uganda. Other partners include key CSOs and private-not-for-profit sectors especially Faith Based Institutions; Women Support and RH focused Organizations; Media Houses; Midwifery Advocacy Groups; academic and research institutions, development partners and the media. Equally important is the partnership with other United Nations agencies to pursue the principle of Delivering as One (DaO) especially through Joint Programming.

In terms of programmatic focus, the Country Programme 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 year, 2010 and 2011. In 2011, a Mid Term Review of the UNFPA Global Strategic Plan was conducted. UNFPA adopted a refined strategic focus, which is designed to direct its work on sexual and reproductive health and reproductive rights, on supporting greater progress towards MDG 5 and towards the ICPD agenda. Consequently, the GoU/UNFPA Country Programme was revised to align with the revised UNFPA Global Strategic Plan. However, the alignment of the Country Programme to the UNFPA Strategic Plan did not substantially change the focus of the Country Programme. The outputs that the Country Programme is delivering are:

**Output 01:** Up-to-date, age and sex disaggregated and analyzed population data is used for development planning, decision making and monitoring progress at National and sub-national levels.

**Output 02:** Health systems are improved to increase women's utilization of midwifery services in pregnancy care, childbirth and the management of related complications.

**Output 03:** Social and institutional structures are mobilized for accelerated uptake of modern family planning methods by women, men and young people

**Output 04:** Capacity strengthened for integration of HIV/AIDS and SRH and HIV prevention for MARPs at National and selected sub-national levels

**Output 05:** Public and civil society sectors' capacity for Gender-Based Violence prevention and management and advancement of Reproductive Rights is strengthened.

**Output 06:** Healthy lifestyle choices related to sexual and reproductive health are increased for young people

In the Country Programme Results Matrix, each of the outputs has indicators, baselines and targets that will guide assessment of performance in achieving desired output results. The results matrix is further elaborated by the Balanced Score Cards that outline the lower level/intermediate results expected from the implementation of the programme that would lead to achievement of output level results. These intermediate results help in articulation of the Annual Workplans.

The Country Programme is implemented through Annual Workplans with a number of Implementing Partners that include Government institutions both at National and Sub national level and Civil Society Organizations. The disbursement of funds to the Implementing partners (IPs) is done on quarterly basis. The implementation of the annual workplans is reviewed through quarterly coordination meetings, routine and joint field monitoring visits and Annual Review and Planning Meetings. The implementing Partners submit quarterly and annual reports. Standard Progress reports are also compiled on an annual basis for all the three programme components.

### 3. Objectives and Scope of the Evaluation

#### a) Evaluation objectives

The main objective of this Country Programme Evaluation is to provide evidence of programme performance and achievement of planned results, provide accountability to stakeholders; and to inform the development of the Eighth UNFPA programme support to the Government of Uganda through feedback of lessons learned.

**Specific objectives are:**

- i. To assess GoU/UNFPA Seventh Country Programme performance in achieving the programme outputs and the programme contribution to the CP outcomes as indicated in the UNDAF.
- ii. To assess the extent to which the implementation framework (Partnership Strategy; Execution/Implementation arrangements; Human Resources; Resource Mobilization; and Monitoring & Evaluation) enabled or hindered achievement of the results chain i.e. what worked well and what did not work well.
- iii. To assess the extent to which the country programme is aligned to the Government priorities stipulated in the National Development Plans and relevant sector plans, the UNDAF and UNFPA Strategic Plan.
- iv. To identify success stories, if any, and document the lessons learnt in programme implementation, management and coordination.

#### b) The Evaluation components and criteria:

The evaluation will have two components each with specific criteria as indicated below.

**i. The analysis of UNFPA focus areas**

The evaluators assess the GoU/UNFPA Country Programme for the OECD/DAC evaluation criteria of Relevance, Effectiveness (progress in the achievement of outputs and outcomes set in the three interrelated focus areas -- population and development, reproductive health and rights and gender equality -- *against what was planned* in the country programme action plan (CPAP), Efficiency and Sustainability.

**ii. The analysis of UNFPA strategic positioning in the country**

The evaluators assess the alignment of the country programme with the UNFPA Strategic Plan and with the UN Development Assistance Framework (UNDAF), including the UNFPA contribution to the UN country team (UNCT) coordination mechanisms. The evaluators also assess the capacity of the CO to respond to the country needs and challenges, as well as the added value of UNFPA vis-à-vis the development community (government, civil society, NGOs, other development partners). The Evaluation criteria for Strategic positioning assessment are: Corporate Dimension, Systemic Dimension, Responsiveness and Added Value.

**c) Time period:** The scope of the evaluation will cover the country programme implementation period from 2010 to 2014. Although the Evaluation is done in the fourth year of implementation of the CP, conclusions on whether the programme results for the entire period will be made based on the progress at the time of evaluation will be made.

**d) Geographical coverage:** The evaluation will concentrate on areas where results are expected ie both at national and district level. Regarding districts, focus will be on the main programme districts of Kanungu, Mubende, Yumbe, Oyam, Katakwi, Moroto, Kotido and Kaabong. For specific and targeted interventions such as GBV, HIV/AIDS, FGM/C the evaluation will cover the targeted districts.

#### 4. Evaluation questions

Evaluation questions are at centre of the evaluation. A substantial part of a CPE is about answering evaluation questions in a credible and evidence-based manner as to provide users of the evaluation with required information for decision making. The following general evaluation questions associated with the evaluation criteria will guide the CPE.

**a) Evaluation questions for UNFPA focus areas:**

**Relevance :***The extent to which the objectives of a development intervention are adapted to national needs (e.g., needs of the population, in particular vulnerable groups) and are aligned with government priorities as well as policies and strategies of UNFPA.*

- To what extent is UNFPA support to Uganda aligned to the objectives in the National Development Plan 2010/11 – 2014/15 and responding to the national priorities?
- To what extent is the UNFPA support in the field of reproductive health, Gender and Population and Development adapted (i) to the needs of the population (ii) capacity and systematic needs of government institutions (iii) and in line with the priorities set by the international and national policy frameworks?

**Effectiveness:** *the degree of achievement of the outputs and the extent to which outputs have contributed to the achievement of the CPAP outcomes.* The central focus of Country Programme Evaluations - their “centre of gravity” - is the outputs and how these contribute to the achievement of the outcomes. Gathering data on *actual outputs* and comparing them to what was expected (*planned outputs*) is the core aspect of the evaluation.

- To what extent were the expected outputs of the CPAP achieved or are likely to be achieved?
- To what extent are population data (demographic statistics, census data, etc.) and population dynamics taken into account in policies, plans and programmes?
- To what extent has the country programme contributed to improving the quality and affordability of SRH services provided, particularly for the midwifery, management of delivery and of its complications, including the surgical repair of obstetrical fistulae, FP, HIV/AIDS prevention and ASRH/Sexuality Education?
- To what extent have the interventions in gender contributed to (i) raising awareness on gender based violence and (ii) positioning this theme on the national and district agenda ?

- To what extent were the targeted groups of beneficiaries reached through Country Programme support?
- To what extent did the outputs contribute to the UNDAF outcomes?
- What were the facilitating/limiting factors (partnerships, coordination, monitoring and evaluation, results based management) for the realization of CPAP results?

**Note:** More specific questions will be formulated during the formulation of the Evaluation design report.

**Efficiency:** *A measure of how resources/inputs (funds, expertise, time, etc.) are converted into results. Or the extent to which outputs and/or outcomes are achieved with the appropriate amount of resources/inputs (funds, expertise, time, administrative costs, etc.).*

- How adequately were the available resources (funds and staff) used to carry out activities?
- To what extent did the intervention mechanisms (financing instruments, administrative regulatory framework, staff, timing and procedures) foster or hinder the achievement of the programme outputs?
- To what extent were UNFPA resources focused on a limited set of core activities likely to produce significant results?

**Sustainability:** *The continuation of benefits from a development intervention after its termination.*

- To what extent has Country Programme been able to support partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?
- To what extent were activities designed in a manner that ensured a reasonable handover to local partners? To what extent has national capacity been developed so that UNFPA may realistically plan progressive disengagement?

*Note: The evaluation questions on all the above criteria will be applied to all the output areas of the Country Programme.*

#### **b) Evaluation questions for UNFPA strategic positioning in Uganda**

**Strategic Alignment (Corporate Dimension):** *The corporate dimension looks at the extent to which the country programme is aligned with the UNFPA Strategic Plan.*

To what extent has the CO positioned ICPD goals and issues within governmental processes at the national and local levels?

- To what extent is the Country Programme and its implementation aligned to the UNFPA corporate mandate as set out in the Strategic Plan?
- To what extent has the CO prioritized intervention strategies targeted at most vulnerable, disadvantaged, marginalized and excluded population groups, in line with the stipulations of the Strategic Plan?
- To what extent has South-South cooperation been mainstreamed in the country programme through the enhanced use of capacities and as a means to share best practices among countries of the South? If so, is this cooperation modality reflected in the results framework by means of specific indicators?
- To what extent is the CO abiding by the corporate principles of national ownership, national leadership and national capacity development? Are these principles effectively applied during the planning and implementation phases?

**Strategic Alignment (Systemic Dimension):** *The systemic dimension looks at the extent to which the GOU/UNFPA Country Programme is aligned with the UN strategy (UNDAF) in the country.*

- To what extent is the country programme, as currently implemented, in line with the UNDAF? Is there any mismatch?
- To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?
- To what extent is the UNFPA CO coordinating with other UN agencies in the country?

**Responsiveness** *The ability of the CO to respond to: (i) changes and/or additional requests from national counterparts e.g., natural disasters, conflicts etc.), and (ii) shifts caused by external factors in an evolving country context.*

- To what extent has the CO been able to respond to changes in national needs and priorities or to shifts caused by crisis or major natural disasters? What was the quality of the response?
- To what extent has the CO been able to respond to specific/ad-hoc/urgent requests of partner country counterparts? What was the quality of the response?

**Added Value:** *The extent to which the UNFPA country programme adds benefit to the results from other development actors' interventions (Stakeholder's perception about UNFPA in the Country)*

- How do the national counterparts and other development actors perceive, recognize and recall UNFPA's performance in the country?
- What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are they a result of UNFPA corporate features or are they explained by the specific features of the CO?
- To what extent would the results observed within the programme focus areas have been achieved without UNFPA support?
- What is the main UNFPA added value in the country context as perceived by national stakeholders? What would the country lose if UNFPA did not have a presence in Uganda?

## 5. Methodology and Approach

The methodology for the Country Programme Evaluation will include both quantitative and qualitative data collection and analysis approaches to generate credible findings and reach concrete conclusions. During the design phase, the evaluators will be required to develop tools for data collection.

### **Data collection methods will include but not necessarily limited to**

- Desk review and content analysis of key documents
- In depth interviews (structured and semi-structured) with key stakeholders (Implementing Partners, Beneficiaries, UNFPA CO staff, Development Partners, etc). This will include quantitative data collection and analysis.
- Observations (including visits to selected project sites)
- Focus Group Discussions with programme partners and beneficiaries

**Data Analysis:** In the design phase evaluators will identify the methods for analyzing data. The focus of the data analysis process is the identification of evidence. Findings, conclusions and recommendations to be presented in the final evaluation report must be evidence-based. Evidence may be based on opinions and perceptions, and on hard data (values of the indicators in the CPAP). During the design phase, the evaluation team should also agree on data validation and triangulation mechanisms which may include internal team-based revisions, presenting and discussing preliminary findings with the Country Office, the Evaluation Reference Group and focus groups.

## 6. Evaluation Process

The evaluation process will comprise of preparation of an inception/design report that will comprehensively cover the design of the evaluation; field data collection and analysis; report writing approach; finalization of report; preparation of a management response; dissemination of the final report; and follow up on the implementation of the recommendations. The findings and recommendations arising out of the Country Programme Evaluation will inform the development of the Eighth Country Programme to be drafted in 2014. The Evaluation Team will work in close consultation with the Evaluation Reference Group in each of the phases and steps of the entire evaluation process.

## 7. Expected output

The following products/services are expected from the evaluators.

- a) Design/inception report that is acceptable to the Evaluation Reference Group (maximum 20 pages)
- b) A debriefing presentation at the end of the field phase
- c) Draft Country Programme Evaluation report at the end of field work
- d) Final Country Programme Evaluation report incorporating comments from the Evaluation Reference Group with a management response annexed to the report (Maximum 50 pages plus annexes)
- e) Other technical papers if required for example during dissemination.

## 8. Evaluation Workplan

The Country Programme Evaluation is expected to take 45 working days from the date of signing the contract. The 45 days will be spread over a period of about 3 months during the period February to April, 2013.

**GoU/UNFPA SEVENTH COUNTRY PROGRAMME EVALUATION**

	2012			2013				
	Oct	Nov	Dec	Jan	Feb	March	April	May
1. Draft Terms of Reference for the CPE		■						
2. Establish Evaluation Reference Group with national leadership		■						
3. Submit TOR to ARO for review and inputs		■						
4. Review of TOR by the Evaluation Reference Group		■						
<b>5. Finalize TORs</b>			■					
6. Recruit members of the Evaluation Team, contract signing, debriefing of the evaluation team			■					
7. Evaluation Team prepare the design report, report discussed by UNFPA and Evaluation Reference Group					■			
<b>8. Approval of the design report</b>					■			
9. Completion of the agenda for meetings and interviews in consultation with stakeholders and preparation for interviews					■			
10. Evaluation Team conduct desk review – including in-depth study of AWP, previous evaluations, etc (secondary sources)					■			
<b>11. Data Collection by Evaluation Team (support may be provided by the M&amp;E Team and Evaluation Reference Group members)</b>					■	■		
12. Data analysis, triangulation (teamwork)						■		
13. Evaluation Team presents preliminary results to CO						■		
<b>14. Delivery of 1st draft evaluation report</b>							■	
15. Provision of Comments from the CO and the Evaluation Reference Group							■	
16. Evaluation Team revises report based on comments and submits to UNFPA							■	
17. UNFPA Uganda Country Office submits draft report to ARO for comments							■	
18. Evaluation Team revises the draft report taking into account comments from RO and other emerging comments							■	
19. Stakeholder meeting convened by GoU and UNFPA s to validate CPE report							■	
20. Evaluation Team receives feedback from Stakeholders, finalizes the report and submits to UNFPA/Evaluation Reference for management response								■
21. UNFPA/Evaluation Reference Group prepares a management response on the CPE recommendations and submits to Evaluation Team								■
<b>22. Evaluation Team annexes the management response to the final report and submits as final</b>								■
23. Uploads final CPE report in Evaluation folder								■
24. Dissemination the CPE report and utilize the Evaluation Report to inform formulation of the Eighth Country Programme								■

Items 1 – 6 and 23 – 24 are purely for the UNFPA Country Office. During the development and presentation of the Design Report, the evaluation team will present the workplan in weeks, not months as indicated above.

#### Lead milestones

1. Finalization of ToRs (December 15, 2012)
2. Approval of the design report (March 5, 2013)
3. Start of field data collection (March 15, 2013)

4. Submission of draft Evaluation report (April 30, 2013)
5. Delivery of Final Evaluation Report (May 15, 2013)

## 9. Composition of the Evaluation Team

The Evaluation team shall comprise of four independent consultants (one international and three nationals) and will be charged with the responsibility of delivering the expected outputs as indicated in 7 above. The consultants will be responsible for conducting the final evaluation of the country programme.

The International consultant will be the team leader and will have the overall responsibility for providing guidance and leadership during the evaluation process and coordinating the drafting of the design report, the draft and final evaluation reports. The team leader should have solid understanding of evaluation methodologies and a proven expertise of research in social science relevant of evaluation. Demonstrated capacity for strategic thinking and policy advice is essential. Team leader should also be familiar with UNFPA or UN operations.

The Evaluation Team members should be specialists in the core areas of evaluation and will be responsible for drafting key parts of the report. The core areas are Population and Development (Data and integration of population dynamics in plans), Reproductive Health focusing on Maternal Health, Family Planning, HIV/AIDS and Adolescent Reproductive Health; Gender with focus on Gender Based Violence and Reproductive Rights.

Consultant for Sexual and Reproductive Health should have at least a Master's Degree in Public Health, or any other relevant field; extensive national and international experience in monitoring and evaluation of Reproductive Health programmes.

Consultant for Population Dynamics should have at least a Master's Degree in a Population related subject, or any other relevant field; extensive national and international experience in monitoring and evaluation of programme population and development programmes

Consultant for Gender and Reproductive Rights should have at least a Master's Degree in Gender and Development Studies, or any other relevant field; extensive national and international experience in monitoring and evaluation of Gender Programmes; Experience on evaluation of UN supported programmes will be an added advantage.

All team members should have in-depth knowledge of UNFPA programmatic areas, issues and challenges in the country; must be committed to respecting deadlines of delivery outputs within the agreed time frame; must be able to work in multidisciplinary teams.

## 10. Management and conduct of the Evaluation

The Evaluation Team will work in close collaboration with the Evaluation Manager and the Evaluation Reference Group during the entire process of conductive the Country Programme Evaluation. The roles and responsibilities of the Evaluation Manager and the Evaluation Reference Group are as follows:

### **Evaluation Manager**

- Lead development and drafting of the TOR and the management response.
- Support the Evaluation Reference Group meetings
- Manage the evaluation budget and ensure logistical and administrative support
- Facilitate access to background documents
- Provide ongoing feedback for quality assurance during the preparation of the design report and the final report
- Upload evaluation TOR and final report into UNFPA central repository
- Upload management response into the Management Response Tracking System.

### **Evaluation Reference Group**

- Contribute and approve the TOR
- Ensure consensus on evaluation design, evaluation recruitment, roles and responsibilities of implementing partners;
- Select and debrief Evaluation team

- Organize technical support and provide continual feedback during the evaluation process
- Approve inception report and final evaluation budget
- Monitor progress and quality of evaluation activities
- Review and comment on drafts
- Arrange meetings with key stakeholders to discuss drafts of the evaluation reports;
- Verify the quality, integrity and relevance of the final evaluation report Approve evaluation reports
- Facilitate access to documentation and key informants
- Ensure discussion of evaluation findings and recommendations with all major stakeholders and agreement on a follow-up plan of action
- Assess performance and approve payments to evaluators
- Disseminate and follow up to evaluation finding

## 11. Evaluation Audience

The primary audience/users of the evaluation are the decision-makers within the Government of Uganda; UNFPA Country Office, the Regional Office and the Executive Board; Development Partners; and all key stakeholders.

The evaluation audience will also include various target groups of the beneficiary institutions and population including adolescents and youth; and women of reproductive age; local governments, Civil Society Organisations and implementing partners.

## 12. Bibliography and resources

The following documents will be shared and consulted by the Evaluation teams:

- i. GoU/UNFPA Seventh Country Programme Document
- ii. GoU/UNFPA Seventh Country Programme Action Plan
- iii. GoU/UNFPA Seventh Country Programme Monitoring and Evaluation Plan
- iv. Re-aligned Country Programme Results Matrix
- v. UNFPA Strategic Plan (2008-2011)
- vi. Revised UNFPA Strategic Plan (2012-2013)
- vii. Final Evaluation of the GoU/UNFPA Sixth Country Programme Report
- viii. United Nations Development Assistance Framework (2010-2014)
- ix. UNDAF Annual Review Reports (2010, 2011)
- x. Mid Term Review of the UNDAF
- xi. National Development Plan (2010/11 – 2014/15)
- xii. Peace Recovery and Development Plan (PRDP)
- xiii. Sectoral Policies and Strategic Plans – Health, Gender, Population Secretariat
- xiv. Annual Work Plans for Implementing Partners (2009, 2010, 2011, 2012)
- xv. Quarterly and Annual Progress and Financial Reports from Implementing Partners (2009, 2010, 2011)
- xvi. Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)
- xvii. Quarterly Review and Coordination Meetings’ reports
- xviii. Audit Reports for all Implementing Partners (2009, 2010, 2011, 2012)
- xix. Field Monitoring Visit Reports
- xx. Country Office Annual Reports (COARs)
- xxi. Handbook to “How to Design and Conduct a Country Programme Evaluation at UNFPA”

## Annex 2: Evaluation Matrix

### 1) Programme Focus Areas

#### a) Evaluation Matrix Population and Development

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
<b>Population and Development component</b>				
<b>Relevance</b>	<ul style="list-style-type: none"> <li>To what extent are P&amp;D results in the CPAP aligned to the objectives in the Vision 2040, the National Development Plan 2010/11 – 2014/15 priorities?</li> <li>To what extent did CPAP implementation remain aligned to the national PD related priorities</li> </ul>	<ul style="list-style-type: none"> <li>Review and compare priorities from UNFPA and Government of Uganda documents to establish the level of alignment of the CP P&amp;D focus to the National priorities and beneficiary need</li> <li>Evidence of CP contribution to the national development priorities</li> <li>Level of adherence to national related P&amp;D needs during CP implementation</li> </ul>	<ul style="list-style-type: none"> <li>Representative from UNFPA office, IPs and Government, District leaders,</li> <li>Strategic Documents: GoU/UNFPA Seventh CPD, CPAP, CPMEP, Re-aligned Country Programme Results Matrix</li> <li>NPP and NPAP 2011/2015</li> <li>Revised UNFPA Strategic Plan (2012-2013 and 2013 - 2014)</li> <li>Final Evaluation of the GoU/UNFPA 6th CPAP</li> <li>NDP (2010/11 – 2014/15)</li> <li>Vision 2040</li> <li>District Development Plans</li> </ul>	Documents review Key Informant Interviews
	<ul style="list-style-type: none"> <li>To what extent is the UNFPA CP aligned to the MDGs and the 1994 International Conference on Population and Development Programme of Action</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of CP alignment to MDGs and ICPD</li> </ul>		
	<ul style="list-style-type: none"> <li>How targeted was the UNFPA Country Programme in terms of coverage, beneficiaries and stakeholders in respect to P&amp;D</li> </ul>	<ul style="list-style-type: none"> <li>Beneficiary institutions – Who, Where and how? POPSEC, UBOS, Sectors, District Planning Units, NPA, MoLG,</li> <li>Evidence of taking into consideration the needs of the target beneficiary institutions</li> </ul>		
<b>Efficiency</b> (results against resources ) organizational and Programmatic efficiency)	<ul style="list-style-type: none"> <li>How adequately were the available resources (funds and staff) used to carry out activities?</li> <li>To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs?</li> <li>To what extent were the activities managed in a manner that would ensure the delivery of high quality results?</li> </ul>	<ul style="list-style-type: none"> <li>Adequacy of resources (Financial, Personnel etc) to deliver the programme P&amp;D outputs/results</li> <li>Appropriateness of the IPs selected to deliver the P&amp;D results</li> <li>Timely transfer of funds</li> <li>Effective mechanisms to control waste and fraud</li> <li>Focus of UNFPA resources on a key high impact activities</li> <li>Comparison of results achieved to the resources. Could the same outputs be achieved with less expenditure?</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff (including finance / administrative departments)</li> <li>AWPs</li> <li>Project standard progress reports</li> <li>Financial Reports from Implementing Partners and UNFPA (Atlas reports)</li> <li>Audit Reports for IPs</li> <li>Field Monitoring Visit Reports</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field excursions/visits</li> </ul>

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>To what extent were the expected outputs related to population and Development of the CPAP achieved or are likely to be achieved? <ul style="list-style-type: none"> <li>Data generation/availability</li> <li>Data use to integrate population dynamics in national and sub national policies, plans and programmes</li> </ul> </li> </ul>	<p><b>Data generation/availability</b></p> <ul style="list-style-type: none"> <li>Existence of new national Survey Reports supported by UNFPA (DHS, Census, National Panel Survey)</li> <li>Availability of in-depth analytical reports (on MH, FP, Young People, GBV and Reproductive Right) and district profiles from Census, DHS and Panel Survey.</li> <li>Availability and access to Web-based Integrated Management Information System.</li> <li>Existence of gender statistics</li> <li>District statistical abstracts</li> <li>Existence of functional integrated sectoral database at the District Planning Unit</li> </ul> <p><b>Data use for integration of population dynamics in relevant national and sub- national plans and programmes</b></p> <ul style="list-style-type: none"> <li>Availability of National Planning Guidelines (for Sectors and LGs) that include integration of population dynamics in the plans</li> <li>Existence of manual to integrate population dynamics and utilized by the 8 sectors and 15 districts.</li> <li>Analyze National, Sectoral and district Plans to establish whether they fully integrate population dynamics (National Plan, 8 Sectors - health, education, community services, lands/housing/urban development, agriculture, planning, environment, local government and 15 districts</li> <li>Existence of DPAP in the 15 targeted districts.</li> </ul> <p><b>Capacity and Advocacy for integration</b></p> <ul style="list-style-type: none"> <li>Technical capacities for integration of population dynamics into plans and programmes among targeted National and District staff</li> <li>Existence of a functional Youth coordination structure /network for engaging young people in planning/policy dialogue and programme.</li> <li>Leadership advocacy and Champion's</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff</li> <li>Other UN agencies</li> <li>MOH, Ministry of Gender and Social Development</li> <li>IPs</li> <li>Sectoral Policies and Strategic Plans – Health, Gender, Population Secretariat</li> <li>Annual Work Plans for Implementing Partners (2010, 2011, 2012 and 2013)</li> <li>Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)</li> <li>Country Office Annual Reports (2010 – 2012)</li> <li>Other Study reports</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field excursions/visits</li> <li>Document review</li> </ul>

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
		<p>mobilization for support of Population, RH, Gender Issues in relation to MDG 5 (A&amp;B) the ICPD.</p> <ul style="list-style-type: none"> <li>User-friendly P&amp;D advocacy and awareness materials produced and used during leadership</li> <li>The National Population Council Act passed by parliament.</li> </ul>		
	<ul style="list-style-type: none"> <li>What were the facilitating factors for the realization of CPAP results?</li> <li>What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?</li> </ul>	<ul style="list-style-type: none"> <li>Any partnerships, coordination, monitoring and evaluation, capacity challenges that facilitated the delivery of P&amp;D results.</li> <li>Challenges/limiting factors</li> <li>How were the challenges addressed?</li> </ul>	<ul style="list-style-type: none"> <li>Programme reports</li> <li>UNFPA and IP Staff</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field excursions/visits</li> <li>Document review</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>Did the programme include in its design a phase out strategy?</li> <li>To what extent were activities designed in a manner that ensured a reasonable handover to local partners?</li> <li>Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?</li> </ul>	<ul style="list-style-type: none"> <li>Established sustainability mechanism for the programme</li> <li>The Likelihood of the programme and its benefits to be sustainable</li> <li>Established systems to continue the programme</li> <li>Capacity development including staff training</li> <li>Community and country ownership including financial resource commitments</li> <li>Partner organizations with sustainability plans</li> </ul>	<ul style="list-style-type: none"> <li>Representative from UNFPA office, IPs and Government representative, District leaders, beneficiaries</li> <li>Strategic Documents. CPAP, AWP, Reports, IP strategic/development plans</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group Discussions</li> <li>Field excursions/visits</li> <li>Documents review</li> </ul>
<b>Lessons and practices</b>	<b>Learnt good</b>	<ul style="list-style-type: none"> <li>Innovative approaches</li> <li>Key lesson in programming</li> <li>Good practices Documented lessons and good practices</li> </ul>	<ul style="list-style-type: none"> <li>Program documents</li> <li>quarterly and annual reports, field reports</li> <li>Good practice documentation</li> </ul>	<ul style="list-style-type: none"> <li>Review documents and interviews</li> <li>Key Informant Interviews</li> </ul>

## b) Evaluation Matrix- Reproductive Health Component

Criteria	Evaluation questions	What to check	Data Sources	Data Collection methods
<b>REPRODUCTIVE HEALTH</b>				
Relevance	<ul style="list-style-type: none"> <li>To what extent is UNFPA support to Uganda in the area of RH aligned to the objectives in the National Development Plan 2010/11 – 2014/15, Vision 2040 and other sector policy frameworks</li> </ul>	<ul style="list-style-type: none"> <li>Review and compare priorities from UNFPA and Government of Uganda documents to establish the level of alignment of the CP to SRH priorities and beneficiary need</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff</li> <li>UNFPA documents (ICPD, CPD, AWP, CPAP)</li> <li>Strategic Documents: GoU/UNFPA Seventh CPD, CPAP, CPMEP, Re-aligned Country Programme Results Matrix</li> <li>Revised UNFPA Strategic Plan (2012-2013 and 2013 - 2014)</li> <li>Final Evaluation of the GoU/UNFPA 6th CPAP</li> <li>IP staff</li> <li>GoU respective ministries representatives and documents ( NDP, Vision 2040, MoH Strategic plan, 2010-14)</li> <li>Programme reports</li> <li>Focus health center records</li> <li>Grantee organization documents and records</li> <li>Target Districts records and documents</li> <li>Programme beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>Document review</li> <li>Key Informant Interviews</li> </ul>
	<ul style="list-style-type: none"> <li>To what extent is the UNFPA CP objectives are in line with UNFPA Global Strategic Plan for the period 2008 to 2011, which has since been revised and extended to 2014</li> </ul>	<ul style="list-style-type: none"> <li>Level of adherence to national related RH needs during CP implementation</li> </ul>		
	<ul style="list-style-type: none"> <li>To what extent is the UNFPA CP aligned and contributes to the MDGs and the ICPD Programme of Action</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of CP alignment MDGs and ICPD</li> </ul>		
	<ul style="list-style-type: none"> <li>How targeted was the UNFPA Country Programme in terms of coverage, beneficiaries and stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Review to establish if the CP addressed the needs of the most vulnerable populations</li> </ul>		
Efficiency	<ul style="list-style-type: none"> <li>How adequately were the available resources (funds and staff) used to carry out activities?</li> <li>To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs?</li> <li>To what extent were the activities managed in a manner that would ensure the delivery of high quality results?</li> </ul>	<ul style="list-style-type: none"> <li>Adequacy of resources (Financial, Personnel etc) to deliver the programme RH out puts/results</li> <li>Appropriateness of the IPs selected to deliver the RH results</li> <li>Timely transfer of funds</li> <li>Effective mechanisms to control waste and fraud</li> <li>Focus of UNFPA resources on a key high impact activities</li> <li>Comparison of results achieved to the resources. Could the same outputs be achieved with less expenditure?</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff (including finance / administrative departments)</li> <li>AWPs</li> <li>Project standard progress reports</li> <li>Financial Reports from Implementing Partners and UNFPA (Atlas reports)</li> <li>Audit Reports for IPs</li> <li>Field Monitoring Visit Reports</li> <li>IP staff</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field excursions/visits</li> </ul>
Effectiveness ( achievement of results)	<ul style="list-style-type: none"> <li>To what extent has the CP improved health systems strengthening to increase women's utilization of midwifery services in pregnancy care, child birth and management of related complications</li> </ul>	<ul style="list-style-type: none"> <li>% of Health Facility deliveries in target districts</li> <li>Evidence of supportive legislative, policy and financing environment for work of midwives</li> <li>Availability and use of revised national midwifery training curriculum</li> <li>Existence of amended Nurses and Midwifery Act, Handbook and Midwifery Implementation Plan</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff</li> <li>Other UN agencies</li> <li>MOH RH department</li> <li>IPs staff</li> <li>Sectoral Policies and Strategic Plans – Health, fistula, SRH</li> <li>Midwifery association of Uganda</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus Group Discussions</li> <li>Document review</li> </ul>

		<ul style="list-style-type: none"> <li>• Number of midwifery training institutions with capacity to train midwives (midwifery tutors, skills lab, practicum sites)</li> <li>• % of Health facilities (Hospitals, HC IVs and HC IIIs) in target districts with capacity for EmONC</li> <li>• Number of Regional Referral Hospitals offering Fistula repair services on routine basis</li> <li>• Number of women treated for Fistula with UNFPA Support</li> <li>• % of Hospitals and HCIVs with functional capacities for Post Abortion Care services (3 staffs trained &amp; MVA kits)</li> <li>• % maternal deaths notified and audited in target districts</li> <li>• Capacity of professional midwifery associations to represent midwives and midwifery profession</li> <li>• Number of districts with capacity to implement MISP</li> </ul>	<ul style="list-style-type: none"> <li>• Annual Work Plans for Implementing Partners (2010, 2011, 2012 and 2013)</li> <li>• Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)</li> <li>• Country Office Annual Reports (2010 – 2012)</li> <li>• Other Study reports</li> <li>• Target beneficiaries</li> </ul>	
	<ul style="list-style-type: none"> <li>• To what extent has the CP improved social and institutional structures for accelerated uptake of FP methods by women, men, and young people</li> </ul>	<ul style="list-style-type: none"> <li>• Percentage of health facilities in target districts without stock-outs of at least 3 FP methods</li> <li>• Number of new clients utilizing family planning methods in targeted districts</li> <li>• Percentage increase in government share in budget allocation for, and expenditure on contraceptives</li> <li>• Proportion of Health Facilities in Target Districts with at least 2 staff that can offer both short term and long acting FP Methods</li> <li>• increase in annual government of Uganda allocation for and expenditure on contraceptives</li> <li>• Existence of national policies, regulations, norms and guidelines that promote FP and availability of reproductive health commodities at appropriate service delivery levels in the public and private sector</li> <li>• Existence of FP programme with religious and cultural institutions (3 religious bodies, 4 cultural institutions)</li> </ul>	<ul style="list-style-type: none"> <li>• UNFPA staff</li> <li>• Other UN agencies</li> <li>• MOH RH department</li> <li>• IPs staff , VHTs</li> <li>• Sectoral Policies and Strategic Plans – Health, fistula, SRH</li> <li>• Annual Work Plans for Implementing Partners (2010, 2011, 2012 and 2013)</li> <li>• Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)</li> <li>• Country Office Annual Reports (2010 – 2012)</li> <li>• Other Study reports</li> <li>• District HCs</li> <li>• Cultural and religious organizations and leaders</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus Group Discussions</li> <li>• Field excursions/visits</li> <li>• Document review</li> </ul>
	<ul style="list-style-type: none"> <li>• To what extent has CP contributed to capacity strengthening for integration of HIV/AIDS, SRH and HIV prevention for MARPS in Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Existence of a National HIV prevention policy includes rights for populations most at risk</li> <li>• Existence of HIV/AIDS and SRH integration strategy</li> <li>• % of Health Units (HC IIIs, HC IVs and Hospitals) providing integrated RH and HIV/AIDS services in target districts</li> <li>• Number of Youth Clubs in target districts engaged in addressing SRH/HIV needs of Young People (part of ASRH)</li> <li>• Existence of Comprehensive Condom Programming Framework</li> <li>• Existence of a 2 year costed female condom operational plan</li> <li>• Evidence of an established programme for MARPs and vulnerable populations.</li> </ul>	<ul style="list-style-type: none"> <li>• UNFPA staff</li> <li>• Other UN agencies</li> <li>• MOH RH department</li> <li>• IPs staff , VHTs</li> <li>• Sectoral Policies and Strategic Plans – Health, fistula, SRH</li> <li>• Annual Work Plans for Implementing Partners (2010, 2011, 2012 and 2013)</li> <li>• Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)</li> <li>• Country Office Annual Reports (2010 – 2012)</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus Group Discussions</li> <li>• Field excursions/visits</li> <li>• Document review</li> </ul>

		<ul style="list-style-type: none"> <li>• Increase in number of CSW accessing HIV/AIDS and SRH services in target districts</li> <li>• Number of target districts with plans that integrate HIV/AIDS with SRH services (six done already cumulatively to reach 14.</li> <li>• Proportion of general hospitals, HCIVs and HCIIIs with functional capacity (3 staffs trained in HIV/SRH integration, data collection tools, etc.) in the 8 target districts and 6 JUPSA pilot districts with cumulative target of 90%</li> <li>• Existence of leadership programmes with MPs, Cultural Leaders, Religious Leaders for HIV prevention focusing on Multiple &amp; Concurrent Partnerships, PMTCT, Harmful socio-cultural practices, Safe Male Circumcision, etc.</li> <li>• Existence of programmes that provides IEC/BCC, counseling, and clinical services for HIV prevention to MARPs, esp. uniformed forces (police, private security firm) and Defense&amp; CSW and disabled, young people.</li> </ul>	<ul style="list-style-type: none"> <li>• Other Study reports</li> <li>• District HCs</li> <li>• Cultural and religious organizations and leaders</li> <li>• Target beneficiaries</li> </ul>	
	<ul style="list-style-type: none"> <li>• To what extent has CP contributed to improvement of health lifestyle choices for young people related to sexual and reproductive health in Uganda</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of curriculum review materials and Teacher Resource Packs for Secondary School Curriculum</li> <li>• Number of Youth Specific policies, guidelines and standards developed (National Youth Policy and Action Plan, National Youth Coordination Framework, School Health Policy and Action Plan, Adolescent Health Policy and Standards of Care, Guidelines for management of Sexual Reproductive Health issues in School setting)</li> <li>• Proportion of HCIVs and Hospitals in target districts that provide routine Youth Friendly Services .Proportion of health facilities functional youth friendly services/corners in the eight districts.</li> <li>• Proportion of governance structures (e.g., BoGs/PTAs) with resolutions in support of integration of sexuality education in co-curricular activities and in provision of YFS.</li> <li>• Existence of functional, non-partisan youth coordination structure or mechanism</li> <li>• Evidence of sexuality education integration in curricular and co- curricular programmes for in and out of school youth</li> <li>• Proportion of schools in the 8 districts with functional school nurse/health programmes.</li> <li>• Number of out of school young people reached with YFS: clinical, counseling and sexuality education services</li> </ul>	<ul style="list-style-type: none"> <li>• UNFPA staff</li> <li>• Other UN agencies</li> <li>• MOH RH department</li> <li>• Sectoral Policies and Strategic Plans – Health, fistula, Youth –SRH policy</li> <li>• Annual Work Plans for Implementing Partners (2010, 2011, 2012 and 2013)</li> <li>• Country Programme Annual Review Reports and Standard Progress Reports (2010, 2011, 2012)</li> <li>• Country Office Annual Reports (2010 – 2012)</li> <li>• Other Study reports</li> <li>• District HCs records and staff</li> <li>• MoGLSD records and staff</li> <li>• Target beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus Group Discussions</li> <li>• Field excursions/visits</li> <li>• Document review</li> </ul>
	<ul style="list-style-type: none"> <li>• What were the facilitating factors for the realization of CPAP results?</li> <li>• What are some of the challenge/limiting</li> </ul>	<ul style="list-style-type: none"> <li>• Any partnerships, coordination, monitoring and evaluation, capacity challenges that facilitated the delivery of P&amp;D results.</li> </ul>	<ul style="list-style-type: none"> <li>• Programme reports UNFPA and IP Staff</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus group</li> </ul>

	factors that may have affected the achievement and implementation of the programme?	<ul style="list-style-type: none"> <li>Challenges/limiting factors</li> <li>How were the challenges addressed?</li> </ul>		<p>discussions</p> <ul style="list-style-type: none"> <li>Field excursions/visits</li> <li>Document review</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>Did the programme include in its design a phase out strategy?</li> <li>To what extent were activities designed in a manner that ensured a reasonable handover to local partners?</li> <li>Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?</li> </ul>	<ul style="list-style-type: none"> <li>Established sustainability mechanism for the programme</li> <li>The Likelihood of the programme and its benefits to be sustainable</li> <li>Established systems to continue the programme</li> <li>Capacity development including staff training</li> <li>Community and country ownership including financial resource commitments</li> <li>Partner organizations with sustainability plans</li> </ul>	<ul style="list-style-type: none"> <li>Representative from UNFPA office, IPs and Government representative, District leaders, beneficiaries</li> <li>Strategic Documents. CPAP, AWP, Reports, IP strategic/development plans</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group Discussions</li> <li>Field excursions/visits <ul style="list-style-type: none"> <li>Documents review</li> </ul> </li> </ul>
<b>Lessons Learnt and good practices</b>	<ul style="list-style-type: none"> <li>What would have done differently with the same resources?</li> <li>What was the most and least successful approach in the delivery of CP outputs?</li> <li>What do you consider the most innovative approach in delivering program approaches?</li> <li>What are the good practices that should be continued and/or replicated elsewhere?</li> </ul>	<ul style="list-style-type: none"> <li>Innovative approaches</li> <li>Key lesson in programming</li> <li>Good practices Documented lessons and good practices</li> </ul>		<ul style="list-style-type: none"> <li>Review documents and interviews</li> <li>Key Informant Interviews</li> </ul>

### c) Evaluation Matrix Gender and Reproductive Rights Component

Criteria	Evaluation questions	What to check for	Data Source s	Data Collection method
Relevance	<ul style="list-style-type: none"> <li>To what extent is the CPAP Gender and Reproductive Rights focus               <ol style="list-style-type: none"> <li>aligned to the priorities of International and national legal and policy frameworks</li> <li>adapted to the needs of the population</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Review and compare priorities from UNFPA and Government of Uganda documents.</li> <li>Evidence of alignment with international and regional instruments including MDGs and ICPD</li> <li>Evidence of adaptation to meeting the needs of the target populations including population in underserved areas and marginalized women</li> <li>Are regional and cultural aspects taken into account?</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff</li> <li>IP staff</li> <li>GoU, MoGLSD</li> <li>Programme reports and documents</li> <li>Grantee organization documents and records</li> <li>Target districts records and documents</li> <li>Programme beneficiaries</li> <li>International/regional instruments</li> <li>Vision 2040</li> <li>NDP</li> <li>District plans</li> <li>SIDPII, Gender Policy, The Constitution of Uganda</li> <li>Domestic relations bill, and other instruments and policy documents</li> </ul>	<ul style="list-style-type: none"> <li>Document review</li> <li>FGDs</li> <li>Key Informant Interviews</li> </ul>
<b>Efficiency</b> (Results against resources ) organizational and Programmatic efficiency)	<ul style="list-style-type: none"> <li>How adequately were the available resources (funds and staff) used to carry out activities?</li> <li>To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs?</li> <li>To what extent were the activities managed in a manner that would ensure the delivery of high quality results?</li> </ul>	<ul style="list-style-type: none"> <li>Adequacy of resources (Financial, Personnel etc) to deliver the programme Gender and RR out puts/results</li> <li>Appropriateness of the IPs selected to deliver the Gender and RR results</li> <li>Timely transfer of funds</li> <li>Effective mechanisms to control waste and fraud</li> <li>Focus of UNFPA resources on a key high impact activities</li> <li>Comparison of results achieved to the resources. Could the same outputs be achieved with less expenditure?</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff (including finance / administrative departments)</li> <li>AWPs</li> <li>Project standard progress reports</li> <li>Financial Reports from Implementing Partners and UNFPA (Atlas reports)</li> <li>Audit Reports for IPs</li> <li>Field Monitoring Visit Reports</li> </ul>	<ul style="list-style-type: none"> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field excursions/visits</li> </ul>
<b>Effectiveness</b>	<ul style="list-style-type: none"> <li>To what extent were the expected outputs related to Gender and reproductive rights of the CPAP achieved or are likely to be achieved?</li> </ul>	<ul style="list-style-type: none"> <li>Targeted districts plans and budgets that incorporate Gender-Based Violence prevention/ response and reproductive rights interventions.</li> <li>Number of Gender-Based Violence survivors utilizing response services in targeted districts</li> <li>Number of sectors implementing the</li> </ul>	<ul style="list-style-type: none"> <li>UNFPA staff (including Gender focal persons and output managers)</li> <li>IP Partners</li> <li>Programme Beneficiaries</li> <li>Project progress Reports</li> </ul>	<ul style="list-style-type: none"> <li>Data extraction</li> <li>Key informant interviews</li> <li>Focus group discussions</li> <li>Field</li> </ul>

Criteria	Evaluation questions	What to check for	Data Source s	Data Collection method
		<p>international instruments and national legislation for GBV prevention and management</p> <ul style="list-style-type: none"> <li>• Number of target districts that have a functional system in place to regularly record GBV incidence at overall district level</li> <li>• Number of selected GBV related policies/legislation passed into law by Parliament <b>(DV, FGM/C, MDB, Sexual Offences, Khaddi's Bill)</b></li> <li>• Number of persons trained in GBV Programming in Humanitarian and Post-conflict situations</li> <li>• Number of communities that declare the abandonment of FGM/C</li> <li>• Existence of functional capacities for GBV prevention &amp; management in the 4 sectors: JLOS, Education, Security/ POLICE &amp; UPDF, Health, and Social Development</li> <li>• Existence of institutionalized GBV programmes in 5 FBOs (resolutions, handbooks, work plan, annual performance reports, institutional policy/guidelines on GBV, activities on GBV, involvement of top leaders in GBV and GBV in Pastoral outreach structures, school GBV programmes)</li> <li>• Functional district and community structures for GBV prevention and response (District GBV prevention and response alliances, Community Groups for GBV prevention and response, women caucuses)</li> <li>• Ordinances, Bylaws and resolutions passed by the district and sub-county leadership</li> <li>• High level National Policy and political commitments</li> <li>• Availability and use of SOPs, referral pathways, guidelines for psycho-social support, fill Police Forms 3, 3A, &amp; 24A</li> </ul>		excursions/visits

Criteria	Evaluation questions	What to check for	Data Source s	Data Collection method
	<ul style="list-style-type: none"> <li>• What were the facilitating factors for the realization of CPAP results?</li> <li>• What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?</li> </ul>	<ul style="list-style-type: none"> <li>• Any partnerships, coordination, monitoring and evaluation, capacity challenges that facilitated the delivery of P&amp;D results.</li> <li>• Challenges/limiting factors</li> <li>• How were the challenges addressed?</li> </ul>	<ul style="list-style-type: none"> <li>• Programme reports UNFPA and IP Staff</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus group discussions</li> <li>• Field excursions/visits</li> <li>• Document review</li> </ul>
<b>Sustainability</b>	<ul style="list-style-type: none"> <li>• Did the programme include in its design a phase out strategy?</li> <li>• To what extent were activities designed in a manner that ensured a reasonable handover to local partners?</li> <li>• Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?</li> </ul>	<ul style="list-style-type: none"> <li>• Established sustainability mechanism for the programme</li> <li>• The Likelihood of the programme and its benefits to be sustainable</li> <li>• Established systems to continue the programme</li> <li>• Capacity development including staff training</li> <li>• Community and country ownership including financial resource commitments</li> <li>• Partner organizations with sustainability plans</li> </ul>	<ul style="list-style-type: none"> <li>• Representative from UNFPA office, IPs and Government representative, District leaders, beneficiaries</li> <li>• Strategic Documents. CPAP, AWP, Reports, IP strategic/development plans</li> </ul>	<ul style="list-style-type: none"> <li>• Key informant interviews</li> <li>• Focus group Discussions</li> <li>• Field excursions/visits <ul style="list-style-type: none"> <li>• Documents review</li> </ul> </li> </ul>
<b>Lessons Learnt and good practices</b>	<ul style="list-style-type: none"> <li>• What would have done differently with the same resources?</li> <li>• What was the most and least successful approach in the delivery of CP outputs?</li> <li>• What do you consider the most innovative approach in delivering program approaches?</li> <li>• What are the good practices that should be continued and/or replicated elsewhere?</li> </ul>	<ul style="list-style-type: none"> <li>• Innovative approaches</li> <li>• Key lesson in programming</li> <li>• Good practices Documented lessons and good practices</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Review documents and interviews</li> <li>• Key Informant Interviews</li> </ul>

## II) Evaluation Matrix for Strategic Alignment

Focus area	Evaluation question	What to check for	Data Source	Data Collection method
<b>CPE COMPONENT 2-STRATEGIC ALIGNMENT</b>				
<b>Strategic Alignment</b>				
<b>Strategic Alignment (Corporate Dimension)</b>	<p>To what extent has the CO positioned ICPD goals and issues within governmental processes at the national and local levels?</p> <p>To what extent is the Country Programme and its implementation aligned to the UNFPA corporate mandate as set out in the Strategic Plan?</p> <p>To what extent has the CO prioritized intervention strategies targeted at most vulnerable, disadvantaged, marginalized and excluded population groups, in line with the stipulations of the Strategic Plan?</p> <p>To what extent has South-South cooperation been mainstreamed in the country programme through the enhanced use of capacities and as a means to share best practices among countries of the South? If so, is this cooperation modality reflected in the results framework by means of specific indicators?</p> <p>To what extent is the CO abiding by the corporate principles of national ownership, national leadership and national capacity development? Are these principles effectively applied during the planning and implementation phases?</p>	<p>Analyze and compare CPAP, UNDAF and UNFPA strategic plan AND actual implementation</p> <p>Identify complementarities or reasons for isolated work;</p> <p>Identify mechanisms used and their effect;</p> <p>Analyze any difficulties that have arisen, if any</p>	<p>Representative from UNFPA office, IPs and Government representative ICPD-POA CPAP &amp; Re-aligned CPAP Results Matrix</p> <p>Revised UNFPA Strategic Plan (2012-2013)</p> <p>UNDAF (2010-2014)</p> <p>UNDAF Annual Review Reports (2010, 2011)</p> <p>MTR of the UNDAF</p> <p>National Development Plan (2010/11 – 2014/15) AWP</p>	<p>Review key documents; look out for similarities and difference of priorities. Identify priorities that have been responded to. UNFPA Global Strategic Plan, UNDAF</p> <p>Review AWP to see what the implementation plans are on the ground.</p> <p>Design interview tools and use these for FGDs &amp; Key Informant Interviews</p>
<b>Strategic Alignment (Systemic Dimension):</b> The systemic dimension looks at the extent to which the GOU/UNFPA Country Programme is aligned with the UN strategy (UNDAF) in the country.	<p>To what extent is the country programme, as currently implemented, in line with the UNDAF? Is there any mismatch?</p> <p>To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?</p> <p>To what extent is the UNFPA CO coordinating with other UN agencies in the country?</p>		As above	<p>Review key documents; look out for similarities and difference of priorities. Identify priorities that have been responded to. UNFPA Global Strategic Plan, UNDAF</p> <p>Design interview tools and use these for FGDs &amp; Key Informant Interviews</p>

Focus area	Evaluation question	What to check for	Data Source	Data Collection method
<p><i>The ability of the CO to respond to: (i) changes and/or additional requests from national counterparts e.g., natural disasters, conflicts etc.), and (ii) shifts caused by external factors in an evolving country context.</i></p>	<p>To what extent has the CO been able to respond to changes in national needs and priorities or to shifts caused by crisis or major natural disasters? What was the quality of the response?</p> <p>To what extent has the CO been able to respond to specific/ad-hoc/urgent requests of partner country counterparts? What was the quality of the response?</p>	<p>Extent, to which the CO has been able to respond as well as the quality of the response, including: (1) the speed and timeliness of the response; (2) the appropriateness of the response i.e. was it adequate to the magnitude of the demands? (3) the balance between short-term responsiveness and long-term development objectives.</p> <p>Flexibility in redirecting funds, adapting objectives and planning to changes in contexts and circumstances.</p> <p>Deviation of mandate and resources allocation</p>	<p>Implementing partners and beneficiaries (most importantly those in the field)</p>	<p>Interviews with government partners, development partners and beneficiaries</p> <p>Focus group</p>
<p><i>The extent to which the UNFPA country programme adds benefit to the results from other development actors' interventions (Stakeholder's perception about UNFPA in the Country)</i></p>	<p>How do the national counterparts and other development actors perceive, recognize and recall UNFPA's performance in the country?</p> <p>What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are they a result of UNFPA corporate features or are they explained by the specific features of the CO?</p> <p>To what extent would the results observed within the programme focus areas have been achieved without UNFPA support?</p> <p>What is the main UNFPA added value in the country context as perceived by national stakeholders? What would the country lose if UNFPA did not have a presence in Uganda?</p>	<p>What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies working in similar areas i.e. UNICEF, UN Women, WHO and UNDP?</p> <p>Are comparative strengths a result of UNFPA corporate features or are they explained by CO's specific aptitudes?</p> <p>What is the main UNFPA added value as perceived by national stakeholders? Why UNFPA as opposed to another agency?</p> <p>Check existing national capacities and interest for working on the same issues.</p>	<p>Programming documents and implementation progress reports</p>	<p>Doc review</p> <p>Interviews with government partners, development agency partners and beneficiaries</p> <p>Focus group</p> <p>Interviews with selected NGOs, and other UN agencies</p>

## Annex 2: List of Persons Met

	Names	Gender	Institution	Title
1	Nakimuli Eva	F	POPSEC	SNPO, FAD
2	Ikirimat Grace	F	POPSEC	SNPO, PPD
3	Tiondi Andrew	M	POPSEC	PNPO
4	Kangabe Edith	F	POPSEC	Ag. Head PPD
5	Olemo J Pete	M	POPSEC	NPO-MED
6	Musinguzi Hassan	M	POPSEC	Head FAD
7	Julie Numuli	F	POPSEC	R/Asst, MED
8	Charles Zirarema	M	POPSEC	Ag. Director
9	Andrew Mukulu	M	UBOS	DPSS
10	Kizito Kasozi	M	UBOS	DIT
11	Godfrey Nabongo	M	UBOS	M/CDPR
12	Bernard Justin Muhwezi	M	UBOS	M/GIS
13	Pamela Kakande	F	UBOS	UNFPA – Focal Person
14	Helen Nviiri	F	UBOS	Principal Statistician
15	Grace Bulenzi-Gulere	F	UBOS	Principal Officer-Statistical Coordination
16	Najjemba Maria		MOH/UNFPA	TA_Midwife
17	Yvonne Mugerwa		MOH/UNFPA	TA_RH
18	Zainab Akol		MOH	PMO/RH
19	Doreen Tukamushaba		MOH	Research Assistant
20	Judith Amongin		MOH	Fin/Admin Officer
21	Olivia Kiconco		MOH-RH	Assistant Program officer
22	Namugeere Miriam		MOH-RH	DNO
23	Dr Tusingwire Collins	M	MOH/RH	Ag.ACHS
24	Jacqueline Nakiwala	F	Catholic Secretariat	Programme Manager
25	Dr. Peter Kyambadde	M	STD-ACP:MoH	Program Officer
26	Alice Nabuloli	F	MoE	Principal Education officer
27	Mr. Mondo KyatekaF.	M	MoLGD	Ass. Commissioner Youth Affairs
28	Roland Byalawa	M	MoE	Focal Person School Health
29	Gorretti Musoke	F	Private Midwives association	President
30	Andre Kibuuka	M	Private Midwives association	coordinator
31	Ezaga Juliet	F	Uganda Nurse and Midwives Council	Training officer/administrator
32	Micheal Dembe	M	Uganda Red Cross Society	Project manager
33	Prince Emalia	M	TEU	Programs' manager
34	Mayanja Abubakar	M	VDU	Executive director
35	Kamya Frank	M	COPTEC/VRF	Administrator
36	Kaweesi Joseph	M	COPTEC	Executive director
37	Mulaka Ronald	M	YRF	Peer educator
38	Kaliisa Elijah	M	TADU	Peer educator
39	Majorie Nakimuli	F	MARPI/STD Clinic	Team leader

40	Demeter Marget Namugabo	F	Reproductive Health Uganda	Medical coordinator
41	Paul Ahumuza	M	Marie Stopes Uganda	Project coordinator
42	Nahaga Samuel	M	A/C	SRH officer
43	Sharon Alumuza	F	A/C	Fellow
44	Ritah Mwangale	F	Uganda Health Marketing Group	Communication coordinator
45	Jackson Chekweko	M	Reproductive Health Uganda	Executive director
46	Ida Kigonya	F	MoGLSD	PCM/PWIDO
47	Brenda Aber	F	MoGLSD	P.D.Trainge documentation
48	Rebecca Nalumansi	F	MoGLSD	Prog.Associate
49	Tirinawe Crescent	M	MoGLSD	SGO
50	Atwijukire Justus	F	MoGLSD	PO monitoring and evaluation
51	Mubaraq Mabuya	M	MoGLSD	Former Component Manager
52	Betty Kasiko	F	UWONET	Director of Programs/ UWONET
53	Juliet Luutu	F	FAWODE	Prog. Asst/ FAWODE
54	Rita Aciro	F	UWONET	ED/UWONET
55	Regina Bafaki	F	ACFODE	ED/ ACFODE
56	Sam Rogers Wairalaga	M	JLOS	M&E Technical Advisor/ Gender Officer
57	Lt. Mutebaazi	M	UPDF	Gender Officer
58	Pastor Msungu	F	Miracle Centre Church/IWCC	Focal Person/Pastor/Women Leader
59	Lydia Komugisha	F	Seventh Day Adventist Church	Program Focal Person
60	Zaituna Ziraba	F	Uganda Muslim Supreme Coucil	Focal Person
61	Disani Mayanja	M	Orthodox Church	Focal Person
62	Kekiconco Phoebe	F	Katete HCIII	N/O
63	Tumwesigye Godfrey	M	Katete HCIII	E/N
64	Musasizi Nelson Smart	M	Katete HCIII	Clinical Officer
65	Ngabirano Simplisio	M	Kiringa GBV Group (SMAG)	SMAG member
66	Kaguuri Polycarp	M	Kiringa GBV Group (SMAG)	SMAG member
67	Rwamahe Alex	M	Kiringa GBV Group (SMAG)	SMAG member
68	Twikirize Lawrence	M	Kiringa GBV Group (SMAG)	SMAG member
69	Muhimbo Herbert	M	Kiringa GBV Group (SMAG)	SMAG member
70	Nyamireere Peninnah	F	Kambuga Hospital	N/O (Midwifery)
71	Namakula Fausta	F	Kambuga Hospital	E/Midwife
72	Tumwesigye Fausta	F	Kambuga Hospital	SNO
73	Twinamasiko Keneth	M	Kambuga Hospital	Medical Social Worker
74	Akankwasa Judith	F	Kambuga Hospital	SCO
75	Ninsiima Rosette	F	Kambuga Hospital	HMIS
76	Kansiime Emilly	F	Kambuga Hospital	R/Midwife
77	Nakaziro Harriet	F	Mubende Hospital	E/M
78	Nalule Irene	F	Mubende Hospital	E/M
79	Mukonyezi Edwin	M	Mubende Hospital	CO
80	Mubeezi Racheal Muyonjo	F	Mubende Hospital	SNO –Ag PWO

81	Kyaterekera Noeline	F	Police	W/AIP
82	Nabukenya Jamirah	F	Police	W/SPC
83	Masinde Peter	M	Police	A/P
84	Engulu Joseph	M	Police	CLO IP
85	Nakawiki Prisca	F	Mubende District	D/statistian
86	Kakinda Matovu W	M	Mubende District	Population officer
87	Peter Drami Oyanga	M	Mubende District	D/planner
88	Ndagire Maria	F	Mubende District	DCDO
89	Dr.Mubiru Wilson	M	Mubende District	DHO
90	Kavuma Charles	M	Mubende District	DHE
91	Ssendikadiwa	M	Mubende District	Ass DHO
92	Lyagoba Paul	M	Mubende District	Ass DHO
93	Masika Prisca	F	Mubende Light YFC	Coordinator
94	Ssendikadiwa	M	Health Office	Ass DHO
95	Lyagoba Paul	M	Health Office	ADHO
96	Masika Prisca	F	Health Office	Coordinator
97	Kamya Davies	M	Kasambya HCIII	H/C Y/FC
98	Mankabirwa specioz	F	Kasambya HCIII	N/O MATWAK
99	Mugalula Stephen	M	Kasambya HCIII	Peer
100	Twongeirwe Getrude	F	Kasambya HCIII	Peer
101	Mukasa Phoebe Justine	F	Kiganda HCIV	N/O
102	Natukunda Caroline	F	KAABONG S.S.S	Peer educator
103	Okello Godfrey	M	KAABONG S.S.S	Peer educator
104	Anyii Odom Angelo	M	KAABONG S.S.S	Peer educator
105	Otim Joseph Lagwok	M	KAABONG S.S.S	Peer educator
106	Adriko Felix	M	KAABONG S.S.S	Peer educator
107	Lokut Calvin D'doms	M	NAKAPELIMORU H/C III	Peer educator
108	Awilli Scovia Okello	F	NAKAPELIMORU H/C III	Enrolled midwife
109	Akullo Paska	M	KAPENGA HC IV	Peer educator
110	Napakori Marriam	F	KAPENGA HC IV	Trained h/ worker
111	Nakwangmagdalene	F	KAPENGA HC IV	Trained h/ worker
112	Nakiru Lily Grace	F	KAPENGA HC IV	Peer educator
113	Nakoli Loyce	F	KAPENGA HC IV	Trained h/ worker
114	Ngole Daniel Lokira	M	KAPENGA HC IV	Trained h/ worker
115	Achan Joyce Lokeris	F	NASINYONOIT GBV Survivor	CO FACILITATOR
116	Ngorok Simon	M	MOGOS GBV Survivor	VHT MEMBER
117	Nakiru Teresas	F	KOLOLO GBV Survivor	MEMBER MOGOS
118	Achayo Susan	F	MOGOS GBV Survivor	MEMBER MOGOS
119	Lodong Mark	M	KOLOLO	CO FACILITATOR
120	Lomuge Lina	F	NASINYONOIT	MEMBER MOGOS
121	Lomuria Musana	M	MOGOS	MEMBER MOGOS

122	Koryang Betty	F	MOGOS	CO FACILITATOR
123	Nakiru Betty	F	NASIYONOIT	MEMBER MOGOS
124	Koryany Josephine	F	NALAKAS PRIMARY SCHOOL	
125	Nakiru School	F	ST. CATHERINE WOMENS GROUP	MEMBER
126	Namoe Jesca	M	MOWIN WOMENS GROUP	MEMBER
127	Iriama Moses	M	KAABONG HOSPITAL	PEER EDUCATOR
128	Noding Lucy	F	KAABONG HOSPITAL	PEER EDUCATOR
129	Nakang Gloria Luyiga	F	KAABONG HOSPITAL	PEER EDUCATOR
130	Komol Joyce	F	KAABONG HOSPITAL	PEER EDUCATOR
131	Lodite Benjamin	M	KAABONG HOSPITAL	VOLUNTEER
132	Olwoch D K Faustine	M	KAABONG HOSPITAL	C.O TEENAGE CLINIC
133	Ajilong Margaret	F	KAABONG HOSPITAL	SNO MIDWIFERY
134	Loduk John Timothy	M	KAABONG	DISTRICT BP2 OFFICER
135	Baatom Ben Koryang	M	KAABONG	DCDO
136	Ekoom Robert	M	KAABONG	AG BIOSTAT
137	Owilli Joel Achilla	M	WAR CHILD UK	DISTRICT PROGRAM CO ORDINATOR
138	Apio Hellen Dorcas	F	KOTIDO H/C IV	ENROLLED NURSE
139	Adong Julie	F	KOTIDO H/C IV	S.N.A
140	Opio Steven Abul	M	KOTIDO H/C IV	PEER EDUCATOR
141	Namuya Bruno	M	URC	VOLUNTEER
142	Eriia Saviour Obwiino	M	KOTIDO H/C IV	PEER EDUCATOR
143	Abura Hannington	M	KOTIDO H/C IV	PEER EDUCATOR
144	Alice A Musana	F	KOTIDO H/C IV	ENROLLED MIDWIFE
145	Ongom Simon Peter	M	Kotido parents Sch. YFC	PATRON
146	Lodiny Rex Azaries	M	KOTIDO	HMIS FP
147	Olanya Eugene	M	ICAIDO	EHO
148	Nachen Lily	F	KOTIDO	AGDCDO
149	Ogwawa Lawrence	M	KDLG	SP/WO
150	Nangio Patricia	F	RLP KOTIDO OFFICE	COORDINATOER
151	Okama Robert Okech	M	RLP KOTIDO OFFICE	RESEARCH ASSISTANT
152	Kiggundu Patrick	M	KOTIDO DLG	POPULATION OFFICER
153	Jackson Matsasga	M	KOTIDO SS	HT
154	Logira Francis	M	KOTIDO SS	PATRON – ARSH
155	Kula Moses	M	KOTIDO SS	DIHTR
156	Kiyonga Sarah	F	KOTIDO SS	STUDENT
157	Awilli Brendah	F	KOTIDO SS	STUDENT
158	Napor Prisca Atebu	F	KOTIDO SS	STUDENT
159	Nakiru Winnie Eko	F	KOTIDO SS	STUDENT
160	Mudong Esther	F	KOTIDO SS	STUDENT
161	Nangiro Paula	F	KOTIDO SS	STUDENT
162	Awii Linah	F	KOTIDO SS	STUDENT

163	Kiyonga Joyce	F	KOTIDO SS	STUDENT
164	Lokawa Jolly	F	KOTIDO SS	STUDENT
165	Chillakweny Alfred	M	KOTIDO SS	STUDENT
166	Nakiru Proscovia	F	KOTIDO SS	STUDENT
167	Kiyonga Collins Joel	M	KOTIDO SS	STUDENT
168	Lomulen Joseph	M	KOTIDO SS	STUDENT
169	Adere Josephine	F	KOTIDO SS	S.NURSE
170	Lomeri Patrick Evra	M	KOTIDO SS	STUDENT
171	Lokwii Jennifer	F	KOTIDO SS	STUDENT
172	Lomongin Daniel Omara	M	KOTIDO SS	STUDENT
173	Lometo John	M	KOTIDO SS	STUDENT
174	Irar Peter Abraham	M	KOTIDO SS	STUDENT
175	Akonya Joshua	M	KOTIDO SS	STUDENT
176	Koryane Laureen	F	KOTIDO SS	STUDENT
177	Chilla Daniel	M	KOTIDO SS	STUDENT
178	Keno Isaiah	M	KOTIDO SS	STUDENT
179	Muron Vincent	M	MOROTO DLG	FOR DHO
180	Amei Peter	F	MOROTO	HMISFP
181	Margie Lolem	F	MOROTO	CDO/ GENDER
182	Lokeris A Patricia	F	MIFUMI MOROTO	PROG MANAGER
183	Anne Grace Aleso	F	WPE IRC MOROTO	PROG MANAGER
184	Ajaro Hellen Ongaleno	F	MOROTO RR HOSPITAL	HEALTH STAFF
185	Ogwang David	M	MOROTO RR HOSPITAL	C/MAN PEER EDUCATOR
186	Kabitanya Lukia	F	MOROTO RR HOSPITAL	SNO
187	Nekesa Rose	F	MOROTO RR HOSPITAL	EIM
188	Lokerith G.A Nangiro	M	MDLG	ECONOMIST
189	Okoth Carolyn	F	POLICE	YE EFFV
190	Rose	M	MSU	
191	Pirlo Alex	M	POPE JOHN PAUL MEM COLLEGE	CLUB PATRON
192	Mazinga Ronald	M	POPE JOHN PAUL MEM COLLEGE	S.MALE TEACHER
193	Kangabe Florence	F	MOROTO HIGH SCHOOL	SENIOR WOMAN TEACHER
194	Lochebo Amos	M	MOROTO HIGH SCHOOL	C/ PERSON
195	Kodoit Timothy	M	MOROTO HIGH SCHOOL	PEER EDUCATOR
196	Agan Joshua	M	MOROTO HIGH SCHOOL	HEADTEACHER
197	Adam Juma B	M	RED CROSS	FOCAL PERSON
198	Akello Stella	F	NADUNGET	ECN
199	Lotimong Agnes	F	NADUNGET	VHT
200	Moru John	M	NAMISIMIS	VHT
201	Lowok Mark	M	NACHORA	VHT
202	Amase Satina	M	NAKAMISTAC	VHT
203	Nachugat Anna	F	KOTARUK	VHT

204	Losike Peter	M	LOKILALA	VHT
205	Lobur Walakaz	M	LOPUIUI	VHT
206	Lochugai Atyama	M	NAKAPELIMEN	VHT
207	Onyamasi J Wekesa	M	NADUNGET HC	1/C - NHCIII (SCO)
208	Aenu Patrick	M	NADUNGET S.S.S	PATRON YFC TEACHER
209	Okidi Dominic	M	NADUNGET S.S.S	SENIOR MAN
210	Ekellot Richard	M	NADUNGET S.S.S	PEER FACILITATOR
211	Agwang Loyce	F	NADUNGET S.S.S	SENIOR WOMAN
212	Kodet Innocent	M	NADUNGET S.S.S	PEER EDUCATOR
213	Wettaka Aramazan	M	NADUNGET S.S.S	PEER EDUCATOR
214	Abba Betty	F	NADUNGET S.S.S	PEER EDUCATOR
215	Akiror Mertan	F	NADUNGET S.S.S	PEER EDUCATOR
216	Lokubap Simon Peter	M	NADUNGET S.S.S	PEER EDUCATOR
217	Kiyonga Paul	M	NADUNGET S.S.S	PEER EDUCATOR
218	Alupo Samali	F	NADUNGET S.S.S	PEER EDUCATOR
219	Akungur Daniel	M	NADUNGET S.S.S	PEER EDUCATOR
220	Angwao Gloria	F	NADUNGET S.S.S	PEER EDUCATOR
221	Pedo Pennina	F	NADUNGET S.S.S	PEER EDUCATOR
222	Amujal Priscilla	F	MRRH	PEER EDUCATOR
223	Aduke Lulyne	F	MRRH	PEER EDUCATOR
224	Okukui Okwii Stephen	M	MRRH	PEER EDUCATOR
225	Adam Juma Bashir	M	RED CROSS (MOROTO)	FOCAL PERSON
226	Ogwang David	M	MRRH	PEER EDUCATOR
227	Omagor Jame Peter	M	MRRH	PEER EDUCATOR
228	Lukoya George	M	MRRH	PEER EDUCATOR
229	Oyei Emmanuel	M	JUBILEE S.S	TEACHER
230	Kisembo Stephen	M	JUBILEE S.S	TEACHER
231	Ngole Paula	F	JUBILEE S.S	STUDENT
232	Lobeerei James	M	JUBILEE S.S	STUDENT
233	Dr Katawera Andrew	M	Katakwi Hospital	Medical Superintendent
234	Mr Okiror Sam	M	Katakwi Hospital	District inspector of schools Katakwi
235	Ms Damalie Asekenye	F	Katakwi Hospital	District Community Development Officer
236	Ms Jane	F	Katakwi Hospital	Midwife Katakwi Hospital
237	Dr Simon Icumar	D	Katakwi Hospital	District Health Officer
238	Ms Margaret Ilukot	F	Katakwi Hospital	LC V-Vice chairperson/Lead Champion
239	Ms Scolia Alupo	M	Katakwi Hospital	Deputy CAO
240	Mr Emma Okiror	M	Katakwi Hospital	Planning Officer/P&D officer
241	Unnamed	F	Katakwi Hospital	ANC attendee 1/ RH Beneficiary KH
242	Unnamed	F	Katakwi Hospital	ANC attendee 2/ RH Beneficiary KH
243	Unnamed Beneficiary	F	Katakwi Hospital	Post Abortal Care/ RH Beneficiary KH

244	Unnamed	F	Katakwi Hospital	User FP services/ RH Beneficiary KH
245	Oola Daniel	M	Katakwi Hospital Yoth Corner Group	Nursig assisstat
246	Okiror Valentine A.	M	Katakwi Hospital Youth Corner Group	Peer Educator
247	Otim Amos Robert	M	Katakwi Hospital Youth Corner Group	Peer Educator
248	Ojangole Ivan	M	Katakwi Hospital Youth Corner Group	Peer Educator
249	Ocuwai Simon	M	Katakwi Hospital Youth Corner Group	Peer Educator
250	Aayu Hellen	F	Katakwi Hospital Youth Corner Group	Beneficiary
251	Istu Gabriel	M	Katakwi Hospital Youth Corner Group	Peer Educator
252	Aupal Emmanuel	M	Katakwi Hospital Youth Corner Group	Peer Educator
253	Opolot Richard	M	Katakwi High School	Teacher
254	Akori Ruth	F	Katakwi High School	Teacher
255	Amagurut Catherine	F	Katakwi High School	Teacher
256	Ariko Justine	F	Katakwi High School	Nurse
257	Asimo Angela	F	Katakwi High School	peer educator
258	Isekuny Angela	F	Katakwi High School	peer educator
259	Olemutum Simon Peter	M	Katakwi High School	peer educator
260	Opio Simon	M	Katakwi High School	peer educator
261	Apolot Stella	F	Katakwi High School	peer educator
262	Atai Sarah	F	Katakwi High School	peer educator
263	Okoboi Patric	M	Katakwi High School	peer educator
264	Apuko Sarume	F	Katakwi High School	peer educator
265	Agora John	M	Katakwi High School	peer educator
266	Ikejat Mohamed	M	Katakwi Technical school (KTC)	Teacher
267	Elietu David	M	Katakwi Technical school (KTC)	Teacher
268	Ekweny Simon Peter	M	Katakwi Technical school (KTC)	Teacher
269	Akiteng Magret	F	Katakwi Technical school (KTC)	Teacher
270	Ajune Immaculate	F	Katakwi Technical school (KTC)	Teacher
271	Opolot Robert	M	Katakwi Technical school (KTC)	Teacher
272	Achola Agnes	F	Katakwi Technical school (KTC)	Student
273	Oonyu Moses	M	Katakwi Technical school (KTC)	Student
274	Okukut Joseph	M	Katakwi Technical school (KTC)	Student
275	Morotum Pius	M	Katakwi Technical school (KTC)	Student

276	Ojom Mories	M	Katakwi Technical school (KTC)	Student
277	Onong Francis	M	Katakwi Technical school (KTC)	Student
278	Okerenyag Isaac	M	Katakwi Technical school (KTC)	Student
279	Akello Robert	M	Katakwi Technical school (KTC)	Student
280	Oyella Catherine	F	Katakwi Technical school (KTC)	Student
281	Akol Rita	F	Katakwi Technical school (KTC)	Student
282	Atim Angella	F	Katakwi Technical school (KTC)	Student
283	Among Eliza	F	Katakwi Technical school (KTC)	Student
284	Otim Moses	M	Katakwi Technical school (KTC)	Student
285	Otwao Rose	F	Magoro Health Centre	-Beneficiary( Mother)
286	Maringa Gerald	M	Magoro Health Centre	-Laboratory Technician
287	Maringa Caroline	F	Magoro Health Centre	- Laboratory assistant
288	Amidongo Stella	F	Magoro Health Centre	- Enrolled nurse
289	Apolot Ester	F	Magoro Health Centre	- beneficiary( mother)
290	Immat Tomet	F	Magoro Health Centre	-beneficiary( Mother)
291	Idoimine Annah	F	Magoro Health Centre	- Beneficiary( Mother)
292	Achomu Angella	F	Magoro Health Centre	- Beneficiary ( Mother)
293	Icheru Juliet	F	Toroma HEALTH CENTRE	P/E
294	Anyakoyit Juliet-	F	Toroma HEALTH CENTRE	P/E
295	Okwere Richard-	M	Toroma HEALTH CENTRE	P/E
296	Chelimo Margret-	F	Toroma HEALTH CENTRE	P/E
297	Akiteng Immaculate-	F	Toroma HEALTH CENTRE	P/E
298	Aseeta Martin	M	Toroma HEALTH CENTRE	P/E
299	Ocen Emma	M	Toroma HEALTH CENTRE	P/E
300	Teko John Robert	M	Toroma HEALTH CENTRE	P/E
301	Alupo Susan	F	Toroma HEALTH CENTRE	P/E
302	Atim Immaculate	F	Toroma HEALTH CENTRE	P/E
303	Aluro Sophia	F	Toroma HEALTH CENTRE	P/E
304	Egwalu Bashir	M	Toroma HEALTH CENTRE	P/E
305	Adilu Paskazia	M	Toroma HEALTH CENTRE	P/E
306	Okipi Edimon	M	Toroma HEALTH CENTRE	P/E
307	Munguleni Coxton	M	Odravu S.S	student

308	Ajio Monika	M	Odravu S.S	student
309	Asibuku Rasul	M	Odravu S.S	student
310	Orodiyo Lidia	M	Odravu S.S	student
311	Gift Zamu	F	Kulikulinga H/C III	student
312	Baka Serifa	F	Kulikulinga H/C III	student
313	Gifit Fikira	F	Kulikulinga H/C III	student
314	Abdulu Samadu	M	Kulikulinga H/C III	student
315	Afeku Miton	M	Kulikulinga H/C III	student
316	Tabani Ratibu	M	Kulikulinga H/C III	student
317	Ozuga Hillary	F	Kulikulinga H/C III	student
318	Anguno Isaac Abiriga	M	Kulikulinga H/C III	student
319	Hassan Joka	M	Kulikulinga H/C III	student
320	Aliga Faruku	M	Yumbe H/C III	student
321	Juruga Majid	M	Yumbe H/C III	student
322	Draman Abubakari	M	Yumbe H/C III	student
323	Babikiri Yossa	M	Yumbe H/C III	student
324	Ambu Rasulu	M	Yumbe H/C III	student
325	Taban Rasul	M	Yumbe H/C III	student
326	Bako Mab's	M	Yumbe H/C III	student
327	Ayikoru Agnes	F	Yumbe H/CIII	student
328	Adaiga Manisuru Sugula	F	Yumbe H/C III	student
329	Amule Rashid	F	Yumbe H/C III	Chairperson
330	Asubo Jouan Viga	M	Yumbe H/C III	Peer educator
331	Alone Amana	F	Yumbe H/C III	Peer educator
332	Draleru Joliet	F	Yumbe H/C III	Peer educator
333	Ayima Akbar	M	Kulikulinga H/C III	Chair person
334	Viko Zainar	F	Kulikulinga H/C III	Secretary
335	Munduru Grace	F	Kulikulinga H/C III	Peer educator
336	Dramuke Kasifa	F	Kulikulinga H/C III	Peer educator
337	Ayikuru Hellen	F	Kulikulinga H/C III	Peer educator
338	Amatre Pontius	M	Kulikulinga H/C III	Health worker
339	Ozuga Hillary	F	Kulikulinga H/C III	Health worker
340	Asuma Majidi	M	Kulikulinga H/C III	Peer educator
341	Bako Haram	M	Kulikulinga H/C III	Vice chairperson
342	Luijah Maturu	M	Odravu S.S	Metron Red cross link
343	Baiga Solomon	M	Odravu S.S	Duty Headmaster
344	Mawa Omar Jurua	M	Odravu S.S	Teacher
345	Asitizuku Palma	F	Odravu S.S	Teacher
346	Onzima Phillip	M	Odravu S.S	Teacher
347	Ogen Andrew	M	Odravu S.S	Teacher

348	Amule Agnes	F	Odravu S.S	School Nurse
349	Dramiga Rahim	M	Yumbe Hospital	Village
350	Opigo Siraji	M	Yumbe Hospital	Health Team
351	Ijotre Kasim	M	Yumbe Hospital	Village Health Team
352	Piriyo Salika	F	Yumbe Hospital	village Health Team
353	Black Man Swadiki	M	Yumbe Hospital	village Health Team
354	Amule Rashid	M	Yumbe Hospitl	Village Health Team
355	Atamvako Zubair	F	Midigo H/C IV	Village Health Team
356	Govule Abakari	M	Midigo H/C IV	Village Health Team
357	Angozaru Sauda	F	Midigo H/C IV	Village Health Team
358	Mr. Angumula Collins	M	Yumbe district logal government	Village Health Team
359	Fr.David Andama	M	FBO	Yumbe UNFPA Champion
360	Asua Swaid	M	Yumbe district local government	District Education Officer
361	Buga Muzasul	M	Yumbe Hospital	Medical superntadent
362	Araba Uesuka Wawa	F	Yumbe Hospital	Nursing officer
363	Aziku Agustus	F	Yumbe Hospital	Enrolled Nurse
364	Swaibu Alahay	M	Uganda Moslem Society	Dikhathi
365	Agaro Caroline	F	Oyam DLG	Assistant district health officer
366	Agong John Maric	M	Oyam DLG	District planner
367	Ogwal Geofrey	M	Oyam DLG	Community development officer
368	Amawoi Simon Ongua	M	Oyam DLG	Health officer-MCH
369	Opio Patrick	M	Anyeke H/C IV	SMCO
370	Dr.okino David	M	Anyeke H/C IV	MO
371	Okori Emmanuel	M	Anyeke H/C IV	Dispenser
372	Okori Richard Bongo	M	Anyeke H/C IV	Store assistant
373	Alinga J.Bosco	M	Anyeke H/C IV	Lab. technician
374	Edi Marino	F	Oyam	HIV Focal person
375	Akello Cijuine	F	Anyeke H/C IV	NO
376	Margret Ogomark	F	Anyeke H/C IV	Midwife
377	Okaka Geofrey	M	Red cross Oyam	focal person
378	Adoc Susan	F	Anyeke H/C IV	Mother
379	Akullu Winny	F	Anyeke H/C IV	Mother
380	Apio Betty	F	Anyeke H/C IV	Mother
381	Acen Esther	F	Anyeke H/C IV	Mother
382	Polly Aol	F	Anyeke H/C IV	Mother
383	Achen Esther	F	Anyeke H/C IV	Mother
384	Meremia Salima	F	Anyeke H/C IV	Mother
385	Akello Dilish	F	Anyeke H/C IV	Mother
386	Agnes Okwir	F	Anyeke H/C IV	Mother

387	Ajok Monica	F	Anyeke H/C IV	Mother
388	Otim Fred	M	Ngai S.S	Peer educator
389	Aremo Samuel	M	Ngai S.S	Peer educator
390	Akwongo Mercy	F	Ngai S.S	Peer educator
391	Waca Oscar	M	Ngai S.S	Peer educator
392	Kenny Maxwell	F	Ngai S.S	treasurer
393	Emor Felix	M	Ngai S.S	Peer educator
394	Ejang Stella	F	Ngai S.S	Peer educator
395	Ocoo Ronald	M	Ngai S.S	Peer educator
396	Akullo Betty	F	Ngai S.S	Peer educator
397	Apio Fiona	F	Ngai S.S	Peer educator
398	Adong Juliet	F	Ngai S.S	Peer educator
399	Atim Winnifred	F	Ngai S.S	Peer educator
400	Akello Sindrella	F	Ngai S.S	Peer educator
401	Ataro Gloria	F	Ngai S.S	Peer educator
402	Apiyo Mercy	F	Ngai S.S	Peer educator
403	Agoa Priscilla	F	Ngai S.S	Peer educator
404	Amongi Conny	F	Ngai S.S	Peer educator
405	Amongi Dilish	F	Ngai H/C III	Mother
406	Apica Dillish	F	Ngai H/C III	Mother
407	Evaline Obote	F	Ngai H/C III	Mother
408	Jackline Omara	F	Ngai H/C III	Mother
409	Susan Eram	F	Ngai H/C III	Mother
410	Evaline Ogom	F	Ngai H/C III	Mother
411	Oyuko Joel Nixon	F	Ngai H/C III	Mother
412	Akot Mirriam	F	Ngai H/C III	Mother
413	Francis Tukwasiibwe	M	UNFPA	M& E
414	Cecile Compaore	F	UNFPA	Deputy Representative
415	Wilfed Ochan	M	UNFPA	Assistant Representative
416	Achola Roselyne	F	UNFPA	NPPP-MoH
417	Akiror Edith	F	UNFPA	Programme Associate, P&D
418	Auma Florence Apuri	F	UNFPA	SNPO_Gender
419	Bagger Ane-Kristine	F	UNFPA	JPO/Programme Analyst (HIV/AIDS)
420	Benipoor Sara	F	UNFPA	Consultant
421	Cherop Tabu Esther	F	UNFPA	NPO-Gender
422	Jhamba Tapiwa	F	UNFPA	Coordinator of JP-Population
423	Kindyomunda Rosemary	F	UNFPA	NPO-HIV/AIDS
424	Kironde Brian	M	UNFPA	NPO-ASRH, youth Networking & sex Education
425	Kyaddondo Betty	F	UNFPA	Consultant

426	Letiyo Evelyn	F	UNFPA	Tech. Specialist GBV prevention and response
427	Madra Primo	M	UNFPA	NPO-Emergencies and post conflict Recovery
428	Mugisha Ambrose R.B	M	UNFPA	NPO-P&D
429	Mukasa Kivunike Peter	M	UNFPA	NPPP-MoH
430	Nakanjako Prossy Jonker	F	UNFPA	SNPO-Communication, Media and Ext.Relations
431	Nalugwa Caroline	F	UNFPA	NPA
432	Nalumansi Rebecca	F	UNFPA	Programme associate -Gender
433	Nalwadda Rose Mary	F	UNFPA	Project Officer on gender & Statistics
434	Ondeko Roselidah	F	UNFPA	Senior GBV Coordinator
435	Orotin Patrick	M	UNFPA	NPO/M&E specialist-JP-Population
436	Tagoola Florence Mpabulungi	F	UNFPA	SNPO-P&D
437	Kafuuko Malinga Brenda	F	UNFPA	Consultant
437 - 458	Key informants from development agencies (Strategic Partners)	F (9) M (12)	UNHCR, UNICEF, UNWomen, UNAIDS, DFID, SIDA, DANIDA, World Bank	Staff members closely working with UNFPA CP

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#### **Annex 4: List of Documents Reviewed/Consulted**

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25. GBV prevention and response SOPs, Referral pathways for Moroto, Kotido, Kaabong, Yumbe, Kanungu, Mubende, Yumbe
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  72. MOH, 2011; NATIONAL HEALTH POLICY: Promoting people’s to enhance socio-economic development July 2010
  73. MoH, National Adolescent Sexual and Reproductive Health Strategy; 2008 – 2013 \_ draft
  74. Report, Evaluation of the Performance of Ambulances in Referral of Obstetric Emergencies in Northern Uganda, Karamoja and West Nile, 2009
  75. MoH and UNFPA: Magnitude, Profile and HIV/STD Related Knowledge and Practices of Commercial Sex Workers in Kampala, Uganda Final Report;2009

## Annex6: Evaluation Work Plan

### Schedule of Tasks, Activities, and Deliverables Consistent with the TOR

What Activities and Deliverables?	When?
Document review	June 17- ongoing
Preparation, presentation and submission of Design Report	June 17 – June 28
Finalize interview scheduling, revisions to Design Report, planning for field work, document review	1 <sup>st</sup> July to 2 <sup>nd</sup> July
Interviews with UNFPA program staff at CO	9 <sup>th</sup> July to 12 <sup>th</sup> July
Interviews in Kampala & Mubende- RH, P&D, Gender equality stakeholders, UN agencies, Government and others	12 <sup>th</sup> to 18 <sup>th</sup> July
Fieldwork North Eastern Uganda (Karamoja)	22 <sup>nd</sup> July -1 <sup>st</sup> August
Field Work Yumbe, Oyam, and Kanungu	15 <sup>th</sup> to 22 <sup>nd</sup> July
Data Analysis	24 <sup>th</sup> to 30 <sup>th</sup> July
First draft report preparation and circulation First draft presentation to ERG	30 <sup>th</sup> to 31 <sup>st</sup> July 5 <sup>th</sup> August
Consolidate feedback by ERG	3 <sup>rd</sup> August
First final draft report presentation	5 <sup>th</sup> August
CO feedback and comments on first draft	8 <sup>th</sup> August
Submission of final report (ET based in home country)	13 <sup>th</sup> August

\*\*\* To be reviewed in line - International consultant travel arrangements

### Annex 7: CPAP7 Implementing Partners

Government (National Level)	Government (Districts)	Civil Society Organizations
Population Secretariat Uganda	KANUNGU District	Communication for Development Foundation Uganda
Bureau of Statistics	MUBENDE District	Church of Uganda
Ministry of Health	YUMBE District	Reproductive Health Uganda
Ministry of Education and Sports	OYAM District	Uganda Episcopal Conference (Catholic Secretariat)
Ministry of Gender Labour and Social Development	KATAKWI District	Uganda Women's Network
	MOROTO District	Uganda Red Cross Society
	KOTIDO District	Straight Talk Foundation
	KAABONG District	American Refugee Committee
		ASB
		Refugee Law Project
		CARE
		War Child Canada
		War Child - UK
		COOPI
		International Rescue Committee
		Child Fund International
		ACORD
<b>Total – 5</b>	<b>Total – 8</b>	<b>Total – 17</b>

## Annex 8: Data Collection Tools

### Population and Development

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government development priorities through “the GoU/UNFPA Seventh Country Programme Action Plan (CPAP7)-2010 to 2014”. The UNFPA management guidelines state that final evaluation of the country program should be undertaken to highlight lessons learned and thereby contribute to the development of the next Country Programme Document (CPD) & CPAP8.

We are a team of consultants, International Consultant and National Consultants from EDISA Consults, that have been assigned to independently assess the GoU/UNFPA CPAP 7 Performance. UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government UNFPA Country Programme for the period 2010 to 2014. Please refer introductory letter from the Population Secretariat.

#### **The main objective of this Country Programme Evaluation is:**

- To provide evidence of programme performance and achievement of planned results,
- To provide accountability to stakeholders
- To inform the development of the Eighth UNFPA programme support to the Government of Uganda through feedback of lessons learned.

As independent evaluators, we shall ensure confidentiality of information you share with us, and it will only be used for reporting purposes for the country programme evaluation. We are guided by a number of ethical principles. We thank you for taking the time to contribute to this key and important phase of the GoU/UNFPA Country Programme. Thank you very much.

*(The evaluator must now introduce him/herself;/name & role in the evaluation and show the letter)*

#### **<sup>10</sup>Basic demographic information of respondent(s)**

Office/District/Implementing Partner name:

Respondent Names:

Gender: M or F

Official Position/Title:

GoU/UNFPA Program Component:

(1) Population & Development

(2) Reproductive Health

(3) Gender and Reproductive Rights

(4) Strategic Level Partner

*(Tick what is applicable and move to the relevant questionnaire)*

Target respondents UNFPA staff and stake holders at national level (including UN agencies, donors, national level implementing partners)- contributing to Population & Development program component

<b><u>Criteria/Evaluation questions</u></b>	<b><u>Specific way of getting the information including who will provide the information</u></b>
<p><b><u>A: RELEVANCE</u></b></p> <p><b><u>National level</u></b></p> <p><i>The GoU/UNFPA Country Programme supports analysis and utilization of up-to-date population data disaggregated by age and sex for development planning, decision-making and monitoring progress at national and sub national levels</i></p> <ol style="list-style-type: none"> <li>1. In your view to what extent is the above aligned to the National Population Policy, National Population Action Plan, NDP and the Vision 2040, priorities?</li> <li>2. How did the program take into account vulnerable populations? Who are these populations? How targeted were country programs in terms of target districts and beneficiaries. Why did you choose beneficiaries versus others</li> </ol> <p><b><u>International alignment (UNFPA staff/ Other UN agencies)</u></b></p> <ol style="list-style-type: none"> <li>3. In your view how consistency of the programme with international agenda, policies and plans (example ICPD, MDG e.tc)</li> </ol>	<p>KI : Charles Zirarema Director POPSEC, Andrew Tiondi – Head M&amp;E POPOSEC, Edith Kangabe (POPSEC), Florence Tagoola UNFPA</p> <p>Document review : CPAP against Vision 2014, NDP, NPP, NPPAP, Report on selection of focus districts for the Country Programme</p> <p>Document review : CPAP and the MDG and ICPD documents KI – Wilfred Ochan – UNFPA</p>

<sup>10</sup> The UNFPA evaluation handbook provides a guide for recording data and this shall be filled in by evaluators or research assistants that help the data collection

<p><b>B: EFFICIENCY</b></p> <p>4. How adequately were the available resources (funds and staff) used to carry out activities for Output 1 as stated above? In your view have resources been provided in a timely manner? If <u>not</u>, Why? What have been the causes? If <u>yes</u>, what factors have contributed to this?</p> <p>5. In your view, were resources distributed in a manner conducive to producing good quality outputs? Has there been concentration or dispersion of funds which could have affected quality of the activities and quality of output, outreach of the outcomes and optimization of the overheads?<i>(To what extent did the financing instruments, administrative regulatory framework, timing and procedures foster or hinder the achievement of the programme outputs?</i></p> <p>6. What would you have done differently with the same resources? Do you have examples on where the program activities strategically benefited from other agencies?</p> <p>7. Was the program involved in supporting soft activities (for advocacy), if yes how did these benefit the program?</p>	
<p><b>C: EFFECTIVENESS</b></p> <p><i>Introduction: The outputs related to population and development: Up-to-date population data disaggregated by age and sex is analyzed and used for development planning, decision-making and monitoring progress at national and sub national levels.</i></p> <p>10. In your view to what extent were the expected outputs related to population and development achieved or are likely to be achieved by 2014 based on the indicators below?</p> <ul style="list-style-type: none"> <li>- <i>Existence of new national survey reports supported by UNFPA like DHS 2011, Census, National Panel Survey.</i></li> <li>- <i>Learn more about why the Census not yet done and implications</i></li> <li>- <i>Availability of in-depth analytical reports on MH, FP, Young People, GBV and Reproductive Right- (state all the reports),</i></li> <li>- <i>Access to web-based integrated management information system</i></li> <li>- <i>Existence of gender statistics, district statistical abstracts</i></li> <li>- <i>Existence of functional integrated sectoral data base at the district planning unit* (need for checklist to measure functionality)</i></li> <li>- <i>Availability of national planning guidelines, existence of manual to integrate population dynamics and utilized by 8 sectors and 15 districts,</i></li> <li>- <i>National/Sectoral/district plans that fully integrate population dynamics.</i></li> <li>- <i>DPAP available in target districts,</i></li> <li>- <i>Technical capacity for integration of population dynamics into plans at national and district level (Assessment Checklist)</i></li> <li>- <i>functional youth coordination structure/network for engaging young people in planning/policy dialogue and program (assessment checklist)</i></li> </ul> <p>11. What have been the facilitating factors, what are some of the challenges/limiting factors that may have affected the achievement of Output 1? How were challenges addressed?</p> <p>12. To what extent has the country program met its outputs under population &amp; development, to reach the intended beneficiary groups.</p> <p>13. <i>To what extent has the UNFPA/GoU Country program contributed to leadership advocacy and champion's mobilization for support of population, RH, gender issues in relation to MDG 5 and the ICPD:</i></p> <ul style="list-style-type: none"> <li>- <i>Number of active champions/ advocacy groups;</i></li> <li>- <i>Have user friendly P&amp;D advocacy and awareness materials produced and used during leadership meetings?</i></li> </ul> <p>14. In relation to the country program, were there unintended effects—positive or negative,</p>	<p>Observation: UBOS - Andrew Mukulu, Mark Kajubi, Pamela Kakande Observation: UBOS - Andrew Mukulu, Mark Kajubi, Pamela Kakande</p> <p>Demonstration of Access: Sectors and District Planning Units</p> <p>Observation: UBOS - Andrew Mukulu, Mark Kajubi, Pamela Kakande UBOS - Andrew Mukulu, Mark Kajubi, Pamela Kakande</p> <p>Assessment using Checklist: District Planning Unit – Districts Population Officer/Districts Planner</p> <p>Observation: Popsec – Edith Kangabe (availability); 8 sector and 8 district planning units (utilisation)</p> <p>Documents review NDP, Sector Plans, District Development Plans (need review checklist)</p> <p>Observation: DPO</p> <p>KI – Sector and District Planning Units (checklist to assess capacity)</p> <p>Assessment using checklist: Asst Commissioner – Mondo Kyateeka (MGLSD), Brian Kironde (UNFPA).</p> <p>KI: Edith Kangabe (POPSEC), Andrew Mukulu (UBOS), District Population Offices, Florence Tagoola/Ambrose (UNFPA)</p> <p>KI: Edith Kangabe (POPSEC), Andrew Mukulu (UBOS), District Population Offices, Florence Tagoola/Ambrose (UNFPA) POPSEC – Ms Stella Kigozi Districts – DPOs</p>

<p>direct or indirect? Why were they generated and what are likely consequences?</p>	<p>POPSEC – Andrew Tiondi, Edith Kangabe UNFPA – Florence Tagoola and Ambrose</p>
<p><b>D: SUSTAINABILITY</b> (<i>The continuation of benefits from a development intervention after its termination</i>)</p> <p>15. Did the programme include in its design a phase out strategy? To what extent were activities designed in a manner that ensured a reasonable handover to local partners?</p> <p>16. Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects? Elaborate, what in-house skills in regard to P&amp;D you think should be transferred to implementing partners? Have you had any difficulties transferring the skills? e.g. planning systems and methodologies, results-based management</p> <p>17. To What extent have the government and the implementing partners planned sufficient financial resources for P&amp;D for continued support whenever this is required e.g. maintenance of facilities, procurement of medicines, conducting refresher training sessions.</p> <p><b>E: LESSONS LEARNT</b></p> <p>18. What was the most and least successful approach in the delivery of the component? What are lessons learnt</p> <p>19. What do you consider the most innovative approach in delivering program outputs? And Why?</p> <p>20. What are the good practices that should be continued and/or replicated elsewhere? What recommendations for the programme and CPAP 8?</p>	<p><b>KI:</b> Florence Tagoola (UNFPA), Andrew Tiondi (POPSEC) DPO/Planner (Districts) Francis (UNFPA) Ambrose (UNFPA)</p> <p>Document Review: Review Programme documents (CPAP) and a sample Annual Workplans and reports to establish evidence of sustainability interventions.</p> <p><b>KI:</b> Florence Tagoola (UNFPA), Andrew Tiondi (POPSEC) DPO/Planner (Districts) Francis (UNFPA) Ambrose (UNFPA)</p>

<p><b>F: Questions on Cross cutting issues and UNFPA STRATEGIC POSITIONING IN UGANDA (UNFPA staff and staff from other UN agencies, UN country team)</b></p> <ol style="list-style-type: none"> <li>1. In your view, to what extent has UNFPA Country Office (CO) prioritized intervention strategies targeted at most vulnerable, disadvantaged, marginalized and excluded population groups, in line with the stipulations of the Strategic Plan?</li> <li>2. To what extent has South-South cooperation been mainstreamed in the country programme through the enhanced use of capacities and as a means to share best practices among countries of the South? If so, is this cooperation modality reflected in the results framework by means of specific indicators?</li> <li>3. To what extent is the CO abiding by the corporate principles of national ownership, national leadership and national capacity development? Are these principles effectively applied during the planning and implementation phases?</li> </ol> <p><i>Strategic Alignment (Systemic Dimension): The systemic dimension looks at the extent to which the GOU/UNFPA Country Programme is aligned with the UN strategy (UNDAF) in the country.</i></p> <ol style="list-style-type: none"> <li>4. To what extent is the country programme, as currently implemented, in line with the UNDAF? Is there any mismatch?</li> <li>5. To what extent does the UNDAF fully reflect the interests, priorities and mandate of UNFPA in the country?</li> <li>6. To what extent is the UNFPA CO coordinating with other UN agencies in the country?</li> </ol> <p><i>Responsiveness &amp; Added Value The ability of the CO to respond to: (i) changes and/or additional requests from national counterparts e.g., natural disasters, conflicts etc.), and (ii) shifts caused by external factors in an evolving country context. ...</i></p> <ol style="list-style-type: none"> <li>7. Please give examples of when UNFPA CO responded to changes in national needs and priorities or to shifts caused by crisis or major natural disasters? What was the quality of the response? Over the period under review</li> <li>8. What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are they a result of UNFPA corporate features or are they explained by the specific features of the CO?</li> <li>9. To what extent would the results observed within the programme focus areas have been achieved without UNFPA support?</li> <li>10. What is the main UNFPA added value in the country context as perceived by national stakeholders? What would the country lose if UNFPA did not have a presence in Uganda?</li> <li>11. Overall, what is your rating of, perception, on UNFPA’s performance in the country?</li> </ol>	<p><b>Wilfred Ochan Florence Tagoola Andrew Tiondi (only some questions)</b></p> <p><b>(why not include these questions when asking the national level questions from the above people?)</b></p> <p><b>UNCT UN agency relevant staff members, donor agency key person, WB, WHO,</b></p> <p><b>UNCT</b></p>
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Do you have additional questions or comments? Thank you very much for contributing to the evaluation

## Reproductive Health

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government development priorities through “the GoU/UNFPA Seventh Country Programme Action Plan (CPAP7)-2010 to 2014”. The UNFPA management guidelines state that final evaluation of the country program should be undertaken to highlight lessons learned and thereby contribute to the development of the next Country Programme Document (CPD) & CPAP8.

We are a team of consultants, International Consultant and National Consultants from EDISA Consults that have been assigned to independently assess the GoU/UNFPA CPAP 7 Performance

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government UNFPA Country Programme for the period 2010 to 2014. Please refer introductory letter from the Population Secretariat.

### **The main objective of this Country Programme Evaluation is:**

- To provide evidence of programme performance and achievement of planned results,
- To provide accountability to stakeholders
- To inform the development of the Eighth UNFPA programme support to the Government of Uganda through feedback of lessons learned.

As independent evaluators, we shall ensure confidentiality of information you share with us, and it will only be used for reporting purposes for the country programme evaluation. We are guided by a number of ethical principles. We thank you for taking the time to contribute to this key and important phase of the GoU/UNFPA Country Programme. Thank you very much.

*(The evaluator must now introduce him/herself;/name & role in the evaluation and show the letter)*

### **11 Basic demographic information of respondent(s)**

Office/District/Implementing Partner name:

Respondent Names:  
or F

Gender: M

Official Position/Title:

GoU/UNFPA Program Component:

(1) Population & Development

(2) Reproductive Health

(3) Gender and Reproductive Rights

(4) Strategic Level Partner

*(Tick what is applicable and move to the relevant questionnaire)*

Target respondents UNFPA staff and stake holders at national level (including UN agencies, donors, national level implementing partners) contributing to Reproductive Health (RH) results

Evaluation Questions	Information Source/ Key Respondents
<p><b>RELEVANCE</b></p> <ul style="list-style-type: none"> <li>• To what extent is UNFPA support to Uganda in the area of RH aligned to the objectives in the National Development Plan 2010/11 – 2014/15, Vision 2040 and other sector policy frameworks?</li> <li>• To what extent is the UNFPA CP aligned and contributes to the MDGs and the ICPD Programme of Action?</li> <li>• How targeted was the UNFPA Country Programme in terms of coverage, beneficiaries and stakeholders?</li> </ul>	<p><b>Document review</b> : CPAP against Vision 2014, NDP, NHP, Health Sector Strategic Investment Plans III &amp; RH Policies e.g ASHR policy, national HIV policy, National Health Policy, National Health Sector Strategic Plan, Reproductive Policy; Roadmap for acceleration of reduction of Maternal and neonatal mortality, reproductive health commodity security strategy, Fistula strategy, Draft youth policy, National HIV/AIDS policy, Guidelines on YFS, national School health policy , ASHR policy, the MDG,ICPD</p> <p>KI –Dr Tusingwire Collins- Assistant commissioner RH (MoH) (0774644929), Dr. Z Akol (MoH), Dr. Primo Madra-Team leader RH Najjemba Maria- Country Midwifery Advisor and/or Ms Enid Mwebaza, Ag. Commissioner Nursing Dr. Kyambadde and/or Dr Musinguzi (ACP), Dr. Mukasa (Fistula). Mr. Kalangwa (RH- commodity security advisor ). Dr Amadua Jacinto, Commissioner Clinical Services or Dr Amone Jackson, Asst Commissioner, Clinical Services</p>
<p><b>EFFECTIVENESS</b></p> <p><b>a) To what extent has the CP improved health systems strengthening to increase women’s utilization of midwifery services in pregnancy care, child birth and management of related complications</b></p>	
<ul style="list-style-type: none"> <li>• % of Health Facility deliveries in target districts (2009-2013)</li> </ul>	District (HMIS)- District HMIS focal person

<sup>11</sup> The UNFPA evaluation handbook provides a guide for recording data and this shall be filled in by evaluators or research assistants that help the data collection

<ul style="list-style-type: none"> <li>Evidence of supportive legislative, policy and financing environment for work of midwives</li> <li>Availability and use of revised national midwifery training curriculum</li> <li>Existence of amended Nurses and Midwifery Act, Handbook and Midwifery Implementation Plan</li> <li>Number of midwifery training institutions with capacity to train midwives (midwifery tutors, skills lab, practicum sites)</li> <li>Capacity of professional midwifery associations to represent midwives and midwifery profession</li> <li>Number of districts with capacity to implement MISP</li> </ul>	<p>Dr. Primo Madra-Team leader RH  Najjemba Maria- National Midwifery Advisor (0772428338) and/or Ms Enid Mwebaza, Ag. Commissioner Nursing  Ms Alice Nabuloli (PEO, Ministry of Education and Sports-0772432071)  Mr. John Wakida, Registrar Uganda Nurses and Midwives Council (0772504410)  Ms Gorret Musoke – President Uganda Private Midwives Association  Ms. Janet Obuni – President Uganda Nurses and Midwives Union  Sr Catherine Nakiboneka (Uganda Catholic Medical Bureau)</p>
<ul style="list-style-type: none"> <li>% of Health facilities (Hospitals, HC IVs and HC IIIs) in target districts with capacity for EmONC</li> </ul>	<p>Target District health centers (Checklist for capacity assessment) – DHO – Primo develop check list</p>
<ul style="list-style-type: none"> <li>Number of Regional Referral Hospitals offering Fistula repair services on routine basis</li> <li>Number of women treated for Fistula with UNFPA Support</li> </ul>	<p>Dr. Mukasa and Programme annual reports  Dr Amadua Jacinto, Commissioner Clinical Services or Dr Amone Jackson, Asst Commissioner, Clinical Services</p>
<ul style="list-style-type: none"> <li>% of Hospitals and HCIVs with functional capacities for Post Abortion Care services (3 staffs trained &amp; MVA kits)</li> </ul>	<p>Target District health centers (Checklist for capacity assessment) – DHO – Primo develop check list</p>
<ul style="list-style-type: none"> <li>% maternal deaths notified and audited in target districts</li> </ul>	<p>Target district-DHO  Dr Tusingwire Collins- Assistant commissioner RH (MoH)  (Dr Sentongo Miriam)</p>
<p><b>b) To what extent has the CP improved social and institutional structures for accelerated uptake of FP methods by women, men, and young people?</b></p>	
<ul style="list-style-type: none"> <li>Percentage of health facilities in target districts without stock-outs of at least 3 FP methods</li> </ul>	<p>Visit the target health centre and check the stock out cards and the national stock out reports.</p>
<ul style="list-style-type: none"> <li>Number of new clients utilizing family planning methods in targeted districts (insert the definition for “New Clients”)</li> </ul>	<p>District HMIS – District HMIS focal point persons (cross check with the focal persons if they follow the same definition)</p>
<ul style="list-style-type: none"> <li>Percentage increase in government share in budget allocation for, and expenditure on contraceptives</li> <li>Existence of national policies, regulations, norms and guidelines that promote FP and availability of reproductive health commodities at appropriate service delivery levels in the public and private sector</li> </ul>	<p>Mr. Kalangwa Albert (MoH)  Dr Tusingwire Collins - Assistant commissioner RH (MoH),</p>
<ul style="list-style-type: none"> <li>Proportion of Health Facilities in Target Districts with at least 2 staff that can offer both short term and long acting FP Methods</li> </ul>	<p>Checklist for staff capacity and HC visits</p>
<ul style="list-style-type: none"> <li>Existence of FP programme with religious and cultural institutions (3 religious bodies, 4 cultural institutions)</li> </ul>	<p>Checklist and ask Rosemary Kindyomunda who handles HIV and GBV.  Visit church of Uganda, catholic secretariat and Moslem supreme council and SDA.  Rosemary provide information on cultural institutions</p>
<p><b>c) To what extent has CP contributed to capacity strengthening for integration of HIV/AIDS, SRH and HIV prevention for MARPS in Uganda?</b></p>	
<ul style="list-style-type: none"> <li>Existence of a National HIV prevention policy includes rights for populations most at risk</li> <li>Existence of HIV/AIDS and SRH integration strategy</li> </ul>	<p>Rosemary and Kyambadde ask for the HIV/AIDS policies</p>
<ul style="list-style-type: none"> <li>% of Health Units (HC IIIs, HC IVs and Hospitals) providing integrated RH and HIV/AIDS services in target districts</li> <li>Proportion of general hospitals, HCIVs and HCIIIs with functional capacity (3 staffs trained in HIV/SRH integration, data collection tools, etc.) in the 8 target districts and 6 JUPSA pilot districts with cumulative target of 90%.</li> </ul>	<p>HIV/AIDS checklist for HC integrating RH and HIV/AIDS, visit and administer the check list</p>
<ul style="list-style-type: none"> <li>Existence of Comprehensive Condom Programming Framework</li> </ul>	<p>Rosemary give a 10 step condom programming and use if for assessment</p>
<ul style="list-style-type: none"> <li>Existence of a 2 year costed female condom operational plan</li> <li>Evidence of an established programme for MARPs and vulnerable populations.</li> <li>Increase in number of CSW accessing HIV/AIDS and SRH services in target districts</li> </ul>	<p>Rosemary and Kalangwa provide the plan and check use  Rosemary and Kyambadde for programme existence and evidence at MARPS institutions ( Uniformed forces and CSW and clients)  Dr. Kyambadde and Programme reports for numbers</p>

<ul style="list-style-type: none"> <li>Number of target districts with plans that integrate HIV/AIDS with SRH services (six done already cumulatively to reach 14).</li> </ul>	Check list for district facilities for integration SRH and HIV/AIDS. Look at district plan.
<ul style="list-style-type: none"> <li>Existence of leadership programmes with MPs, Cultural Leaders, Religious Leaders for HIV prevention focusing on Multiple &amp; Concurrent Partnerships, PMTCT, Harmful socio-cultural practices, Safe Male Circumcision, etc.</li> </ul>	-Use Checklist -Rosemary Kindyomunda handle with HIV and GBV.
<ul style="list-style-type: none"> <li>Existence of programmes that provides IEC/BCC, counseling, and clinical services for HIV prevention to MARPs, esp. uniformed forces (police, private security firm) and Defence &amp; CSW and disabled, young people.</li> </ul>	Visit church of Uganda, catholic secretariat and Moslem supreme council and SDA. Rosemary provide information on cultural institutions
<p><b>d) To what extent has CP contributed to improvement of health lifestyle choices for young people related to sexual and reproductive health in Uganda</b></p>	
<ul style="list-style-type: none"> <li>Availability of curriculum review materials and Teacher Resource Packs for Secondary School Curriculum</li> </ul>	National Curriculum development centre (Ask Brain Kironde for information and contact)
<ul style="list-style-type: none"> <li>Number of Youth Specific policies, guidelines and standards developed (National Youth Policy and Action Plan, National Youth Coordination Framework, School Health Policy and Action Plan, Adolescent Health Policy and Standards of Care, Guidelines for management of Sexual Reproductive Health issues in School setting)</li> </ul>	Mondo Kyateeka Ass. Commissioner for Youth, MoGLSD
<ul style="list-style-type: none"> <li>Proportion of HCIVs and Hospitals in target districts that provide routine Youth Friendly Services</li> </ul>	Visit the HCs and checklist for YFS ( ask Brian for the HCs, Redcross checklist (Dembe Micheal)
<ul style="list-style-type: none"> <li>Proportion of governance structures (e.g. BoGs/PTAs) with resolutions in support of integration of sexuality education in co-curricular activities and in provision of YFS.</li> </ul>	Visit sample schools and review minutes
<ul style="list-style-type: none"> <li>Number of Youth Clubs in target districts engaged in addressing SRH/HIV needs of Young People (part of ASRH), Measured under output 6</li> <li>Proportion of schools in the 8 districts with functional school nurse/health programmes.</li> </ul>	Cross check with Brain for source of information Review annual reports
<ul style="list-style-type: none"> <li>Evidence of sexuality education integration in curricular and co-curricular programmes for in and out of school youth</li> <li>Number of out of school young people reached</li> </ul>	Cross check with Brain for source of information Review annual reports
<p><b>Questions on Effectiveness RH continued</b></p>	
<ol style="list-style-type: none"> <li>What were the facilitating factors for the realization of RH results? What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme? How were the challenges addressed?</li> <li>To what extent have RH results reached the intended beneficiary groups? Have there been any tangible changes as a result of interventions? (adolescents, mothers, FP users)</li> <li>What have been unintended effects –positive or negative, direct or indirect? Why were they generated and what are likely consequences?</li> <li>Please share with us any synergies among the approaches that have been used to deliver the RH services during the CPAP implementation? Is there any added value of the different approaches and counter effects of one against the other components? Probe for maama Kits with a baby sheet (lessu) influence fertility?, ASRH services and HIV risk behaviour and teenage pregnancy.</li> <li>Please share with us among the approaches that were used to deliver ASRH, what was the most appropriate and why?</li> <li>Do you have any views on an alternate approach?</li> </ol>	<p><u>KII</u> MoH staff UNFPA focal staff MoGLSD Reproductive health Uganda Uganda red cross for question 5</p>
<p><b>EFFICIENCY</b></p>	
<ol style="list-style-type: none"> <li>To what extent were the activities managed in a manner that would ensure the delivery of high quality results?</li> <li>To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs? What would have done differently with the same resources to achieve the stated results?</li> </ol>	<p>Plan to get opinions thgh FGDs from VHTs for RH and FP Family planning camps Peer educators for ASHR Women caucus for UWONET for integration of Gender and RH services</p>
<p><u>Cross cutting issues</u></p>	
<ol style="list-style-type: none"> <li>Were there any partnerships, coordination, monitoring and evaluation, capacity challenges that facilitated the delivery of RH (midwifery, FP, HIV and ASRH) results?</li> </ol>	<p><b>KIIs</b> MoH staff UNFPA focal staff MoGLSD</p>

<p>10. How did you take care of gender equality, Youth, and other vulnerabilities in programming? What evidence on this?</p>	<p>Reproductive Health Uganda and consortium Uganda red cross for question 5 <b>Document review</b> : CPAP and annual work plans for partners</p>
<p><u>Sustainability</u> (<i>Continuity of benefits after 7<sup>th</sup> CP</i>)</p> <p>11. To what extent were activities designed in a manner that ensured a reasonable handover to local partners?</p> <p>12. Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?</p> <p>13. Community and country ownership including financial resource commitments</p>	<p><b>KIIs</b> MoH staff UNFPA focal staff MoGLSD Reproductive health Uganda Uganda red cross for question 5</p> <p><b>Document review</b> : CPAP and annual work plans for partners</p>
<p><u>Lessons Learnt and recommendations</u></p> <p>14. What was the most and least successful approach in the delivery of the RH component? What are lessons learnt?</p> <p>15. What do you consider the most innovative approach in delivering program outputs? And Why?</p> <p>16. What are the good practices that should be continued and/or replicated elsewhere? What recommendations for the programme and CPAP 8?</p>	<p><b>KIIs</b> MoH staff UNFPA focal staff MoGLSD Reproductive health Uganda Uganda red cross for question 5</p> <p>Document review : CPAP and annual work plans for partners</p>

Thank you very much, do you have additional comments or questions?

## Gender Equality and Reproductive Rights

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government development priorities through “the GoU/UNFPA Seventh Country Programme Action Plan (CPAP7)-2010 to 2014”. The UNFPA management guidelines state that final evaluation of the country program should be undertaken to highlight lessons learned and thereby contribute to the development of the next Country Programme Document (CPD) & CPAP8.

We are a team of consultants, International Consultant and National Consultants from EDISA Consults that have been assigned to independently assess the GoU/UNFPA CPAP 7 Performance

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government UNFPA Country Programme for the period 2010 to 2014. *Please refer introductory letter from the Population Secretariat.*

### **The main objective of this Country Programme Evaluation is:**

- To provide evidence of programme performance and achievement of planned results,
- To provide accountability to stakeholders
- To inform the development of the Eighth UNFPA programme support to the Government of Uganda through feedback of lessons learned.

As independent evaluators, we shall ensure confidentiality of information you share with us, and it will only be used for reporting purposes for the country programme evaluation. We are guided by a number of ethical principles. We thank you for taking the time to contribute to this key and important phase of the GoU/UNFPA Country Programme. Thank you very much.

*(The evaluator must now introduce him/herself;/name & role in the evaluation and show the letter)*

### **12 Basic demographic information of respondent(s)**

Office/District/Implementing Partner name:

Respondent Names:

Sex: M or

F

Official Position/Title:

GoU/UNFPA Program Component:

(1) Population & Development

(2) Reproductive Health

(3) Gender and Reproductive Rights

(4) Strategic Level Partner

*(Tick what is applicable and move to the relevant questionnaire)*

Target respondents UNFPA staff and stake holders at national level (including UN agencies, donors, national level implementing partners), N Women, & key UNDAFF partners; MGLSD officials, UWONET & Other key partners contributing to the Gender /Reproductive Rights component

<u>Evaluation Question</u>	<u>Information source/key informer</u>
<p><b>Relevance</b></p> <ul style="list-style-type: none"> <li>• To what extent is the CPAP Gender Equality and Reproductive Rights focus               <ul style="list-style-type: none"> <li>iii) aligned to the priorities of International and national legal and policy frameworks</li> <li>iv) adapted to the needs of the population</li> </ul> </li> </ul>	<p><b>Document review</b> : CPAP against Vision 2014, NDP, MDGs, ICPD, Social sector investment plan, DRB, MDB, Draft Gender policy, Gomma declaration, International resolution 1325, FGM act, FGM Guideline, the prevention of trafficking act, 2009- See other policy documents listed below</p> <p>KIIs MoGLSD- Crescent Turinawe, and Jane Mpagi, Aida- GoU/UNFPA focal person Florence &amp; Esther-UNFPA, UN Women- Joint Programme- Gender Equality UNICEF-staff have changed DFID are donors</p>
<p><b>Efficiency</b></p> <ul style="list-style-type: none"> <li>• How adequately were the available resources (funds and staff) used to carry out activities?</li> <li>• To what extent did the fund management mechanisms (financing instruments, administrative regulatory framework, timing and procedures) foster or hinder the achievement of the programme outputs? To what extent were the activities managed in a manner that would ensure the delivery of high quality results?</li> </ul>	<p><u>Focus group discussions on GBV action groups</u> Donors- DFID, French Embassy-FGM, Norway JPP on GBV (info from Roselinda-)</p>
<p><b>EFFECTIVENESS</b></p> <p><b>To what extent were the expected outputs related to Gender and reproductive rights of the CPAP achieved or are likely to be achieved?</b></p>	
<ul style="list-style-type: none"> <li>• Targeted districts plans and budgets that incorporate Gender-Based Violence prevention/ response and reproductive rights interventions.</li> </ul>	<p>Checklist to review integration and financial allocation in the district plans and budgets (</p>

<sup>12</sup> The UNFPA evaluation handbook provides a guide for recording data and this shall be filled in by evaluators or research assistants that help the data collection

	similar to P&D)
<ul style="list-style-type: none"> <li>Number of Gender-Based Violence survivors utilizing response services in targeted districts</li> </ul>	District Gender Officer ( data from 2009-2013) GBV Shelters at health facilities, at the police, GBV school clubs/integration
<ul style="list-style-type: none"> <li>Number of sectors implementing the international instruments and national legislation for GBV prevention and management</li> </ul>	Ask Rebecca Nalumansi (UNFPA Staff) (MoGLSD)
<ul style="list-style-type: none"> <li>Number of target districts that have a <b>functional system in place</b> to regularly record GBV incidence at overall district level (<i>Define functional system</i>)</li> </ul>	Checklist from Florence (UNFPA) and Rebecca ( MoGLSD) and use it for district assessment
<ul style="list-style-type: none"> <li>Number of selected GBV related policies/legislation passed into law by Parliament (<b>DV, FGM/C, MDB, Sexual Offences, Khaddi's Bill</b>)</li> </ul>	Ask Rebecca, Florence, Crescent and Turinawe for the policies passed into law
<ul style="list-style-type: none"> <li>Number of persons trained in GBV Programming in Humanitarian and Post-conflict situations</li> </ul>	Programme reports and Ask Florence and Rebecca Primo/Mbarara Office- the Red Cross
<ul style="list-style-type: none"> <li>Number of communities that declare the abandonment of FGM/C (MOROTO)</li> </ul>	Programme reports and ask Esther (6 districts Moroto, Nakapiripiti, Amudat, Kween, Bukwo, Kapchorwa)
<ul style="list-style-type: none"> <li>Existence of functional capacities for GBV prevention &amp; management in the 4 sectors: JLOS, Education, Security/ POLICE &amp; UPDF, Health, and Social Development (UPDF- Establish Gender Officers- )</li> </ul>	As Rebecca Nalumansi and Turinawe (MoGLSD). (JLOS, Education, Security/ POLICE & UPDF, Health, and Social Development-possible FGD, resources allocated and implementation of commitments)
<ul style="list-style-type: none"> <li>Existence of institutionalized GBV programmes in 5 FBOs (resolutions, handbooks, work plan, annual performance reports, institutional policy/guidelines on GBV, activities on GBV, involvement of top leaders in GBV and GBV in Pastoral outreach structures, school GBV programmes)</li> </ul>	Ask Rosemary and Peace for the checklist, report for FBOs POPSEC- UMSC, SDA, Born Against: <i>Eva Nakimuli</i> CoU is Independent IP (5FBOs: Catholic secretariat, UPMB, SDA, UMSC, Born agains-)
<ul style="list-style-type: none"> <li>Functional District and community structures for GBV prevention and response (District GBV prevention and response alliances, Community Groups for GBV prevention and response, women caucuses)</li> <li>Ordinances, Bylaws and resolutions passed by the district and sub-county leadership</li> <li>High level National Policy and political commitments</li> </ul>	District Gender officer, table for Gender groups, Francis and Florence (table for ordinances )
<ul style="list-style-type: none"> <li>Availability and use of SOPs, referral pathways, guidelines for psycho-social support, fill Police Forms 3, 3A, &amp; 24A</li> </ul>	Checklist for these forms at police posts, districts, and health facilities
<ul style="list-style-type: none"> <li><u>Cross cutting issues</u> <ol style="list-style-type: none"> <li>Now tell us about the program support systems (partnerships, coordination, monitoring and evaluation, capacity); and how they created opportunities/challenges that facilitated the delivery of results.</li> <li>Tell us of how you ensured cross cutting issues are taken care of: gender, age disaggregation, factoring in Youth in development, RH &amp; Gender programs?</li> </ol> </li> </ul>	<b>KIIs</b> MoGLSD staff ( Rebecca, Crescents and Jane Mpagi) IPs for gender (UWONET) UNFPA Focal staff ( Florence and Esther ) <b>Document review</b> : CPAP and annual work plans for partners
<ul style="list-style-type: none"> <li><u>Sustainability</u> <ol style="list-style-type: none"> <li>To what extent were activities designed in a manner that ensured a reasonable handover to local partners? (Has the Country Programme been able to support partners and the institutional beneficiaries (National and district) in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?)</li> <li>To what extent have the district/community/ country taken steps towards full ownership of activities results? Are there any financial resource commitments for gender at district or national level?</li> </ol> </li> </ul>	<b>KIIs</b> MoGLSD staff ( Rebecca, Crescents and Jane Mpagi) IPs for gender (UWONET) UNFPA Focal staff ( Florence and Esther ) <b>Document review</b> : CPAP and annual work plans for partners, case studies and good practices
<ul style="list-style-type: none"> <li><u>Lessons Learnt and recommendations</u> <ol style="list-style-type: none"> <li>What was the most and least successful approach in the delivery of the Gender Equality and Reproductive Rights component? What are lessons learnt?</li> <li>What do you consider the most innovative approach in delivering program outputs? And Why?</li> <li>What are the good practices that should be continued and/or replicated elsewhere? What recommendations for the programme and CPAP 8?</li> </ol> </li> </ul>	<b>KIIs</b> MoGLSD staff ( Rebecca, Crescents and Jane Mpagi) IPs for gender (UWONET) UNFPA Focal staff ( Florence and Esther ) <b>Document review</b> : CPAP and annual work plans for partners, cases studies and good practices

Thank you very much, do you have additional comments or questions

### **Additional Information for data collector**

- I. Functional capacities for GBV prevention & management: -
- II. Functional system- Data tool, staff trained and are using the tool to capture data, analyze, interpret and use; Procurement of resources like computer e.t.c to enable the use
- III. High level National Policy and political commitments?? NAP-Goma Declaration, CEDA, 1325 (\*\*)- Policy, Budget/Resource Allocation, Implementation, M&E & L
- IV. SOPs, referral pathways, guidelines for psycho-social support, -MGLSD, Gender officer at district level
- V. Fill Police Forms 3, 3A, & 24A- What was revised?? Task shifting to nurses and doctors
- VI. Mifumi:- in Moroto, Mbarara- ‘ Survival Support Groups’,
- VII. UWONET key partner- policies, registration, and links JLOS and other key
- VIII. Program Structure, UNFPA and POPSEC- Lead agencies
- IX. Components

### **Take note of key policy documents and at District Level, there are by laws and ordinances**

- i. The National Gender Policy (NGP), written in 1997 and revised in 2007 has the purpose to ensure that all Government policies and programs, in all areas and at all levels, are consistent with the long-term goal of eliminating gender inequalities. It provides a framework for redressing gender imbalances as well as mainstreaming gender in planning, resource allocation and implementation of development programs.
- ii. The National Action Plan for Women, 2007 is a guiding document for each sector, government bodies and ministries as well as for non-state actors on how to formulate actions that support and promote women’s empowerment and advancement in order to improve the status and quality of life for all women in all spheres of life.
- iii. The draft National Policy on Sexual and Gender Based Violence (SGBV) 2011, awaits to be passed
- iv. Police forms 3, 3A, 24A have been revised, to make them more responsive for use in handling cases of rape and defilement. The new forms were gazetted and guidelines for its implementation were produced in 2012.
- v. Legislation on women’s access to land and family property, revision: The Constitution of Uganda (1995) Article 273 (3) accords men and women equal rights to own land in accordance with various land tenure systems; The Land Act (1998) amended in 2004 (section 39) provides the legal framework through which the fundamental rights of women are protected as a mechanism to redress gender disparity to access and control over economically significant resources and benefits. It provides for consent of a spouse in the event of any transaction on family land
- vi. Policies for free access to basic (primary) and secondary education for boys and girls- Universal Primary Education (UPE) & Universal Secondary Education (USE).
- vii. The Trafficking and Smuggling in Persons Act, 2009 that has helped in protection of girls and women,
- viii. The Domestic Violence Act of 2010,
- ix. The Prohibition of FGM Act (2010)
- x. Equal opportunities Act 2010
- xi. The National plan of action for implementation of resolutions 1325, 1820 and Goma declaration on GBV and conflict resolution – 2011
- xii. GBV guidelines for establishment of safety shelters (2013)
- xiii. The penal code, the Defilement Act and the Children’s Act all have provisions to protect against child marriage and forced marriage and thus protect the rights of the girl child
- xiv. The checklist on mainstreaming gender and human rights in legislation has been shared as the first parliamentary concern and the Ministry of Justice and will help in the future in the drafting of legislations.

## Checklist at the district

### POPULATION AND DEVELOPMENT

Data Availability and use for integration of population variables into Development plans, annual workplans:		
<b>A: Functionality of the District Harmonized Database</b>	Yes / No	Observations and further comments
1. Statistical Committee – minutes of regular quarterly meetings are available		
2. Database set up by UBOS - check computer data		
3. Departmental databases updated – Health, Education, Community Services (Probation for GBV data), Agriculture, Natural Resources		
4. Departmental Submissions to the Planning Unit for consolidation and Harmonization ( <i>Previous 12 months</i> )		
5. Generation and summarizing the data/information for guiding planning – proof of data: information/briefs, trends, status reports		
6. Evidence of use in planning and decision making- ( <i>Look at documents in office quoting data collected, are they giving latest population statistics, gender – disaggregation</i> )		
7. The data are available all year round		Ask any senior staff.
<b>B: Integration of Population issues into District Development Plans- Availability of population issues in the plan</b>		
1. Availability of District Population Action Plan (DPAP)		
2. Finance and planning: (i) population structure, (ii) population research, (iii) birth rate, (iv) family size, (v) orphan hood, (vi) low status of women, (vii) unmet need for family planning and (viii) livelihood of population		List what is seen in the report.
3. The district development plan has information on production and marketing sector: (i) fragmentation, soil degradation, (ii) food security, (iii) food insecurity, (iv) depleting water resources, (v) pollution of water resources, (vi) vulnerability to STIs/ HIV, (vii) marketing of produce and local products		List what is seen in the report
4. Health issues. In particular (i) morbidity and mortality rates among infants, children and mothers (ii) fertility in terms of early pregnancies, early marriages, contraceptive prevalence and ANC (iii) Hygiene and sanitation, household latrine coverage (iv) access to health services like EMoC (v) staffing levels at health facilities (vi) Health information issues		List what is seen in the report
5. Education and sports: (i) sanitation and hygiene (ii) school enrolment (iii) school structure (iv) literacy levels (v) Reproductive health for adolescents (ASRH) (vi) performance levels		List what is seen in the report
6. Community based services sector: (i) Level of employment by sex and age (ii) Child abuse/rights (iii) crime rates (iv) domestic violence (v) orphan hood and vulnerable children (vi) youth participation (vii) level of elderly, disabled in the population by administrative units (viii) women involved in planning (ix) welfare of women in communities (x) influence of culture in communities (xi) population affected by disasters like floods		List what is seen in the report
7. Natural resources sector: (i) Land fragmentation, land shortage, (ii) deforestation, (iii) encroachment on wetlands, (iv) climatic changes, (v) upcoming urban centres, (vi) rural-urban migration, (vii) bush burning, soil erosion and (viii) environmental pollution		List what is seen in the report
8. Works and technical services sector: (i) poor transport and communication, (ii) poor housing, (iii) Low access to safe water (iv) Poor sanitation in households and institutions		List what is seen in the report
<b>C: Budget Frameworks and the Annual Workplans</b>		
9. The district has budget line for Population issues		Indicate % of district budget that is allocated to population issues and % that is actually spent.
10. The annual workplans of the district have population issues		List the population issues included

<b>D: Capacity for data management and integration</b>		
11.	Availability of staff trained in data management and integration, How many were trained by UBOS in data management and integration	
12.	Equipment and software for data management are available	Name the kind of computer and kind of software
13.	Evidence of data analysis of the data collected: Existence of tables, trends, reports using the data, conference paper presentation	Specify the titles for the reports, tables and trends
14.	The Planner, DPO and Statistician attend budget meetings regularly –Evidence in minutes of meetings	

#### DISTRICT HEALTH OFFICE

<b>DHO's Office</b>		
1.	% of midwifery staffing positions filled	Actual positions filled _____ Staffing norm _____
2.	Number of midwife students bonded under UNFPA programme, number completed, number recruited by the district. <i>(Important- Moroto/Kotido)</i>	
3.	% Health facilities deliveries in the target district (HMIS)	2009 _____ 2010 _____ 2011 _____ 2012 _____ 2013 _____
4.	Number of new clients <sup>13</sup> utilizing family panning methods (HMIS) (2009-2013)	2009 _____ 2010 _____ 2011 _____ 2012 _____ 2013 _____
5.	% of HC/facilities (HCIV, HCIII and Hospital) with capacity for EMONC in the target districts <i>(Refer page 10 for EMONC-definition)</i>	
6.	% of hospitals and health centre IV and hospitals with functional capacity for Post Abortal Care <i>( 3 trained staff and Manual Vacuum Aspiration (MVA) Kits)</i>	
7.	% of maternal deaths notified and audited in target districts	
8.	% of health centers with stock outs of at least three modern Family Planning (FP) services <i>(Injectaplan is a must, plus any other 2 methods)</i>	
9.	Proportion of health facilities with at least two staff that can offer two FP methods ( short term and long acting method)	
10.	District has plan that integrate HIV/AIDS, SRH <i>(at national level work commenced in 2012, thus assess level of district doing this)</i>	
11.	Proportion of health facilities and hospitals that provide youth friendly services	
12.	Forms for capturing VHT data are available	
13.	The data from VHT are analyzed and reported	See evidence from reports

<sup>13</sup> A person using the Family Planning method for the first time

**GENDER EQUALITY AND REPRODUCTIVE RIGHTS – District Gender officer OR District Community Services Officer**

Key observations	Responses	Comments
1) Check for integration of GBV prevention and response in the district plan and budgets		
2) Number of Gender based survivors utilizing responses services in the target districts (2009-2013)- Legal (Police/Magistrate) and Health, and community support systems		
3) Number of target districts that have a functional system in place to regularly record GBV incidences –(Functionality include any electronic or manual data bases that are regularly updated, trained staff, summaries of data analysis to inform decision making)		
4) Number of districts with functional Districts and community structures for GBV prevention and response		
- Availability of GBV coordination group at districts		
- Number and total membership of Anti GBV groups		
- Number and total membership of Male Action Groups		
- Review minutes of the GBV reference group and Anti GBV clubs. Do minutes indicate discussions on prevention and response to GBV?		
5) List ordinances and bylaws and resolutions passed the districts and Sub-counties on GBV prevention and Response		
6) Number of target districts with and using Standard operating procedures (SOP) and referral path ways and guidelines for psycho-social support		
- Check for availability and use of SOPs		
- Check for availability and use of referral pathways		
- Check for availability and use of guidelines for psycho-social support		
<b>Moroto district check out- FGM</b>		
<b>DISTRICT POLICE STATION &amp; Magistrate court</b>		
Check availability and use of Police Forms 3, 3A, & 24A (Qualitative...)		
Referral to Magistrate court		
<b>HEALTH UNIT</b>		
Differentiate between GBV versus Assault		
Data and handling/experience		
Trained personnel/ resourcing & Motivation		

**Summary Gender Checklists**

- The by laws, ordinances \*\*\*
- Integration
- GBV service utilization\
- Political commitments (budget allocation, resolutions, passed and in progress)
- Functional GBV information systems (data, computer data base, trained staff, systems for data collection, up-to date data sets, quarterly report shared and used for information)
- Functional GBV Referral system
- SOPs

**SECTION II: HIV/AIDS, RH and FP integration, Gender BV Management**

Demographic information	Response
1. Date of visit	
2. Name of facility	
3. Name of person (s) interviewed, 3b) Sex 3c) Title	
4. Type of Facility	1) HEALTH FACILITY 2) OUTREACH
5. Level of Facility	a) Clinic, b) HCII, c) HCIII, d) HCIV e) Hospital
<b>What Services Provided?</b>	<b>Responses (Yes or No)</b>
1. Does the health facility offer HIV/AIDS, FP and RH in an integrated manner?	
2. Does the facility have trained staff in HIV/AIDS/ RH and FP integration?	
3. Does the facility have data collecting tools HIV/AIDS/ RH and FP integration?	
4. Does the facility has a register which integrate the three services, RH, FP and HIV/AIDS (	
5. Does the facility keep updated, clear records on clients and activities	
6. Does the facility provide Nutrition education advice	
7. Does the facility provide Sexual Abuse/GB Violence prevention and response services	
8. What other RH services does the facility deliver:	
a. Contraception (List methods)	
b. Pregnancy testing	
c. Antenatal Care	
d. Postnatal Care	
e. Delivery	

**Section IV: Services Provided**

Question	Response	Comments
1. Are condoms provided to both males & females? Are female condoms available and on distribution?	Yes/No	
2. Has the facility had any stock outs of the FP services (Depo and any other two) methods) in the last three months	Yes/No	
3. Are referrals made for services not provided at the clinic (e.g., handling sexual abuse)? Please give examples.	Yes/No	
4. Does the Youth corner organize outreaches in the community?		

**Section V**

Question	Response	Comments
<b>GBV Check list at Health Facility</b>		
1. Does the facility have staff trained on GBV response and prevention?		
2. Are staffs in position to take off samples/specimens from GBV survivors?		
3. Record keeping on GBV within health facility and how it is managed		

**FACILITY CHECKLIST  
OBSERVATION CHECKLIST YOUTH FRIENDLY CORNERS**

**SECTION I.GENERAL BACKGROUND INFORMATION**

Item	Response
1. Date of visit	
2. Name of facility	
3. Location	<input type="checkbox"/> 1 Rural <input type="checkbox"/> 2 Urban <input type="checkbox"/> 3 Suburban
4. Type of Facility	2) HEALTH FACILITY    2) OUTREACH
5. Level of Facility	b) Clinic, b) HCII, c) HCIII, d) HCIV e) Hospital
6. Number of Rooms: (Total: _____)	Waiting Room _____ Examination Room _____; Lab _____ other Exclusive for adol _____ -.)
7. Hours of operation _____	Are they displayed on sign post? _____
8. Number of staff trained in YFS	Number of Female staff _____ Number of male Staff _____

**Section VI: Peer Education/peer counseling Program- Adolescent Sexual Reproductive Health Services**

Question	Response	Look out for qualitative comments/ Stories/Results
1. Is there adolescent peer education/peer counseling program for Youth? If yes how many peer educators attached to the facility? <i>Skip to next section if no peer education/counseling program is available</i>	Yes/No	
2. Are there male and female peer educators ?	Yes/No	
3. Is there a system for supervising and monitoring peer counselors?	Yes/No	
4. Do you have Youth friendly corner committee? ( <i>Look out for gender representation</i> )	Yes/No	
5. Does the facility have Youth clubs attached to the youth corner	Yes/No	

**Section VIII: SRH Educational Activities**

Question	Response	Comments
1. Are educational materials for SRH available on-site (audio or Visual, computers, printed material)? Which ones?	<input type="checkbox"/> 1.None    2.audio or Visual <input type="checkbox"/> 3.Computers    4.Printed material <input type="checkbox"/> 5.Others	<input type="checkbox"/>
2. In what languages are SRH IEC materials available?	<input type="checkbox"/> 1.English    2.Local Language    3.Both <input type="checkbox"/> 4.None	<input type="checkbox"/>
3. Are group discussions held?	Yes/No	
4. Are there ways clients can access information or counseling off-site (telephone hotline, website, materials sent by mail)?	<input type="checkbox"/> 1.Telephone hotline    2.Website <input type="checkbox"/> 3.Materials sent by mail    4.SMS <input type="checkbox"/> 5.None	<input type="checkbox"/>

**Section IX: Supportive Policies/activities**

Question	Response
1. Do clear written guidelines for serving adolescents exist?. If yes list them	Yes/No
2. How often does DHT and /or HSD supervise the clinic staff?	1.Monthly    2.Quarterly    3.Twice a year 4.Annually    5.Never
3. How are the youth involved in planning/organizing activities	
4. Explain the existing feedback mechanism form users and community	
5. What are the biggest challenges faced by the Youth Corner	
6. Do you have any suggestions for improvement of Youth Friendly Services?	

**OBSERVATION CHECKLIST: FUNCTIONALITY OF FACILITIES WITH EMOC AND PAC SERVICES**

**Table 1: Signal functions used to identify basic and comprehensive emergency obstetric care services**

Availability of items for Emergency Obstetric Care (EMOC)	Response		Comments
1. Can give injectable (parenteral) antibiotics	Yes	No	
2. Can give (administer) injectable Oxytocin to enable contractions of the uterus for stopping excessive bleeding (uterotonic injectable drugs)	Yes	No	
3. Can give injectable drugs, that control fits (convulsions) that can occur with pregnant women when they suffer severe high blood pressure ( preeclampsia and eclampsia, i.e. magnesium sulfate).	Yes	No	
4. Manually remove the placenta, when it is retained	Yes	No	
5. Remove retained products (e.g. manual vacuum extraction, dilation and blunt curettage)	Yes	No	
6. Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery)	Yes	No	
7. Perform basic resuscitation on a new born baby (neonatal)(e.g. with bag and mask) <i>(Go to 8-9 for only hospitals and health centres 4, if not proceed to 10)</i>	Yes	No	
8. Perform surgery (e.g. caesarean section)	Yes	No	
9. Perform blood transfusion	Yes	No	
10. Check for stock out for any of the above services (1-9, where applicable) in the last 3 months/If any stock out registered , list the item and for how long	Yes	No	
<b>Capacity Assessment For Post Abortion Care Services (PAC)</b>			
11. Does the facility (hospital and Health center IV) has at least 3 staff trained in PAC)	Yes	No	
12. Does the facility has Manual Vacuum Aspiration (MVA) (PAC) kit available	Yes	No	

**CHECKLIST FOR SCHOOLS  
ADOLESCENT FRIENDLY SERVICES IN SCHOOLS**

Demographic information	Response	
1. Date of visit		
2. Name of School		
3. Name of person (s) interviewed, 3b) Sex 3c) Title		
4. District/Sub county		
Type of School	Public/ Private owned	
<b>Questions/Checklist</b>		
1) Does the school have a school management committee? (PTA /Board)	Yes	No
2) Has the school board/management passed a resolution in support of Youth Friendly Services?	Yes	No
3) Is the committee sensitized on HIV/AIDS and Adolescent Friendly Services (AFS)	Yes	No
4) Are there teacher trained in Adolescent Friendly Services (AFS)	Yes	No
5) Are there peer educators in the school?	Yes	No
6) How many of peer educators are male and how many female?	_____ M	_____ F
7) Are all classes represented for peer educators?	Yes	No
8) Is there a student body representative (head boy/girl, prefect) as one of the peer educators?	Yes	No
9) Is there a trained health worker to offer Adolescent Friendly Services (AFS) in the school?	Yes	No
10) Is there a clear referral system in the school for Adolescent Friendly Services (AFS)	Yes	No
11) Is there a special room where adolescents receive services in private?	Yes	No
12) How is gender based violence prevention and management handled?		
13) Comment on functionality of the Adolescent Friendly Services (AFS) at the school in terms of supervision, challenges and motivation		

### The 3 arms of Adolescent Friendly Services

- The school
- Work site groups e.g markets, boda boda –these are linked to health facilities
- Health facility based

### **Beneficiaries tool**

GoU/UNFPA Country Program Evaluation: Data Collection Tool-Focus Group Discussions/KI/Group discussion: with program beneficiaries at community level

UNFPA closely works with the Government of Uganda and other national implementing partners supporting Government development priorities through “the GoU/UNFPA Seventh Country Programme Action Plan (CPAP7)-2010 to 2014”. The UNFPA management guidelines state that final evaluation of the country program should be undertaken to highlight lessons learned and thereby contribute to the development of the next Country Programme Document (CPD) & CPAP8.

We are a team of consultants, International Consultant and National Consultants from EDISA Consults, that have been assigned to independently assess the GoU/UNFPA CPAP 7 Performance. Please refer introductory letter from the Population Secretariat.

#### **The main objective of this Country Programme Evaluation is:**

- To provide evidence of programme performance and achievement of planned results,
- To provide accountability to stakeholders
- To inform the development of the Eighth UNFPA programme support to the Government of Uganda through feedback of lessons learned.

As independent evaluators, we shall ensure confidentiality of information you share with us, and it will only be used for reporting purposes for the country programme evaluation. We are guided by a number of ethical principles. We thank you for taking the time to contribute to this key and important phase of the GoU/UNFPA Country Programme. Thank you very much.

*(The evaluator must now introduce him/herself; name & role in the evaluation and show the letter)*

#### **14Basic Background information of respondent(s)**

District/Implementing Partner name: \_\_\_\_\_

Name of the Beneficiary Group: \_\_\_\_\_

GoU/UNFPA Program Component:

(1) Population & Development

(2) Reproductive Health

(3) Gender and Reproductive Rights

*(Tick what is applicable and move to the relevant questionnaire)*

**Target respondents:** Trained mid-wives, Beneficiaries and vulnerable communities (clients of family planning esp. camps; VHTs for RH and FP ; community drug distributors, MARPs and Peer educators; GBV community groups, FGM Community groups in Moroto

#### **Description of the program from the beneficiaries perspective**

1. Please give a brief description of the program you are involved in?
2. What was your involvement in the implementation of this programme?

#### **RELEVANCE**

3. How has the programme you are involved in met your needs or those of your target beneficiaries? *(Check for evidence of adaptation of the mentioned intervention to meeting the needs of the target populations including population in underserved areas and marginalized women)*
4. How targeted was the programme to the needs and the different types of the beneficiaries in the target community or district? Probe: are there any other needs or beneficiaries that were not targeted?

#### **Effectiveness**

5. What have you as a group/individual benefited from this program?
6. What are the approaches and outputs that you consider to be most successful in the program and Why?
7. What were the facilitating factors for the realization of results?
8. What are some of the challenge/limiting factors that may have affected the achievement and implementation of the programme?
9. How were challenges addressed or if not addressed yet; how would you like these challenges to be addressed?

#### **Efficiency**

10. Please share with us what you think of the approaches that were used to deliver output or benefits
11. Do you think program benefits would have been delivered with better approaches?
12. What would have been done differently with the same resources to deliver better results?

#### **Sustainability**

13. What are the chances that the programme benefits will continue to be enjoyed even if the IPs *(put the name of UNFPA partner IP you are visiting)* you have been working with stopped ( look for capacity building, ownership, financial resource commitments, leadership, structures and infrastructure to mention)

#### **Lessons Learnt and recommendations**

14. What are lessons learnt? What success stories? Any recommendations for future programs?

<sup>14</sup> The UNFPA evaluation handbook provides a guide for recording data and this shall be filled in by evaluators or research assistants that help the data collection