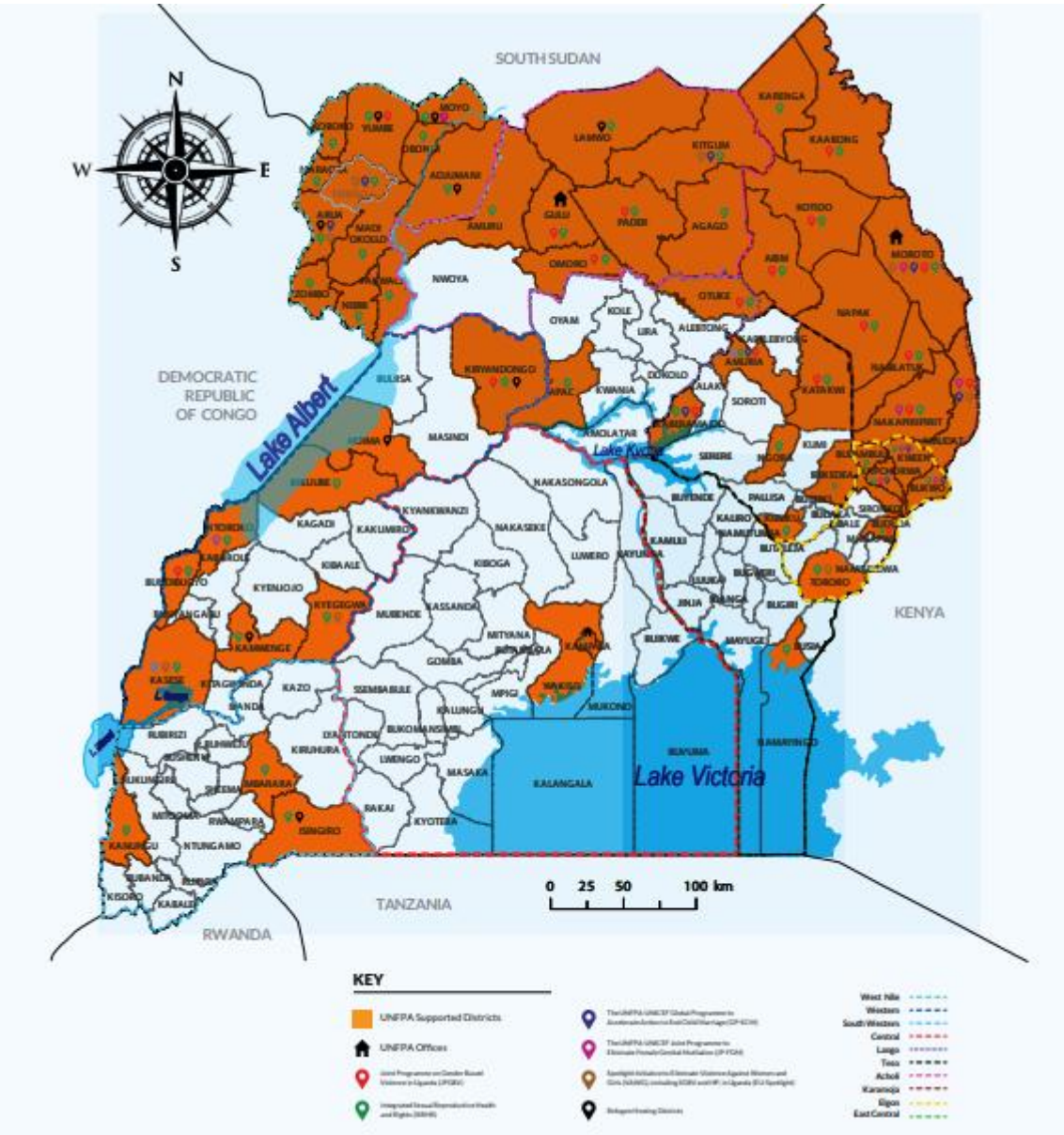
THE UNITED NATIONS POPULATION FUND AND THE GOVERNMENT OF THE REPUBLIC OF UGANDA 9TH COUNTRY PROGRAMME 2021-2025

EVALUATION REPORT

JANUARY 2025



Source: UNFPA Uganda (http://uganda.unfpa.org/)

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ACRONYMS

ACORD	Agency for Cooperation in Research and Development
ADA	Australian Development Cooperation
AIC	AIDS Information Center
ANC	Antenatal Care
ANSWER	Advancing Sexual Reproductive Health and Rights
BRAC	Bangladesh Rehabilitation Assistance Committee
CBO	Community-Based Organization
CDO	Community Development Office
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CO	Country Office
COARs	Country Office Annual Reports
COARs	Country Office Annual Reports
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPMEP	Country Programme Monitoring and Evaluation Plan
CQI	Continuous Quality Improvement
CRRF	Comprehensive Refugee Response Framework
CSO	Civil Society Organisation
CSO	Civil Society Organization
CYP	Couple Years of Protection
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DaO	Delivering as One
DFID	Department for International Development
DHO	District Health Office
DHS	Demographic and Health Survey
ELA	Empowerment and Livelihoods for Adolescents
EmONC	Emergency Obstetric and Neonatal care
EQ	Evaluation Question
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office
EU	European Union
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender-Based Violence
GEWE	Gender Equality and Women Empowerment
GTA	Gender Transformative Approaches
HDI	Human Development Index
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HUMC	Health Unit Management Committee

ICPD	International Conference on Population and Development
IP	Implementing Partners
IRC	Inter-Religious Council
JLOP	Justice Law and Order Sector
JPGBV	Joint Programme on Gender Based Violence
KII	Key Informant Interview
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, or Questioning
MARPs	Most at Risk Populations
MDA	Ministries, Departments, and Agencies
MGLSD	Ministry of Gender Labour and Social Development
MMR	Maternal Mortality Rate
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MoJ	Ministry of Justice
MoJCA	Ministry of Justice and Constitutional Affairs
MPDSR	Maternal And Perinatal Death Surveillance Response
NDP	National Development Plan
NGO	Non-Governmental Organization
NGP	National Gender Policy
NPA	National Planning Authority
NPC	National Population Council
ODA	Official Development Assistance
OECD	Organisation of Economic Cooperation and Development
OPD	Organisations of Persons with Disabilities
OPM	Office of the Prime Minister
PD	Population and Data
PDM	Parish Development Model
PLWD	Persons Living with Disability
PNC	Postnatal Care
RAHU	Reach A Hand Uganda
RHU	Reproductive Health Uganda
SASA	Start, Awareness, Support and Action
SGBV	Sexual and Gender-Based Violence
UDHS	Uganda Demographic and Health Survey
SGD	Sustainable Development Goals
SIDA	Swedish International Development Cooperation Agency
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change
UBOS	Uganda Bureau of Statistics
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS	Joint United Nations Programme of HIV/AIDS
UNCT	United Nations Country Team
UNEG	United Nations Evaluation Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
VHT	Village Health Team
WAY	Women, Adolescents and Youth
WHO	World Health Organization

KEY FACTS TABLE

Land	
Geographical location	East Africa, West of Kenya, East of the DRC, North of Tanzania, South of South Sudan
Land area	241 5507 square kilometres
	Open water bodies cover 36 864 01 square kilometres
Terrain	Mostly Plateau with rim of mountains
People	
Population[1]	Total Population 45 935 046; Male population=49.0%; Female population=51.0% (UBOS, 2024); Sex Ratio=96.0; Population density=227; Total number of households=10 845 119; Average Household Size==4.4.
	Annual Population Growth Rate 2.9 %.
Government	
	Republic per 1995 Constitution, amended in 2005
	1962: Independence from British colonial rule;
	1971-1979: Military takeover/government characterised by dictatorship and economic decline;
	1980-Return of democratically elected government
	1981-1986: Civil war
	1986: National Resistance Movement Unitary Government
	1986-2006: Civil war in Northern Uganda
	2001- to-date: Current National Resistance Government under multiparty dispensation.
Economy	
Q3 2023/24 QGDP growth rate (2016/17) constant prices (%)[2]	6.6
Q3 2023/24 QGDP at constant prices (billion shillings)[3]	33 416
Annual GDP growth rate 2023/24 (2016/17 constant prices) (%)[4]	6.0
Annual GDP at current prices 2023/24 (billion shillings)[5]	202 131
Annual GDP Per Capita at current prices 2022/23(US $)[6]	1 146
Annual average Inflation rate CY 2022(2016/17 = 100) (%)[7]	7.2
Annual average Inflation rate FY 2021/22 (2016/17 = 100) (%)[8]	3.4
Social and Health Indicators	
Human Development Index Rank[9]	0.5550
Unemployment Rate (overall)[10]	3.39%
Life expectancy at birth (Total)[11]	63.7 years

[1] Uganda Bureau of Statistics 2024. National Population and Housing Census 2024 Report
[2] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[3] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[4] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[5] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[6] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[7] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[8] Key Economic Indicators (133rd Issue: Q3 2023/24 (UBOS, 2024)
[9] Uganda UNDP Human Development Report, 2024: Available at: https://hdr.undp.org/data-center/country-insights#/ranks
[10] Statista: Socioeconomic Indicators: Available at: https://www.statista.com/outlook/co/socioeconomic-indicators/uganda#:~:text=The%20unemployment%20rate%20in%20Uganda%20is%20forecast%20to%203.39%25%20in%202024.
[11] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/

Life expectancy at birth (Males) [12]	62.8 years
Life expectancy at birth (Female) [13]	64.5 years
Age Dependency Ratio[14]	103.3, (2014 Census)
Total Fertility Rate[15]	5.4 Births per woman
Infant Mortality Rate[16]	43 deaths per 1000 live births
Under Five Mortality Rate[17]	64 deaths per 1,000 live births
Maternal mortality ratio[18]	336 per 100,000 live births

Sustainable Development Goals Status		
Goal	**Indicator and Source**	**Status**
SDG1	Proportion of population below the international poverty line[19]	41.2% (2020)
SDG2	Prevalence of wasting among children under 5 years of age[20]	3.2% (2022)
	Proportion of children moderately or severely stunted[21]	24.4% (2022)
	Prevalence of overweight among children under 5 years of age[22]	3.4% (2022)
SDG3	Maternal Mortality Ratio per 100 000 live births[23]	189 (2022)
	Under-five mortality rate[24]	52 per 1000 live births (2022)
	Infant mortality rate[25]	36 per 1000 live births (2022)
	Neonatal mortality rate[26]	22 per 1000 live births (2022)
	Number of new HIV infections per 1,000 uninfected population[27]	1.28 (2021)
	Prevalence of hepatitis B surface antigen (HBsAg) per 100,000 population[28]	26.5 (2022)
	Tuberculosis incidence per 1,000 population[29]	142 (2020)
	Proportion of women married or in a union of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods[30]	57.9% (2022)
SDG4	Proportion of children in Primary Three attaining minimum proficiency in reading and mathematics[31]	49.9% (2018)
	Proportion of children who are developmentally on track in at least three of the following domains: literacy-numeracy, physical development, social-emotional development, and learning (primary 3 literacy)[32]	55.8% (2022)

[12] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[13] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[14] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[15] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[16] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[17] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[18] Uganda Bureau of Statistics: Uganda Profile. Available at: https://www.ubos.org/uganda-profile/
[19] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[20] UDHS 2022, UBOS
[21] UDHS 2022, UBOS
[22] UDHS 2022, UBOS
[23] UDHS 2022, UBOS
[24] UDHS 2022, UBOS
[25] UDHS 2022, UBOS
[26] UDHS 2022, UBOS
[27] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[28] UDHS 2022, UBOS
[29] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[30] UDHS 2022, UBOS
[31]Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[32] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf

Sustainable Development Goals Status		
	Proportion of children at end of Lower Secondary education (Senior Four) achieving a minimum proficiency level in reading (English) and numeracy (mathematics) (senior 4 literacy) [33]	78.1% (2020)
SDG5	Proportion of seats held by women in national parliaments (% of total number of seats)	33.8% (2021)
	Proportion of seats held by women in local governments (% of total number of seats) [34]	46.0% (2021)
	Proportion of ever-partnered women and girls subjected to physical, psychological and sexual violence by a current or former intimate partner in the previous 12 months (sexual violence) [35]	10.7% (2022)
SDG6	Proportion of population using safely managed drinking water services	81.40% (2022)
	Proportion of the population using safely managed sanitation services, including a handwashing facility with soap and water[36]	34.2% (2022)
SDG7	Proportion of population with access to electricity[37]	26.3% (2022)
	Proportion of population with primary reliance on clean fuels and technology[38]	0.1% (2022)
SDG8	Annual growth rate of real GDP per capita[39]	0.2 (2021)
	Annual growth rate of real GDP per employed person[40]	27.6% (2021)
	Proportion of informal employment in total employment, by sector and sex (ILO harmonized estimates[41]	88.1% (2020)
	Proportion and number of children aged 5-17 years engaged in child labour, by sex and age[42]	39.5% (2021)
SDG10	Growth rates of household expenditure or income per capita among the bottom 40 per cent of the population and the total population[43]	2.5% (2020)
SDG11	Total expenditure (public and private) per capita spent on the preservation, protection and conservation of all cultural and natural heritage, by type of heritage (cultural, natural, mixed and World Heritage Centre designation), level of government (national, regional and local/municipal), type of expenditure (operating expenditure/ investment) and type of private funding (donations in kind, private non-profit sector and sponsorship) [44]	45 (2021)
SDG12	Implementation of standard accounting tools to monitor the economic and environmental aspects of tourism sustainability[45]	5 (2020)
SDG13	Number of deaths, missing persons and directly affected	103 (2018)

[33] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[34] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[35] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[36] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[37] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[38] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[39] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[40] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[41] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[42] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[43] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[44] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[45] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf

Sustainable Development Goals Status		
	persons attributed to disasters per 100,000 population[46]	
SDG15	Forest area as a proportion of total land area[47]	13 (2021)
	Proportion of traded wildlife that was poached or illicitly trafficked[48]	0.3% (2022)
SDG16	Proportion of population that feel safe walking alone around the area they live in after dark[49]	61% (2017)
	Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month[50]	75.8% (2022)
	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age[51]	40.4% (2022)
SDG17	Proportion of domestic budget funded by domestic taxes[52]	61.6 (2021)
	Volume of remittances (in United States dollars) as a proportion of total GDP[53]	2.8 (2021)
	Proportion of individuals using the Internet[54]	Fixed (0.13%); Mobile (99.9%); Number (21,916,218

[46] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[47] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[48] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[49] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[50] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[51] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[52] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[53] Office of the Prime Minister, Factsheet 2024:https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf
[54] Office of the Prime Minister, Factsheet 2024: https://sdgs.opm.go.ug/wp-content/uploads/2024/07/SDG-VNR-FACT-SHEET-2024-PV.pdf

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

The Evaluation Report is organised in alignment with the **UNFPA Evaluation Handbook (2024)**. It is structured as follows:

- **Chapter 1: Introduction** – This chapter outlines the purpose and objectives of the 9th Government of Uganda (GoU)/UNFPA Country Programme (CP), along with the scope of the evaluation, its methodology, and the evaluation process.

- **Chapter 2: Country Context** – This chapter presents an overview of the national development landscape, highlighting key challenges and strategies.

- **Chapter 3: UN and UNFPA Strategic Response** – This chapter reviews the broader UN and UNFPA strategic response, with a focus on the 9th CP and its predecessor, the 8th CP. It also includes the United Nations Country Team (UNCT) in Uganda partnership with the Government of Uganda through the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025.

- **Chapter 4: Evaluation Findings** – This chapter addresses all evaluation questions, organised under the criteria of relevance, coherence, effectiveness, efficiency, sustainability, coordination, coverage, and connectedness. Also provided in this chapter is an overview of key lessons learned from the 9th CP, highlighting its successes and areas requiring further attention in Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, and Population Dynamics.

- **Chapter 5: Conclusions** – Strategic and programmatic conclusions derived from the evaluation findings are presented in this chapter.

- **Chapter 6: Recommendations** – Recommendations are provided at both strategic and programmatic levels to inform future planning and decision-making.

The report concludes with a set of annexures, which include: the terms of reference, a list of persons and institutions visited or interviewed, the evaluation matrix (with data collected), data collection tools, a stakeholder map, the CPE agenda, documents reviewed, and the reconstructed Theory of Change.

ACKNOWLEDGEMENTS

The United Nations Population Fund (UNFPA) extends its deepest gratitude to all institutions and individuals who contributed to the successful completion of the Country Programme Evaluation (CPE) of the 9th Government of Uganda/UNFPA Country Programme (2021–2025) in Uganda.

Special recognition is given to the Ministries, Departments, and Agencies (MDAs) consulted through interviews and review meetings, including: the Office of the Prime Minister (OPM), National Planning Authority (NPA), Ministry of Education and Sports (MoES), Ministry of Gender Labour and Social Development (MGLSD), Ministry of Health (MoH), Justice Law and Order Sector (JLOS) of the Ministry of Justice and Constitutional Affairs (MoJCA), and Uganda Bureau of Statistics (UBOS). Appreciation is also extended to the development partners who participated during the interviews: the Embassy of Sweden, the Embassy of Denmark, and the Netherlands Embassy.

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EXECUTIVE SUMMARY

Purpose, scope of the evaluation and intended audience: This report presents the process, findings, conclusions and recommendations of the UNFPA Uganda 9th programme cycle (2021– 2025) Country Programme Evaluation (CPE). The evaluation of the 9th CP was conducted to assess its performance, ensure accountability for resource use, and inform evidence-based decision-making for the next programming cycle (2026–2030). This evaluation also aimed to enhance organisational learning by identifying best practices, lessons learnt and recommendations to guide future interventions. The intended audience includes the UNFPA Country Office, Regional Office, Headquarters, the Executive Board, government agencies, development partners, and other stakeholders.

The objectives of this CPE were (i) to provide the UNFPA Uganda CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Uganda 9th CP (2021-2025), and (ii) to broaden the evidence base to inform the design of the next programme cycle. The specific objectives were (i) to provide an independent assessment on the relevance, coherence, effectiveness, efficiency and sustainability of the UNFPA 9th CP; (ii) to provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives; (iii) to provide an assessment of the role played by the UNFPA Uganda CO in the coordination mechanisms of the United Nations Country Team (UNCT), with a view to enhancing the United Nations collective contribution to national development results; and (iv) to draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle. The geographic scope of the CPE covered 40 core districts in Uganda, including seven refugee-hosting districts, reflecting the 9th CP's dual focus on humanitarian and development goals. The thematic scope included increasing access to integrated SRHR services, empowering women and youth, strengthening GBV prevention and response, and enhancing population data systems to address inequalities and the International Conference on Population and Development (ICPD) commitments. It also encompassed cross-cutting issues such as human rights, gender equality, and disability, as well as transversal functions like coordination, M&E, innovation, and resource mobilisation. The temporal scope spanned interventions planned and implemented from 2021 to 2025.

The 9th UNFPA Uganda Country Programme: The 9th CP was developed in collaboration with the Government of Uganda, civil society, development partners, the private sector, and academia. It focused on three strategic outcomes: ensuring marginalised women, adolescents, and youth can access reproductive rights and SRHR services free from discrimination or violence; promoting gender equality and addressing GBV and harmful practices in development and humanitarian contexts; and strengthening population data systems for sustainable, inclusive development. Aligned with Uganda's Vision 2040 and NDP III, the 9th CP integrated SRHR, gender equality, and population dynamics into the national development agenda.

CPE Methodology: The CPE employed a theory-based, non-experimental approach guided by the UNFPA Evaluation Handbook and Evaluation Policy, using contribution analysis to address twelve core questions on evaluation criteria. Participants, including implementing

partners, government and CSOs, donors, UN agencies, and beneficiaries, were selected through purposive and convenience sampling. A mixed-methods approach incorporated document review, interviews with 62 stakeholders, 29 focus group discussions, site visits, and a health facility assessment to evaluate SRHR/HIV/GBV service capacity. Data collection, conducted both virtually and in person, was triangulated using qualitative and quantitative analysis. The CPE employed an inclusive and participatory approach, engaging a wide range of implementing partners (IPs) and stakeholders, including persons living with disabilities (PLWD) and most-at-risk populations (MARPs), while ensuring gender balance throughout the process. The evaluation team adhered to rigorous ethical standards and quality control measures, with oversight provided by the Evaluation Manager to ensure compliance. To validate the CPE design, preliminary findings, and the final report, the evaluation included consultations through meetings and workshops with the Evaluation Reference Group (ERG), UNFPA Country Office, and implementing partners. These interactions fostered collaboration, transparency, and shared ownership of the evaluation process and outcomes.

Main Findings

Relevance: The 9th CP was closely aligned with Uganda's Vision 2040, NDP III, and global commitments like the SDGs and ICPD25, addressing critical priorities in SRHR, GBV, and youth empowerment. It supported national frameworks, strengthened data systems, and enhanced evidence-based planning, contributing to improved access to contraceptives and addressing gaps in maternal and adolescent health. At the sub-national level, interventions were tailored to disparities in underserved and refugee-hosting districts. Innovative approaches, such as mobile clinics and telehealth, ensured adaptability during the COVID-19 pandemic, while efforts to strengthen health systems and foster social norm change positioned the 9th CP as a driver of equitable development. However, limited government capacity and resources constrained full policy implementation.

Coherence: The evaluation highlighted strong coherence in the 9th CP's implementation, driven by effective collaboration with UN agencies, government ministries, development partners, and the private sector. Partnerships with organisations like UN-Women, UNHCR, and WHO, and alignment with frameworks like the Comprehensive Refugee Response Plan, avoided duplication and fostered synergy. Collaborative approaches, including joint work plans and inter-agency coordination, streamlined operations and aligned interventions with national and local priorities. At the sub-national level, engagement with local governments, implementing partners, and communities improved service delivery and multi-sectoral collaboration. Programmes such as the Advancing Sexual Reproductive Health and Rights (ANSWER) and Women, Adolescents and Youths (WAY) harmonised SRHR and GBV services for host and refugee populations. Humanitarian efforts integrated lifesaving SRHR and GBV services into national strategies, addressing critical needs. However, gaps in coordination at sub-county and community levels remain a challenge.

Effectiveness: The 9th CP demonstrated significant effectiveness in achieving many of its planned outputs and outcomes, particularly in the areas of SRHR service provision, gender equality, and data systems strengthening. Notable achievements include surpassing targets for contraceptive availability, with 85.9% of primary service delivery points maintaining no stock-outs by 2024 and developing 62 policies and strategies promoting gender equality and SRHR access. Utilization of SRHR services also improved, with substantial increases in family planning users, antenatal visits, and postnatal care. Additionally, gender equality interventions exceeded expectations. However, gaps persisted, particularly in health facility readiness for

emergency obstetric care and integration of SRH/HIV/GBV services, where only 32% of facilities met integration standards. Barriers such as logistical constraints and inadequate resources limited the programme's reach, especially for marginalised groups like persons with disabilities and remote populations. Cross-cutting lessons emphasised the importance of integration across SRHR, HIV, and GBV programmes, alongside economic empowerment initiatives, to sustain impact. Tailored strategies and community engagement emerged as critical for addressing cultural resistance and enhancing programme effectiveness across diverse contexts. These findings highlight the need for enhanced inclusivity, capacity building, and logistical support to optimize CP9's reach and long-term impact.

Efficiency: The 9th CP showcased substantial efficiency through strategic partnerships, adaptive budgeting, and innovations like digital tools and community-based approaches, effectively minimising costs while sustaining impactful SRHR and GBV services. Leveraging local health systems, cross-training Village Health Teams, and collaborating with agencies like UN Women, UNICEF and WHO optimised resource use, even during emergencies like COVID-19. However, logistical challenges in remote districts revealed gaps in supply chains and transport frameworks. Expanding mobile clinics and integrated outreach models offers potential solutions, ensuring that the next CP continues to address growing demands and deliver comprehensive services effectively However, there were issues related to delayed release of funds to implementing partners (partly due to delays by some IPs to account for funds in time) which reflects capacity gaps in IPs capacity. Some stakeholders too were concerned about UNFPA CO's preference to sub-contract International NGOs rather than grassroots community-based organisations that operate at a relatively lower cost and increase potential for coverage, capacity enhancement and sustainability.

Sustainability: The 9th CP demonstrated strong sustainability by integrating its interventions into Uganda's national, subnational, and community structures. By embedding SRHR, GBV, and other initiatives into existing health systems and policies, such as the Uganda Demographic Health Survey and National GBV database, the 9th CP ensured continuity beyond the programme's lifespan. Partnerships with government ministries, NGOs, and community structures bolstered local ownership, while capacity-building efforts at all levels equipped health workers, educators, and community leaders to sustain progress in SRHR and GBV service delivery. These efforts were complemented by disability-inclusive practices, underscoring the 9th CP's commitment to leaving no one behind. However, challenges such as resource gaps in refugee-hosting districts highlight the need for continued support to ensure the durability of programme outcomes.

Coordination: UNFPA has played a key role in enhancing coordination mechanisms during the 9th CP. At the national level, it actively participated in inter-agency task forces, joint UN monitoring efforts, and supported platforms like the GBV National Reference Group to align SRHR and GBV programming with national priorities and foster multi-sectoral integration. At the district level, it institutionalised planning and review meetings, improving accountability, resource sharing, and harmonisation of interventions through tools like the 3W Matrix. Field officers strengthened local implementation, particularly in refugee-hosting districts, by integrating GBV prevention and SRHR services into humanitarian frameworks. Despite these achievements, sub-county and community-level coordination remains inconsistent, highlighting the need for innovative approaches to strengthen local structures.

Coverage: The 9th CP's coverage was extensive, reaching millions of beneficiaries across Uganda's rural, urban, and refugee-hosting districts. Targeted interventions prioritised

adolescents, women, and vulnerable groups, with tailored approaches such as mobile clinics and culturally sensitive health services addressing unique needs in underserved areas. Despite its broad reach, gaps persist in some remote sub-counties and marginalised populations, including persons with disabilities and adolescent boys. Strategic use of data-driven planning and partnerships enhanced service delivery, yet logistical constraints, funding limitations, and language barriers remain obstacles to achieving full coverage. Expanding resources, transport, and inclusive outreach strategies will be crucial for closing these gaps and ensuring equitable access to health services.

Connectedness: The 9th CP's connectedness to Uganda's broader development goals was evident through its alignment with Vision 2040, the National Development Plan, and the SDGs. Its SRHR and GBV interventions contributed to reducing maternal mortality, empowering youth, and promoting gender equality. Integration with frameworks such as the Comprehensive Refugee Response Framework (CRRF) ensured that the 9th CP's initiatives addressed both immediate humanitarian needs and long-term development priorities. Evidence from programmes like WAY and JPGBV highlights the 9th CP's role in fostering social cohesion and economic empowerment, reinforcing Uganda's demographic dividend goals. Strengthening partnerships and investing in inclusive strategies will further enhance the next CP's alignment with Uganda's aspirations for an equitable and resilient society.

Lessons learnt: The 9th CP's **key lessons** underline the importance of community-based approaches, mobile clinics, and peer-led education in advancing SRHR, demonstrating their ability to enhance service access, sustainability, and behaviour change. Capacity-building efforts equipped healthcare workers and local leaders to sustain SRHR services, although inclusivity gaps for adolescent boys and persons with disabilities persisted. In gender equality, community engagement and safe spaces for women and girls fostered trust and resilience, while aligning GBV initiatives with Uganda's gender policies, such as the National Policy on Elimination of Gender-Based Violence and related frameworks, amplified their relevance and impact. However, deeper engagement with men and boys is needed to challenge harmful norms and broaden reach. The 9th CP's use of data-driven approaches was pivotal in identifying needs and adapting to crises like COVID-19, ensuring service continuity. Training in data utilisation improved local decision-making but revealed variability across districts, emphasising the need for sustained mentorship. Future programmes should focus on integrating data systems across sectors, scaling community-based models, and addressing inclusivity challenges to enhance impact and sustainability.

Main conclusions

The 9th CP's **strategic** alignment with Uganda's national development frameworks, including Vision 2040 and the National Development Plan, positioned the CP as a critical contributor to advancing health, gender equality, and social inclusion goals. By integrating SRHR, GBV prevention, and youth empowerment within national policies, the 9th CP fostered ownership and relevance, especially in addressing the needs of marginalised populations like refugees and ethnic minorities. UNFPA's leadership in interagency coordination, alongside strategic partnerships with stakeholders such as UN Women, UNICEF and WHO, enhanced coherence and reduced duplication in delivering essential health services. However, gaps in district-level coordination and timely resource allocation highlight the need for strengthened frameworks and financial responsiveness to optimise programme efficiency. Additionally, the 9th CP demonstrated a robust commitment to gender and human rights, advancing inclusive programming for vulnerable groups, including persons with disabilities and ethnic minorities. Its tailored interventions, such as mobile clinics and community-based outreach, successfully

reached underserved areas but faced resistance in culturally conservative regions. Strategic improvements, including enhanced data systems and culturally sensitive approaches, are needed to bridge persistent gaps, particularly for hard-to-reach populations and those affected by stigma or discrimination. **Programmatically,** the 9th CP made significant progress in improving maternal health, reducing GBV, and addressing adolescent SRHR needs through integrated approaches. Community-based models, health worker training, and peer-led initiatives enhanced service delivery and fostered long-term behaviour change, although logistical constraints in remote areas limited the 9th CP's impact. The inclusion of youth-focused and disability-sensitive strategies was effective but remains inconsistent, emphasising the need for tailored interventions to ensure equitable access. Furthermore, the 9th CP's efforts to build local capacity, engage community stakeholders, and integrate services for SRHR, HIV, and GBV strengthened the sustainability of its outcomes. Nonetheless, coverage gaps persisted, particularly for persons with disabilities and marginalised adolescents in rural and refugee-hosting areas. Addressing these challenges through targeted, inclusive programming, expanded infrastructure, and continued advocacy will be essential for maintaining the 9th CP's momentum and ensuring sustainable progress toward Uganda's development goals.

Recommendations:

At **the strategic level**, recommendations emphasise the need to align the 9th CP interventions with Uganda's national and local priorities by fostering inclusive stakeholder consultations to address the specific needs of underserved districts and regions, such as Karamoja. Greater collaboration with cultural leaders and strengthening focus on social norm change is recommended to reduce resistance to SRHR and GBV prevention and response services, enabling more effective delivery of gender-sensitive, rights-based programming. To improve efficiency, district-level, coordination mechanisms at the community level and working with grassroots level IPs should be strengthened to minimise overlaps and optimise resource utilisation, particularly in refugee-hosting and remote areas. To improve effectiveness, continuing to invest in strengthening integrated delivery of SRHR and GBV prevention and response services is recommended with greater focus on improving service uptake for adolescents and young people in underserved districts.

At the **programmatic level,** recommendations focus on strengthening service delivery by institutionalising Continuous Quality Improvement (CQI) and prioritising investments in health facilities to maximise impact. Improving the timeliness of funding disbursements and increasing data investment at district levels will enhance evidence-based programming and service efficiency. Strengthening health systems in facilities providing maternal health and family planning services, alongside optimising the EmONC network, will enhance timely access to life-saving care. Additionally, addressing cultural and language barriers in refugee settings through tailored staffing will improve access to sexual and reproductive health services. Strengthening community resilience by training health teams and fostering partnerships will sustain SRHR, GBV, and HIV services beyond UNFPA's direct support. Additionally, scaling effective social norm change and gender transformative interventions, will enhance efforts to reduce GBV and harmful practices. Resource consolidation, rather than geographic expansion, will maintain programme quality and foster inclusion, particularly for persons with disabilities and adolescent girls. Expanding data systems to identify underserved populations will further support targeted, equitable service delivery.

CHAPTER 1: INTRODUCTION

1.1 Purpose and Objectives of the Country Programme Evaluation

The United Nations Population Fund (UNFPA) Uganda Country Office (CO) commissioned an evaluation of the Ninth Country Programme (2021-2025) to fulfil several key purposes outlined in the 2024 UNFPA Evaluation Policy. The evaluation assesses programme performance to ensure accountability for development results and resource use, supports evidence-based decision-making for future programming, and promotes organizational learning by identifying and sharing best practices. Additionally, it empowers stakeholders at community, national, and regional levels through active engagement in the evaluation process. Collectively, these objectives strengthen UNFPA Uganda CO's strategic positioning, foster continuous learning, and provide insights for the next programme cycle. The **intended audience** were the UNFPA Country Office, Regional Office, Headquarters, the Executive Board, government agencies, development partners, and other stakeholders.

The overall objectives of the evaluation were (a) to provide an independent assessment of the 9th Country Programme's relevance, impact, coherence, effectiveness, efficiency, and sustainability, strengthening UNFPA's accountability to donors, partners, and stakeholders, and (b) to generate the lessons learned and actionable recommendations to inform the design of the next programme cycle (2026-2030).

The **specific objectives** were to:

- Impartially assess the relevance, impact, coherence, effectiveness, efficiency, and sustainability of the 9th Country Programme, focusing on progress towards defined outputs and outcomes.
- Evaluate the reach and effectiveness of UNFPA's humanitarian assistance in linking immediate support to long-term development goals.
- Review UNFPA Uganda CO's contributions within UNCT coordination mechanisms and its role in advancing national development goals.
- Identify lessons learned and formulate practical recommendations for the upcoming programme cycle.

1.2 Scope of the evaluation

The evaluation encompassed the scope of the 9th CP focusing on Uganda's 40 core districts, including refugee-hosting areas, to assess the geographic, thematic, and temporal scope of interventions. These districts, concentrated in regions such as West Nile, Karamoja, Acholi, and others, represent the primary areas for the 9th CP's four thematic intervention areas: (a) Sexual and Reproductive Health, (b) Adolescents and Youth, (c) Gender Equality and Women's Empowerment, and (d) Population Dynamics. The evaluation also considered programmatic and organisational aspects, including responsiveness to prior recommendations and alignment with UNFPA's strategic plans and Uganda's aspirations to achieve Middle Income Country status by 2040. Cross-cutting issues like human rights, gender equality, and disability were reviewed alongside transversal functions such as coordination, M&E, innovation, resource mobilisation, and

strategic partnerships, ensuring a comprehensive assessment of the 9th CP's impact and sustainability.

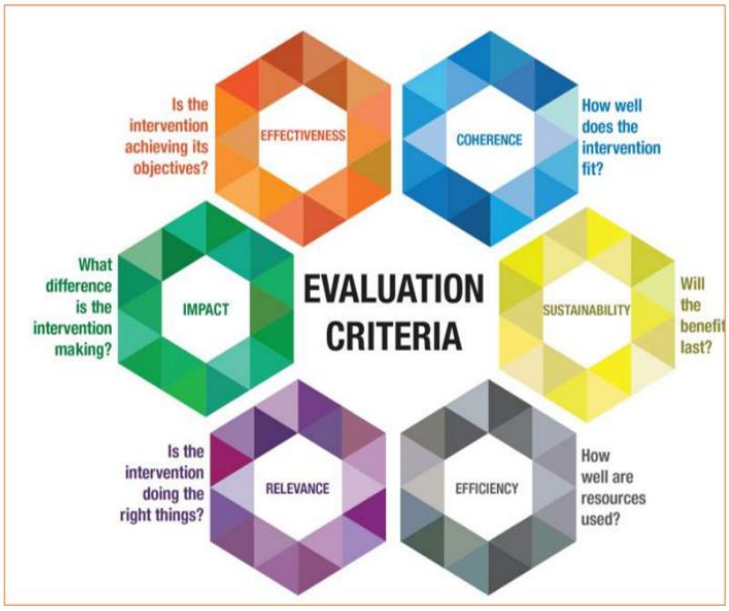
1.3 Evaluation methodology and approach

1.3.1 Evaluation criteria and evaluation questions

a) Evaluation criteria

The evaluation followed the five Organisation of Economic Cooperation and Development's (OECD)/Development Assistance Committee (DAC) criteria that emphasize assessment of the programmes' dimensions of relevance, coherence, effectiveness, efficiency and sustainability[55] (Figure 1).

Figure 1: OECD DAC evaluation criteria for programme evaluation



In addition, the evaluation assessed the extent to which the UNFPA Uganda Country Office (CO) harmonized interventions with other actors, promoted synergy and avoided duplication Furthermore, the evaluation uses the humanitarian-specific criteria of coverage and connectedness to investigate the following: (i) to what extent UNFPA has been able to provide life-saving services to affected populations that are hard-to-reach; and (ii) to work across humanitarian- development-peace nexus and contribute to building resilience. Table 1 below shows the evaluation criterion definitions that were adopted.

b) Evaluation questions

The evaluation questions which are related to the above OECD/DAC criteria are summarised in Table 1 below.

[55] DAC, Better Criteria for Better Evaluation: Revised Evaluation Criteria Definitions and Principles for Use: OECD/DAC Network on Development Evaluation. 2019.

Table 1. Evaluation questions

Criterion	Evaluation questions
Relevance	EQ1: To what extent did the 9th Country Programme (CP) design and theory of change (ToC) respond to (i) national policies, strategies and priorities; (ii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, and how did it adapt to contextual changes to achieve results?
	EQ2: To what extent did the 9th CP interventions incorporate cross-cutting issues and accelerators (as defined in UNFPA Global Strategy) to respond to the diverse needs of marginalized and vulnerable populations, including people with disabilities (PWD), adolescents and youth, persons affected by humanitarian crises including refugees, key populations, and other vulnerable populations?
Coherence	EQ3: To what extent were the 9th CP interventions inter-linked, integrated and complementary? Did the interventions have a synergistic effect, and were they linked with government programmes, and other projects implemented by other UN agencies, INGOs and development partners in the country?
Effectiveness	EQ4: To what extent have the strategies and interventions 9th CP delivered outputs and contributed to the achievement of the outcomes of the country programme in particular: (i) increased access and use of integrated SRH services; (ii) empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights, (iii) advancement of gender equality and the empowerment fall women and girls and (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes? Which specific programme models proved to be more effective in delivering results? How and for whom?
	EQ5: To what extent did the 9th CP deliver results for the most vulnerable and left behind populations, including adolescents and youth, PWDs, key populations, refugees and other populations affected by humanitarian crises, and those living in remote and underserved areas?
	EQ6: To what extent were the investments in innovations effective and contributed to the achievement of results? How effectively were innovations developed, tested, documented, disseminated and scaled-up? Did the 9th CPD introduce innovative approaches that could be scaled up for wider impact?
	EQ7: What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development to accelerate results?
Efficiency	EQ8: To what extent have resources (human, financial and administrative), policies, procedures and tools, and delivery modalities of the 9th CP, contributed to effective and timely delivery of services and achievement of the outputs and outcomes defined in the county programme?
Sustainability	EQ9: To what extent has the programme been able to support the government, implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

Criterion	Evaluation questions
Coordination	EQ10: To what extent did the governance structures (DaO, partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs
Coverage	EQ11: To what extent did UNFPA humanitarian interventions systematically reach all geographic areas in which affected populations (women, adolescents and youth) reside?
Connectedness	EQ12: To what extent has the UNFPA humanitarian response taken into account longer-term development goals articulated in the results framework of the country programme?

1.3.2 Selection of districts and stakeholders

The selection of districts and stakeholders for primary data collection in the evaluation of Uganda's 9th Country Programme (the 9th CP) was guided by the UNFPA Evaluation Handbook to ensure a representative and comprehensive assessment. This selection process was further guided by the Stakeholder Mapping which is showcased in Annexure 5. The process prioritized geographic spread, balancing core districts, where most resources and activities were concentrated, with non-core districts, which provide insights into the broader applicability of interventions. Key factors included regional representation, diversity of interventions, refugee-hosting status, and project duration, prioritizing those operational for over a year to account for sustained implementation. Core districts such as Adjumani, Amudat, Kitgum, and Moroto were included due to their resource concentration and longer-standing projects. Non-core districts, including Madi-Okollo, Kamuli, and Kyegegwa, provided valuable perspectives on the programme's wider impact. Three districts—Adjumani, Madi-Okollo, and Kyegegwa—host refugees, reflecting the programme's dual humanitarian and development focus. The inclusion of districts with regional or referral hospitals, such as Madi-Okollo, Kitgum, and Kamuli, ensured the evaluation captured the integration of sexual and reproductive health services. Kampala was included for national-level Key Informant Interviews (KIIs). Figure 2 illustrates the selected districts for the evaluation.

Figure 2: Map of Uganda showing selected districts for the CPE.

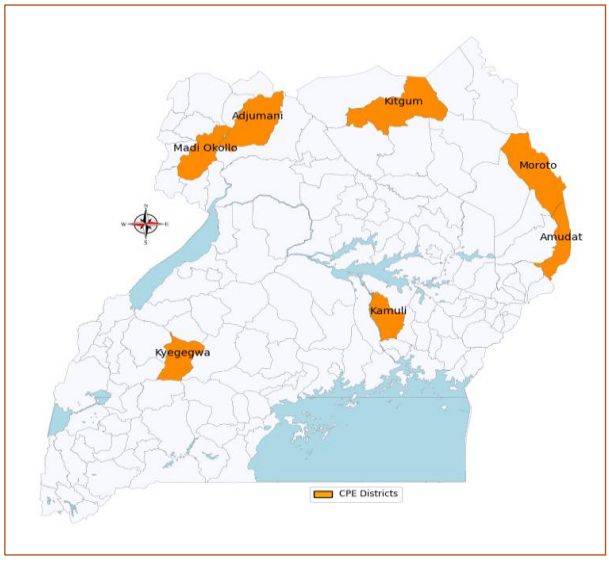


Table 2: List of selected districts and stakeholders

Region	Selected District	Core/Non-core	Implementing Partner(s)	Projects (exposure>1 yr)
Eastern	Kamuli	Non-Core	BRAC, MoJCA	ECM; MHTF; Supplies Partnership; SAYANA
West Nile	Adjumani	Core	RHU, CARE, LWF, OUTBOX	ANSWER: WAY; MHTF; RHCS; SAYANA
West Nile	Madi-Okollo	Non-Core	CARE, IRC, OUTBOX	ANSWER: SIF (Rich Baby Healthy Family); WAY; MHTF; RHCS; SAYANA; EU SPOTLIGHT
Northern	Kitgum	Core	ACORD, CARE, RHU	GBV/SRH; GPECMUGA; ATA18; GPFGM; EU Spotlight; WAY; MHTF; RHCS; SAYANA
Karamoja	Amudat	Core	BRAC, RAHU, MoES	GBV/SRH; EU SPOTLIGHT; ATA18; GPECMUGA; GPFGM; JUPSA; RISE; MHTF; RHCS; SAYANA
Karamoja	Moroto	Core	BRAC, IRC, RAHU	JPGBV/SRH; ATA18; MHTF; RHCS; SAYANA
Western	Kyegegwa	Non-Core	ACORD, CARE, MoH	EU SPOTLIGHT; MHTF; RHCS; SAYANA CERF

1.3.3 Ethical Considerations

The evaluation was conducted in compliance with the UNFPA Evaluation Policy, the United Nations Evaluation Group (UNEG) Ethical Guidelines, the Code of Conduct for Evaluation in the UNEG, and the United Nations Norms and Standards for Evaluation. The evaluation team adhered to key ethical principles, including: (a) compliance with international norms and standards, (b) obtaining informed consent from respondents, (c) ensuring confidentiality, (d) safeguarding sensitive information, (e) avoiding bias, (f) promoting sensitivity to discrimination issues, (g) preventing harm, and (h) respecting dignity and diversity. Ethical practices were integrated into all stages of the evaluation, with each team member demonstrating a commitment to ethical behaviour. Prior to the evaluation, an intensive brainstorming session was held among team members to reinforce understanding of ethics in evaluation and to equip the team to address ethical challenges effectively during the Comprehensive Programme Evaluation.

Obtaining Consent

The evaluation team ensured that informed consent was obtained from all participants prior to their involvement in interviews or discussions. For respondents under the age of 18, both parental permission and the child's assent were secured before participation in focus group discussions (FGDs). Consent was obtained either orally or in writing, depending on the context and respondent preferences, ensuring that all participants, including adolescents, were fully aware of the purpose and nature of the evaluation.

Differentiation of Participants

To ensure inclusivity, the evaluation adhered to the UN Sustainable Development Group (UNSDG) programming principle of 'Leaving No One Behind.' This guided the selection of respondents, ensuring representation across various age groups, genders, and vulnerable categories, including marginalized populations targeted by UNFPA programmes. This approach

ensured that diverse perspectives were captured and that all voices were considered in assessing the programme's impact at the district level.

1.3.4 Methods of data collection

The evaluation employed a mixed-method design, utilising both qualitative and quantitative data collection methods. The evaluation employed a participatory approach, actively engaging UNFPA staff, key stakeholders, and beneficiaries throughout the process.

Document review

Key informant interview

Focus group discussion.

Observation

The data collection methods employed are detailed in the following sections.

a) Evaluation Matrix

The evaluation serves as a comprehensive tool to ensure that the methodological approach is robust, coherent, and aligned with the evaluation objectives. The Evaluation Matrix is attached to Annexure 3. The matrix facilitated the appraisal of the entire methodological process, helping to map out the key evaluation questions, indicators, data sources, and methods of analysis. This structured framework ensured that all relevant aspects of the Country Programme are thoroughly assessed, providing a clear roadmap for data collection, analysis, and synthesis.

b) Qualitative data collection methods

Qualitative data collection methods for the evaluation combined traditional approaches such as Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Document Reviews, and Observations with innovative techniques like Outcome Harvesting and Most Significant Change (MSC). Outcome Harvesting was particularly effective in retrospectively identifying and analysing changes, highlighting how UNFPA's interventions contributed to those outcomes, including unexpected ones. This approach, along with MSC, captured valuable lessons and provided deeper insights to inform the design and strategic direction of the next Country Programme. The integration of diverse methods ensured a comprehensive and nuanced understanding of the programme's impact and effectiveness, forming a robust basis for actionable recommendations.

i) Key Informant Interviews (KIIs)

Key Informant Interviews (KIIs) were conducted at both national and subnational levels to gather comprehensive insights for the evaluation. At the national level, participants included representatives from government entities such as the Office of the Prime Minister, Ministry of Health, Ministry of Gender, Labour and Social Development, Ministry of Education and Sports, National Population Council, Uganda AIDS Commission, and Uganda Bureau of Statistics. UN agencies, including UNFPA, UNICEF, WHO, UNDP, UNWomen, UNHCR, and UNAIDS, were also engaged. Additionally, academic institutions, NGOs, faith-based organisations, and funding agencies such as SIDA, EU, DANIDA, DFID, and Irish Aid participated. At the subnational level, stakeholders included Chief Administrative Officers, District Health Officers, planners, community development officers, education officers, implementing partners, faith-based

organisations, cultural institutions, and UNFPA field staff. The KIIs, guided by tailored interview guides for national and subnational levels, focused on evaluation criteria such as relevance, coherence, effectiveness, efficiency, sustainability, coordination, and connectedness. Discussions were moderated and audio-recorded, with note-takers ensuring a comprehensive record. The iterative process allowed for emerging issues to be explored until saturation was reached, ensuring a thorough and nuanced understanding of the programme's impact.

ii) Focus Group Discussions (FGDs)

Focus Group Discussions (FGDs) were conducted with project beneficiaries, including women, adolescents/youth, men, key populations, and refugees across intervention districts. Separate FGDs, consisting of 6-12 participants, were held for each group to explore their attitudes, experiences, and perceptions of the programme interventions. Facilitated by a moderator and supported by a note taker, the discussions were audio-recorded, and supplementary notes were taken to ensure a comprehensive record. The process was iterative, allowing for the inclusion of new questions to examine emerging themes and continued until data saturation was reached. Tailored FGD guides were developed for each beneficiary group to ensure targeted and relevant discussions.

iii) Document review

The document review, guided by the Evaluation Handbook and a document repository checklist, followed OECD/DAC evaluation criteria, focusing on relevance, coherence, effectiveness, efficiency, sustainability, and other aspects like coordination and coverage. Key sources included the Country Programme Document (CPD), annual and quarterly work plans, Country Office Annual Reports (COARs), mid-term reviews, and field mission reports, providing actionable insights for improvement (see Annexure 7). Evaluations of the WAY and ANSWER programmes contributed to the analysis, with the ANSWER evaluation employing a rigorous Difference-in-Difference (DiD) methodology to assess UNFPA's impact. Additional sources, such as the ADA Programme Evaluation, the Gap Analysis Uganda Consolidated Report, and the JPGBV Mid-Term Review, enriched the evidence base, offering a comprehensive understanding of programme outcomes.

iv) Observations

Field observations were standardised and facilitated using a structured observation guide.

The data collection tools which constituted of Key Informant Interview guides, Focus Group Discussion guides, and the Observation guide are showcased in Annexure 4.

Table 3 below shows a summary of the total number of the KIIs and FGDs held at the National and sub-national levels.

Table 3. Distribution of KIIs and FGDs

Level	Category	Number
National level		
	KIIs	16
District level		
Adjumani	KIIs	11
	FGD	06
Amudat	KIIs	06
	FGD	03
Kamuli	KIIs	05
	FGD	03
Kyegegwa	KIIs	07
	FGD	03
Kitgum	KIIs	03
	FGD	06
Madi-Okollo	KIIs	07
	FGD	04
Moroto	KIIs	07
	FGD	04
Total (KIIs and FGDs)	**KIIs**	**62**
	FGD	**29**

The higher number of KIIs in Adjumani compared to other humanitarian districts is attributed to the availability of key informants during the evaluation period. Although the evaluation stipulated a minimum of 6-7 KIIs per district, the final numbers varied depending on the accessibility and willingness of informants to participate in the interviews. Adjumani, being a core humanitarian district with multiple stakeholders, presented more opportunities to engage with a diverse group of key informants, which contributed to the higher count.

c) Quantitative data collection methods

Quantitative data was collected through retrospective review of records, documents, websites and online databases to obtain data on key output and outcome indicators. A structured abstraction tool was used to guide quantitative data collection from the various data sources including documents, websites and online databases. The abstraction tool comprised of the key performance output and outcome indicator data elements required for the evaluation. In addition, a health facility assessment for integrated HIV, SRH and GBV services was conducted.

i) Health Facility Assessment for Integrated SRH, HIV and GBV Services

The Ministry of Health (MoH) adopted an integrated approach to delivery of SRH, HIV and GBV services as a key strategy to improve maternal and neonatal outcomes, as well as improving adolescent and youth health in the country. In tandem with this strategic direction, the GOU/UNFPA CP9 supported District local governments and health facilities to strengthen integration of SRHR/HIV/GBV services. Monitoring the health facility capacity to provide integrated SRHR/HIV/GBV services was considered as a key country program performance indicator. The health facility assessment established the current capacity of health facilities to

provide integrated SRHR/HIV/GBV services based on the MoH integration performance standards, application of the scorecard and validation of the key service delivery output data from the health facilities. The assessment covered a total of **81** health facilities (HC IIIs and above) across the 7 districts. They included 67 HC IIIs, 7 HC IVs, 6 General Hospitals and 1 Regional Referral Hospital (Table 4).

Table 4. Health facilities assessed by district and level of care.

No.	District	Health facility level				Total
		HC III	HC IV	General Hospital	RRH	
1.	Adjumani	16	1	1	0	18
2.	Amudat	4	1	1	0	6
3.	Kamuli	11	2	1	0	14
4.	Kitgum	11	1	2	0	14
5.	Kyegegwa	10	1	1	0	12
6.	Madi-Okollo	6	1	0	0	7
7.	Moroto	9	0	0	1	10
Overall		**67**	**7**	**6**	**1**	**81**

At each health facility, data was collected by trained research assistants using an electronic structured tool. Data was collected through interviews with health workers, observation of the existing standards and review of health service statistical data from monthly and quarterly reports. Facility scores were awarded based on the evidence of availability and functionality of the different elements for HIV, SRH and GBV integration. Facility **s**cores were grouped into 3 categories: >=80% (green colour code) which implies good performance; 65%-79% (yellow colour code) which corresponds to average performance and <65% (Red colour code) which implies poor performance (Table 5).

Table 5. Facility assessment scores for HIV, SRH and GBV integration

No	Score category	Interpretation	Colour code
1.	>=80%	Good performance	**Green**
2.	65%-79%	Average performance	**Yellow**
3.	<65%	Poor performance	**Red**

1.3.4 Data Analysis

Separate analyses for qualitative data (narrative) and quantitative data (descriptive) were conducted. The findings from each analysis were integrated and triangulated for corroboration purposes.

Qualitative data analysis

The recorded KIIs and FGDs were transcribed verbatim and thoroughly reviewed by the evaluation team to familiarise themselves with the data. Thematic analysis was conducted by identifying key ideas and concepts from the transcripts, which were organised into specific categories. Relevant quotes were highlighted, extracted, and rearranged under the identified themes for analysis. Data interpretation considered internal consistency, frequency, specificity, and cross-cutting trends. The

analysis was structured around the key evaluation questions, with responses organised, grouped, and summarised accordingly.

Quantitative data analysis

Data obtained from various documents, websites, and online databases was analysed using a univariate approach to summarise key variables, generating descriptive statistics such as numbers, frequencies, and percentages. These metrics provided an overview of the programme's performance on individual indicators. To assess the achievement of programme goals, comparisons were made between actual performance data and the programme's indicator targets, identifying the extent to which targets were met or exceeded.

Contribution Analysis and Triangulation

Contribution analysis was used to assess the coherence of the results chain and intervention logic outlined in the CPD, along with the effectiveness of the UNFPA 9th CP in delivering planned activities, outputs, and their contributions to outcomes across programme components. All evaluation criteria were comprehensively addressed, with a focus on implementation modalities and efficiency. Triangulation of data from various sources, including prior evaluations, facilitated the formulation of conclusions and recommendations, capturing both expected and unexpected outcomes. The findings and analysis were structured following the formats specified in the UNFPA Handbook on Evaluation, ensuring clarity and consistency in their presentation within the report.

Data Quality Assurance

During the field phase, the CPE Team ensured that all the Research Assistants and had a clear understanding of the types of information to be collected and the appropriate methods for recording and archiving this information. Data quality was upheld through triangulation of data sources, collection methods, and analyses. Validation of preliminary findings with key stakeholders further enhanced data quality by addressing any potential factual errors, misinterpretations, or missing evidence that could affect the findings. Secondary data was sourced from various documents provided by the CO and other stakeholders, and its quality was deemed satisfactory for use in the evaluation.

1.3.5 Limitations and Risks

Table 6 below shows the CPE limitations/risks, and the mitigation measures employed.

Table 6. Limitations, Risks and Mitigation Measures

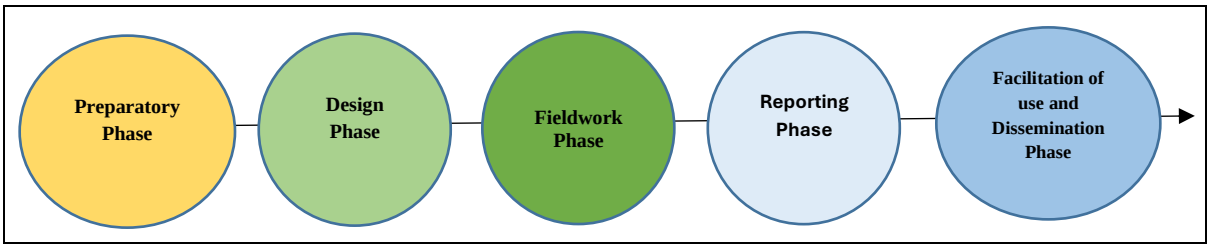
No	Limitation	Risk	Mitigation Measures
1.	Delays in securing Key Informant Interviews (KIIs)	Risked timeliness of data collection and limited stakeholder coverage, introducing potential bias.	The team adhered to a realistic schedule, made early appointments, and utilised virtual platforms where physical interviews were not feasible.
2.	Multi-lingual settings in districts.	Miscommunication with beneficiaries could compromise the accuracy of findings.	Local-language Research Assistants ensured effective communication and accurate records.

3.	Potential bias from stakeholders.	Stakeholders might filter information or present it in a specific light, affecting data reliability.	Facilitation strategies ensured interviewees felt at ease, promoting candid and unbiased responses.

1.3.6 Process Overview

The CPE comprised five phases: 1) Preparatory phase, 2) Design phase, 3) Field phase, 4) Reporting phase, and 5) Facilitation of use and dissemination phase, as illustrated in Figure 3.

Figure 3: Phases of the Evaluation



Source: Adapted from UNFPA CPE Handbook

The evaluation team began with the design phase. The activities conducted throughout the CPE, along with their timelines, are detailed in the CPE Agenda in Annexure 6.

CHAPTER TWO: COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

Uganda faces significant development challenges shaped by its rapidly growing population, regional instability, and socio-economic disparities, which are addressed through strategies such as Vision 2040, the National Development Plans (NDPs), and the Sustainable Development Goals (SDGs). With a population of 45.9 million in 2024, reflecting an annual growth rate of 2.9%, Uganda's youthful demographic (over 50% under 18) presents both opportunities for a demographic dividend and challenges in resource allocation, urban planning, and service delivery (UBOS, 2024)[56]. Refugee influxes from neighbouring conflict-affected countries have further compounded pressures on resources and infrastructure, despite Uganda's progressive refugee policy. Economic indicators show some progress, such as GDP growth and improved Human Development Index (HDI) rankings, yet challenges like multidimensional poverty, regional inequality, and gender disparities persist[57]. The COVID-19 pandemic exacerbated these issues, disrupting education, increasing gender-based violence, and pushing millions into poverty. Uganda's strategic focus on population dynamics, including leveraging data from the 2024 census and fostering investments in health, education, and economic opportunities, aims to harness the demographic dividend while addressing dependency burdens. Integrating accurate population data into NDP IV ensures alignment with Uganda's broader development goals, emphasising sustainable industrialisation, inclusive growth, and socio-economic transformation[58] [59].

2.1.1 Population and Development

Uganda's population dynamics, as highlighted by the 2024 National Population and Housing Census, reveal both significant opportunities and challenges for the country's socio-economic development. With a population of approximately 45.9 million, reflecting a growth rate of 2.9% and a youthful demographic—over 50% under 18 years—the potential for a demographic dividend is evident. However, this rapid growth, driven by high fertility rates of 5.2 children per woman, imposes substantial pressures on resources such as land, healthcare, and education. Uganda's Vision 2040, the Third National Development Plan (NDP III), and the forthcoming NDP IV emphasize the need for strategic investments in health, education, and job creation to harness this demographic potential while addressing dependency burdens and ensuring sustainable development. Population density has increased to 227 persons per square kilometre, with significant regional disparities necessitating tailored policies to address unique sub-regional challenges. Census data is integral to planning frameworks, guiding initiatives like Vision 2040 and NDP IV, which aim for sustainable socio-economic transformation through goals such as increased household incomes and sustainable industrialization. Investments in education, healthcare, and infrastructure remain critical to navigating the complexities of Uganda's

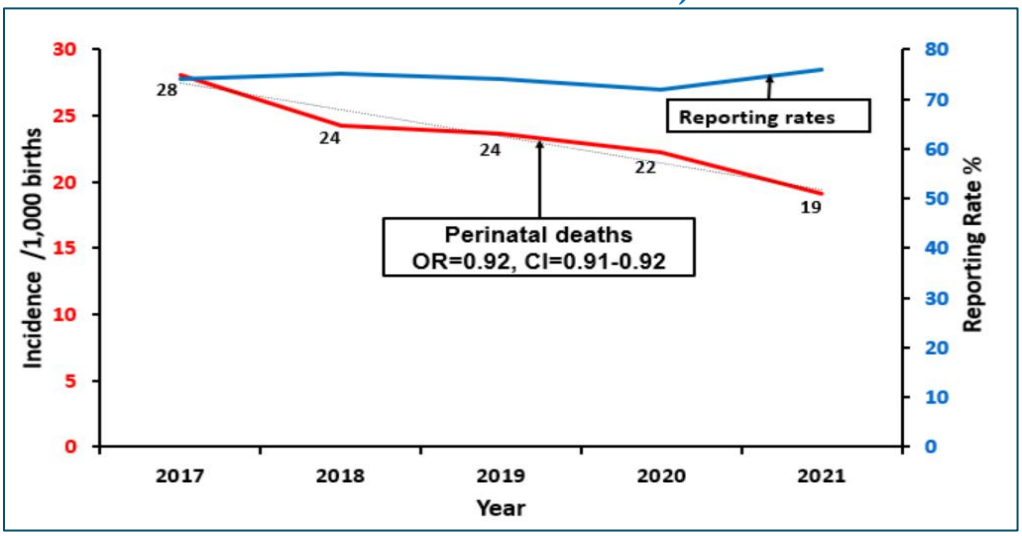
[56] UBOS (2024). Results from the Uganda National Census.
[57] UNDP (2024) Human Development Report, 2024
[58] UNDP (2024) Human Development Report, 2024
[59] Uganda Gender Equality Strategy (2022-2025).

demographic trends, fostering economic progress, and improving the quality of life for all Ugandans (Uganda Bureau of Statistics 2024) [60].

2.1.2 Sexual and Reproductive Health

Uganda's sexual and reproductive health (SRH) landscape is shaped by a dynamic policy framework aimed at ensuring universal access to SRH services and aligning with international commitments, including the Sustainable Development Goals (SDGs) and the African Union Agenda 2063. Despite progress in maternal and neonatal health through initiatives such as the midwifery programme and integrated SRH/HIV services, systemic challenges like high unmet family planning needs (24% among married women) and cultural barriers persist. Fertility rates, though declining, remain high at 5.2 children per woman, and unsafe abortion continues to contribute to maternal mortality. Adolescent girls and young women face heightened vulnerability, with teenage pregnancies at 24–25% and a disproportionate burden of HIV (four times higher than male peers). Emerging strategies, such as youth-friendly services and digital health solutions, show promise in addressing these gaps. While Uganda has made notable strides in reducing maternal mortality from 336 to 189 deaths per 100,000 live births and infant mortality from 43 to 36 deaths per 1,000 live births, perinatal deaths remain high at 19 per 1,000 births (Figure 3) [61]. Cervical cancer is the leading cancer among women, driven by high HPV prevalence (33.6%) and low screening uptake (13%). Infertility, affecting 6.4% of women, adds to the SRH burden, compounded by socio-economic and psychological impacts. UNFPA's contributions, including capacity-building, policy advocacy, and community-based interventions, have been pivotal, yet further efforts are required to ensure equitable, integrated, and rights-based SRH services across Uganda[62].

Figure 4. Trends in perinatal deaths in Uganda, 2017-2021 (Source: Uganda National Institute of Public Health)



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

Despite substantial policy frameworks and interventions, gender equality, sexual and gender-based violence (SGBV), and social inclusion remain pressing challenges in Uganda. Physical

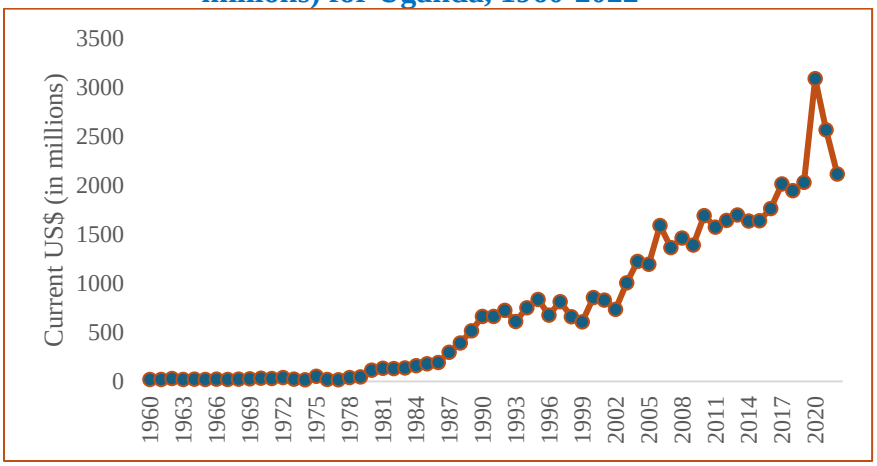
[60] Uganda Bureau of Statistics 2024. National-Population and Housing Census-2024 Preliminary Report
[61] WHO Factsheet: Newborn mortality, 2022
[62] The National policy guidelines and service standards for Sexual Reproductive Health and Rights, 2017

violence against women has declined from 56% in 2011 to 44% in 2022, yet spousal violence and sexual violence persist, with 54% of ever-married women and 17% of women overall affected, respectively.[63] Men also experience significant rates of violence, reflecting systemic issues tied to harmful norms and power dynamics. Regional disparities are evident, with violence most prevalent in Teso and Karamoja and lower rates in Kampala and Buganda. Uganda's legal and policy instruments, such as the Domestic Violence Act (2010), FGM Act (2010), and National Gender Action Plan, aim to address these issues, alongside multi-sectoral efforts like the Uganda Gender Policy and gender-responsive budgeting initiatives.[64] However, barriers such as funding gaps, cultural resistance, and implementation challenges hinder progress. UNFPA has been instrumental in supporting SRHR and GBV services in refugee-hosting districts, integrating these into humanitarian settings, and strengthening health systems. Despite these efforts, underserved and refugee communities face ongoing barriers, necessitating sustained and collaborative interventions to advance SRHR outcomes, reduce GBV, and promote gender equality nationwide.

2.2 The Role of External Assistance

Uganda's reliance on external development assistance has been pivotal in supporting its national budget and advancing socio-economic growth. Since the 1960s, Uganda's net official development assistance (ODA) has steadily increased, from an annual average of USD 20 million in the early years to over USD 3 billion by 2020. This rise reflects the country's evolving development needs, economic reforms, and global economic trends. Notable spikes in ODA coincided with critical periods, such as the late 1980s and early 2000s, which marked intensified development efforts. In 2020, ODA peaked at USD 3.086 billion, driven by increased support to address challenges like the COVID-19 pandemic. However, subsequent years saw a slight decline, with Uganda receiving USD 2.564 billion in 2021 and USD 2.114 billion in 2022.[65] Multilateral institutions, including the World Bank, African Development Bank, and European Union, remain key contributors to Uganda's external financing, emphasizing the strategic role of ODA in achieving national priorities like Vision 2040 and the National Development Plan IV (NDP IV) (Figure 5).

Figure 5. Net official development assistance and official aid received (current US$, millions) for Uganda, 1960-2022



Source: World Bank. (2023).

[63] UBOS (2021). National Survey on Violence in Uganda Module I: Violence Against Women and Girls
[64] These are further elaborated in the "Lyndsay McLean and Paul Bukuluki 2016. National GBV Diagnostic. World Bank and MGLSD Report
[65] World Bank. (2023). Net official development assistance and official aid received (current US$, millions) for Uganda, 1960-2022. World Bank Data. Retrieved from https://data.worldbank.org

CHAPTER 3: UNFPA RESPONSE AND PROGRAMME STRATEGIES

3.1 United Nations and UNFPA Strategic Response

The United Nations Country Team (UNCT) in Uganda, in partnership with the Government of Uganda, aligned its efforts with national development priorities through the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 [66]. This framework, developed collaboratively with the government, supports Uganda's Vision 2040 and the Sustainable Development Goals (SDGs), focusing on transformative governance, shared prosperity, and human well-being. Effective coordination among UN agencies, including UNFPA, WHO, UNICEF, and UNAIDS, under initiatives like '2gether4SRHR' and the Joint Programme on Adolescents and Youth, has enhanced resource sharing, policy alignment, and integrated service delivery.

3.2 UNFPA Response through the Country Programme

3.2.1 The 8th Country Programme (2016-2020) Goals and Achievements

The 8th Country Programme (2016-2020) laid the foundation for these efforts by focusing on four strategic outcomes. It aimed to increase the availability and use of integrated SRH services, including family planning, maternal health, and HIV, ensuring these services were gender-responsive and met human rights standards for quality and equity. Additionally, it prioritized the needs of adolescents, particularly young girls, in national development policies, emphasizing comprehensive sexuality education and SRH services. The programme also advanced gender equality and the empowerment of women and girls, ensuring reproductive rights for the most vulnerable populations. Lastly, it strengthened national policies and international development agendas by integrating evidence-based analysis on population dynamics and their links to sustainable development, SRH, HIV, and gender equality. These initiatives set the groundwork for the strategic directions pursued in the 9th Country Programme.

3.2.2 The 9th Country Programme Strategy and Goals (2021-2025)

The 9th Country Programme (2021-2025) aligns with Uganda's Vision 2040, NDPIII, and the UNSDCF, addressing critical demographic and developmental challenges with a $95.3 million budget. Its four key outcome areas include Sexual and Reproductive Health (SRH), Gender Equality and Women's Empowerment, Population Dynamics, and Programme Coordination and Assistance.

Sexual and Reproductive Health (SRH): The programme aims to strengthen Uganda's health systems to provide universal access to integrated SRH/HIV/GBV services, including family planning, maternal health, and GBV prevention. By improving supply chain systems, scaling up high-impact practices like community-based family planning, and enhancing health worker capacity, the programme addresses unmet needs and ensures consistent service delivery. It targets

[66] Uganda United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025

a 15% reduction in unmet family planning needs by 2025 and focuses on improving maternal and neonatal care through data-driven decision-making and capacity building.

Gender Equality and Women's Empowerment: This component promotes women's and girls' informed decisions on sexual and reproductive health while addressing GBV and harmful practices. Interventions include community campaigns to shift harmful gender norms, establishing safe spaces for GBV survivors, and integrating GBV services into health facilities. Multi-sectoral coordination with justice, education, and health sectors enhances prevention and response mechanisms, empowering women and promoting economic participation.

Population Dynamics: The programme builds Uganda's capacity to utilise population data for evidence-based planning. By supporting surveys, censuses, and administrative data activities, it integrates population dynamics into policies at both national and local levels. Training for district planners and fostering dialogue with national authorities ensure alignment with Vision 2040 and NDPIII, promoting sustainable development and human capital advancement. The 9th CP's holistic approach ensures its contributions to Uganda's socio-economic growth, gender equality, and sustainable health outcomes.

3.2.3 Appraisal of the Theory of Change for the 9th Country Programme Evaluation

The Theory of Change (ToC) for the 9th CP was critically appraised and refined through a multi-stakeholder analysis guided by the principles of the UNFPA Evaluation Handbook (2024)[67]. The appraisal validated the ToC's alignment with national development goals, including Uganda's Vision 2040 and SDG commitments, particularly in the areas of SRHR, gender equality, and population dynamics. Strategic assumptions and risks were also examined and refined to ensure the ToC's resilience and feasibility in addressing key development challenges.

Key Outcomes of the Appraisal

- The ToC demonstrated a robust design, articulating comprehensive interventions and measurable outcomes to address key development challenges effectively.
- Strengths included the integration of multi-sectoral approaches, alignment with national and international priorities, and a strong focus on inclusivity and sustainability.
- Critical risks and assumptions were identified, highlighting the need for their explicit incorporation into the reconstructed ToC to enhance feasibility and resilience.

The reconstructed ToC reflecting these considerations is provided in **Annexure 8**. It incorporates a more dynamic approach to addressing evolving challenges while leveraging opportunities for sustained impact. This process underscores UNFPA's commitment to fostering resilience, inclusivity, and coherence in its programming for Uganda.

[67] UNFPA Independent Evaluation Office (2024). Evaluation Handbook. 2024 Edition.

Table 7. Risks and Assumptions Identified During the Theory of Change Appraisal

No	Category	Description
Risks		
1.	Government Commitment	Political shifts or reduced prioritisation of SRHR, gender equality, or population goals could undermine programme sustainability.
2.	Donor Support	Reduced financial contributions from international and bilateral donors may create funding gaps for key interventions.
3.	Cultural Resistance	Persistent social and gender norms may delay or obstruct the uptake of SRHR services and gender equality initiatives.
4.	Financial Constraints	Inadequate budget allocations at the national and sub-national levels may limit programme implementation, particularly in underserved regions.
5.	External Shocks	Health crises like COVID-19 or natural disasters could disrupt programme implementation and service delivery.
6.	Capacity Gaps	Local institutions may face challenges in sustaining programme outcomes due to limited technical, financial, or human resources.
Assumptions		
1.	Government Commitment	National and sub-national governments will maintain alignment with and commitment to SRHR, gender equality, and population goals.
2.	Donor Support	Financial and technical support from donors will remain consistent throughout the programme lifecycle.
3.	Stakeholder Collaboration	Implementing partners, civil society, and other stakeholders will actively participate in programme implementation and alignment.
4.	Advocacy Effectiveness	Advocacy efforts will effectively counter cultural resistance and promote positive social and gender norm changes.
5.	Service Demand	Communities, including marginalised populations, will recognise the value of and demand SRHR, GBV, and related services.
6.	Institutional Readiness	National and local institutions will successfully integrate and sustain programme activities within existing frameworks.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter provides a triangulated analysis of the 9th CP integrating data from both primary and secondary sources. The primary data includes perspectives gathered through interviews and focus group discussions with a broad spectrum of stakeholders, encompassing the 9th CP beneficiaries, UNFPA Country Office (CO) staff, implementing partners (IPs), development partners, and representatives of marginalised groups, such as persons with disabilities (PWDs), adolescents, refugees, and indigenous communities. Additionally, the analysis draws on insights from duty bearers, including government officials, civil society organisations (CSOs), faith-based organisations (FBOs), cultural leaders, and private sector actors. These stakeholders, representing rights holders and duty bearers, provided critical insights into the programme's reach, relevance, and coherence. Secondary data sources complement this analysis, including comprehensive reviews of UNFPA programme documents such as strategic plans, monitoring and annual reports, implementation frameworks, previous evaluation reports, and stakeholder maps. This holistic approach, with a focus on inclusivity and collaboration, ensures a robust understanding of the linkages among stakeholders and the impact of the 9th CP interventions on Uganda's diverse population, particularly those in underserved and marginalised communities.

4.2 Relevance of the 9th Country Programme

The evaluation of the relevance of the 9th CP was guided by two key evaluation questions. Evaluation Question 1 **(EQ1)** examined the extent to which the programme design and Theory of Change aligned with national policies, strategies, and priorities, UNFPA's strategic objectives, and international frameworks such as the ICPD Programme of Action and the Sustainable Development Goals (SDGs). Evaluation Question 2 **(EQ2)** assessed the incorporation of cross-cutting issues and accelerators to address the diverse needs of marginalised populations, including persons with disabilities (PWDs), youth, refugees, and other vulnerable groups.

Summary

The 9th CP aligned closely with Uganda's development policies, SDGs, and ICPD Programme of Action, addressing SRHR and GBV needs among vulnerable communities. It contributes to the National Development Plan, Vision 2040, and HSSP by meeting health and social needs, especially in underserved areas. Feedback highlights the need for adaptation to address community-specific challenges, including service access disparities, cultural considerations, and resource gaps for marginalised groups. While well-aligned with Uganda's frameworks, ongoing evaluation and adjustments will enhance the 9th CP's impact and sustainability in advancing health and equity goals.

4.2.1 Relevance to National Government and UNFPA Policies

Findings showed strong alignment between the 9th CP and Uganda's national priorities, including Vision 2040, NDP III, and sectoral frameworks such as the Reproductive Health Commodity Security Strategic Plan. The 9th CP effectively addressed barriers to SRHR and GBV prevention, contributing to socio-economic transformation by reducing maternal mortality, expanding access to family planning, and supporting youth empowerment. Its integration with Uganda's data systems, such as the UDHS and refugee statistics, strengthened evidence-based planning and resource allocation. The 9th CP also aligned with international commitments, including the ICPD25 Nairobi Summit and SDGs 3, 5, and 10, emphasising SRHR, gender equality, and reduced inequalities. At the sub-national level, the 9th CP supported health systems in underserved and refugee-hosting regions, aligning with District Development Plans and frameworks such as the Comprehensive Refugee Response Framework (CRRF). Targeted interventions addressed maternal mortality, adolescent fertility, and SRHR service gaps, fostering social cohesion and equitable access for refugees and host communities.

4.2.2 Adaptation and innovation During COVID-19

The 9th CP demonstrated effective adaptation to the COVID-19 pandemic by introducing mobile health clinics and telehealth services, ensuring the uninterrupted delivery of SRHR and GBV services. These innovative measures underscored the programme's relevance to Uganda's shifting health priorities and highlighted its resilience in responding to emerging challenges.

4.2.3 Alignment to Needs of Target Groups

The 9th CP effectively responded to the needs of marginalised populations, including women, adolescents, refugees, persons with disabilities (PWDs), and indigenous communities. For PWDs, the programme improved access to SRHR services through community outreach and partnerships with organisations of persons with disabilities (OPDs), though gaps in healthcare worker training and the availability of assistive technologies persisted. Peer-led SRHR education and youth-friendly health corners successfully reduced stigma and improved contraceptive uptake among adolescents and youth. In indigenous communities, mobile clinics mitigated the challenges of geographic isolation, although the adoption of culturally sensitive approaches remained essential. For refugees, the 9th CP enhanced SRHR and GBV services through targeted community outreach, resource distribution, and integration into government frameworks. However, language barriers underscored the need for culturally appropriate care and multilingual health workers. The refugee-focused interventions aligned with the Comprehensive Refugee Response Framework (CRRF), ensuring equitable health access and bolstering Uganda's humanitarian response.

4.2.4 Contrasting and Supporting Perspectives

Evaluations of related programmes, including ANSWER and WAY, underscored the relevance of the 9th CP. The ANSWER programme highlighted significant reductions in maternal mortality and increased contraceptive uptake in underserved regions, while the WAY programme demonstrated the effectiveness of youth-focused SRHR education initiatives. However, challenges in implementing consistent disability-inclusive programming were evident, particularly regarding gaps in health worker training and the availability of assistive technologies. The 9th CP adopted a comprehensive approach to addressing critical SRHR and GBV needs, empowering vulnerable populations and aligning with Uganda's national priorities and global commitments. Persistent issues, such as adolescent fertility and disparities in healthcare access, emphasised the need for sustained efforts to ensure inclusivity and equitable healthcare delivery.

4.3 Coherence with other Initiatives

The evaluation of the coherence of the 9th CP was guided by Evaluation Question 3 (**EQ3),** which sought to assess the extent to which interventions under the programme were interlinked, well-integrated, complementary, and synergistic to maximise collective impact.

Summary

The 9th CP's coherence with other initiatives has been largely effective, driven by strategic partnerships, regular coordination meetings, and alignment with national policies. These efforts have reduced duplication and optimised resource use, addressing SRHR, GBV, and youth empowerment needs. Joint programmes, such as JPGBV, highlight the potential for greater synergy and coordination. However, challenges remain, including cultural barriers, policy-based constraints, and the dilution of impact due to thinly spread interventions. While the 9th CP aligns with shifts to PBA, PBB, and PDM, a clearer strategy to fully integrate these approaches could enhance coherence and maximise programming and budgeting synergies.

4.3.1 Ensuring synergy and avoiding duplication with other interventions

Joint Ownership Among Participating UN Organizations: The 9th CP fostered strong collaborations with UN agencies such as UN Women, UNICEF, WHO, UNHCR, and UNAIDS, ensuring harmonization of approaches for SRHR and GBV initiatives across national and sub-national levels. Joint programmes, such as the Joint Programme on Gender-Based Violence (JPGBV) and the Spotlight Initiative, exemplified this collaboration. For instance, in regions like West Nile, annual joint workplans streamlined efforts, minimized duplication, and optimized resource use. Similarly, UNFPA partnered with UN Women on the Access to Justice project, improving GBV response mechanisms while building the capacity of justice institutions. Private sector collaborations, such as with MTN, supported health infrastructure and innovative SRHR solutions, showcasing the programme's ability to integrate multi-stakeholder efforts for sustained impact.

Advancing an Integrated Approach to SRHR at National and Sub-National Levels: UNFPA advanced integration of SRHR, HIV, and GBV services through capacity-building initiatives, joint coordination platforms, and policy dissemination efforts. Programmes such as the ANSWER and ADA leveraged partnerships to harmonize interventions, while sub-county-level coordination meetings clarified roles and optimized resource allocation. Tools like the 3W Partner Matrix (Who, What, Where) enhanced coherence, minimized duplication, and aligned activities across programmes. However, limited engagement with community-based organizations (CBOs) as implementing partners affected localized capacity building and coherence at the grassroots level.

Inter-Agency and Sector Working Meetings: Regular inter-agency meetings and sector working groups strengthened alignment of the 9th CP interventions with national strategies. Technical working groups, such as the National GBV Reference Group and HIV coordination platforms, facilitated the review and approval of policies like the Adolescent SRH booklets and School Health Policy. Multisectoral coordination meetings, such as those for Menstrual Health Management (MHM), ensured harmonized standards and streamlined service delivery. However, stakeholders

emphasized the need for consistent partner meetings and clearer coordination roles to enhance alignment and reduce overlap.

Coherence in Humanitarian Settings: UNFPA's leadership in GBV humanitarian working groups enhanced coherence in refugee-hosting regions, where SRHR and GBV services were integrated into emergency programming. Programmes like the WAY initiative supported both refugees and host communities, fostering social cohesion and aligning with Uganda's Comprehensive Refugee Response Plan (CRRF). Activities included the recruitment of midwives, provision of dignity kits, and establishment of referral systems for maternal health services. These efforts ensured alignment with national and international frameworks, though logistical challenges in some refugee settlements limited full coverage.

Aligning with the Shift to Programme-Based Approaches (PBA) and the Parish Development Model (PDM): The transition to Programme-Based Budgeting (PBB) presented opportunities for CP9 to align its interventions with national priorities. However, gaps in coordination and capacity within the PBA and PBB frameworks limited full integration. Similarly, the Parish Development Model (PDM) offered potential synergies by promoting localized decision-making, but evidence of CP9's engagement with PDM structures remained limited. Strengthened collaboration with the PDM secretariat could enhance coherence at sub-county and community levels.

Spreading Thinly vs. Comprehensive Coverage: A key challenge identified was the programme's tendency to spread thinly across multiple districts without achieving comprehensive coverage. Stakeholders noted that limited geographic reach diluted impact at the community and household levels. Greater focus on micro-level programming with full district coverage was recommended to maximize results and ensure equitable access to SRHR and GBV services.

4.3.2 Identification of Conflicting Policies or Strategies

Although the 9th CP generally aligned well with national policies to promote coherence, several socio-cultural and political challenges hindered the acceptance and implementation of SRHR, family planning, and GBV prevention and response initiatives. Deeply entrenched cultural beliefs and resistance to family planning emerged as significant barriers, highlighting the need for targeted sensitisation campaigns and enhanced engagement with cultural leaders to bridge gaps between CP9 objectives and local expectations. Within refugee communities, harmful social and gender norms created cultural scepticism that conflicted with family planning goals, necessitating sustained advocacy and collaboration with both refugee and host community leaders to address misconceptions and improve programme acceptance. At the national level, evolving social and political dynamics further complicated SRHR programming. Resistance to comprehensive sexuality education and recent political statements opposing family planning have created additional obstacles to achieving Uganda's demographic objectives. Religious and cultural leaders also continued to influence public perceptions, often framing SRHR services in ways that conflict with CP9 goals. UNFPA responded to these challenges by partnering with the National Population Council (NPC) to promote evidence-based advocacy and facilitate dialogue with policymakers, religious leaders, and cultural institutions. This collaborative approach aimed to address resistance and ensure family planning and SRHR remained integral to Uganda's broader developmental agenda. Restrictive policies, such as Uganda's Anti-Homosexuality Bill, further constrained the inclusivity of SRHR services, particularly for LGBTQI+ persons. To mitigate these impacts, UNFPA collaborated with UNAIDS to adapt service delivery strategies, uphold human rights

standards, and continue advancing health objectives. This multi-faceted response underscored CP9's commitment to navigating complex socio-political landscapes to promote equitable access to SRHR and GBV services.

4.4 Effectiveness of approaches, programmes and interventions

The evaluation of the effectiveness of the 9th CP focused on assessing whether the programme's outputs and outcomes were achieved in alignment with its objectives, results, and set targets, including variations across different groups. Specifically, Evaluation Question 4 (**EQ4)** examined the extent to which the programme's strategies contributed to outcomes such as increased access to integrated SRH services, youth empowerment, gender equality, and the use of population data for evidence-based policymaking. It also sought to identify which programme models were most effective and for whom. Evaluation Question 5 (**EQ5)** evaluated the programme's ability to deliver results for the most vulnerable and marginalised populations, including adolescents, persons with disabilities, refugees, key populations, and those living in underserved and remote areas. Evaluation Question 6 (**EQ6)** assessed the effectiveness of investments in innovations and their role in achieving programme results. This included evaluating how innovations were developed, tested, documented, disseminated, and scaled up, as well as determining whether these approaches could be expanded for broader impact. Finally, Evaluation Question 7 (**EQ7)** explored key lessons learned and best practices that could enhance the knowledge base of UNFPA and its partners. These insights aim to inform future programming and policy development, accelerating progress and impact in achieving national and global development goals.

Summary

The triangulated findings underscore the 9th CP's effectiveness in addressing Uganda's SRHR, GBV, and adolescent health goals. Through strategic partnerships, integrated program delivery, and an evidence-based approach to population data, CP9 has made significant strides in reaching high-need populations and contributing to improved maternal and adolescent health outcomes. However, logistical challenges and gaps in program reach highlight the need for additional support and inclusivity measures to ensure that the 9th CP's interventions comprehensively address the needs of all targeted communities across Uganda. By leveraging cross-cutting lessons and adapting successful approaches to district-specific contexts, the 9th CP can enhance its effectiveness and sustain its impact on Uganda's health and gender equality goals.

Sexual and Reproductive Health and Rights (SRHR)

4.4.1 Contribution to the achievement of the outcomes of the country programme

The Intervention and Results Logic for Sexual Reproductive Health and Rights

The strategic outcome for SRHR aimed to ensure that every woman, adolescent, and youth, particularly those furthest behind, could access integrated sexual and reproductive health services and exercise reproductive rights free of coercion, discrimination, and violence. This was achieved through two key outputs: (1) strengthening the capacity of national healthcare facilities and providers to deliver universal, high-quality SRH/GBV/HIV services, especially to vulnerable groups, and (2) empowering women and young people, including those in hard-to-reach areas, to make informed choices and access integrated SRHR services. UNFPA's support led to several notable achievements, including increased availability and utilization of contraceptives, resulting in reduced unmet need for family planning and lower fertility rates; improved capacity of health

facilities in target districts to provide emergency obstetric and newborn care, as well as integrated SRH/HIV/GBV services, enhancing maternal and infant outcomes; expanded policies and regulations promoting gender equality and equitable access to SRHR; broader coverage of high-risk populations with integrated SRH services; empowerment of marginalized adolescent girls through life skills programmes; and increased surgical repairs for women and girls with obstetric fistula.

Evaluation of the Results and Intervention Logic for SRH Component:

Output 1: National health care facilities and providers have increased capacity to provide universal access to and coverage of high quality integrated SRH/GBV/HIV services, particularly for the most vulnerable women and young people, including in humanitarian settings.

Under output 1, the evaluation assessed performance of 4 indicators: 2 out of 4 (50%) were achieved; 1 (25%) indicator was likely to be achieved and 1 (25%) was unlikely to be achieved. (Table 8).

Table 8. Progress of SRH provision indicators (output 1)

Programme	Total indicators	Achieved: ≥100%	Most likely to be achieved: 70-99%	Likely to be achieved: 25-69%	Unlikely to be achieved: <25%	No data reported
SRHR	4	2	0	1	1	0
Percentage	**100%**	**50%**	**0**	**25%**	**25%**	**0**

It is apparent that the outcome targets related to availability of contraceptives at the health facilities and policies, laws, strategies and regulations to promote gender equality and equitable access to integrated SRHR services were achieved. The target for enhancing the capacity of health facilities to provide integrated SRH/HIV/GBV services is likely to be achieved whereas that for strengthening the capacity of health facilities to provide emergency obstetrics and newborn care services is unlikely to be achieved. This is because emergency obstetric and newborn care requires heavy investment that is beyond the reach and mandate of UNFPA

Table 9. Output and outcome indicator targets for provision of SRHR services

No	Indicator description	Results	Baseline	2021	2022	2023	2024
1.1.1	Percent of primary service delivery points with no 'stock-out' of contraceptives in the last three months	Target		74.9%	76.2%	77.4%	78.7%
		Actual	73.6%	78.0%	78.0%	85.9%	85.9%
1.1.2	Percent of health facilities in target districts with capacity and readiness to provide emergency obstetrics and newborn care services	Target		20.2%	32.7%	45.1%	57.6%
		Actual	7.8%	7.8%	7.8%	12.0%	12.0%
1.1.3		Target		514	561	607	654

No	Indicator description	Results	Baseline	2021	2022	2023	2024
	Number of health facilities that meet at least 80% of the basic standards of SRH/HIV/GBV integration, with UNFPA support	Actual	467	467	467	525	*224
1.1.4	Number of policies, laws, strategies and regulations developed/reviewed to promote gender equality and equitable access to integrated SRHR services	Target		24	28	32	36
		Actual	20	24	30	42	62

* This was an estimate from 81 facilities in 7 districts representing the targeted 701 facilities across 40 districts.

It is important to note that when estimating the number of health facilities that meet at least 80% of the basic standards of SRH/HIV/GBV integration, only 81 health facilities from 7 districts where the evaluation was conducted were assessed and the findings were extrapolated to represent the targeted 701 health facilities. It is therefore possible that if all the health facilities in the UNFPA supported districts were assessed, the target could have been achieved.

Output 2: Women and young people, including those in hard-to-reach communities and those most at risk, are empowered to make informed choices, and utilize high quality, integrated, sexual and reproductive health and rights, information, and services.
Under output 2, the evaluation assessed performance of 5 indicators: 2 out of 5 (40.0%) indicators were achieved; 1 (20.0%) indicator did not have data reported; and 2 (40.0%) were most likely to be achieved (Table 10).

Table 10. Progress of SRH provision indicators (output 2)

Programme	Total indicators	Achieved: ≥100%	Most likely to be achieved: 70-99%	Likely to be achieved: 25-69%	Unlikely to be achieved: <25%	No data reported
SRHR	5	2	2	0	0	1
Percentage	**100%**	**40%**	**40%**	**0**	**0**	**20%**

The output targets related to most at-risk and priority populations reached with integrated SRH/HIV/GBV services through static and integrated community outreaches were overachieved. The output target for couple years of protection (CYP) and women and adolescent girls living with obstetric fistula who receive surgical repair are most likely to be achieved. There was no data for the output indicator for women of reproductive age-group who make their own decisions on SRHR. UNFPA should therefore drop this indicator whose data is not available (Table 11).

Table 11. Output and outcome indicator targets for utilization of SRHR services

No	Indicator description	Results	Baseline	2021	2022	2023	2024
1.2.1	Number of CYP dispensed with support from UNFPA	Target		5,441,487	5,833,673	6,225,858	6,618,044
		Actual	5,049,302	4,778,607	5,149,710	6,600,851	6,472,479

No	Indicator description	Results	Baseline	2021	2022	2023	2024
1.2.2	Percent of women (15-49yrs) in programme districts make own decisions on SRHR	Target		61.8%	65.1%	68.4%	71.7%
		Actual	58.5%	63.4%	no data	no data	no data
1.2.2b	No. of MARPS and Priority Populations reached with integrated SRH/HIV/GBV services through static and integrated community outreaches with UNFPA support (per year)	Target		50,000	150,000	250,000	350,000
		Actual		131,975	492,530	894,010	383,882
1.2.2c	No. of marginalized adolescent girls reached by life skills programmes that build their health, social, or economic assets with UNFPA support, during the CP9 (also linked to SP Outcome 2)	Target		21,440	34,304	56,168	56,168
		Actual		80,466	99,330	126,418	126,418
	No. of women and adolescent girls living with obstetric fistula who receive surgical repair (annually)	Target		2,000	1,500	1,500	1,500
		Actual		1,760	1,797	1,560	1,287

The theory of change for the SRHR component was well-designed, with a clear intervention logic. Output 1 focused on enhancing health care facilities' capacity to deliver universal, high-quality integrated SRH/GBV/HIV services, particularly for vulnerable women and youth, including in humanitarian settings. Output 2 aimed to empower women and youth, especially in hard-to-reach areas, to make informed choices and access integrated SRHR services. The strategic outcome and outputs were well-articulated, with clear linkages between interventions, outputs, and outcomes. Indicators were generally sufficient to measure progress, though one indicator, "Percent of women (15-49yrs) in programme districts make their own decisions on SRHR," lacked data and should be dropped. Performance assessment showed 44.4% of indicators over-achieved, 22.2% likely to be achieved, 11.1% most likely to be achieved, 11.1% unlikely to be achieved, and 11.1% lacking data.

Table 12. Progress of SRH provision indicators (outputs 1 and 2)

Programme	Total indicators	Achieved: ≥100%	Most likely to be achieved: 70-99%	Likely to be achieved: 25-69%	Unlikely to be achieved: <25%	No data reported
SRHR-Output 1	4	2	0	1	1	0
SRHR-Output 2	5	2	2	0	0	1

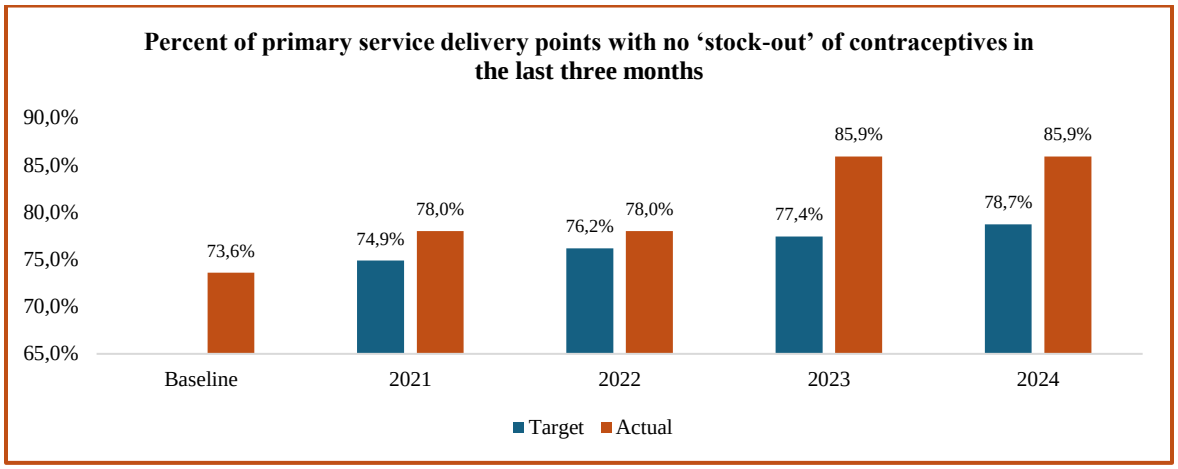
Total	**9**	**4**	**2**	**1**	**1**	**1**
Percentage	**100%**	**44.4%**	**22.2%**	**11.1%**	**11.1%**	**11.1%**

Achievement of SRH outcomes

a) Increased access to and utilization of family planning services.

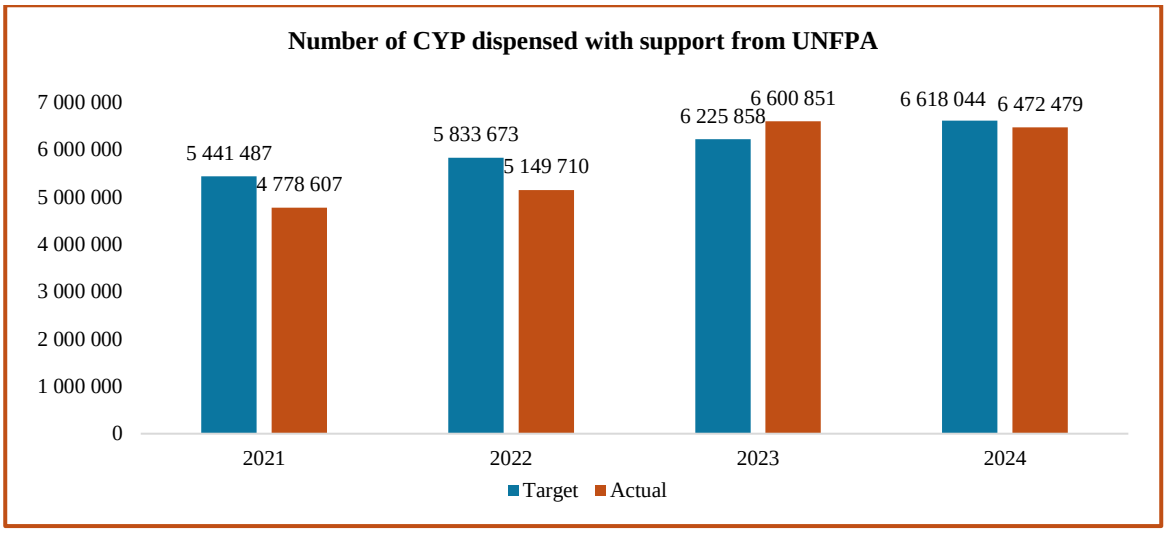
Key interventions to enhance the demand for and supply of modern contraceptives included community-based distribution, initiatives to boost service uptake, and technical support for forecasting, procurement, and supply chain management at national and district levels. Comprehensive condom programming expanded SRH/GBV/HIV coverage for key populations, and strengthened integration of services at policy, systems, and service delivery levels further improved capacity. Increased government financial support for SRH and bolstered human resource capacity expanded the reach of quality family planning services. These efforts significantly reduced contraceptive stock-outs, with service delivery points reporting no stock-outs rising from 73.6% in 2020 to 85.9% in 2024 (Figure 6).

Figure 6. Primary service delivery points with no 'stock-out' of contraceptives



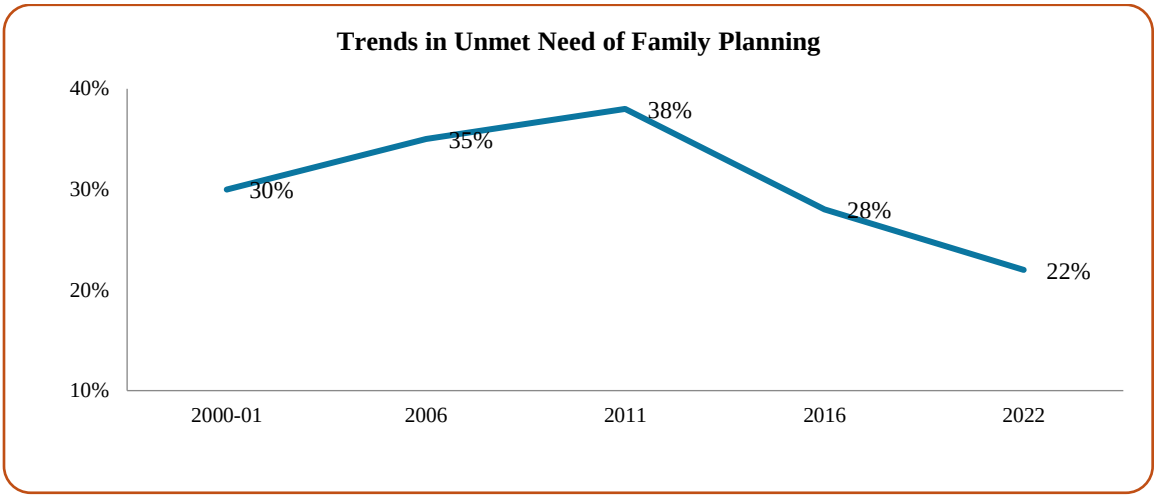
The introduction of an alternative distribution system for family planning commodities, which engaged the private sector, significantly improved the availability of commodities, particularly in rural and hard-to-reach areas. UNFPA's investments in demand-creation activities—such as mobilizing community champions, leveraging community resource persons, conducting community-based distribution through outreaches, and implementing social marketing and franchising strategies—further expanded access to family planning commodities in these underserved regions. This approach led to increased utilization of family planning services, as evidenced by the rise in Couple-Years of Protection (CYP) dispensed with UNFPA support, from 6,225,858 in 2023 to 6,472,479 in 2024 (Figure 7).

Figure 7. Number of CYP dispensed with support from UNFPA.



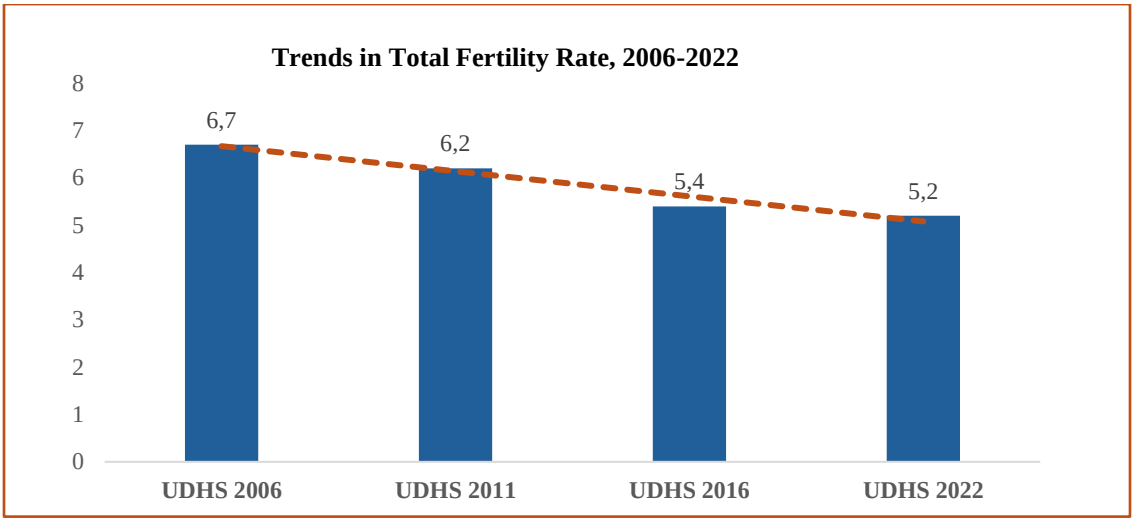
According to the UDHS 2022, a progressive decline in the unmet need for family planning from 2011 to 2022 has been registered (Figure 8).

Figure 8. Trends in Unmet Need of Family Planning: UDHS 2022



In the same vein, a progressive decline in the total fertility rate (TFR) has been observed over the years, from 6.7 in 2006 to 5.2% in 2022 (Figure 9).

Figure 9. Trends in Total Fertility Rate: UDHS 2022



The ANSWER evaluation, employing a robust Difference-in-Difference (DiD) analysis, demonstrated significant programme impacts, including a 27% increase in modern contraceptive use among adolescents and young women and reductions in maternal mortality in targeted regions. The integration of youth-friendly services, such as peer-led education and youth corners, effectively reduced stigma and improved awareness of family planning options. Additionally, the programme's combination of SRHR and GBV services, particularly in refugee-hosting districts, highlighted the value of integrated healthcare and psychosocial support. Beneficiaries from the Acholi and West Nile sub-regions praised the programme for reducing GBV incidents through community dialogue, gender norm transformation, and enhanced access to healthcare and legal services. These efforts, supported by demand creation and training for justice, health, and social welfare workers, align closely with CP9's objectives of fostering gender equity and reducing health disparities among vulnerable groups.

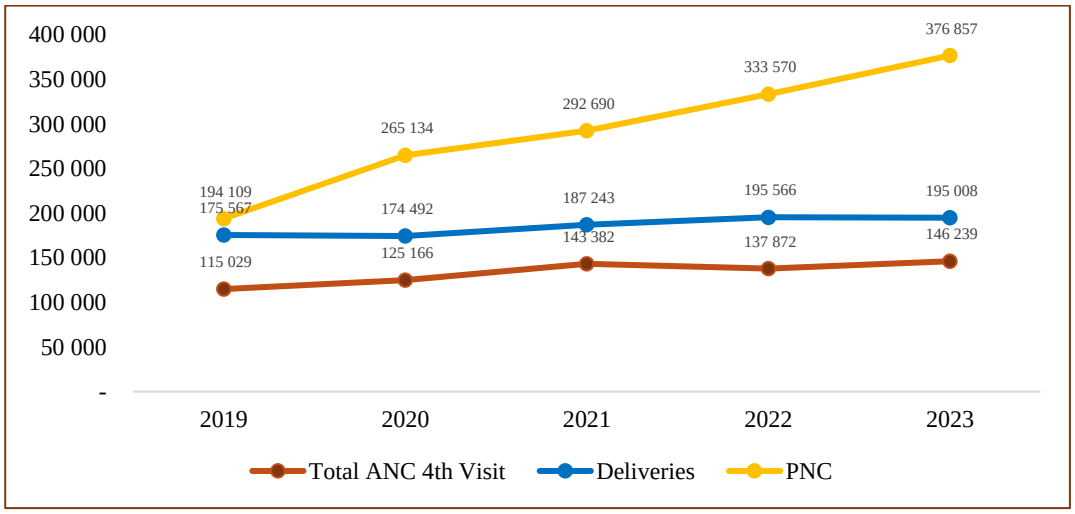
> "I am one of the married men in the community and also one of them handling and teaching people of sexual abuse, GBV and Domestic Violence in families or groups. Our priorities as a group or family are stopping early marriage. Taking the children to the hospital when he or she is sick and monitoring children's health. In terms of conflicts, talking to families involved in domestic violence that can't agree on what the community or family says by talking to all of them such that they can talk to each other so that they stay together", (FGD with Adult Men _ Moroto District)
>
> "All the groups have been reached in that people have been taught, no one is left behind, girls are now playing songs of free domestic violence, performing drama, this program has helped by bringing people together to talk and this has touched other people and this should continue so that all people are reached if there those not yet in the program", (FGD with Adult Women – Moroto District)

b) Emergency obstetric and newborn care (EmONC)

Although the indicator target for "percent of health facilities in target districts with capacity and readiness to provide emergency obstetrics and newborn care services" is unlikely to be achieved, there was an improvement from 7.8% in 2020 to 12.0% in 2024. Several strategic interventions for enhancing the district capacity to deliver comprehensive high quality maternal and newborn health services were supported by UNFPA. These included provision of basic amenities and infrastructure to support EmONC services, post abortion care, and obstetric fistula management; training and support supervision of health workers in EmONC services and supporting functionalization of maternal and perinatal death surveillance response (MPDRS) committees at

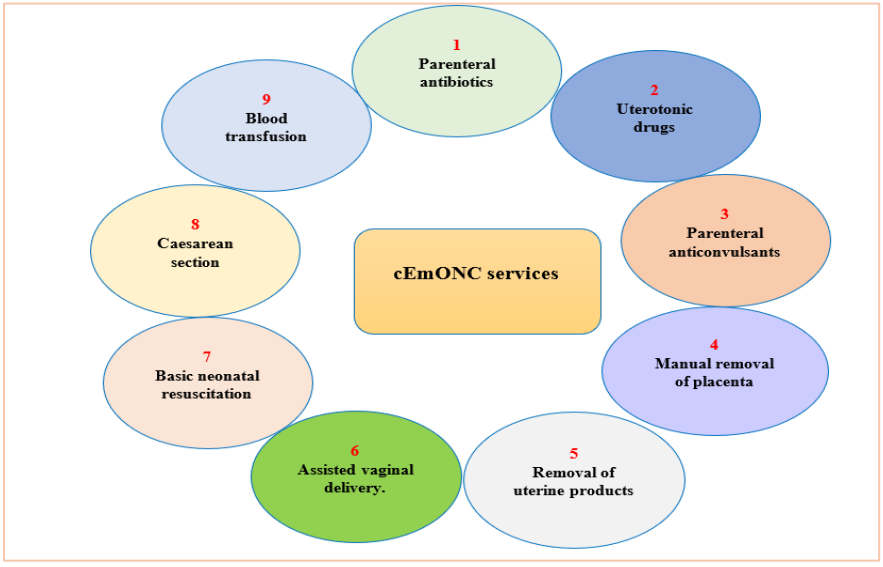
community, health facility and district level, among others. Analysis of National HMIS data from the UNFPA supported districts showed that between 2019 and 2023, there was an increase in the number of ANC4 visits from 115,029 to 146,236, health facility deliveries increased from 175,567 to 195,008 and PNC visits increased from 194,109 to 376,857 (Figure 10). The UNFPA interventions could have contributed to the observed improvements.

Figure 10. Utilization of SRHR services at UNFPA supported health facilities (HMIS data)



The delivery of quality emergency obstetrics and newborn care (EmONC) services is inherently complex, requiring a robust supply chain to ensure the continuous availability of essential medicines and health supplies, as well as a skilled, sufficient, and motivated workforce to deliver these services. Adequate financing is critical to sustain both the skilled workforce and the provision of necessary medicines and commodities. Comprehensive emergency obstetric and newborn care (CEmONC) encompasses key signal functions such as Caesarean section, blood transfusion, basic neonatal resuscitation, uterotonic drugs, parenteral antibiotics, parenteral anticonvulsants, assisted vaginal delivery, manual removal of the placenta, and removal of uterine products (Figure 11).

Figure 11. CEmONC signal functions



CEmONC services are typically delivered at hospitals and health center IVs. Interviews held with District Health Officers revealed concerns about gaps in the supply chain system, particularly with the national warehouses, leading to stockouts of essential medical supplies:

> "I have always complained about the inefficiencies of national medical stores. There are always stock outs, they delay delivering and even when they deliver, they don't deliver according to the orders we make. We draw the delivery schedule, but they don't follow them. In addition, they deliver medicines which are in inadequate quantities, less than what we ordered for. We then have to deal with the discrepancies which we have to follow up" (KII with HealthCare Worker)

In addition, the absence of key staff such as medical officers and anaesthetists at some hospitals and HC IV facilities affects the provision of CEmNOC services, particularly, caesarean sections. Besides, according to the interviews held with the DHOs, the numbers of other critical cadres for CEmNOC service delivery such as midwives and nursing officers were insufficient and do not cope with the community demand:

> "We are operating on a very old structure which needs to be revised. When you look at that old structure, a HC IV is supposed to have 2 medical officers only. That means that if one medical officer is a manager, it leaves the other to do service delivery and its overwhelming for one medical officer to attend to out-patients, perform surgery and any other related clinical work, especially at very busy HC IV facilities" (KII with HealthCare Worker)

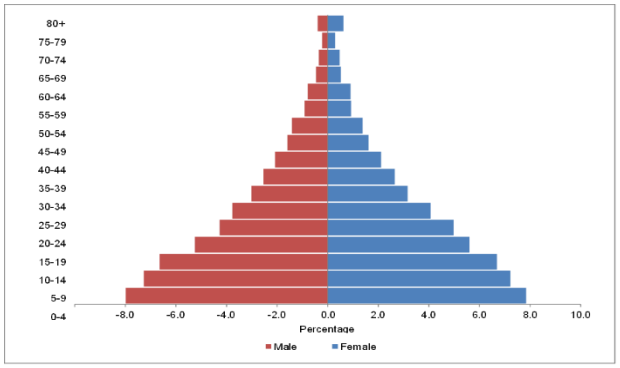
Strengthening logistics and supply chain management systems at all levels is crucial to addressing stockouts of essential medicines and commodities. Efforts should focus on increasing the health workforce capacity, both in numbers and skills, to provide quality CEmONC services. The Government should raise the national health sector budget, particularly for essential medicines, supplies, and equipment, while UNFPA could supplement national supplies and support workforce skilling in supported districts. Addressing issues like late deliveries, order discrepancies, nearly expired drugs, and delayed emergency responses requires training health workers on accurate and timely order processes, alongside improved monitoring and delivery systems by the National Medical Stores to enhance efficiency and reliability.

Adolescents and Youth (A&Y)

The Intervention and Results Logic for Adolescent and Youth Programming

Empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights.

Background: Uganda has the second youngest population globally, with 73.7% of its citizens aged 30 years and below, presenting challenges for its social, economic, and health systems, including high unemployment, strain on resources, and poor education outcomes. Health challenges linked to the youth bulge include early marriages, teenage pregnancies, mental health issues, substance abuse, and sexually transmitted infections like HIV. Among 15-24-year-olds, comprehensive knowledge of HIV



Uganda's Population Pyramid (UBOS 2024)

transmission is limited (56% of females and 54% of males), with 80% of new HIV infections in this group occurring among adolescent girls. Gender-based violence is pervasive, with 65% of defilement victims aged 15-17 years. Access to youth-friendly services is inadequate, with only 10% of health facilities offering such services, while barriers like cost, distance, stigma, and cultural opposition hinder contraceptive use (15-19 years: 9.4%; 20-24 years: 33.4%; 25-29 years: 37.7%). Uganda's teenage childbearing rate of 24% is among the highest in sub-Saharan Africa, driven by poverty, early marriages (34% of girls married by 18), and limited contraception access, exposing young girls to health risks.

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

The evaluation established that the strategies and interventions of the CP9 contributed to the empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights. The UNFPA strategies and interventions included but were not limited to strengthening the health system in the targeted districts to increase the availability, accessibility and quality of SRHR services; supporting adolescents in schools with sexuality education and implement relevant policies to improve SRHR, prevent and respond to GBV; supporting out of school adolescent girls and boys with age appropriate, correct and comprehensive SRHR information to enable increased utilization of services and empowering community members (host and refugees) to transform negative gender and social norms and thus reduce GBV, teenage pregnancy and child marriage while increasing acceptance for modern contraceptive methods and timely referral for post GBV health services. UNFPA supported the establishment of safe spaces and support groups for both in-school and out-of-school youth and adolescents. The safe and support spaces offer private and confidential meeting environment in which adolescents share or are equipped with correct knowledge on SRH including family planning and are often stocked with SRH products such as sanitary pads. In the same spaces adolescent girls are given basic training in financial literacy. Furthermore, in the safe spaces, adolescent boys are sensitized on menstruation and menstrual hygiene so that they could support female students and create a less stigmatizing environment at school. The safe spaces were also linked to health facilities and health workers. As such, through the safe spaces, adolescents had access to health professionals on SHRH information and services. Furthermore, over 400,000 marginalized adolescent girls were reached with life skills programmes that build their health, social, or economic assets. A significant number of young people were also reached with life skills education and socio-economic activities, through school health and sanitation club activities, YSLA groups/girls socio-economic empowerment platforms among others:

> "UNFPA availed funding which was used to reach out to the marginalized groups. As the department, there are two programs that we acquire resources from the government and that is UNICEF and UNFPA, but if UNFPA and UNICEF weren't there, we would not be able to reach the community members because the support that they offer to us and other organisations is the one that is making a difference in the community since also the other partners they support also support us. It is not only the UNFPA but also the other partners like BRAC and Action Aid that also supplement our work of which through them we are able to keep up as a district (KII with CDO)"
> `

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

Despite the interventions, teenage pregnancy and motherhood have remained a major health and social concern in Uganda. The 2022 UDHS indicated that 23.5% of women age 15-19 had initiated childbearing by the time of the survey, with 18.4% having already had a live birth, while 5.1% were pregnant with their first child. The percentage of women aged 15-19 who have given birth or are pregnant with their first child has stagnated between 2006 and 2022, ranging between 24% and 25%. In FGDs, some respondents observed that while instances of early and forced marriages appear to have decreased, the teenage pregnancy rate among girls has not changed. This was attributed to persistent poverty in some households, which leads some young girls to marry early or engage in early sexual activity to meet their material needs.

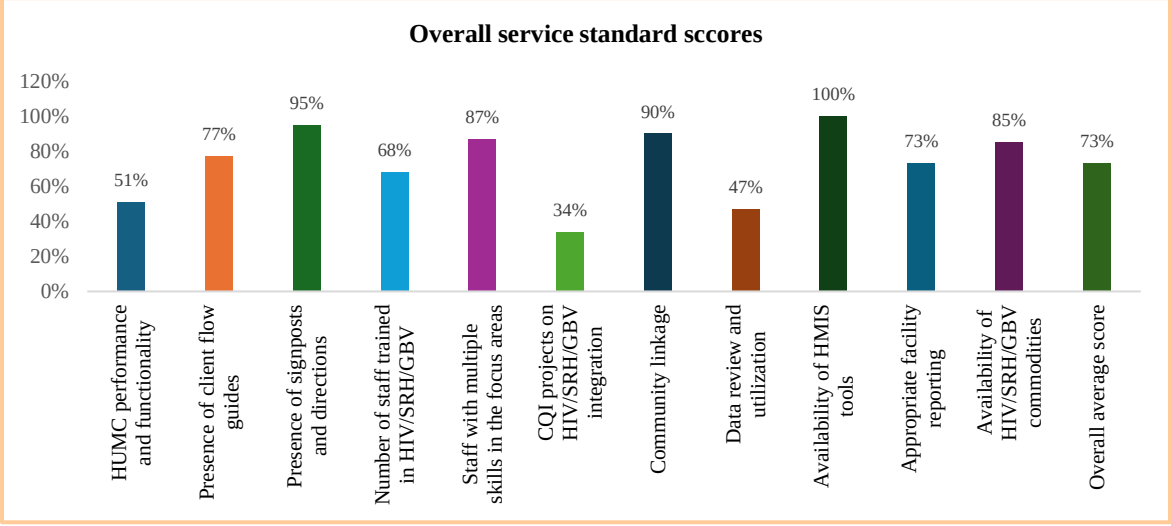
> "You also see an increase in young women taking up family planning and sending children to school, leading to reduction in teenage pregnancy and early marriages, but this is gradual", (KII with Gender Focal Person, Kyegegwa)

Interventions including economic strengthening, provision of youth friendly services and social and structural interventions for stigma reduction, violence prevention and peer support are required to tackle the high teenage pregnancy and motherhood.

Integration of HIV, SRH and GBV service delivery at the health facilities

The Ministry of Health adopted an integrated approach to delivering SRH, HIV, and GBV services to enhance maternal and neonatal outcomes and improve adolescent and youth health. In alignment with this strategy, the 9th GoU/UNFPA Country Programme supported district governments and health facilities to strengthen service integration. A health facility assessment in seven evaluation districts revealed that only 26 out of 81 facilities (32%) met at least 80% of the Ministry of Health's integration performance standards, translating to 224 facilities out of the programme's target of 701. Overall, service delivery standards across the districts were moderate (73%), with high performance in areas such as HMIS tools availability (100%), signage (95%), community linkages (90%), and availability of commodities (85%). Average performance was observed in client flow guides (77%), reporting (73%), and staff training (68%). However, significant gaps were noted in continuous quality improvement (CQI) projects (34%), data review and use (47%), and the functionality of Health Unit Management Committees (51%). (Figure 12).

Figure 12. Overall service standard scores



The overall service standard scores and the corresponding colour codes are showcased in Table 13.

Table 13. Overall service standard scores

No	Service standard	Scores (%) and colour code
1	HUMC performance and functionality	51%
2	Presence of client flow guides	77%
3	Presence of signposts and directions	95%
4	Number of staff trained/Oriented in SRH/HIV/GBV	68%
5	Staff with multiple skills in the focus areas	87%
6	CQI projects on SRH/HIV/GBV integration	34%
7	Community linkage	90%
8	Data review and utilization	47%
9	Availability of HMIS tools	100%
10	Appropriate facility reporting	73%
11	Availability of HIV/SRH/GBV commodities	85%
Overall average score		73%

The key service gaps identified include the lack of continuous quality improvement (CQI) projects for HIV/SRH/GBV integration, low levels of data review and use, and insufficient functionality of Health Unit Management Committees (HUMCs). To address these gaps, health facilities need support to institutionalise CQI practices for integrated HIV/SRH/GBV services. This involves training and mentoring health facility teams in CQI principles, establishing functional CQI committees, and implementing targeted CQI projects. Enhancing the functionality of HUMCs is critical for improving client satisfaction, community participation, and health service advocacy. This requires capacity building through training in Ministry of Health HUMC guidelines, periodic supervision, and facilitating quarterly meetings. Additionally, conducting accessibility audits is essential to ensure compliance with disability inclusion standards, focusing on ramps, communication aids, and assistive technologies. Documenting reasonable accommodation measures, such as sign language interpreters and alternative formats for information, is necessary to promote inclusivity and effective service delivery for persons with disabilities (PWDs).

Gender Equality and Women's Empowerment (GEWE)

The Intervention and Results Logic for Gender Equality and Women Empowerment

Advancement of gender equality and the empowerment (GEWE) for all women and girls: The strategic outcome for GEWE was "every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence". GEWE had only one output namely: National, sub-national, and community capacities strengthened to prevent and respond to sexual and gender-based violence and other harmful practices, including female genital mutilation and child marriage in all settings. The strategic interventions included: (i) Advocacy for law reforms to align the national legal framework to international and continental instruments; (ii) support innovative approaches for gender-based violence case management, reporting, and knowledge generation; (iii) strengthen information management systems for gender based violence; (iv) Scaling up youth, women and community capacities and engagement to eliminate

discriminatory gender and sociocultural norms and all forms of violence and harmful practices; (v) support implementation of special courts to increase access to justice for women and girls; (vi) support the roll out of the male engagement strategy for the active involvement of men and boys to prevent and address gender-based violence and (vii) partnership and coordination for joint programming and improved coordination of GBV.

Evaluation of the theory of change for GEWE

The CPE team observed that there was a clear strategic linkage between the interventions and the outputs. The output and strategic actions generally contributed to the outcome, although the team noted that all the indicators were output-based (numbers) which do not measure geographical coverage.

Evaluation of the Results and Intervention Logic for GEWE

Achievements under GEWE

The evaluation assessed performance of 5 indicators: 5 out of 5 (100%) indicators were achieved; (Table 14).

Table 14. Progress of GEWE indicators

Programme	Total indicators	Achieved: ≥100%	Most likely to be achieved: 70-99%	Likely to be achieved: 25-69%	Unlikely to be achieved: <25%	No data reported
GEWE	5	5	0	0	0	0
Percentage	**100%**	**100%**	**0**	**0**	**0**	**0**

All the outputs for gender equality and women empowerment were achieved and surpassed in some cases (Table 15)

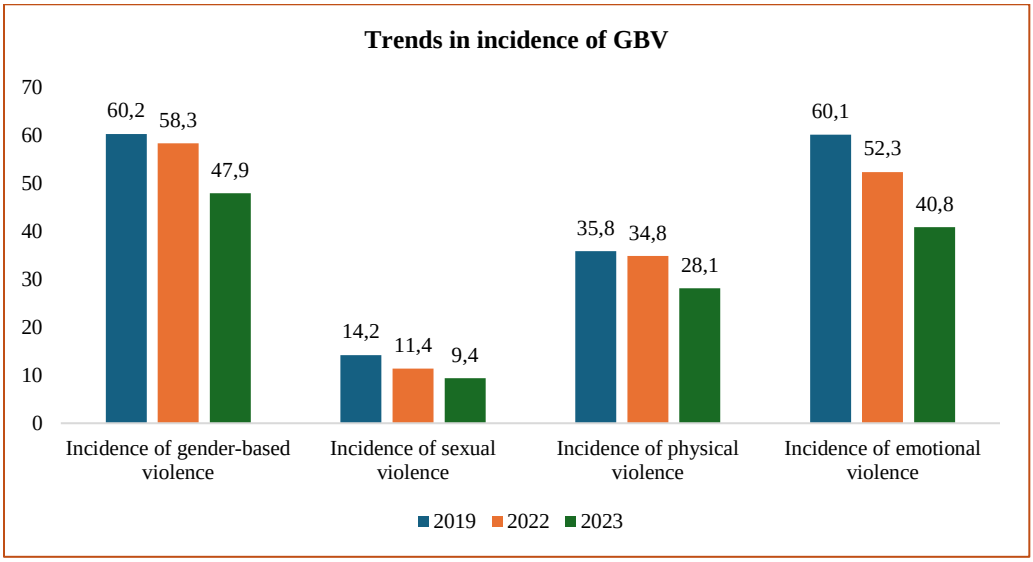
Table 15. Output and outcome indicator targets for GEWE

No	Indicator description	Results	Baseline	2021	2022	2023	2024
2.1.1	Number of districts that made public declarations to eliminate harmful practices, including child, early and forced marriage and female genital mutilation	Target		57	68	78	89
		Actual	46	42	61	76	97
2.1.2	Number of young people and women who receive, with support from UNFPA, prevention and/or protection services and care related with harmful practices,	Target		660,334	1,245,250	1,830,167	2,415,083
		Actual	75,417	694,371	1,684,593	2,526,890	2,810,319

No	Indicator description	Results	Baseline	2021	2022	2023	2024
	including child marriage and female genital mutilation disaggregated by type						
	2.1.1c Number of districts which can collect and disseminate disaggregated data on both the incidence and prevalence of gender-based violence, with support from UNFPA	Target		10	15	24	56
		Actual		25	25	32	56
	Number of functional multi-sectoral coordination structures for GBV/SRH/FGM/HP strengthened for prevention and response to GBV and SRHR at national district and sub county national level	Target		20	20	20	20
		Actual		20	25	25	25
	Number of Districts with Functional GBV Coordination mechanism - meeting at least every 6 months	Target		18	20	20	20
		Actual		18	22	22	22

There is evidence to show that the programme contributed to the outcome indicator for the CP9, that is "advancement of gender equality and the empowerment (GEWE) for all women and girls". **Reduction in GBV:** Evaluation of the Joint Programme on GBV (JPGBV) reported a reduction in incidence of GBV, including incidence of sexual violence, physical violence and emotional violence (Figure 13).

Figure 13. Trend in incidence of GBV

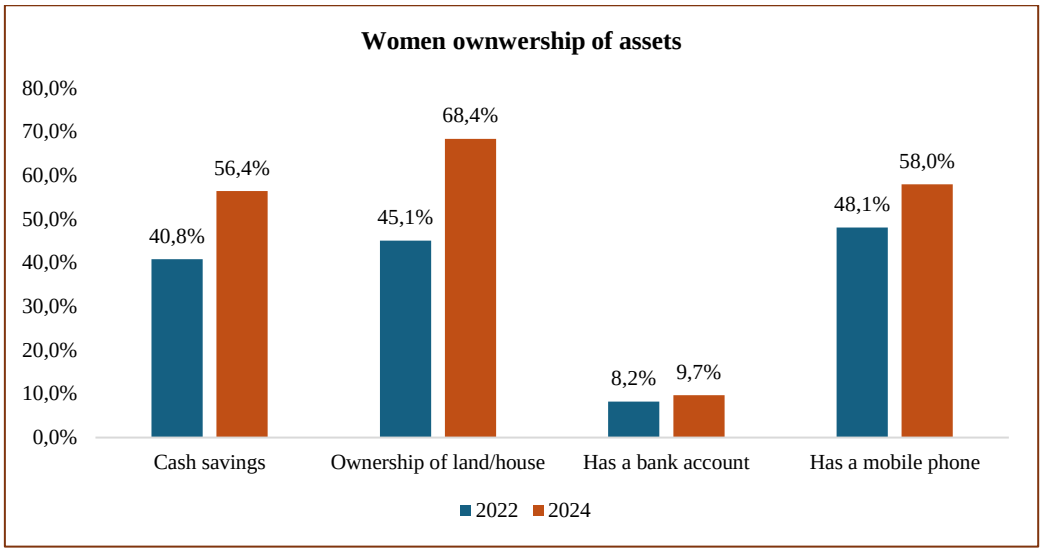


There was compelling evidence that UNFPA significantly contributed to reducing incidents of GBV through various community-based interventions (ELA, SASA!, clubs, media) and responsiveness and capacity of duty-bearers; and involvement of men and boys (male champions and MAGs). The reductions in GBV prevalence highlights the synergetic effects of these three pathways – transformative approach to social norms at community and attitudes at individual level; capacity strengthening of the duty-bears and engaging men and boys in GBV prevention and SRHR. These interventions included dialogues at the community level and home visits that promoted non-violent resolutions of family disputes including violence against children, shifting men's attitudes and behaviors away from violence, training community champions and volunteers, and enhancing the responsiveness of community leaders, the police and prosecutors. Some quotes allude to the findings on improved GBV indicators confirms the general perception in the community these:

> "We used to fight, currently we no longer fight; we have also learned to resolve disagreements and misunderstanding through sitting down to resolve them as we remind ourselves of the past. Even if there is poverty, we tolerate it among ourselves and encourage each other", (FGD with men 25 years and above).
>
> "There have been reduced cases of violence against women and girls, this is all with due credit because men and women know the outcomes of GBV and the role the law will play incase GBV or Violence Against Children cases are reported, this has enabled locals in our community to live in respectful, peace and harmony", (FGD with male SASA)

Improved women empowerment: In the same vein, there was evidence that women empowerment in the supported districts had improved. Overall, women empowerment in terms of having control over their own earnings and participation in decision making significantly improved. The percentage of women with control over their own earnings increased from 36.8% in 2022 to 79.1% in 2024, surpassing the programme endline target of 50.0%. Similarly, women participation in household decision making increased from 31.6% to 69.4%, surpassing the programme target of 50.0%. The percentage of women with cash savings increased from 40.8 % to 56.4% and the percentage of women who own land/house increased from 45.1% in 2022 to 68.4% in 2024 (Figure 14).

Figure 14. Women ownership of assets (household survey data for the JPGBV program evaluation)



Some of the beneficiary voices acknowledging the improved women empowerment with U NFPA support are illustrated below:

> "I got the training from NURI on agricultural after the training with the little I have learnt I know I can go and work with it and also sensitizing us on issues of monthly periods which I can use to train others and with the agriculture knowledge I can go and buy some seeds and plant them which will grow and help me when I don't have money. For me I was trained in agriculture, I didn't know how to plant crops like tomatoes now I have the knowledge they trained us on how to grow watermelon, I can grow and sale some and eat others", (FGD ADOLESCENT HOST MADI-OKOLLO)

Strengthening of policy, legal and accountability framework for GEWE: There was strong evidence that UNFPA has improved the legal and policy environment for GEWE in Uganda by contributing to the development, reviews and enactment of relevant policies and laws through advocacy, strategic partnerships and collaborations, technical and financial support to the relevant institutions that fast tracked the enactment of the laws. UNFPA contributed to improved implementation of GBV and SRHR laws, policies and standards by government institutions and civil society organizations (CSOs) at both the national and sub-national levels through financial support to enactment and implementation activities, training and mentorship of duty-bearers (justice actors, midwives, CDOs), financing of CSOs as Ips, dissemination and orientation of duty-bearers on policies and strategies, technical support supervisions, support the development of implementation guidelines, and advocacy.

Strengthened implementation of multi-sectoral interventions: UNFPA strengthened coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention were achieved. There was evidence of strengthened coordination, partnerships, and adaptive learning as noted by some of stakeholders. UNFPA provided both technical and financial support for coordination meetings, review meetings and supported development and functioning of communication platforms to enhanced coordination. National GBV Reference Group was re-vamped with expanded membership including office of the prime minister and justice actors, while the support to the quarterly HIV technical working group meetings that included technical staff from MoES as well as the MOH, MGLSD, UN agencies and CSOs reviewed and recommended for further endorsement of the Adolescent SRH booklets to be

distributed in all schools. Further, support was provided to review meetings held with 36 DLG stakeholders aimed at increasing awareness of the SE framework, SE operational guidelines and understanding the whole school approach in the delivery of SE in schools. Action plans were developed to rollout SE in schools.

Advancing integration of gender equality and human rights dimensions: The evaluation noted that UNFPA has been instrumental in integrating and advancing gender equality and the human rights of people. For example, in partnership with the Ministry of Gender, Labour and Social Development (MGLSD) and the National Planning Authority (NPA), the program contributed to the Midterm review of the third National Development Plan (NDP III) and facilitated the development of a position paper on the integration of gender and equity issues in the forthcoming NDP IV. During the commemoration of the 16 Days of Activism, the programme also made recommendations to enact the legislation that prevents GBV but also establish shelters and increase funding to address child marriage and teenage pregnancy. For example, through community platforms, a total of 10,657 vulnerable girls at risk of violence or GBV, accessed gender-transformative messages to reduce child and forced marriage and teenage pregnancy, GBV, gender inequality and increase economic opportunities. Among other achievements, the programme created a critical mass of community champions and activists to challenge the existing social norms, patriarchal norms, and promote gender equality and women's rights, engaged men to challenge existing patriarchal tendencies, conducted advocacy outreaches to prevent GBV, strengthened gender and human rights evidence generation through data collection and use, created awareness about human rights and gender equality through cultural communities. For example, through community cultural organizations, Cross-Cultural Foundation of Uganda (CCFU) supported young people in raising awareness about gender equality and human rights.

Streamlining collection and dissemination of GBV data: UNFPA supported development of a National GBV database for systematically and consistently collecting data to inform programming decisions for GBV. However, it was noted that the GBV database is not fully functional to support regular collection, analysis and dissemination of quality GBV data. Poor documentation and reporting across all the districts through the NGBVD and its limited downtime undermine the functionality of the database.

Population Dynamics (PD)

The Results and the Intervention Logic for PD Component

The strategic outcome for data and accountability is "Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development". This strategic outcome had one output namely "National population data systems strengthened to address inequalities, advance the commitments of the Programme of Action of the International Conference on Population and Development to inform rights-based policies, programmes and accountability". The output interventions focused on the following: (i) advocacy for integration of population dynamics in planning and formulation of policies and programmes; (ii) supporting data analytics to better understand and create linkages between sexual reproductive health, harmful practices including in humanitarian settings, and existing polices; (iii) Supporting the conduct of the population and housing census and other surveys; (iv) generation of disaggregated data and knowledge on humanitarian situation and refugee response, including ensuring integration of SRH indicators, and conducting in-depth analysis on vulnerabilities of young people and women during

emergencies such as COVID-19; (v) strengthening platforms for youth and women participation in policy, planning, monitoring, and accountability; (vi) supporting harmonization of the different routine data systems to use real time data as evidence for planning and decision making including capacity development in population data systems and (vii) working with other partners and stakeholders, leveraging the comparative advantage of the diverse actors to create and explore new opportunities for accelerated demographic transition, innovative financing mechanisms through South-South and triangular cooperation and other initiatives. The theory of change for this component was based on a comprehensive intervention logic. The strategic outcome and the outputs were coherent with measurable targets and achievements. However, similar to the observations made under GEWE, ¾ indicators under data and accountability are numeric based.

Evaluation of the Results and Intervention Logic for PD Component

Achievements under data and accountability

The evaluation assessed performance of 4 indicators for data and accountability: 3 out of 4 (75%) indicators were achieved; and 1 (25%) indicator was most likely to be achieved (Table 16).

Table 16. Progress of data and accountability indicators

Programme	Total indicators	Achieved: ≥100%	Most likely to be achieved: 70-99%	Likely to be achieved: 25-69%	Unlikely to be achieved: <25%	No data reported
Data and accountability	4	3	1	0	0	0
Percentage	**100%**	**75%**	**25%**	**0**	**0**	**0**

Most of the outputs and outcome targets related to data and accountability were successfully achieved. This includes establishing the targeted number of functional national and district data management systems, which enable the mapping and profiling of demographic and geographic disparities, disasters, and socioeconomic inequalities (Table 17).

Table 17. Output and outcome indicator targets for Data and accountability

No	Indicator description	Results	Baseline	2021	2022	2023	2024
3.1.1	Percent of public national and sub-national institutions whose development plans that integrate recommendations from national DD compliance framework	Target		40.0%	55.0%	70.0%	85.0%
		Actual	25.0%	72.6%	77.9%	77.9%	80.0%
3.1.2	Number of functional national and district data management systems that allow for mapping and profiling of demographic and geographic disparities, disasters and socioeconomic inequalities	Target		3	4	5	5
		Actual	2	4	5	5	5
3.1.3	Number of in-depth analytical reports on sexual and reproductive health and youth-related themes from census and	Target		8	10	12	14
		Actual	6	8	12	19	26

No	Indicator description	Results	Baseline	2021	2022	2023	2024
	survey data including in humanitarian settings						
3.1.4	Number of functional national and subnational platforms for young people and women to participate in policy development, programming, peace building and demand for account	Target		8	11	14	17
		Actual	5	5	46	64	64

The main achievement for the population and accountability component was work around the demographic dividends. Demographic dividend (DD) refers to the growth in an economy that results from a change in the age structure of a country's population. This is typically brought on by a decline in fertility and mortality rates. To receive a demographic dividend, a country must go through a demographic transition where it switches from a largely rural economy with high fertility and mortality rates to an urban society characterized by low fertility and mortality rates. In view of this, UNFPA through the National Planning Authority and National Population Council supported the modelling of the DD which showed that Uganda's demographic indicators and emerging economic opportunities can be turned into a sizeable DD that can propel the country to achieving the socioeconomic transformation envisaged in Vision 2040. Under the DD initiative, UNFPA supported the following activities:

- Engagement of district leaders to integrate FP/DD/SRH and GBV indicators and resources to reach the last mile and ensure nobody was left behind
- Harmonization and strengthening of GBV/SRH information management systems including HMIS, NGBVD, EMIS, JLOS data system, Child help line and the GBV helpline
- Conduct of the National Housing and Population Census 2024.
- Analyses of data from existing datasets such as UDHS 2022 and National Housing and Population Census 2024 to model the contribution of SRH to harnessing of the DD.

4.4.2 Reaching Intended Populations and Areas

The 9th CP effectively targeted high-priority groups, including adolescents, refugees, and women in rural and underserved areas, delivering significant impact through tailored SRHR education and family planning services. Refugee communities, such as Kyaka II, highlighted the programme's benefits for adolescents and young mothers but noted the need to expand its reach to boys and address specific community needs. District leadership affirmed the success of CP9's interventions but emphasized the necessity of additional logistical support to fully meet refugee population needs. While SRHR services were impactful, particularly in refugee settlements with limited health resources, funding constraints hindered consistent outreach to vulnerable groups like persons with disabilities (PWDs). Transportation and infrastructure challenges further restricted access in remote areas, underscoring the need for enhanced logistical resources. Health officials recommended strengthening GBV interventions by equipping shelters, tailoring support for PWDs, and implementing targeted awareness campaigns to address the unique GBV risks faced by women and girls with disabilities.

4.4.3 Cross-Cutting Lessons and Best Practices

Integration of SRHR, HIV, and GBV programmes under the 9th CP proved to be a best practice, enabling a holistic approach to maternal and adolescent health. The coordination of SRHR services with economic empowerment initiatives for adolescent girls created sustainable impacts beyond immediate health outcomes, particularly enhancing resilience among young mothers. Insights at

national and sub-national levels highlighted the effectiveness of this integrated approach, with collaboration between the 9th CP and local implementing partners addressing gender and health issues comprehensively. Integrated SRHR and GBV services effectively reduced risky behaviours, teenage pregnancies, and GBV incidents while fostering social change. However, district-specific challenges, such as cultural resistance to family planning, underscored the need for tailored strategies and ongoing community sensitisation to maximise the programme's impact.

4.5 Efficiency of Use of UNFPA Resources

The evaluation of the efficiency of the 9th CP, guided by Evaluation Question 8 (**EQ8)**, assessed how effectively human, financial, and administrative resources, as well as policies, tools, and delivery modalities, supported the timely delivery of services and achievement of programme outputs and outcomes. It focused on the programme's ability to maximise impact, ensure cost-effectiveness, and deliver results within the planned timeframe using available resources.

Summary

The 9th CP demonstrated a high level of efficiency in deploying resources to deliver impactful SRHR and GBV interventions across Uganda. Through strategic partnerships, adaptive budgeting, and localized approaches, CP9 maximized resource utilization to sustain critical services, particularly during emergencies like COVID-19. Innovations such as e-health platforms, remote trainings, and Village Health Team (VHT) integration enhanced cost-effectiveness and sustainability, while administrative collaborations with partners like UNICEF and WHO reduced operational costs. Despite strong budget implementation rates (90.4%–92.1%), challenges remain, including partial geographical coverage, duplication of efforts with other agencies, and logistical constraints in remote districts. Addressing these gaps through strengthened partnerships with local organisations, comprehensive district-level programming, and improved supply chain frameworks will further enhance the 9th CP's resource efficiency and long-term impact.

Use of UNFPA Resources

The 9th CP demonstrated a high level of efficiency in deploying resources to deliver impactful interventions across Uganda. The 9th CP CP9 leveraged strategic partnerships, adaptive budgeting, and localized approaches to maximize resource utilization and sustain integrated SRHR and GBV services, ensuring continuity for vulnerable populations. Despite commendable efficiency strategies, challenges remain in partnerships, geographical coverage, and programme integration, highlighting the need for further refinements to enhance cost-effectiveness and programmatic impact.

Funding Efficiency

The 9th CP demonstrated effective resource optimization through strategic partnerships, adaptive budgeting, and innovative service delivery. Funds were reallocated during the COVID-19 pandemic to sustain essential SRHR and GBV services, with cost-saving measures such as remote training and virtual meetings allowing resources to be directed to underserved areas. High budget implementation rates, rising from 90.4% in 2021 to 92.1% in 2022 and stabilizing at 92.0% in 2023, reflect strong financial management (see Figure 15 and Figure 16). However, challenges

persist in achieving full efficiency, particularly regarding partnerships, geographical coverage, and programme integration. While the 9th CP's efficiency strategies are commendable, there are areas requiring refinement to further enhance cost-effectiveness and programmatic impact.

Figure 15: Evolution of Overall Budget and Expenditure: 9th CP (2021-2023)[68]

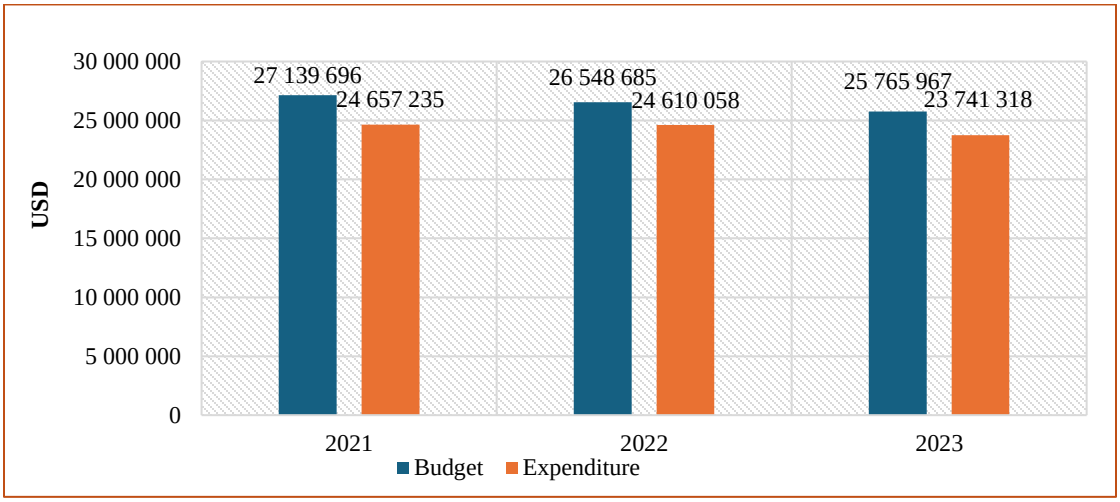
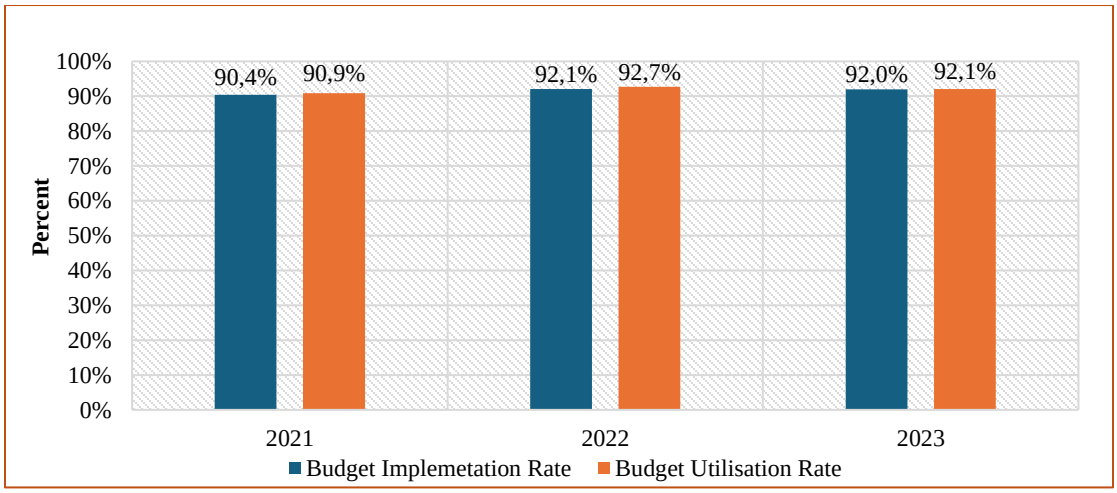


Figure 16: Budget Implementation and Utilisation Rates (2021-2023)[69]



Leveraging Partnerships for Resource Optimisation

The 9th CP effectively leveraged partnerships with local and international stakeholders to extend the reach of its services. For example, collaborations with local NGOs expanded maternal health and GBV interventions, while partnerships with refugee-focused organizations enabled service delivery within tight budget constraints. The integration of Village Health Teams (VHTs) into SRHR outreach programs minimized operational costs and empowered local structures to sustain these initiatives beyond the 9th CP's direct funding. Similarly, the 9th CP aligned its SRHR and

[68] UNFPA Uganda Cognos Reports.

[69] UNFPA Uganda Cognos Reports.

GBV interventions with Uganda's Comprehensive Refugee Response Framework (CRRF) to pool resources and avoid duplication. This approach enhanced cost-effectiveness in refugee-hosting districts, where shared resource allocation supported both host and refugee populations. By coordinating with other humanitarian actors, CP9 ensured efficient service delivery even in resource-constrained environments. However, challenges persist with programme coherence and coordination. Evidence suggests duplication of efforts between UNFPA and other UN agencies, such as UNICEF, particularly in areas like adolescent health. A more deliberate alignment of roles and responsibilities between agencies is necessary to eliminate redundancies and maximise the value of shared resources. The 9th CP must strategically position itself by identifying and investing in areas where it holds a unique comparative advantage, ensuring that efforts complement rather than overlap with those of other stakeholders.

Geographical Coverage and Comprehensive Programming

The 9th CP's emphasis on community-based models further exemplified its efficient use of resources. By building the capacity of local health workers and deploying VHTs, the program reduced reliance on external staffing and logistics, enabling cost-effective service delivery in remote and underserved areas. For instance, cross-training VHTs in SRHR and GBV prevention created a versatile workforce capable of addressing multiple community needs simultaneously. This strategy not only conserved resources but also enhanced the sustainability of health services by embedding skills within local systems. Despite these successes, limitations in geographical coverage were noted. While interventions are reported at the district level, coverage often remains partial, targeting specific communities rather than entire districts. This partial reach undermines the intended impact, particularly for programmes addressing social norms, where success relies on widespread community engagement. Achieving comprehensive coverage across entire districts is critical to ensuring consistent results and avoiding dilution effects in targeted interventions.

Adaptation During Emergencies

During emergencies, the 9th CP demonstrated exceptional agility in reallocating resources to high-priority areas. For instance, in response to the COVID-19 pandemic, UNFPA implemented telehealth support and mobile health units to sustain access to SRHR services in high-need areas. These adjustments minimized disruptions to service delivery while optimizing available resources.

Challenges and Areas for Improvement

While the 9th CP's resource optimization strategies were largely effective, logistical challenges occasionally hindered service delivery in remote regions. Delays due to supply chain bottlenecks and limited transport resources highlighted the need for enhanced logistical planning. Additionally, demand often exceeded supply in refugee-hosting districts, emphasizing the importance of further strengthening partnerships and resource mobilisation to meet growing needs. Further, the 9th CP's resource efficiency can be enhanced by addressing the gap in sub-national data systems. While national-level systems are supported, there is limited technical capacity for managing and utilising disaggregated data at the district and sub-county levels. Placing dedicated technical experts at field office levels would strengthen data systems, enabling evidence-based planning and more efficient resource allocation at the local level. In sum, the 9th CP's funding strategies demonstrated considerable efficiency by leveraging partnerships, prioritizing local capacity building, and adapting to emerging challenges. These efforts ensured impactful service delivery while maximizing resource utilization across Uganda's underserved districts. However, addressing partnership approaches, comprehensive coverage, programme integration, and sub-national data

systems logistical gaps and ensuring comprehensive district coverage remain critical for optimizing resource allocation and sustaining long-term program impact.

Personnel

UNFPA achieved significant personnel efficiency during the 9th CP implementation by prioritizing capacity building and integrating with existing local health systems. Rather than relying on temporary external staffing, the programme focused on empowering local healthcare providers to fill critical gaps in SRHR service delivery. The training and deployment of UNFPA-supported midwives contributed to increased antenatal care coverage, demonstrating the effectiveness of leveraging local expertise to address service delivery constraints. A key component of this approach was the strategic engagement of Village Health Teams (VHTs), These community structures were mobilised to deliver SRHR education to adolescents and rural women, ensuring sustainable outreach beyond the 9th CP funding cycle. VHTs were specifically assigned to high-priority groups, such as pregnant women and adolescents in underserved areas, optimizing resource utilization and minimizing redundancies. Furthermore, VHTs were cross trained in both SRHR and GBV prevention, creating a versatile and cost-effective workforce capable of addressing multiple health challenges simultaneously. This operational model reflects deliberate workforce alignment during CP9's implementation, ensuring that community resource persons or structures were effectively allocated to maximise impact and sustainability within local health systems.

Innovation and Digitisation in the 9th CP

The 9th CP integrated a suite of digital and technological innovations across its programmes to enhance efficiency, accountability, and service delivery, particularly in addressing maternal health, Sexual and Reproductive Health and Rights, Gender-based violence, and Adolescent and Youth health needs. These innovations, developed in collaboration with diverse stakeholders, exemplify the transformative potential of technology in delivering equitable health outcomes to underserved and vulnerable populations. Additionally, opportunities for scaling these innovations have been strategically identified to mainstream them into broader programmatic implementation, ensuring their long-term sustainability and impact.

Maternal Health Innovations

UNFPA introduced several digital solutions to mitigate challenges in maternal health and ensure equitable access to quality care. The **Rich Baby, Healthy Family** platform addressed the financial barriers many pregnant women and adolescent girls face by enabling them and their families to save for maternal health costs via mobile money. This behaviourally driven savings initiative empowered users to prepare financially for maternal healthcare needs. The **GetIn mobile app**, tailored for community health workers (CHWs) and midwives, facilitated the registration, tracking, and follow-up of pregnant women, particularly teenage mothers. By fostering seamless coordination between CHWs and healthcare facilities, the app ensured timely antenatal care and maternal health services for at-risk populations. Complementing this **was mScan,** a low-cost, portable ultrasound device that improved early detection of maternal risk factors in rural areas. This innovation enhanced diagnostic accessibility and contributed significantly to reducing maternal mortality. The **DrugDash application** addressed inefficiencies in the health supply chain by providing real-time data on the stock status of health commodities at various health facilities. District Health Officers used the platform to redistribute resources effectively, minimizing stockouts and wastage while improving service delivery reliability. During the COVID-19

pandemic, UNFPA leveraged partnerships with **SafeBoda**, a motorcycle hailing service, and **Jumia**, an e-commerce platform, to ensure uninterrupted access to reproductive health commodities. **SafeBoda** facilitated the distribution of free condoms and integrated reproductive health products into its e-Shop, while **Jumia** hosted a dedicated SRHR store, enabling users to discreetly order products such as contraceptive pills and HIV test kits.

Adolescent and Youth Innovations

To address the unique health needs of adolescents and youth, the 9th CP implemented several tailored solutions. The **SmartBag4Girls**, an eco-friendly menstrual kit, provided reusable pads, a sewing kit, and comprehensive menstrual health management information. Similarly, **EcoSmart Pads,** produced through a partnership with KAO Corporation, offered affordable and environmentally friendly sanitary pads, improving menstrual hygiene management among girls and women in low-income households and refugee communities. The **Stage platform** created a digital space for young people to share ideas and collaborate on addressing social issues in their communities. It fostered a culture of social change and community-driven solutions, while the **UpAccelerate-WAY Edition** incubator nurtured youth entrepreneurial talent by supporting innovative solutions to SRHR and GBV challenges. Beneficiaries received mentorship, seed funding, and training to build self-sustaining businesses that could address health challenges within their communities.

Gender and Women's Empowerment (GEWE) Innovations

To combat GBV, UNFPA supported the deployment of **SafePal**, a mobile and web-based platform enabling young people to confidentially report sexual violence and access critical services such as healthcare, legal aid, and safe shelters. Additionally, the **Corporate Collective Against GBV (CCAG)** brought together companies to address GBV in and beyond the workplace, promoting safe environments and building the capacity of employers to respond to GBV issues. In communities affected by female genital mutilation (FGM), **AXCES Mobile** recruited, trained, and deployed trusted Village Volunteer Agents to mobilise and sensitise communities, report FGM cases, and support survivors with referrals to essential services. This grassroots approach effectively tackled harmful practices while strengthening community-driven advocacy.

Scalability and Future Integration

UNFPA has identified strategic opportunities for scaling these innovations to maximise their impact and embed them into broader programmatic frameworks. Through initiatives such as the ANSWER Programme, Women, Adolescents, and Youth Rights and Empowerment Programme (WAY), Spotlight Initiative, and UN Joint Programme on Gender-Based Violence (UNJPGBV), UNFPA plans to expand the reach of these digital solutions. These programmes provide entry points for mainstreaming innovations into donor-funded projects, ensuring they address critical SRHR and GBV gaps across Uganda. Scalability efforts focus on integrating these technologies into local health systems, fostering national ownership, and building the capacity of community health workers and stakeholders. For instance, **DrugDash** can be scaled to cover all health facilities nationwide, addressing systemic supply chain challenges. Similarly, the success of **SafePal** and **GetIn** demonstrates the feasibility of expanding these platforms to underserved regions. Innovations like **SmartBag4Girls** and **EcoSmart Pads** can further benefit adolescent girls by scaling production and distribution networks, particularly in rural and refugee communities in Uganda.

Administrative Efficiency

The 9th CP achieved administrative cost savings through strategic collaborations and innovative approaches, enabling the redirection of resources to critical areas like adolescent health and maternal care. Partnerships with UN agencies, such as UNICEF for shared SRHR data management platforms and WHO for joint monitoring visits, significantly reduced software and logistical costs. During the COVID-19 pandemic, virtual platforms replaced in-person meetings, contributing to a 45% reduction in travel expenses between 2020 and 2021. These savings were reinvested in expanding mobile health services to remote districts. Collaborative efforts with local NGOs facilitated timely access to SRHR and GBV resources, including the rapid distribution of menstrual hygiene kits to adolescent girls. By integrating capacity building, digital tools, and inter-agency partnerships, the programme minimized costs while enhancing service delivery, ensuring optimal resource utilization and sustained health outcomes in underserved regions.

Timeliness of Resource Allocation

The 9th CP demonstrated commendable agility in reallocating resources during emergencies, notably during the COVID-19 pandemic, ensuring uninterrupted service delivery for maternal health and HIV prevention. This flexibility highlights the programme's capacity to adapt to dynamic operational demands. However, logistical challenges occasionally delayed the delivery of critical SRHR resources to remote sub-counties, where needs were greatest. Supply chain bottlenecks and high-demand periods further exposed gaps in distribution networks, particularly in refugee communities where growing demand often outpaced supply. Evaluations, including those from the ADA and JPGBV programmes, emphasized the effectiveness of mobile clinics and integrated outreach in bridging service gaps in hard-to-reach areas. These approaches provide a model for addressing logistical constraints. Strengthening supply chain frameworks, enhancing transport capacity, and expanding mobile outreach models are critical for ensuring the timely and equitable delivery of resources. Addressing these challenges will enable the 9th CP to sustain its responsiveness and maximize its impact across Uganda’s diverse and underserved regions.

4.6 Sustainability of the CP9 outcomes

The evaluation of the sustainability of the 9th CP outcomes was guided by Evaluation Question 9 **(EQ9)**, which assessed the extent to which the programme has supported the government, implementing partners, and rights-holders, particularly women, adolescents, and youth in developing capacities and establishing mechanisms to ensure the durability of effects. The evaluation examined the programme's efforts to embed interventions within existing national frameworks, strengthen partnerships and collaborations, and build capacity at national and sub-national levels.

Summary
The 9th CP demonstrated a strong commitment to ensuring the sustainability of its outcomes by working within existing national frameworks, strengthening partnerships, and building local capacities. At the national level, the programme integrated SRHR and GBV interventions into Uganda's health, legal, and psychosocial systems, supported policy development, and enhanced data systems to enable evidence-based planning. Subnational and community-level efforts included collaborating with district structures, cultural and religious leaders, and community health workers to deliver interventions, ensuring ownership and continuity. Partnerships with government ministries, CSOs, FBOs, and the private sector fostered a multi-sectoral approach that complemented government efforts and promoted cost-effective outcomes. Capacity-building initiatives equipped healthcare providers, educators, and community leaders with the skills needed to independently sustain SRHR and GBV services. However, challenges remain, particularly in resource-constrained refugee-hosting areas and the need for disability-inclusive practices. Overall, the 9th CP's focus on integrating interventions into national systems, fostering local ownership, and strengthening capacity provides a solid foundation for Uganda to sustain progress in health, gender equality, and social inclusion beyond the programme's lifespan.

4.6.1 Working within the existing national framework, structures and systems

The 9th CP leveraged existing national, subnational, and community structures to ensure sustainability and promote ownership of programme outcomes in SRHR, gender equality, GBV, and social inclusion. At the national level, UNFPA focused on integrating initiatives into health, legal, and psychosocial systems, supporting the development and dissemination of policies, plans, and guidelines to sustain benefits beyond the programme's lifespan. Robust data systems, such as the UDHS and the National GBV database, enable data-driven policies and demographic monitoring to inform long-term development goals. At the subnational level, collaboration with district structures like DHOs, CDOs, police, CSOs, and NGOs facilitated coordinated interventions, including the enactment of by-laws on SRHR, GBV prevention, and alcohol abuse. District stakeholders widely acknowledged their involvement in programme design, implementation, and monitoring, with confidence that many outcomes will persist. At the community level, interventions were delivered through established structures, including health facilities, schools, religious and cultural institutions, and political frameworks, which hold the potential to sustain activities beyond the programme. Disability-inclusive practices were embedded into policies, emphasizing the importance of integrating these measures into long-term government strategies to ensure the continuation of inclusive programming.

4.6.2 Partnerships and collaborations

The 9th CP was developed collaboratively with the Government of Uganda and involved extensive consultations with partners at national, subnational, and community levels. Key national partners included ministries such as MGLSD, MoH, and MOES, as well as institutions like UBOS, NPC, and NPA. Subnational partnerships involved district governments, CSOs, NGOs, and cultural and religious institutions, while community-level engagement included leadership structures, community health workers, and peer educators. A well-coordinated, multi-sectoral approach ensured all stakeholders played complementary roles. Ministries provided strategic oversight, CSOs led advocacy and service delivery, FBOs promoted social norm change, the private sector contributed innovation and financing, and the media raised awareness and drove behaviour change.

Beneficiaries actively participated in planning, implementation, and monitoring, enhancing programme relevance and sustainability. Regular coordination meetings at all levels strengthened progress reviews and strategic issue resolution. This partnership model supported cost-efficiency and effectiveness, ensuring the achievement and sustainability of programme outcomes in SRHR, gender equality, and GBV prevention.

4.6.3 Capacity building

The 9th CP strengthened systems at national, subnational, and community levels to improve SRHR, gender equality, social inclusion, and SGBV prevention. Through cascading training programmes, the programme built the capacity of medical, legal, and psychosocial support service providers, equipping district and community structures with sustainable skills to address SRHR and GBV needs independently. Capacity-building initiatives targeted district teams, local structures, and community change agents such as health workers, teachers, cultural and religious leaders, peer educators, and model parents, ensuring that skills and knowledge remain within communities beyond the programme's lifespan. Integration of SRHR, HIV, and GBV services into health facilities and training of health staff established a sustainable framework for service delivery. To enhance inclusivity, future capacity-building efforts should include mandatory training for implementing partners on disability-inclusive practices, with mechanisms allowing PWDs to evaluate and provide feedback to improve programme inclusivity and accessibility.

4.7 Coordination mechanisms within and across sectors

The evaluation of coordination within the 9th Country Programme was guided by Evaluation Question 10 **(EQ10),** which examined the extent to which the governance structures including Delivering as One (DaO), the partnership strategy, execution and implementation arrangements, and the joint programme modality fostered or hindered the achievement of the programme outputs. This analysis focused on the effectiveness of coordination mechanisms in enhancing collaboration, reducing duplication, and ensuring the smooth implementation of interventions to achieve the intended results.

Summary

UNFPA has been instrumental in strengthening coordination mechanisms at national, district, and community levels during the 9th CP. Nationally, it engaged in inter-agency task forces, joint monitoring with UN agencies, and supported platforms like the GBV National Reference Group, aligning SRHR and GBV programming with national priorities and promoting multi-sectoral integration. At the district level, UNFPA institutionalized planning and review meetings, enhancing accountability, resource sharing, and intervention harmonization through tools like the 3W Matrix. Field officers bolstered local implementation, especially in refugee-hosting districts, integrating GBV prevention and SRHR services into humanitarian frameworks. However, coordination at sub-county and community levels remains inconsistent, necessitating innovative strategies for strengthening local structures. Overall, UNFPA's efforts have significantly improved programme alignment, cross-sector collaboration, and the effectiveness of SRHR, GBV, and youth empowerment interventions across Uganda.

4.7.1 Contributions to the Consolidation of UNCT Mechanisms

The 9th CP significantly enhanced coordination mechanisms at national and district levels, improving the integration and delivery of SRHR, GBV, and youth empowerment programmes. At the national level, UNFPA engaged in inter-agency task forces and coordination platforms, aligning programmatic priorities with Uganda's development goals and fostering multi-sectoral approaches through initiatives like the National GBV Reference Group. In refugee-hosting districts, coordination efforts streamlined service delivery by involving district leaders, implementing partners, and stakeholders in structured review meetings, reducing duplication and integrating GBV prevention and SRHR services into humanitarian responses. Decentralised offices and field officers facilitated regular planning meetings and site visits, while tools like the 3W Matrix clarified partner roles and minimised overlap. Collaborative efforts, such as those with CARE International in Kamuli, strengthened cross-sectoral integration, while capacity-building in districts like Moroto and Amudat reinforced local partnerships and accountability. However, challenges persist in engaging sub-county and community structures consistently. Addressing these gaps will require innovative strategies to sustain coordination momentum across all levels. UNFPA's leadership has fostered cohesive and effective programming, integrating SRHR and GBV services into Uganda's broader development and humanitarian frameworks.

4.8 Coverage of Targeted Populations and Areas

The evaluation, guided by Evaluation Question 11 **(EQ11),** assessed the extent to which the 9th CP ensured equitable access to services across targeted regions, particularly for women, adolescents, and youth. It examined the programme's ability to systematically reach all geographic areas, including underserved and hard-to-reach locations, while identifying gaps and challenges in achieving comprehensive coverage.

Summary

The 9th CP has achieved significant progress in extending SRHR and GBV services to targeted populations, including women, adolescents, refugees, and underserved rural communities. Through strategic outreach, partnerships, and innovative approaches like mobile health units and community-based interventions, the 9th CP has expanded access in priority districts, particularly in rural and refugee-hosting areas. Notable successes include fostering social cohesion between host and refugee communities, enhancing youth-friendly services, and integrating SRHR services into local health systems. However, persistent gaps remain due to logistical constraints, limited resources, and cultural barriers, particularly in reaching adolescent boys, persons with disabilities, and isolated sub-counties. Evaluations such as the Gap Analysis, ADA, WAY, and JPGBV underscore the need for increased inclusivity, additional logistical support, and tailored interventions to address the unique needs of underserved populations. Strengthening partnerships, expanding culturally and linguistically sensitive approaches, and enhancing resource allocation will be critical to achieving comprehensive and equitable coverage across Uganda's diverse implementation contexts.

4.8.1 Extent of Coverage Across Intended Populations and Areas

The 9th CP achieved significant progress in expanding SRHR and GBV services to high-need populations in Uganda, including women, adolescents, refugees, and underserved rural communities. Aligned with Uganda's Vision 2040 and the SDG commitments, the programme

reached over 2.5 million individuals by 2023, with tailored interventions in refugee settlements like Tika and districts such as Kitgum and Madi-Okollo. Partnerships with Village Health Teams (VHTs) and local health workers in remote areas like Karamoja and northern Uganda addressed healthcare access barriers, while community outreach and youth-focused SRHR services fostered long-term engagement with vulnerable groups. Initiatives like the ADA project and WAY programme reduced health disparities, promoted social cohesion, and addressed unmet health needs. However, logistical constraints, funding limitations, and gaps in reaching persons with disabilities and adolescent boys highlight the need for stronger community-based approaches and inclusive targeting frameworks. While the 9th CP made substantial contributions to advancing Uganda's health and development goals, additional investments in resources, logistics, and inclusivity are essential to ensure equitable access and comprehensive coverage, particularly in remote regions.

4.8.2 Identification and Response to Significant Gaps in Coverage

The evaluation highlights the 9th CP's significant progress in expanding SRHR and GBV services to underserved populations, including women, adolescents, refugees, and rural communities, aligning with Uganda's Vision 2040 and SDG commitments. Key evaluations, such as those from the ADA, WAY, JPGBV, and ANSWER programmes, reveal the 9th CP's targeted efforts to address gaps in health service delivery. Successes include enhanced service delivery in high-need regions like Adjumani and Kyegegwa, the use of culturally and linguistically competent health workers in refugee settlements, and mobile health units reaching remote areas. However, challenges persist, including gaps in service access for marginalized groups such as persons with disabilities, adolescent boys, and rural GBV survivors, compounded by logistical and resource constraints. Stakeholders emphasize the need for additional resources, stronger community engagement, and inclusive strategies to address these disparities. While the 9th CP made strides in reducing health disparities through innovative and targeted interventions, achieving comprehensive and equitable service delivery will require strengthened logistical frameworks, deeper partnerships, and a focused allocation of resources to ensure no population is left behind.

4.9 Connectedness to Broader Development Goals

The evaluation of the connectedness to broader development goals under the 9th Country Programme was guided by Evaluation Question 12 **(EQ12),** which examined the extent to which the UNFPA humanitarian response has taken into account longer-term development goals articulated in the results framework of the country programme. This assessment focused on how well the humanitarian interventions were aligned with and contributed to sustainable development

Summary

The 9th CP aligned with Uganda's Vision 2040, National Development Plan, and the SDGs, particularly SDG 3 and SDG 5, by addressing SRHR and GBV needs while supporting long-term goals like reducing maternal mortality and fostering gender equality. Its focus on refugee-hosting districts enhanced inclusivity and social cohesion, aligning with the Comprehensive Refugee Response Framework. The 9th CP strengthened health systems by integrating SRHR and GBV services, empowering community actors, and investing in data systems like the Uganda Demographic Health Survey for evidence-based policymaking. Culturally sensitive interventions promoted sustainable societal shifts, bridging immediate needs with long-term objectives, and advancing Uganda's demographic and social equity goals.

objectives, ensuring that immediate responses were connected to Uganda's broader development priorities and long-term outcomes.

4.9.1 Connections between CP9 Interventions and Broader Development/ Humanitarian Goals

The evaluation highlights the 9th CP's strong alignment with Uganda's Vision 2040, National Development Plan, and SDGs 3 and 5, demonstrating its significant contributions to health, gender equality, and social equity. By integrating SRHR and GBV interventions within national frameworks, the programme supports sustainable outcomes, addressing barriers such as teenage pregnancies, early marriages, and GBV while fostering educational and economic opportunities. Initiatives like the Uganda Demographic Health Survey and family planning investments have strengthened data-driven planning, empowering youth to make informed reproductive health decisions and advancing Uganda's demographic dividend strategy. Interventions in refugee-hosting regions have promoted inclusivity, social cohesion, and resilience, while programmes like ADA, WAY, JPGBV, and ANSWER have targeted underserved areas, reduced health disparities, and supported socio-economic development. Through culturally sensitive and integrated SRHR services, the 9th CP has driven societal change, empowered communities and aligned with Uganda's long-term development and SDG objectives, effectively balancing immediate needs with long-term impacts.

4.9.2 Linkages between Immediate Interventions and Long-Term Objectives

The 9th CP strategically links immediate health interventions with Uganda's long-term development goals by addressing urgent needs while building sustainable systems. Support for national data initiatives, such as the Uganda Demographic Health Survey (UDHS) and census, has strengthened data-driven planning, aligning with the demographic dividend strategy to prioritise youth and vulnerable populations. At the community level, the 9th CP has enhanced health systems, particularly in refugee settlements, by establishing community-based structures for health and family planning education. Focused on youth empowerment and SRHR education, the 9th CP fosters behaviour change, reduces teenage pregnancies, and promotes economic empowerment. Integration of SRHR and maternal health services with local governance ensures service continuity in resource-limited areas, while culturally sensitive approaches in refugee-hosting regions address harmful gender norms and promote GBV prevention. Projects like ADA, WAY, and JPGBV demonstrate the 9th CP's success in balancing immediate health outcomes with long-term goals of social equity and economic resilience. By embedding SRHR services in local systems, empowering Village Health Teams (VHTs), and enhancing refugee-hosting region services, the 9th CP advances Uganda's Vision 2040 and SDG 5, creating inclusive, sustainable societal shifts. Investments in robust data systems further enable resource allocation and demographic challenge management, ensuring lasting health and socio-economic benefits.

4.10 Lessons Learned

The evaluation highlights essential lessons learned from the 9th CP showcasing both its successes and the areas requiring further attention across Sexual and Reproductive Health and Rights, Gender Equality and Women's Empowerment, and Population Data systems.

4.10.1 Sexual and Reproductive Health and Rights

Key Lessons and Best Practices in SRHR

Community-Based Approaches Drive Impact: Community-based initiatives, particularly those involving Village Health Teams (VHTs), significantly improved access to SRH services in underserved and remote areas. These teams leveraged local trust and cultural understanding to deliver family planning, antenatal care, and GBV support. By embedding these services within the community, the programme ensured sustainability even beyond CP9's direct funding.

Mobile Clinics Ensure Service Continuity*:* Mobile clinics proved invaluable, particularly during emergencies or in hard-to-reach areas. They bridged gaps created by inaccessible or under-resourced health facilities, ensuring uninterrupted delivery of SRH services, including maternal health and contraceptive care. Their integration with community outreaches enhanced their efficiency and reach, providing comprehensive health packages that addressed multiple needs in one intervention.

Peer-Led Education Fosters Long-Term Behaviour Change: Peer-led initiatives targeting adolescents and youth emerged as a powerful tool for addressing sensitive SRH issues. By employing relatable peer educators, the 9th CP effectively tackled stigma around topics like contraceptive use and teenage pregnancy. These efforts contributed to sustained changes in adolescent behaviour and increased uptake of SRH services.

Capacity Building Strengthens Sustainability*:* Investments in training healthcare workers and equipping local health facilities reinforced the resilience of community health systems. These capacity-building initiatives ensured the continuity of SRH service delivery even after project timelines ended, demonstrating the value of embedding resources and skills locally.

Gaps Identified in SRH

Inclusivity Challenges Persist*:* Despite significant progress, certain groups—particularly adolescent boys and persons with disabilities—remain underserved by SRH programmes. This gap stems from both structural barriers, such as inaccessible facilities, and social stigmas that limit their engagement with services.

Cultural and Social Barriers to Access: Entrenched cultural norms and stigmas surrounding reproductive health, particularly family planning, hinder service utilization among marginalized groups. Resistance from religious or community leaders often exacerbates these barriers, reducing the impact of SRH interventions.

Insufficient Cross-Learning Mechanisms: The programme lacked a robust framework for systematically documenting and sharing lessons learned. This limited opportunities for cross-country learning, particularly in areas like contraceptive uptake and youth empowerment, where CP9 demonstrated success.

Transferable Insights for Future SRH Programming

Scaling Up Mobile Clinics: Mobile clinics should be integrated as a permanent feature of SRH outreach, particularly in underserved regions and during emergencies. Their success under the 9th CP highlights their potential for addressing accessibility challenges in both stable and crisis contexts.

Expanding Peer-Led Models: Formalising and scaling up peer-led education initiatives can enhance engagement with adolescents and youth, ensuring they receive accurate, relatable SRH information. These models have demonstrated success in addressing stigma and promoting behaviour change.

Cultural Sensitivity in Interventions: Engaging religious and cultural leaders as allies in SRH programming is critical. Their endorsement of family planning and other SRH practices can significantly reduce resistance and improve community acceptance, making interventions more effective.

Inclusive Strategies for Underserved Groups*:* Targeted approaches are needed to address the specific barriers faced by adolescent boys and persons with disabilities. This includes designing tailored outreach activities, providing accessible services, and conducting focused advocacy to reduce stigma.

Systematising Documentation and Sharing: Establishing mechanisms for capturing and disseminating lessons learned can amplify the impact of successful SRH interventions. Cross-country learning in areas like youth empowerment and contraceptive uptake can inform global best practices and improve programme design. By applying these lessons and addressing the gaps, future SRH interventions can build on the 9th CP's successes to achieve greater inclusivity, impact, and sustainability.

4.10.2 Gender Equality and Women's Empowerment

Key Lessons and Best Practices for GEWE

Community Engagement Enhances Outcomes: Collaborations with local leaders and cultural institutions proved effective in raising awareness and reducing stigma around GBV. By embedding interventions within trusted community structures, the 9th CP fostered a sense of ownership and increased the visibility of gender equality initiatives.

Safe Spaces Build Trust*:* The establishment of safe spaces for women and girls provided critical psychological support and a secure environment for accessing GBV services. These spaces enhanced trust in service delivery and created avenues for women and girls to share their experiences without fear of judgment.

Policy Alignment Strengthens Impact*:* the 9th CP's alignment with Uganda's gender policies (e.g. National Policy for Elimination of GBV, Gender Policy) and SDG 5 enabled sector-wide collaboration, integrating GBV interventions into health systems and amplifying their reach. This strategic alignment fostered coherence and minimized duplication across sectors. However, as the planning and budgeting approach increasingly shifts from sector to programme-based approach to planning and budgeting, CP should be more intentional at aligning its programmes and approaches to PBA and PBB.

Economic Empowerment Drives Change: Empowering women economically increased their participation in GBV prevention and mitigation efforts, contributing to broader social change. Financial independence also strengthened women's resilience and capacity to advocate for their rights.

Engaging Men and Boys is Crucial*:* Deeper community dialogue that includes men and boys as allies in promoting gender equity emerged as a vital approach. Their active involvement in challenging harmful norms is essential to achieving transformative gender outcomes.

Gaps Identified

Resistance to Norm Change: Cultural resistance to addressing harmful social and gender norms persisted in some districts, highlighting the need for sustained advocacy and tailored strategies to address deeply rooted traditions.

Inconsistent Accessibility of Safe Spaces: While safe spaces were impactful, their availability was inconsistent across districts, limiting their reach. This highlights the need for scaling up these services to underserved areas.

Economic Empowerment Gaps: Although economic empowerment was effective, it remained limited to pilot initiatives, leaving many women unable to access the support required to achieve financial independence.

Transferable Insights for Future Programming

Integrating GBV Services with Broader SRHR Initiatives: Expanding the integration of GBV services with SRHR programmes ensures a more comprehensive approach to women's health and empowerment.

Expanding Safe Spaces: Scaling up safe spaces, especially in rural and refugee-hosting districts, can enhance the accessibility and reliability of GBV services.

Tailored Engagement with Men and Boys: Designing specific interventions to engage men and boys in discussions around gender equality and their role as allies is critical for long-term behaviour change.

Broadening Economic Empowerment Initiatives: Establishing scalable economic empowerment programmes, including vocational training and microfinance, can create sustainable pathways for women to overcome gender barriers.

Leveraging Policy Frameworks: Continued alignment with national and international gender policies ensures that interventions remain strategic and coordinated across sectors.

4.10.3 Population and Data Systems

Key Lessons and Best Practices for PD

Data-Driven Decision Making Enhances Program Effectiveness: The 9th CP utilized data from the Uganda Demographic Health Survey (UDHS) and the national census to effectively plan and target interventions for underserved populations, including refugees and marginalized groups. This

data-driven approach enabled the 9th CP to focus resources where they were most needed, ensuring equitable service delivery and program impact.

Adaptive Responses Enabled by Data: The flexibility of the 9th CP's data systems was critical during crises, such as the COVID-19 pandemic. Data insights informed resource reallocation to high-priority areas like SRHR and maternal health, ensuring continuity of essential services in a rapidly evolving context.

Capacity Building Strengthens Local Decision-Making: Training district officials in data analysis and utilization improved local planning, accountability, and transparency. This approach ensured that interventions were not only evidence-based but also better aligned with district-specific needs, enhancing the overall effectiveness of the 9th CP's initiatives.

Gaps Identified

Limited Integration Across Systems: While the 9th CP made significant strides in data use, some gaps remain in the integration of various data systems across sectors, such as health, education, and population. Improved coordination and harmonization of data platforms could further enhance program planning and implementation.

Variable Data Utilisation at Sub-National Levels*:* Despite training efforts, the extent of data utilization by district officials varied, with some districts showing limited application of skills in routine planning and reporting. This underscores the need for continued mentoring and technical support.

Transferable Insights for Future Programming

Integrated Data Systems for Coordination and Efficiency: Investing in comprehensive, integrated data systems across multiple sectors enhances coordination and efficiency. This approach enables seamless data sharing and informed decision-making across health, education, and population sectors, resulting in more cohesive and impactful programming.

Adaptive Planning Mechanisms for Resilience: Strengthening adaptive planning mechanisms, backed by robust data systems, ensures resilience during emergencies. The ability to rapidly analyze data and adjust interventions allows programs to maintain continuity and relevance, even in dynamic and challenging environments such as pandemics. This aligns with well-developed collaborative learning and adaptation strategies as well as complex aware monitoring strategies.

Capacity Building for Data-Informed Decision-Making: Sustained capacity-building initiatives at local levels are vital to embedding a culture of data-informed decision-making. By empowering district officials and local stakeholders through training and mentoring, programs can achieve long-term impact and sustainability, ensuring that data utilization becomes an integral part of routine planning and implementation.

4.10.4 Summary of Lessons Learned from the 9th CP

The 9th CP highlighted the value of community-based approaches, inclusive engagement, and data-driven planning in achieving impactful and sustainable outcomes. In SRHR, initiatives like Village Health Teams, mobile clinics, and peer-led education expanded access and influenced behaviour change, particularly among adolescents, while emphasizing the need to address inclusivity gaps

and cultural stigmas. Gender equality efforts were strengthened through community engagement with local leaders, safe spaces for women, and economic empowerment initiatives, which supported GBV prevention and broader social change. Alignment with Uganda's gender policies and SDG 5 enhanced multi-sectoral programming. For population and data systems, the 9th CP showcased the importance of data-informed decision-making, particularly during crises, and district-level capacity building to ensure targeted and impactful interventions. These lessons highlight the need for integrated approaches, offering actionable insights to refine and scale future programming.

CHAPTER 5: CONCLUSIONS

This chapter presents the key conclusions drawn from the evaluation of the 9th CP, structured to highlight both strategic and programmatic insights. The conclusions are based on a triangulated analysis of data, incorporating desktop reviews, inputs from programme beneficiaries, country office perspectives, as well as feedback from development and implementing partners. Each conclusion addresses the 9th CP's alignment with Uganda's national development frameworks, its efficiency and effectiveness in resource use, coordination with other stakeholders, and its success in reaching and impacting the intended target populations. This analysis identifies the 9th CP's achievements and highlights areas where strategic adjustments could enhance sustainability, inclusivity, and responsiveness, positioning UNFPA to further support Uganda's health, gender equality, population and data and development goals.

5.1 Strategic Level

1. **Alignment with National Development Frameworks and Policies**

The 9th CP demonstrated strong alignment with Uganda's national development frameworks, including Vision 2040, the National Development Plan (NDP), and the Health Sector Strategic Plan (HSSP). The 9th CP's emphasis on SRHR, GBV prevention, population and data and youth empowerment reflects the national commitment to advancing health, gender equality, and social inclusion. The 9th CP's design, which was informed by substantial stakeholder engagement at both national and district levels, enhanced its relevance and local ownership. This alignment has been particularly beneficial in addressing the needs of refugees and marginalized groups, supporting Uganda's policy goals to foster inclusivity and social equity.

Origin: EQ1, EQ2
Evaluation criteria: Relevance, responsiveness
Recommendation: Strategic level R1

2. **Integration of Gender, Human Rights, and Inclusivity in Programming**

The 9th CP played a pivotal role in advancing gender-sensitive and rights-based approaches within Uganda's national policy landscape, contributing to key policies such as the National Strategy to End Child Marriage and the Revised National Policy on the Elimination of Gender-Based Violence. These efforts ensured that vulnerable populations, including adolescents, women, refugees, and Persons with Disabilities (PWD), had access to comprehensive SRHR and GBV services. The programme also supported advocacy for inclusive programming to address systemic barriers faced by LGBTIQ+ individuals in accessing SRHR services, despite persistent challenges such as stigma and restrictive policies. Additionally, targeted efforts were made to support ethnic minorities, particularly in the Karamoja region, where interventions were tailored to the unique cultural and geographic challenges of these communities. Examples include culturally sensitive SRHR outreach and the deployment of mobile clinics to serve nomadic populations. Beyond Karamoja, the 9th CP extended its focus to other marginalised ethnic groups, incorporating insights

from local leaders and ensuring minority representation in programming. Initiatives such as the use of local dialects in communication materials and the recruitment of health workers from minority backgrounds strengthened trust and improved the relevance of SRHR/HIV/GBV services. However, challenges remain, particularly in culturally conservative districts where family planning and other SRHR services face resistance due to entrenched social and gender norms. To enhance inclusivity and effectiveness, the programme must further develop community-specific strategies, including stronger collaborations with cultural leaders, disability-inclusive services, and continued advocacy for LGBTIQ+ rights. A more systematic approach to mainstreaming a rights-based framework should also include targeted outreach to ethnic minorities and the monitoring of equity indicators to ensure that no population is left behind.
Origin: EQ2, EQ3
Evaluation criteria: Relevance, coherence
Recommendation: Strategic level R2

3. **UNFPA's Leadership in Interagency Coordination and Coherence**

UNFPA's active participation in the UN Country Team (UNCT) was essential to establishing coherent, integrated responses to Uganda's health and gender priorities. Through partnerships with agencies like UN Women, UNICEF, WHO, and UNAIDS, UNFPA strengthened the coherence of SRHR, HIV, and GBV interventions across sectors. However, district-level coordination varied in effectiveness, with some districts experiencing occasional overlaps or gaps due to limited clarity in roles. Strengthening coordination frameworks, especially in remote and refugee-hosting areas, would enhance program efficiency and minimize duplication.
Origin: EQ10, EQ3
Evaluation criteria: Coordination, coherence
Recommendation: Strategic level R3

5.2 Programmatic Level

4. **Addressing Service Gaps to Strengthen HIV/SRH/GBV Integration and Delivery**

The findings highlight significant service gaps that need to be addressed to enhance the integration and delivery of HIV/SRH/GBV services. These include the absence of Continuous Quality Improvement (CQI) projects (34%), low data review and utilization (47%), and inadequate performance and functionality of Health Unit Management Committees (HUMC) (51%). Addressing these gaps is crucial to improving service quality and achieving sustainable progress in the integration of HIV/SRH/GBV interventions.
Origin: EQ11, EQ4, EQ8
Evaluation criteria: Coverage, effectiveness, efficiency
Recommendation: Programmatic level R4

5. **Efficient Resource Management and Timely Funding Allocation**

UNFPA implemented resource allocation strategies aimed at maximising impact, such as adaptive budgeting and streamlined partnerships. Analysis of financial data indicates that these measures enabled cost savings during 2023, which were redirected to high-priority areas, including underserved populations in remote districts. Remote training and digital platforms introduced during the COVID-19 pandemic further reduced training and logistical expenses allowing additional resources to be allocated to essential services. However, periodic delays in funding disbursement, as reflected in district-level reports, posed challenges to timely implementation, particularly in areas with the greatest resource needs. Continued efforts to improve the timeliness

of resource flows and enhance district-level financial responsiveness will be critical to further improving efficiency.
Origin: EQ8, EQ6
Evaluation criteria: Efficiency, innovation
Recommendation: Programmatic level R5

6. **Strengthening Data Systems for Evidence-Based Programming**

UNFPA's investments in population data systems, including the Census 2024, Uganda Demographic Health Survey (UDHS) 2022, have significantly enhanced Uganda's capacity for data-driven decision-making. While these data initiatives align well with Uganda's demographic dividend strategy, gaps in staffing and resource allocation for data management remain. Increased investment in data capacity, particularly at the district level, would allow for improved alignment of programming with emerging needs and facilitate more targeted, effective interventions.
Origin: EQ4
Evaluation criteria: Effectiveness
Recommendation: Programmatic level R6

7. **Effectiveness in Reducing Maternal Mortality and Supporting Adolescent Health**

The 9th CP's strategic focus on SRHR contributed to notable improvements in maternal health, adolescent health, and GBV prevention in target districts. Maternal health programmes, particularly community-based interventions and health worker training demonstrated progress in enhancing safe delivery practices and increasing access to antenatal care. A key success of the 9th CP was its consistent support for midwives, recognizing their pivotal role in reducing maternal mortality and improving neonatal health outcomes. In collaboration with MoH, MoES and the Uganda Midwives Association, UNFPA implemented targeted training programs to build midwives' capacity in emergency obstetric and neonatal care (EmONC), GBV integration, family planning, and HIV counselling. These initiatives not only enhanced the quality of maternal health services in health facilities, including those in underserved and humanitarian settings, but also addressed critical gaps in skilled birth attendance and postnatal care. Despite these achievements, data from district-level assessments indicate persistent challenges in reducing maternal mortality rates, especially in remote areas where logistical constraints and resource limitations hindered service delivery. These findings highlight the need for sustained support for midwives through strategic partnerships and enhanced logistical planning to achieve comprehensive coverage and impactful outcomes.
Origin: EQ4, EQ5
Evaluation criteria: Effectiveness
Recommendation: Programmatic level R7

8. **Enhanced Capacity for Family Planning in Refugee and Host Communities**

The 9th CP's SRHR programmes in Ugandan refugee districts, such as Adjumani and Madi-Okollo, have effectively improved health outcomes and strengthened community cohesion. However, cultural and language barriers remain a challenge. To enhance impact, programmes should be tailored to specific community needs, including recruiting staff proficient in South Sudanese languages, to better support South Sudanese refugees.
Origin: EQ5, EQ11
Evaluation criteria: Effectiveness, coverage
Recommendation: Programmatic level R8

9. **Building Community Resilience through Integrated SRHR, GBV, HIV, and Youth Empowerment**

The 9th CP's integration of SRHR, GBV prevention, HIV services, and youth empowerment created a sustainable model that addressed overlapping health and social needs. Evidence from stakeholder interviews and district-level assessments indicates that this integrated approach improved access to comprehensive health services in districts like Kamuli and Kitgum. Specific interventions, including targeted community outreach and health worker training, contributed to increased HIV testing, counseling, and prevention services. However, while programme stakeholders suggested that these efforts may have contributed to reduced teenage pregnancies and risky behaviours among adolescents, no direct causal link was established during the evaluation. Expanding such integrated interventions, combined with tailored outreach to culturally conservative communities, would further enhance programme efficacy and sustainability.

Origin: EQ4, EQ7, EQ9

Evaluation criteria: Effectiveness, Sustainability

Recommendation: Programmatic level R9

10. **Advancing Gender Equality through Empowerment Initiatives**

The 9th CP's gender-sensitive programming made significant progress in advancing women's and girls' rights by fostering autonomy through SRHR education initiatives. These interventions increased community awareness of gender equality and initiated critical discussions on reducing GBV. However, deeply entrenched cultural resistance in some districts remains a significant barrier to achieving lasting gender transformation. Evaluation findings highlighted mixed results in changing social norms and reducing GBV. While some districts reported reductions in GBV incidents, others continued to experience persistent challenges. The limited reach, intensity, and uniformity of interventions hindered the 9th CP's broader impact. Social norm change efforts lacked systematic application of key Gender Transformative Approaches (GTA) tools, which constrained the 9th CP's ability to target harmful norms effectively. Additionally, engagement with influential cultural and community leaders was inconsistent. In regions like Karamoja, where these leaders hold substantial sway, missed opportunities to collaborate weakened the 9th CP's influence on social attitudes. These findings emphasize the need for more robust and context-specific strategies, including consistent application of GTA tools, deeper engagement with cultural leaders, and stronger advocacy to address resistance. Expanding the intensity and reach of these initiatives is critical to achieving transformative gender equality outcomes and reducing GBV across diverse communities.

Origin: EQ4

Evaluation criteria: Effectiveness

Recommendations: Programmatic level R10; R11

11. **Addressing Coverage Gaps for Comprehensive SRHR Services**

Despite the 9th CP's broad reach, significant challenges in accessing SRHR services persist, particularly for remote and marginalized populations, including persons with disabilities (PWD). Coverage gaps highlight the need for inclusive outreach strategies that address specific barriers faced by underserved groups. Evidence underscores that adolescent girls, especially in rural and refugee-hosting districts, encounter multiple obstacles such as stigma, cultural resistance, and inadequate adolescent-friendly health services, all of which limit their access to care. For PWD, the lack of disability-inclusive infrastructure and services remains a critical gap. Issues such as

limited availability of assistive technologies, communication aids (e.g., sign language interpreters), and trained health workers hinder their access to SRHR services. Community feedback highlighted the necessity of tailored interventions, including training healthcare providers in disability-sensitive approaches and integrating disability-disaggregated data into planning to better understand and meet their needs. Enhanced data systems are also essential to identifying underserved areas and populations effectively. Targeted interventions, including culturally sensitive and gender-specific strategies, would significantly strengthen CP9's ability to provide equitable and inclusive SRHR services. Expanding disability-inclusive programming, coupled with comprehensive adolescent-focused initiatives, represents a key opportunity to improve SRHR outcomes and ensure no one is left behind.

Origin: EQ11, EQ5

Evaluation criteria: Coverage, inclusivity

Recommendations: Programmatic level R12, R13

CHAPTER 6: RECOMMENDATIONS

Based on the conclusions of the 9th CP evaluation, the following recommendations were developed to support continued alignment with Uganda's national development frameworks, increase resource efficiency, strengthen coordination, and ensure the sustainability of the 9th CP's impact. The recommendations are structured into strategic and programmatic levels and are organised by implementation timeframe.

6.1 Strategic Level

Short-term Period

1. **Strengthen Alignment with National and Local Priorities**

Operational Implications: To enhance the strategic alignment of CP9, UNFPA should prioritise wide-ranging consultations during programme design and implementation, engaging stakeholders from national to district levels. For example, some of the district-level reports from underserved districts and regions indicate a mismatch between the services provided and the specific needs of local populations, such as culturally tailored SRHR interventions in Karamoja. By fostering greater inclusivity in consultations, UNFPA can ensure that programme activities are responsive to both national policies and district-specific priorities, particularly in humanitarian settings.
Priority: High; **Target Level:** UNFPA CO, MDAs, DLGs; **Based on Conclusion:** 1

2. **Enhance Cultural Adaptation in Gender and Rights-Based Programming**

Operational Implications: UNFPA should develop community-specific strategies that involve cultural leaders in districts with conservative attitudes towards family planning and SRHR. Collaborating with influential local leaders and strengthening focus on social norm change can reduce resistance to SRHR and GBV prevention and response services, enabling the more effective delivery of gender-sensitive, rights-based programming.
Priority: High; **Target Level:** UNFPA CO, DLGs; **Based on Conclusion:** 2

3. **Refine Coordination Mechanisms at the District and Community Level**

Operational Implications: Strengthening the coordination frameworks, particularly at the district and community level and working with grassroots level IPs, will minimise overlaps and clarify roles. UNFPA should ensure structured coordination meetings with partners and local authorities, especially in refugee-hosting areas and remote districts, to optimise resources and service delivery.
Priority: High; **Target Level:** UNFPA CO, NPA, DLGs; **Based on Conclusion:** 3

6.2 Programmatic Level

Short-term Period

4. **Strengthen Service Delivery through Targeted and Integrated Interventions**

Operational Implications: To enhance the integrated delivery of Sexual and Reproductive Health and Rights (SRHR) and Gender-Based Violence (GBV) prevention and response services, with a particular focus on adolescents and young people in underserved districts, UNFPA should institutionalize Continuous Quality Improvement (CQI) within HIV/SRH/GBV service integration. This requires strengthening health systems by training health teams, mentoring staff, and establishing functional CQI committees to drive ongoing service enhancements based on accurate data. Expanding targeted outreach programmes and youth-friendly service enhancements will ensure accessible service points in underserved areas, while strengthening multi-sectoral coordination and community engagement will address barriers to access and increase service utilization among vulnerable groups.

Priority: High; **Target Level:** UNFPA CO, NPA, DLGs; **Based on Conclusion:** 4

Medium Period

5. **Improve Timeliness of Funding Disbursement to Enhance Service Delivery**

Operational Implications: UNFPA should review current financial management systems to address periodic delays in funding disbursements. Efforts should focus on reducing disbursement times to support prompt implementation, especially in high-need areas. Training for IPs on UNFPA's financial procedures could enhance programmatic efficiency.

Priority: High; **Target Level:** UNFPA CO; **Based on Conclusion:** 5

6. **Increase Data Investment for Evidence-Based Programming**

Operational Implications: Greater investment in data infrastructure and staffing, particularly at the district level, will enhance UNFPA's capacity for targeted, evidence-based interventions. Building technical expertise and resources for data management at CO and district levels will strengthen monitoring and inform strategic decisions.

Priority: High; **Target Level:** UNFPA CO, NPA, MDAs, DLGs; **Based on Conclusion:** 6

7. **Enhance Maternal Health Services through Health Systems Strengthening**

Operational Implications: UNFPA should work with the Ministry of Health (MoH) to strengthen maternal and obstetric care by optimizing the Emergency Obstetric and Neonatal Care (EmONC) network. This involves supporting health systems strengthening for facilities that offer maternal health and family planning services to ensure that they are accessible within a two-hour travel time for the majority of the population in their catchment areas. The approach should prioritize health facilities serving the highest population densities in the community, maximizing the reach and impact of maternal health interventions. Support should include staff recruitment, targeted training, infrastructure improvements, and equipping facilities with essential supplies for comprehensive maternal care. This targeted optimization strategy will address maternal mortality hotspots and ensure timely access to life-saving care.

Priority Level: High; **Target:** UNFPA CO, MoH; **Based on Conclusion:** 7

8. **Address Cultural and Language Barriers in Refugee SRHR Services**
Operational Implications: Recruiting culturally and linguistically appropriate staff (e.g., South Sudanese-speaking health workers) will improve SRHR outreach in refugee settlements. Tailored interventions will help overcome existing cultural barriers and enhance SRHR accessibility in these communities.
Priority Level: High; **Target:** UNFPA CO, MoH, DLGs; **Based on Conclusion:** 8

9. **Build Community Resilience for Sustainable Health Interventions**
Operational Implications: Enhancing district health teams, training community health workers, and fostering partnerships with local authorities will help sustain SRHR, GBV, and HIV prevention services beyond UNFPA's support. Strengthening logistical support will further promote programme ownership and long-term sustainability.
Priority Level: Medium; **Target:** UNFPA CO, DLGs; **Based on Conclusion:** 9

10. **Strengthen Social Norm Change and Gender Transformative Interventions**
Operational Implications: Efforts to increase effectiveness, reach, and scale of social norm change interventions to address harmful social norms that drive tolerance of GBV and harmful practices and constrain uptake of SRHR services are required. There is a need to review and consider other social norm change strategies that have demonstrated effectiveness in Uganda, such as the 'Responsible, Engaged, and Loving (REAL) Fathers Initiative' and the DREAMS model, while employing social network analysis and diffusion mechanisms to enhance social norm change at the community level.
Priority: High; **Target Level:** UNFPA CO, MDAs, DLGs; **Based on Conclusion:** 10

11. **Incorporate Social Norms Diagnostic Tools**
Operational Implications: UNFPA and partner MDAs should apply diagnostic tools, such as the Social Norms Exploration Tool (SNET) and the Getting Practical Toolkit, for designing and implementing social norm-shifting interventions. These tools and frameworks can enhance the effectiveness of existing strategies. Lessons from 'PASSAGES' on community-level engagement and organized diffusion should also be considered.
Priority: High; **Target Level:** UNFPA CO, MDAs, DLGs; **Based on Conclusion:** 10

12. **Evaluate Geographic Expansion with a Focus on Resource Consolidation**
Operational Implications: To balance geographical expansion and resource efficiency, UNFPA should consolidate programme reach within existing districts rather than extending into new areas. Strengthening decentralised offices and adding staff where necessary will ensure consistent service quality across all districts and regions, particularly for marginalised groups such as persons with disabilities (PWD) and adolescent girls.
Priority: High; **Target Level:** UNFPA CO; **Based on Conclusion:** 11

13. **Expand Data Systems to Address SRHR Coverage Gaps**
Operational Implications: Improved data collection and monitoring systems will help identify underserved populations, including boys, adolescent girls, and persons with disabilities (PWD). These systems should guide tailored, disability-inclusive and adolescent-focused interventions that bridge existing coverage gaps. Integrating disability-disaggregated data into planning will further enhance the ability to address barriers to SRHR access.
Priority Level: Medium; **Target:** UNFPA CO, NPA, MDAs; **Based on Conclusion:** 11.

ANNEXES

ANNEXURE 1: TERMS OF REFERENCES

Introduction

The United Nations Population Fund (UNFPA) is the lead United Nations agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. The strategic goal of UNFPA is to "achieve universal access to sexual and reproductive health, realize reproductive rights, and accelerate progress on the implementation of the Programme of Action of the International Conference on Population and Development (ICPD)."[70] In pursuit of this goal, UNFPA works towards three transformative and people-centered results: (i) end preventable maternal deaths; (ii) end unmet need for family planning; and (iii) end gender-based violence (GBV) and all harmful practices, including female genital mutilation and child, early and forced marriage. These transformative results contribute to the achievement of all the 17 Sustainable Development Goals (SDGs), but directly contribute to the following: (a) ensure healthy lives and promote well-being for all at ages (Goal 3); (b) achieve gender equality and empower all women and girls (Goal 5); (c) reduce inequality within and among countries (Goal 10); take urgent action to combat climate change and its impacts (Goal 13); promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels (Goal 16); and strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development (Goal 17). In line with the vision of the 2030 Agenda for Sustainable Development, UNFPA seeks to ensure increasing focus on "leaving no one behind" and emphasizing "reaching those furthest behind first".

UNFPA has been operating in Uganda since 1987. The support that the UNFPA Uganda Country Office (CO) provides to the Government of Uganda under the framework of the ninth Country Programme (CP) 2021-2025) responds to national priorities as articulated in the National Strategic Vision 2040, the third National Development Plan (NDP III, 2020/21-2024/25 National Vision 2040, African Union Agenda 2063 and the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 - which prioritizes 1)Transformative and inclusive governance; 2) Shared prosperity in a healthy environment and 3)Human wellbeing and resilience.

The ninth Country Programme (2021-2025) was designed to contribute to the attainment of Sustainable Development Goals 1,3, 4, 5, 10,16, and 17 within the context of the Decade of Action, and to support implementation of the commitments made by the Government of Uganda at the 2019 Nairobi Summit to prevent adolescent pregnancy, end all forms of gender-based violence, other harmful practices such as child

[70] UNFPA Strategic Plan 2022-2025The document is available at: https://www.unfpa.org/strategic-plan-2022

marriage, and accelerate implementation of the International Conference on Population and Development (ICPD) Programme of Action.

The overall vision ninth Country Programme (2021-2025) was to ensure universal access, for women and young people in Uganda to quality, integrated sexual and reproductive health and rights information and services, intended to support attainment of the three transformative results in UNFPA Strategic Plan 2018-2021, and 22-2025, namely to end unmet need for family planning, end preventable maternal deaths, end gender-based violence. The objective was that, by 2025, the programme would contribute to reducing the unmet need for family planning in Uganda by 15 percent points, thus contributing to a reduction in unintended pregnancies and maternal deaths.

The ninth country programme prioritized (1) strengthening the integration, quality improvement, accessibility and availability of sexual and reproductive health services for the most vulnerable populations including young people and women; (2) advocacy to strengthen the policy and enabling environment to improve uptake of sexual and reproductive health services, including family planning; (3) empowering young people, women and marginalized groups to make informed choices about their health and wellbeing and exercise their rights to utilize sexual and reproductive health services; (4) strengthening communities and institutions to prevent gender-based violence and harmful practices against young people and women, particularly in humanitarian contexts, (5) evidence-based advocacy to increase sustainable financing for family planning and sexual and reproductive health and rights services; and (6) strengthening data systems to support the generation and use of disaggregated data on vulnerable populations including young people and women, to enhance mutual accountability and better inform targeted policies and programming.

The ninth progamme primarily targeted young people ages 15-24 years, and women of reproductive age, including those in hard-to-reach communities such as the mountainous regions, ethnic minorities, refugees, internally displaced and migrant populations. Based on recommendations from the 8th Country Programme evaluation, ninth Country Programme (2021-2025) prioritised 40 core districts in which to implement a full package of interventions. These were the districts with the worst SRH/HIV/GBV indicators; and where UNFPA had strong presence. Expansion to more districts was guided by resource availability.

The ninth Country Programme (2021-2025) took into consideration the prevailing humanitarian-development-peace nexus, applying a continuum approach to ensure that humanitarian assistance and refugee response interventions focused on optimizing access to quality and inclusive sexual and reproductive health and rights services and life-saving humanitarian interventions by strengthening health and protection systems and resilience of national institutions and communities. Minimum standards for prevention and response to GBV in emergencies were to be implemented, while ensuring community participation and ownership to address social and gender norms, discourage harmful practices such as child marriage among displaced populations.

One key principle was to continue to leverage partnerships with a broad range of stakeholders at national and sub-national levels, such as government ministries, district local government, parliament, parastatals, agencies, development partners, civil society, cultural and religious institutions, private sector, media, academia, international financial institutions and beneficiaries for inclusive programme delivery.

The 2024 UNFPA Evaluation Policy encourages CO to carry out CPEs every programme cycle, and as a minimum every two cycles."[71] The country programme evaluation (CPE) will provide an independent assessment of the performance of the UNFPA ninth country programme 2021 - 2025) in Uganda and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results. The CPE will also draw conclusions and provide a set of actionable recommendations for the next programme cycle.

The evaluation will be implemented in line with the UNFPA Evaluation Handbook. The Handbook provides practical guidance for managing and conducting CPEs to ensure the production of quality evaluations in line with the United Nations Evaluation Group (UNEG) norms and standards and international good practice for evaluation.[72] It offers step-by-step guidance to prepare methodologically robust evaluations and sets out the roles and responsibilities of key stakeholders at all stages of the evaluation process. The Handbook includes links to a number of tools, resources and templates that provide practical guidance on specific activities and tasks that the evaluators and the CPE Manager perform during the different evaluation phases. The evaluators, the CPE Manager, CO staff and other engaged stakeholders are required to follow the full guidance of the Handbook throughout the evaluation (as specified at different stages).

The main audience and primary intended users of the evaluation are: (i) The UNFPA Uganda CO; (ii) the Government of Uganda; (iii) implementing partners of the UNFPA Uganda CO; (iv) rights-holders involved in UNFPA interventions and the organizations that represent them (in particular women, adolescents and youth); (v) the United Nations Country Team (UNCT); (vi) ESARO; and (vii) donors. The evaluation results will also be of interest to a wider group of stakeholders, including: (i) UNFPA headquarters divisions, branches and offices; (ii) the UNFPA Executive Board; (iii) academia; and (iv) local civil society organizations and international NGOs. The evaluation results will be disseminated as appropriate, using traditional and digital channels of communication.

The evaluation will be managed by the CPE Manager within the UNFPA Uganda CO in close consultation with the Government of Uganda, through the National Population Council, that coordinates the country programme, with guidance and support from the regional monitoring and evaluation (M&E) adviser at the ESARO, and in consultation with the evaluation reference group (ERG) throughout the evaluation process. A team of independent external evaluators will conduct the evaluation and prepare an evaluation report in conformity with these terms of reference and the detailed guidance in the Handbook.

[71] UNFPA Evaluation Policy 2024, p. 25. The document is available at

[72] UNEG, Norms and Standards for Evaluation (2016). The document is available at https://www.unevaluation.org/document/detail/1914

Country Context

Population

Uganda's population has grown from 9.5 million in 1969 to 34.6 in 2014 (Census, 2014). It is projected to reach 70 million by 2040. With an annual population growth rate of 3%, Uganda has one of the fastest growing populations in the world. The high population growth rate is attributed mainly to a high fertility rate. The fertility rate in Uganda has dropped from 6.2 in 2011 (UDHS, 2011) to 5.4 in 2016 (UDHS, 2016), it has declined further but only marginally to 5.2 in 2022 (UDHS, 2022). As such, Uganda's current level of fertility remains one of the highest in sub-Saharan Africa (UDHS, 2022).

There has also been a decline in mortality indices. Under-five (U5MR) has decreased from 128 deaths in 2006 to 64 deaths per 1,000 live births in 2016 (UDHS, 2006; 2016); and to 52 in 2022 (UDHS, 2022). Further, Maternal Mortality Ratio (MMR) has also decreased from 435 in 2006 to 336 deaths per 100,000 live births in 2016 (UDHS, 2006; 2016); and then sharply down 10 189 deaths per 100,000 live births in 2022 (UDHS, 2022). However, the decline in fertility rate has been slower than the decline in U5MR and MMR. Consequently, the population of Uganda has increasingly become younger. Today, 66% of the population is below the age of 24 years (UDHS, 2022), compared to 68% in 2016 (UDHS, 2016); and about half (49%) of the population consist of young people under the age of 15 years (UDHS, 2022), compared to 48% in 2016 (UDHS, 2016).

Family Planning

The family planning programme in Uganda has made significant progress in recent years, with fertility rates reducing from 5.4 births per woman in 2016 to 5.2 in 2022, an increase in the modern Contraceptive prevalence rates among the married women from 35% (UDHS 2016) to 38% (UDHS 2022) and a reduction in unmet need for family planning from 28% (UDHS 2016 UDHS) to 24% (UDHS 2022) . Although there have been improvements in the indicators, they remain far below the anticipated national targets of having a total fertility rate below 4, modern contraceptive prevalence rate at 50% and an unmet need for family planning at 10% for all women by 2025 (NDPIII, FP CIP 2021-2025). Teenage pregnancy contributes up to 28% of maternal deaths in Uganda. Currently, 24% of adolescent girls become pregnant before the age of 19 (UDHS, 2016, UDHS, 2022), this has stagnated for the last 2 decades and is one of the highest in Sub-Saharan Africa.

Key bottlenecks to contraceptive use among women and adolescents are compounded by socio-cultural barriers and inconsistent contraceptive supply among other reasons. As such, approximately 24% of adolescent girls become pregnant before the age of 19 (UDHS, 2022), which is one of the highest in Sub-Saharan Africa. Teenage pregnancy contributes up to 28% of maternal deaths in Uganda.

Youth Demographic Dividend

Sixty-five percent of Ugandan youth in the age bracket of 20-24 are unemployed; and 90 percent of those above 25 years are either unemployed or underemployed. Thus the child dependency ratio in Uganda remains high, standing at 103 children per 100 working population (UNHS, 2017). That notwithstanding, 41 percent of the youth are not in education, employment nor training (NEETs), thus about 4.5 million youth categorized as NEETs. This hampers the ability of the family and the Government to provide basic needs and social services such as food, shelter, clothing, education, health, safe water and health services. However, the Government has prioritized strategic investments in health, education, skilling and empowerment of young people to accelerate the demographic transition and harness the demographic dividend. This is well articulated in the national Vision 2040, which aims to transform the country from a predominantly rural and low-income country to a competitive upper middle-income economy by 2040, and is further defined in the third national development plan (2020/21 – 2024/2025)

Unemployment and incidence of poverty was worsened by the advent of COVID-19. Prior to 2020, Uganda's economy had been on a steady trajectory, and was regarded as one of the fastest growing in sub-Saharan Africa, having expanded by over 6% from FY2017/18 and FY 2028/19. The NDP III (2020/21 –

2024/25) projected average economic growth of 7% over that period[73]. However, the outbreak of COVID-19 slashed the growth rate to 3% and 3.4% in FY2019/20 and 2020/2021 respectively; and was projected to stagnate at 3% to 4% in 2021/22. According to the (UNHS)(2019/20) the incidence of income poverty increased from 19% prior to Covid-19 era, to 22% during Covid-19. At the same time, the number of households in subsistence economy increased from 3.3 million to 3.5 million, while the number of households operating enterprises reduced from 51% before Covid-19 to 37% after Covid-19, and the most affected were urban areas. Findings from a study to determine the socio-economic impact of COVID-19 indicates that COVID-19 has and will have multiple effects on the economy, poverty, livelihood, employment, vulnerability, including increased incidence of domestic violence. The pandemic negatively affected the provision of quality health, education, social protection and other basic services across the country[74]

Maternal Health

Uganda has made remarkable strides in improving maternal health outcomes from 336/100,000 live births in 2016 to 189/100,000 live births. This progress is evident in the significant increase in institutional deliveries, rising from 60% in 2011 to 86% in 2022, and the decline in home deliveries from 32% in 2011 to 13% in 2022. Similarly, skilled birth attendance has seen a steady increase of 60% in 2011 to 77% in 2016 and 86% in 2022, demonstrating a significant investment in strengthening the health system. While the first ANC attendance (with skilled providers among women age 15-49) increased from 97% in 2016 to 99% in 2022, the fourth ANC visits declined from 73% to 68% during the same period.

Despite improvements in overall access to maternal health services, significant quality challenges remain. Early initiation of antenatal care (ANC) is low, with only 37% of women seeking care within the first trimester. Additionally, the EMoNC assessment conducted in 2023 shows that only 12% of recommended EMoNC facilities are fully functional (able to provide the 7/9 signal functions). Although the recent Service Delivery Points (SDP) Survey (2022) shows that the percent of SDPs with no stockout of reproductive health (RH) commodities had improved from 73% (in 2020) to 86% in 2023, stock-outs of some essential medicine and supplies at health facilities are a common occurrence. These quality gaps, alongside factors like limited access, inadequate referral systems, staff shortages, and stockouts contribute to the persisting high maternal morbidity and mortality rates in Uganda.

HIV Prevention

According to UPHIA 2022 the current prevalence of HIV among adults aged 15-49 years in Uganda is 5.1% (6.5% among women and 3.6% among men) reflecting a slight decrease from 5.8% in UPHIA 2020; and varying considerably across the 11 Geographic regions in the survey, with the lowest region being West Nile at 2.3%, followed by Karamoja region at 2.8%. In 2023, an estimated 1.4 million adults and children are living with HIV in Uganda, with approximately 54,000 new infections and 17,000-related deaths during the year (UNAIDS, 2023).

Key drivers of HIV infections include risky sexual behaviour, low comprehensive knowledge on HIV, low individual risk perception and low access to services by most-at-risk populations. Weak integration of services, inadequate human resources and stock-outs of condoms and test kits further constrain HIV/AIDS prevention efforts. Other factors include low coverage of youth friendly services at health facilities – forcing girls into early sexual relationships, early marriage and early child bearing, and constrain efforts to reduce teenage pregnancy.

[73] Uganda, NPA, NDP III

[74] Uganda, United Nations, CCA (ed Dec. 2021)

Gender and human rights

Uganda has a strong policy and legal framework to promote gender equality. However, the implementation of the policies, as well as monitoring and reporting on recommendations from treaty bodies, remains weak. The prevalence of gender-based violence is high, with half of men and women aged 15 – 49 having experienced physical violence in 2016 since the age of 15. The percent of women who have experienced physical violence since the age of 15 has declined from 56% in 2011 to 51% in 2016, and to 44% in 2022. Among the men, the percentage decreased from 56% in 2011 to 32% in 2016 and 39% in 2022. The incidence of physical violence among women declined from 34% in 2006 to 27% in 2011, to 22% in 2016 and then to 23% in 2022. The incidence of physical violence among men in 2022 was 13.5%. Impacting on progress towards this outcome, 2023 was marked by the closures of the Office of the High Commissioner for Human Rights (OHCHR) country office and the phase-out of the Democratic Governance Facility (DGF), the passage of the Anti-Homosexuality Act of 2023, continued entrenched patriarchal gender norms, and a decline in financing for gender equality, among others.

Humanitarian response

Uganda has been facing Africa's largest refugee crisis with a total number currently standing at 1,611,732 refugees from South Sudan and the Democratic Republic of Congo. The refugee crisis shows no sign of abating. Eighty-one per cent of the refugees are women and children while 57 percent of the refugee population are children under 18 years of age. Out of those, 51% are women, and 24 percent are youth are estimated to be young people (age 15-24)[75]. The government has made refugee-hosting areas a national priority through the Settlement Transformative Agenda (STA) which is aligned to the National Development Plan II. The rapidly increasing number of refugees in the country has resulted in limited access to sexual and reproductive health care services and rights of women, girls and youth in refugee and host communities.

Data and population dynamics

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

UNFPA Country Programme

UNFPA has been operating in Uganda since 1987 towards enhancing Sexual and Reproductive Health and Rights (SRHR), advancing gender equality, realizing rights and choices for young people, and strengthening the generation and use of population data for development. UNFPA is currently implementing the 9th CP in Uganda. The 9th country programme (2021-2025) is aligned with the third Uganda National Development Plan (2020/21-2024/25), National Vision 2040, African Union Agenda 2063 and the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025 - which prioritizes 1)Transformative and inclusive governance; 2) Shared prosperity in a healthy environment and 3)Human wellbeing and resilience. In 2022, the UNFPA Uganda CO undertook the process of aligning the 9th country programme to the UNFPA Strategic Plan 2022-2025]. It was developed in consultation with the Government, civil society, bilateral and multilateral development partners, including United Nations organizations, the private sector and academia.

The UNFPA Uganda CO delivers its country programme through the following modes of engagement: (i) advocacy and policy dialogue, (ii) capacity development, (iii) knowledge management, (iv) partnerships and coordination, and (v) service delivery]. The **overall goal** of the UNFPA Uganda 9th country programme

[75] https://data.unhcr.org/en/documents/details/107754

2021-2025 is **universal access to sexual and reproductive health and reproductive rights and accelerate the implementation of the ICPD Programme of Action,** as articulated in the UNFPA Strategic Plan 2022-2025. The country programme contributes to the following **outcomes** of the UNFPA Strategic Plan 2022-2025:

Outcome 1: By 2025, the reduction in the unmet need for family planning has accelerated
Outcome 2: By 2025, the reduction of preventable maternal deaths has accelerated
Outcome 3: By 2025, the reduction in gender-based violence and harmful practices has accelerated

The UNFPA Uganda 9th country programme (2021-205) has three thematic areas of programming with four interconnected **outputs** that contribute to the outcomes in the Strategic Plan 2022-2025. These outputs are

Outcome 1: Sexual and reproductive health and rights

Output 1.1: Primary health care system at national and subnational level has increased capacity to provide universal access to and coverage of high quality integrated sexual and reproductive health and rights, HIV, and gender based violence services, particularly for the most vulnerable women and young people, including in humanitarian settings

Output 1.2: Women and young people, including those in hard-to-reach communities and those most at risk, are empowered to make informed choices and utilize high quality, integrated, sexual and reproductive health and rights, information, and services

Outcome 2: Gender equality and human rights

Output 2.1: National, sub-national, and community capacities strengthened to prevent and respond to sexual and gender-based violence and other harmful practices, including female genital mutilation and child marriage in all settings

Outcome 3: **Population dynamics**

Output 3.1: National population data systems strengthened to address inequalities, advance the commitments of the Programme of Action of the International Conference on Population and Development to inform rights-based policies, programmes and accountability

Note: Adolescents and Youth are mainstreamed throughout the three outcomes

All the outputs contribute to the achievement of each outcome; they have a multidimensional, 'many-to-many' relationship with these outcomes.

Output 1: Increased access and Utilization to Integrated package of rights

- **80%** of service delivery points have no 'stock-out' of contraceptives
- **70%** of health facilities in programme area with capacity to provide EmONC
- **701** health facilities providing integrated SRH/HIV/ GBV services
- **40** policies, guidelines, and strategies addressing SRH rights, and population dynamics

Output 2: informed choice and use of SRHR services

- **615,907** of new users of modern contraceptives
- **625,000** young people and women reached by life skills programmes that build their health, social, or economic assets
- **75%** of affected population reached with integrated SRH/HIV/GBV services in humanitarian settings

Output 3: Prevention and response to sexual and GBV and other harmful practices

- **100** districts that made public declarations to eliminate harmful practices, including child, early and forced marriage and female genital mutilation
- **3,000,000** young people and women have received prevention and/or protection services and care related with harmful practices

Output 4: Strengthened data system for strategic positioning, targeting and accountability

- **100% of public national and sub-national institutions** whose development plans that integrate recommendations from national DD

- **6 data management systems** that allow for mapping and profiling of demographic and geographic disparities, disasters and socioeconomic inequalities
- **16 in-depth analytical reports** generated from census and survey data
- **20 functional platforms for young people and women** to exercise leadership and exact accountability on reproductive rights.

The UNFPA Uganda CO also engages in activities of the UNCT, with the objective to ensure inter-agency coordination and the efficient and effective delivery of tangible results in support of the national development agenda and the SDGs. Beyond the UNCT, the UNFPA Uganda CO participates in the Humanitarian Country Team (HCT) to ensure that inter-agency humanitarian action is well-coordinated, timely, principled and effective, to alleviate human suffering and protect the lives, livelihoods and dignity of people affected by humanitarian crisis.

The central tenet of the CPE is the country programme **theory of change** and the analysis of its logic and internal coherence. The theory of change describes how and why the set of activities planned under the country programme are expected to contribute to a sequence of results that culminates in the strategic goal of UNFPA is presented in Annex A. The theory of change will be an essential building block of the evaluation methodology. The country programme theory of change explains how the activities undertaken contribute to a chain of results that lead to the intended or observed outcomes. At the design phase, the evaluators will perform an in-depth analysis of the country programme theory of change and its intervention logic. This will help them refine the evaluation questions (see preliminary questions in section 5.2), identify key indicators for the evaluation, plan data collection (and identify potential gaps in available data), and provide a structure for data collection, analysis and reporting. The evaluators' review of the theory of change (its validity and comprehensiveness) is also crucial with a view to informing the preparation of the next country programme's theory of change.

The UNFPA Uganda 9th country programme 2021-2025 is based on the following results framework presented below:

Uganda UNFPA 9th Country Programme (2021-2025) Results Framework

Goal: Achieved universal access to sexual and reproductive health, realized reproductive rights, and reduced maternal mortality to accelerate progress on the ICPD agenda, to improve the lives of adolescents, youth and women, enabled by population dynamics, human rights, and gender equality

UNFPA Strategic Plan Outcomes

SP Outcome: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence	**SP Outcome**: Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence	**SP Outcome:** Everyone, everywhere, is counted, and accounted for, in the pursuit of sustainable development

UNFPA Uganda 9th country programme Outcomes

CPD Outcome 1 (UNSDCF Outcome 3.1): By 2025, people, especially the vulnerable and marginalized, have equitable access to and utilization of quality basic social and protection services **Outcome Indicators:** ● Proportion of women of reproductive age who have their need for family planning unmet with modern methods disaggregated by age: *Baseline*: 28% (2016); *Target*: 10% ● Proportion of births attended by skilled personnel: *Baseline*: 73% (2016); *Target*: 80% ● Number of functional national and subnational platforms for dialogue on reproductive rights, fully engaging civil society, including faith-based and state actors: *Baseline:* 5 *Target*: 20 ● Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by age and place of occurrence: *Baseline*: 39.6% (2016); *Target*: 30%	**CPD Outcome 2 (UNSDCF Outcome 3.2):** By 2025, gender equality and human rights of people in Uganda are promoted, protected and fulfilled in a culturally responsive environment **Outcome Indicators:** ● Proportion of women of reproductive age who have their need for family planning unmet with modern methods disaggregated by age: Baseline: 28% (2016); Target: 10% ● Proportion of births attended by skilled personnel: Baseline: 73% (2016); Target: 80% ● Number of functional national and subnational platforms for dialogue on reproductive rights, fully engaging civil society, including faith-based and state actors: Baseline: 5 Target: 20 ● Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by age and place of occurrence: Baseline: 39.6% (2016); Target: 30%	**Outcome 3 UNSDCF Outcome 1:** By 2025, Uganda has inclusive and accountable governance systems and people are empowered, engaged and enjoy human rights, peace, justice and security **Outcome Indicators:** ● Number of districts supported to generate and use small area statistics for SRH and other demographic and socio indicators for planning and decision making. *Baseline*: 89 (2019); *Target*: 134 ● Number of sectors apart from health and within education, finance, gender, youth, labor that have strategies which integrate the sexual and reproductive health of adolescents and youth, including those marginalized *Baseline: 3 (2019); Target: 6*

UNFPA Uganda 9th country programme Outputs

Output 1: National health care facilities and providers have increased capacity to provide universal access to and coverage of high quality integrated SRH/GBV/HIV services, particularly for the most vulnerable women and young people, including in humanitarian settings **Indicators:** ● **80%** of service delivery points have no 'stock-out' of contraceptives, from 73.6% ● **70%** of health facilities have capacity to provide EmONC ● **701** health facilities that meet at least 80% of the basic standards of SRH/HIV/GBV (from 467 in 2020)	**Output 2:** Women and young people, including those in hard to reach communities and those most at risk, are empowered to make informed choices, and utilize high quality, integrated, sexual and reproductive health and rights, information, and services **Indicators:** ● **38%** increment in the number of CYP dispensed with support from UNFPA (from 5,049,302 in 2019 to 7,010,229 in 2025) ● **75%** of women (15-49yrs) in programme districts make own decisions on SRHR (from 58.5% in 2016) ● **75%** of population in humanitarian settings reached with integrated SRH/HIV/GBV services	**Output 3:** National, sub-national, and community capacities strengthened to prevent and respond to sexual and gender-based violence and other harmful practices, including female genital mutilation and child marriage in all settings **Indicators:** ● **100 districts** commit to eliminate harmful practices, ● **39% increment** in the number of young people and women who receive prevention, protection and care services for GBV and other harmful practices (including FGM, and child marriage) – from 75,417 (2019) to 3,000,000 in 2025	**OUTPUT 4:** National population data systems strengthened to address inequalities, advance the commitments of the Programme of Action of the International Conference on Population and Development to inform rights-based policies, programmes and accountability **Indicators:** ● **100%** of public institutions integrate recommendations from national DD framework (from 25% in 2019) ● **6** data management systems that allow for mapping and profiling of demographic and geographic disparities, disasters and socioeconomic inequalities (from 2 in 2019) ● **16** in-depth analytical reports generated from census and survey data (from 6 in 2019) ● **20** functional platforms for young people and women to exercise leadership and exact accountability on reproductive rights (from 5 in 2019).

UNFPA Uganda 9th country programme Intervention Areas

Strategic Interventions **Advocacy and policy dialogue:** ● Support advocacy for and implementation of policies and strategies for access of in and out-of-school young people to integrated SRH information and services; ● Advocate for sustainable and innovative financing and financial protection to support the provision of integrated HIV, sexual and reproductive health and rights, and gender based violence services ● Support government in the implementation of sexual and reproductive health and rights and	**Strategic Interventions** **Advocacy and policy guidance** Advocacy for and implementation of sexuality education for in and out-of-school young people; **Knowledge generation and sharing:** ● Support innovative approaches focused on HIV prevention among young people, key, and most-at-risk populations including scaling up initiatives for young people to access reproductive health services ● Use innovative approaches to ensure women and girls have access to information and services on menstrual health and hygiene including continued support for developing eco-friendly and reusable sanitary pads **Capacity building**	**Strategic Interventions** **Advocacy and policy guidance** Advocacy for law reforms to align the national legal framework to international and continental instruments; **Knowledge generation and sharing** Support innovative approaches for gender-based violence case management, reporting, and knowledge generation Strengthen information management systems for gender based violence **Capacity building** Scaling up youth, women and community capacities and engagement to eliminate discriminatory gender and sociocultural norms and all forms of violence and harmful practices **Service delivery**	**Strategic Interventions** **Advocacy and Policy dialogue** ● Advocacy for integration of population dynamics in planning and formulation of policies and programmes **Knowledge generation and sharing** ● Support data analytics to better understand and create linkages between sexual reproductive health, harmful practices including in humanitarian settings, and existing polices; ● Support the conduct of the population and housing census and other surveys ● Generation disaggregated data and knowledge on humanitarian situation and refugee response, including ensuring integration of SRH indicators, and conducting in-depth analysis on vulnerabilities of young people and

gender based violence policies and strategies **Knowledge generation and sharing:** ● Provide technical support and scale up maternal and perinatal death reviews at national and sub-national levels **Capacity building** ● Provide support to strengthen midwifery training, associations, and regulatory frameworks for improving skilled attendance at birth; ● Build the capacity of health service providers to deliver rights based family planning, emergency obstetric care, and reproductive health including the minimum initial services package, **including within the context of COVID-19 and Ebola** **Service delivery** ● Support availability as well as monitor, track, and report on reproductive health commodities, supplies, and contraceptives Support and scale up maternal and perinatal death reviews	● Support for the empowerment and livelihoods for adolescents' clubs to build adolescent girls' health, social, and economic assets; **Service delivery** - Support community outreach initiatives including pregnancy mapping to stimulate demand for maternal health service; **Partnership and coordination** ● Enhance partnerships with government, religious, cultural, and civil society and youth led organizations to sustain the provision of integrated sexual and reproductive health and rights information and services	Support implementation of special courts to increase access to justice for women and girls Support the roll out of the male engagement strategy for the active involvement of men and boys to prevent and address gender-based violence; **Partnership and coordination** Partnership and coordination for joint programming and improved coordination of GBV	women during emergencies such as COVID-19 **Capacity building** ● Strengthen platforms for youth and women participation in policy, planning, monitoring, and accountability ● Support harmonization of the different routine data systems to use real time data as evidence for planning and decision making including capacity development in population data systems **Partnerships** ● Work with other partners and stakeholders, leveraging the comparative advantage of the diverse actors to create and explore new opportunities for accelerated demographic transition, innovative financing mechanisms through South-South and triangular cooperation and other initiatives

Nota Bene: "Country Programme Intervention Areas" boxes: **In bold**: Activities that were not initially planned, yet were implemented; *in italics*: Activities that were initially planned but were not implemented.

Evaluation Purpose, Objectives and Scope

Purpose

The CPE will serve the following four main purposes, as outlined in the 2024 UNFPA Evaluation Policy: (i) oversight and demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making to inform development, humanitarian response and peace-responsive programming; and (iii) aggregating and sharing good practices and credible evaluative evidence to support organizational learning on how to achieve the best results; and (iv) empower community, national and regional stakeholders.

Objectives

The **objectives** of this CPE are:

i. To provide the UNFPA Uganda CO, national stakeholders and rights-holders, the UNFPA ESARO, UNFPA Headquarters as well as a wider audience with an independent assessment of the UNFPA Uganda 9th country programme 2021-2025).
ii. To broaden the evidence base to inform the design of the next programme cycle.

The **specific objectives** of this CPE are:

i. To provide an independent assessment on the relevance, impact, coherence, effectiveness, efficiency and sustainability of the UNFPA 9th Country Programme..
ii. To provide an assessment of the geographic and demographic coverage of UNFPA humanitarian assistance and the ability of UNFPA to connect immediate, life-saving support with long-term development objectives.
iii. To provide an assessment of the role played by the UNFPA Uganda CO in the coordination mechanisms of the UNCT, with a view to enhancing the United Nations collective contribution to national development results. To draw key conclusions from past and current cooperation and provide a set of clear, forward-looking and actionable recommendations for the next programme cycle.

Scope

Geographic Scope

The evaluation will cover the following regions and districts where UNFPA implemented interventions as shown in the Table 1 below

Table 1: GoU/UNFPA 9TH COUNTRY PROGRAMME DISTRICTS

W. Nile	Bunyoro	Karamoja	Acholi	Teso	Buganda	Ankole	Sebei	Busoga	Lango	Bukedi	Bugisu
Adjumani	Bundibugyo	Amudat	Agago	Amuria	Kampala	Mbarara	Bukwo	Namayingo	Apac	Tororo	Bududa
Arua	Isingiro	Nakapiripirit	Amuru	Katakwi	Masaka City	Isingiro	Kween	Mbale City	Otuke	Kibuku	
Arua City	Kamwenge	Moroto	Gulu	Soroti City	Mukono MC	Kisoro	Kapchorwa	Kamuli			
Koboko	Kanungu	Napak	Gulu City	Bukedea	Wakiso MC						
Madi-Okollo	Kasese	Kotido	Kitgum	Kaberamaido							
Maracha	Kyegegwa	Abim	Lamwo	Katakwi							
Moyo	Kiryandongo	Karenga	Omoro	Ngora							
Nebbi	F/Portal City	Kaabong	Pader								
Obongi	Kanungu	Nabilatuk	Nwoya								
Pakwach	Kikube										
Terego											
Yumbe											
Zombo											
13	**10**	**9**	**9**	**7**	**4**	**3**	**3**	**3**	**2**	**2**	**1**

The evaluation will focus primarily on the 9th GoU-UNFPA CP 40 core districts where most of the resources of the CP have been invested, including 7 refugee hosting districts, as highlighted (in sky blue) in Table 1 above.. These are the districts where all/most of 4 thematic intervention areas have been implemented, namely (a) Sexual Reproductive Health; (b) Adolescents and Youth; (c) Gender Equality and Women Empowerment; and (d) Population Dynamics. Other districts will be considered on the basis of special programmes were or are being implemented in the course of the programme cycle, e.g. Kampala and Mubende.

Thematic Scope

The evaluation will cover the following thematic areas of the 9th CP: (i) increased capacity to provide universal access to and coverage of high quality integrated sexual and reproductive health and rights: (ii) Women and young people are empowered to make informed choices and utilize high quality, integrated, sexual and reproductive health and rights, information, and services; (iii) Strengthened capacity to prevent and respond to sexual and gender-based violence and other harmful practices; (iv) Population data systems strengthened to address inequalities and ICPD commitments

In addition, the evaluation will cover cross-cutting issues, such as human rights; gender equality; disability;, etc., and transversal functions, such as coordination; Monitoring and Evaluation (M&E); innovation; resource mobilization; strategic partnerships, etc..

Temporal Scope

The evaluation will cover interventions planned and/or implemented within the time period of the CP: 2021-2025.

Evaluation Criteria and Preliminary Evaluation Questions

Evaluation Criteria

In accordance with the methodology for CPEs outlined in section 6 , the evaluation will examine the following five OECD/DAC evaluation criteria: relevance, coherence, effectiveness, efficiency and sustainability.[76] It will also use the evaluation criterion of coordination to assess the extent to which the UNFPA Uganda CO harmonized interventions with other actors, promoted synergy and avoided duplication under the framework of the UNCT; and the HCT. Furthermore, the evaluation will use the humanitarian-specific evaluation criteria of coverage and connectedness to investigate: (i) to what extent UNFPA has been able to provide life-saving services to affected populations that are hard-to-reach; and (ii) to work across humanitarian- development-peace nexus and contribute to building resilience.

Table 2: Evaluation Criterion

Criterion	Definition
Relevance	The extent to which the intervention objectives and design respond to rights-holders, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.

[76] The full set of OECD/DAC evaluation criteria, their adapted definitions and principles of use are available at: https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf. They also include impact, but this is beyond the scope of the CPE.

Coherence	The compatibility of the intervention with other interventions in the country, sector or institution. The search for coherence applies to other interventions under different thematic areas of the UNFPA mandate which the CO implements (e.g., linkages between SRHR and GBV programming) and to UNFPA projects and projects implemented by other UN agencies, INGOs and development partners in the country.
Effectiveness	The extent to which the intervention achieved, or is expected to achieve, its objectives and results, including any differential results across groups.
Efficiency	The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way. Could the same results have been achieved with fewer financial or technical resources, for instance?
Sustainability	The extent to which the net rights-holders of the intervention continue, or are likely to continue (even if, or when, the intervention ends).
Coverage	The extent to which major population groups facing life-threatening conditions were reached by humanitarian action. Evaluators need to assess the extent of inclusion bias – that is, the inclusion of those in the groups receiving support who should not have been (disaggregated by sex, socio-economic grouping and ethnicity); as well as the extent of exclusion bias, that is, exclusion of groups who should have been covered but were not (disaggregated by sex, socio-economic grouping and ethnicity).
Connectedness	The extent to which activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account, which is a nexus approach, and that also indicates the complementarity of UNFPA with other partner interventions.

Preliminary Evaluation Questions

The evaluation of the country programme will provide answers to the evaluation questions (related to the above criteria), which determine the thematic scope of the CPE.

The evaluation questions presented below are indicative and preliminary. Based on the review of the theory of change, the country office staff are expected to develop a set of questions directly relevant to the country programme under evaluation and insert them in this section. At the design phase, the evaluators are expected to refine and develop a final set of evaluation questions, in consultation with the CPE Manager at the UNFPA Uganda CO and the ERG.

Relevance

EQ1. To what extent did the 9th Country Programme (CP) design and theory of change (ToC) respond to (i) national policies, strategies and priorities; (ii) the strategic direction and objectives of UNFPA; and (iv) priorities articulated in international frameworks and agreements, in particular the ICPD Programme of Action and the SDGs, and how did it adapt to contextual changes to achieve results?

EQ2. To what extent did the 9th CP interventions incorporate cross-cutting issues and accelerators (as defined in UNFPA Global Strategy) to respond to the diverse needs of marginalized and vulnerable populations, including people with disabilities (PWD), adolescents and youth, persons affected by humanitarian crises including refugees, key populations, and other vulnerable populations?

Coherence

EQ3. To what extent are the interventions in the ninth CP inter-linked, well integrated and complementary, have a synergistic effect, and are linked with government programmes, and projects implemented by other UN agencies, INGOs and development partners in the country?

Effectiveness

EQ4. To what extent have the strategies and interventions 9th CP delivered outputs and contributed to the achievement of the outcomes of the country programme in particular (i) increased access and use of integrated SRH services; (ii) empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights, (iii) advancement of gender equality and the empowerment fall women and girls; (iv) increased use of population data in the development of evidence-based national development plans, policies and programmes? *Which specific programme models proved to be more effective in delivering results? How and for whom?*

EQ5. To what extent did the 9th CP deliver results for the most vulnerable and left behind populations, including adolescents and youth, PWDs, key populations, refugees and other populations affected by humanitarian crises, and those living in remote and underserved areas?

EQ6. To what extent were the investments in innovations effective and contributed to the achievement of results? How effectively were innovations developed, tested, documented, disseminated and scaled-up? Did the 9th CPD introduce innovative approaches that could be scaled up for wider impact?

EQ7. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA and partners and be applied in future programme and policy development to accelerate results?

Efficiency

EQ8. To what extent have resources (human, financial and administrative), policies, procedures and tools, and delivery modalities of the 9th CP, contributed to effective and timely delivery of services and achievement of the outputs and outcomes defined in the county programme?

Sustainability

EQ9. To what extent has the programme been able to support the government, implementing partners and rights-holders (notably, women, adolescents and youth) in developing capacities and establishing mechanisms to ensure the durability of effects?

Coordination

EQ10. To what extent did the governance structures (DaO, partnership strategy; execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs.

Coverage

EQ11. To what extent have UNFPA humanitarian interventions systematically reached all geographic areas in which affected populations (women, adolescents and youth) reside?

Connectedness

EQ12 To what extent has the UNFPA humanitarian response taken into account longer-term development goals articulated in the results framework of the country programme?

The final evaluation questions and the evaluation matrix will be presented in the design report.

Approach and Methodology

Evaluation Approach

Theory-based approach

The CPE will adopt a theory-based approach that relies on an explicit theory of change, which depicts how the interventions supported by the UNFPA Uganda CO are expected to contribute to a series of results (outputs and outcomes) that contribute to the overall goal of UNFPA. The theory of change also identifies the causal links between the results, as well as critical assumptions and contextual factors that support or hinder the achievement of desired changes. A theory-based approach is fundamental for generating insights about what works, what does not and why. It focuses on the analysis of causal links between changes at different levels of the results chain that the theory of change describes, by exploring how the assumptions behind these causal links and contextual factors affect the achievement of intended results.

The theory of change will play a central role throughout the evaluation process, from the design and data collection to the analysis and identification of findings, as well as the articulation of conclusions and recommendations. The evaluation team will be required to verify the theory of change underpinning the UNFPA Uganda 9th country programme (2021-2025) (see Annex A) and use this theory of change to determine whether changes at output and outcome levels occurred (or not) and whether assumptions about change hold true. The analysis of the theory of change will serve as the basis for the evaluators to assess how relevant, coherent, effective, efficient and sustainable was the support provided by the UNFPA Uganda CO during the period of the 9th country programme. Where applicable, the humanitarian context needs to be considered in analyzing the theory of change.

As part of the theory-based approach, the evaluators shall use a contribution analysis to explore whether evidence to support key assumptions exists, examine if evidence on observed results confirms the chain of expected results in the theory of change, and seek out evidence on the influence that other factors may have had in achieving desired results. This will enable the evaluation team to make a reasonable case about the difference that the UNFPA Uganda 9th country programme (2021-2025) made.

Participatory approach

The CPE will be based on an inclusive, transparent and participatory approach, involving a broad range of partners and stakeholders at national and sub-national level. The UNFPA Uganda CO has developed an initial stakeholder map (see Annex B) to identify stakeholders who have been involved in the preparation and implementation of the country programme, and those partners who do not work directly with UNFPA, yet play a key role in a relevant outcome or thematic area in the national context. These stakeholders include government representatives, civil society organizations, implementing partners, the private sector, academia, other United Nations organizations, donors, policy makers (Parliament) and, most importantly, rights-holders (notably women, adolescents and youth. They can provide information and data that the evaluators should use to assess the contribution of UNFPA support to changes in each thematic area of the country programme. Particular attention will be paid to ensuring the participation of women, adolescents and young people, especially those from vulnerable and marginalized groups (e.g., young people and women with disabilities, etc.).

The CPE Manager in the UNFPA Uganda CO has established an ERG comprised of key stakeholders of the country programme, including: governmental and non-governmental counterparts at national level,

including organizations representing young people, persons with disabilities, academia and the regional M&E adviser in UNFPA ESARO. The evaluation team will work with the ERG which will oversee the entire process of the CPE and provide feedback and guidance at the different stages in the evaluation process.

Mixed-method approach

The evaluation will primarily use qualitative methods for data collection, including document review, interviews, group discussions and observations during field visits, where appropriate. The qualitative data will be complemented with quantitative data to minimize bias and strengthen the validity of findings. Quantitative data will be compiled through desk review of documents, websites and online databases to obtain relevant financial data and data on key indicators that measure change at output and outcome levels. The use of innovative and context-adapted evaluation tools (including ICT) is highly encouraged.

These complementary approaches described above will be used to ensure that the evaluation: (i) responds to the information needs of users and the intended use of the evaluation results; (ii) upholds human rights and principles throughout the evaluation process, including through participation and consultation of key stakeholders (rights holders and duty bearers); and (iii) provides credible information about the benefits for duty bearers and rights-holders (women, adolescents and youth) of UNFPA support through triangulation of collected data.

Methodology

The evaluation team shall develop the evaluation methodology in line with the evaluation approach and guidance provided here and in the UNFPA Evaluation Handbook. This will help the evaluators develop a methodology that meets good quality standards for evaluation at UNFPA and the professional evaluation standards of UNEG. It is essential that, once contracted by the UNFPA Uganda CO, the evaluators acquire a solid knowledge of the Handbook and the required methodology of UNFPA, and of the evaluation quality assurance and assessment process, including the assessment grid.

The CPE will be conducted in accordance with the UNEG Norms and Standards for Evaluation,[77] Ethical Guidelines for Evaluation,[78] Code of Conduct for Evaluation in the UN System[79], and Guidance on Integrating Human Rights and Gender Equality in Evaluations.[80] When contracted by the UNFPA Uganda CO, the evaluators will be requested to sign the UNEG Code of Conduct[81] prior to starting their work.

The methodology that the evaluation team will develop builds the foundation for providing valid and evidence-based answers to the evaluation questions and for offering a robust and credible assessment of UNFPA support in Uganda. The methodological design of the evaluation shall include in particular: (i) a theory of change; (ii) a strategy for collecting and analyzing data; (iii) specifically designed tools for data

[77] Document available at: http://www.unevaluation.org/document/detail/1914.
[78] Document available at: http://www.unevaluation.org/document/detail/102.
[79] Document available at: http://www.unevaluation.org/document/detail/100.
[80] Document available at: http://www.unevaluation.org/document/detail/980.
[81] UNEG Code of conduct: http://www.unevaluation.org/document/detail/100.

collection and analysis; (iv) an evaluation matrix; and (v) a detailed evaluation work plan and agenda for the field phase.

The evaluation team is required to follow all the guidance in the Handbook throughout the whole evaluation process, including using the templates and links provided. Notably, these include the templates for the evaluation matrix and the stakeholder agenda. They must also follow the editorial guidance in drafting the design and final evaluation reports and ensure that the evaluation report meets the requirements of the evaluation and assessment (EQA) grid.

The evaluation matrix

The evaluation matrix is the centerpiece of the methodological design of the evaluation. The matrix contains the core elements of the evaluation. It outlines (i) *what will be evaluated:* evaluation questions for all evaluation criteria and key assumptions to be examined; and (ii) *how it will be evaluated*: data collection methods and tools and sources of information for each evaluation question and associated key assumptions. By linking each evaluation question (and associated assumptions) with the specific data sources and data collection methods required to answer the question, the evaluation matrix plays a crucial role before, during and after data collection. The design and use of the evaluation matrix is described in Chapter 2, section 2.2.2.2 of the Handbook.

- In the design phase, the evaluators should use the evaluation matrix to develop a detailed agenda for data collection and analysis and to prepare the structure of interviews, group discussions and site visits. At the design phase, the evaluation team must enter, in the matrix, the data and information resulting from their desk (documentary review) in a clear and orderly manner.
- During the field phase, the evaluation matrix serves as a working document to ensure that the data and information are systematically collected (for each evaluation question) and are presented in an organized manner. Throughout the field phase, the evaluators must enter, in the matrix, all data and information collected. The CPE Manager will ensure that the matrix is placed in a Google drive and will check the evaluation matrix on a daily basis to ensure that data and information is properly compiled. S/he will alert the evaluation team in the event of gaps that require additional data collection or if the data/information entered in the matrix is insufficiently clear/precise.
- In the reporting phase, the evaluators should use the data and information presented in the evaluation matrix to build their analysis (or findings) for each evaluation question. The fully completed matrix is an indispensable annex to the report and the CPE Manager will verify that sufficient evidence has been collected to answer all evaluation questions in a credible manner.

As the evaluation matrix plays a crucial role at all stages of the evaluation process, it will require particular attention from both the evaluation team and the CPE Manager. The evaluation matrix will be drafted in the design phase and must be included in the design report. The completed evaluation matrix will be annexed to the final evaluation report to enable users of the evaluation report to access the supporting evidence for the answers to the evaluation questions. Confidentiality of respondents must be assured in how their feedback is presented in the evaluation matrix.

Finalization of the evaluation questions and related assumptions

Based on the preliminary questions presented in the present terms of reference (section 5.2) and the theory of change underlying the country programme (see Annex A), the evaluators are required to refine the evaluation questions. In their final form, the questions should reflect the evaluation criteria (section 5.1) and clearly define the key areas of inquiry of the CPE. The final evaluation questions will structure the evaluation matrix and shall be presented in the design report.

The evaluation questions must be complemented by a set of critical assumptions that capture key aspects of how and why change is expected to occur, based on the theory of change of the country programme. This will allow the evaluators to assess whether the preconditions for the achievement of outputs and the contribution of UNFPA to higher-level results, in particular at outcome level, are met. The data collection for each of the evaluation questions and related assumptions will be guided by clearly formulated quantitative and qualitative indicators, which need to be specified in the evaluation matrix.

Sampling strategy

The UNFPA Uganda CO will provide an initial overview of the interventions supported by UNFPA, the locations where these interventions have taken place, and the stakeholders involved in these interventions. As part of this process, the UNFPA Uganda CO has produced an initial stakeholder map to identify the range of stakeholders that are directly or indirectly involved in the implementation or affected by the implementation of the CP (see Annex B).

Building on the initial stakeholder map and based on information gathered through document review and discussions with CO staff, the evaluators will develop the final stakeholder map. From this final stakeholder map, the evaluation team will select a sample of stakeholders at national and sub-national level who will be consulted through interviews and/or group discussions during the data collection phase. These stakeholders must be selected through clearly defined criteria and the sampling approach outlined in the design report (for guidance on how to select a sample of stakeholders see Handbook, section 2.3). In the design report, the evaluators should also make explicit which groups of stakeholders were not included and why. The evaluators should aim to select a sample of stakeholders that is as representative as possible, recognizing that it will not be possible to obtain a statistically representative sample.

The evaluation team shall also select a sample of sites that will be visited for data collection and provide the rationale for the selection of the sites in the design report. The UNFPA Uganda CO will provide the evaluators with necessary information to access the selected locations, including logistical requirements and security risks, if applicable. The sample of sites selected for visits should reflect the variety of interventions supported by UNFPA, both in terms of thematic focus and context.

The final sample of stakeholders and sites will be determined in consultation with the CPE Manager, based on the review of the design report.

Data collection

The evaluation will consider primary and secondary sources of information. For detailed guidance on the different data collection methods typically employed in CPEs, see Handbook, section 2.2.3.1

Primary data will be collected through semi-structured interviews with a wide range of key informants at national and sub-national levels, as well as Focus Group Discussions with service providers and rights-holders (notably women, adolescents and youth) and direct observation during visits to selected sites.

Secondary data will be collected through extensive document review**,** primarily focusing on the resources highlighted in section 14 of these terms of reference. The evaluation team will ensure that data collected is disaggregated by sex, age, location, and other relevant dimensions, such as disability status, to the extent possible.

The evaluation team is expected to dedicate a total of four weeks for data collection in the field. The data collection tools that the evaluation team will develop, which may include protocols for semi-structured interviews and group discussions, checklists for direct observation at sites visited (see template for observation during on-site visits) or a protocol for document review, shall be presented in the design report.

Data analysis
The evaluation matrix will be the major framework for analyzing data. The evaluators must enter the qualitative and quantitative data in the evaluation matrix for each evaluation question and each assumption. Once the evaluation matrix is completed, the evaluators should identify common themes and patterns that will help to answer the evaluation questions. The evaluators shall also identify aspects that should be further explored and for which complementary data should be collected, to fully answer all the evaluation questions and thus cover the whole scope of the evaluation (see Handbook, Chapter 4).

Validation mechanisms
All findings of the evaluation need to be firmly grounded in evidence. The evaluation team will use a variety of mechanisms to ensure the validity of collected data and information as highlighted in the Handbook (and see section 7 below). Data validation is a continuous process throughout the different evaluation phases, and the proposed validation mechanisms will be presented in the design report. In particular, there must be systematic triangulation of data sources and data collection methods, internal evaluation team meetings to corroborate and analyze data, and regular exchanges with the CPE Manager. A debriefing meeting with the CO and the ERG takes place at the end of the field phase, when the evaluation team present the emerging findings of the evaluation.

Evaluation Process
The CPE process can be broken down into five different phases that include different stages and lead to different deliverables: preparation phase; design phase; field phase; reporting phase; and phase of dissemination and facilitation of use. The CPE Manager and the evaluation team leader must undertake quality assurance of each deliverable at each phase and step of the process, with a view to ensuring the production of a credible, useful and timely evaluation.

Preparation Phase The CPE Manager at the UNFPA Uganda CO leads the preparation phase of the CPE. This includes:

- CPE launch and orientation meeting for CO staff
- Evaluation questions workshop
- Establishing the evaluation reference group
- Drafting the terms of reference
- Assembling and maintaining background information

- Mapping the CPE stakeholders
- Recruiting the evaluation team.

The full tasks of the preparation phase and responsible entities are detailed in Chapter 1 of the Handbook.

7.2. Design Phase The design phase sets the overall framework for the CPE. This phase includes:

- Induction meeting with the evaluation team
- Orientation meeting with the CO staff
- Desk review by the evaluation team and preliminary interviews, mainly with CO staff
- Developing the evaluation approach i.e., critical analysis of the theory of change suing contribution analysis, refining the preliminary evaluation questions and developing the assumptions for verification, developing the evaluation matrix, methods for data collection, and sampling method
- Stakeholder sampling and site selection
- Developing the field work agenda
- Developing the initial communications plan
- Drafting the design report version 1
- Quality assurance of design report version 1
- ERG meeting to present the design report
- Drafting the design report version 2
- Quality assurance of design report version 2

At the end of the design phase, the evaluation team will develop a **final design report** that presents a robust, practical and feasible evaluation approach, detailed methodology and work plan. The evaluation team will develop the design report in consultation with the CPE Manager and the ERG and submit it to the regional M&E adviser in UNFPA ESARO for review.

The detailed activities of the design phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 2.

Field Phase The evaluation team will collect the data and information required to answer the evaluation questions in the field phase. Towards the end of the field phase, the evaluation team will conduct a preliminary analysis of the data to identify emerging findings that will be presented to the CO and the ERG. The field phase should allow the evaluators sufficient time to collect valid and reliable data to cover the thematic scope of the CPE. A period of four weeks for data collection is planned for this evaluation. However, the CPE Manager will determine the optimal duration of data collection, in consultation with the evaluation team during the design phase.

The field phase includes:

- Preparing all logistical and practical arrangements for data collection
- Launching the field phase
- Collecting primary data at national and sub-national level
- Supplementing with secondary data
- Collecting photographic material

- Filling in the evaluation matrix
- Conducting a data analysis workshop
- Debriefing meeting and consolidating feedback for the debrief

At the end of the field phase, the evaluation team will hold a **debriefing meeting with the CO and the ERG** to present the initial analysis and emerging findings from the data collection in a PowerPoint presentation. The meeting will serve as a mechanism for the validation of collected data and information and the exchange of views between the evaluators and important stakeholders. It will enable the evaluation team to refine the findings, which is necessary so they can then formulate their conclusions and begin to develop credible and relevant recommendations. Should the debriefing meeting find that there are gaps in the data gathered, the CPE Manager and the CO will assist the evaluation team to set up further interviews or to identify further documents as required.

The detailed activities of the field phase with guidance on how they should be undertaken are provided in the Handbook, Chapter 3.

Reporting Phase In the reporting phase, the CPE Manager and the evaluation team will have a further meeting to agree next steps and deadlines, review the required evaluation report structure, and reflect on the requirements of the EQA grid. The team follows up on any further interviews or documents to review. The team leader finalizes the distribution of tasks for the team with deadlines for their completion, one important aspect of which is consolidating the evaluation matrix to meet quality standards. The reporting phase includes:

- Brainstorming on feedback from the ERG and CO debrief meeting
- Additional data collection if required
- Consolidating the evaluation matrix
- Drafting the findings and conclusions
- Identifying tentative recommendations using the recommendations worksheet
- Drafting CPE report version 1
- Quality assurance of CPE report version 1 and recommendations worksheet by the CPE Manager and RO M&E Adviser
- ERG meeting on CPE report version 1
- Recommendations workshop with ERG to finalize recommendations
- Revision of CPE report version 1
- Drafting CPE version 2
- Quality assurance of CPE report version 2 by the CPE Manager and RO M&E Adviser
- Final CPE report

The Handbook, Chapter 4, provides comprehensive details of the process that must be followed throughout the reporting phase, including details of all quality assurance steps and requirements for an acceptable report. The evaluation report is considered final once it is formally approved by the CPE Manager in the UNFPA Uganda CO.

At the end of the reporting phase, the CPE Manager and the regional M&E Adviser will jointly prepare an internal EQA of the final evaluation report. The Independent Evaluation Office will subsequently conduct the final EQA of the report, which will be made publicly available.

Dissemination and Facilitation of Use Phase This phase focuses on strategically communicating the CPE results to targeted audiences (short term) and facilitating the use of the CPE to inform decision-making and learning for programme and policy improvement (long term). It serves as a bridge between generating evaluation results, and the practical steps needed to ensure CPE leads to meaningful programme adaptation. While this phase is specifically about dissemination and facilitating the use of the CPE results, its foundation rests upon the preceding phases. This phase is largely the responsibility of the CPE manger, CO communications officer and other CO staff. However, key responsibilities of the evaluation team in this phase include:

- Taking photographs during primary data collection and during the evaluation process
- Adhering to the editorial guidelines of the United Nations and the UNFPA Evaluation Office to ensure high editorial standards
- Contribute to the finalization of the communications plan

The detailed guidance on the dissemination and facilitation of use phase is provided in the Handbook, Chapter 5.

Expected Deliverables

The evaluation team is expected to produce the following deliverables:

- **Design report.** The design report should translate the requirements of the ToR into a practical and feasible evaluation approach, methodology and work plan. In addition to presenting the methodology, the design report provides information on the country situation and the UN and UNFPA response. The Handbook section 2.4 provides the required structure of the design report and guidance on how to draft it.
- **PowerPoint presentation of the design report.** The PowerPoint presentation will be delivered at an ERG meeting to present the contents of the design report and the agenda for the field phase. Based on the comments and feedback of the ERG, the CPE Manager and the regional M&E adviser, the evaluation team will develop the final version of the design report.
- **PowerPoint presentation for debriefing meeting with the CO and the ERG.** The presentation provides an overview of key emerging findings of the evaluation at the end of the field phase. It will serve as the basis for the exchange of views between the evaluation team, UNFPA Uganda CO staff (incl. senior management) and the members of the ERG who will thus have the opportunity to provide complementary information and/or rectify the inaccurate interpretation of data and information collected.
- **Draft evaluation report.** The draft evaluation report will present the findings and conclusions, based on the evidence that data collection yielded. It will undergo review by the CPE Manager, the CO, the ERG and the regional M&E adviser, and the evaluation team will undertake revisions accordingly.
- **Drafting of tentative recommendations using the Recommendation Worksheet for** review by the ERG (see Handbook section 4.3).
- **Final evaluation report.** The final evaluation report *(maximum 70 pages, excluding annexes)* will present the findings and conclusions, as well as a set of practical and actionable recommendations to

inform the next programme cycle. The Handbook section 4.5 provides the structure and guidance on developing the report. The set of annexes must be complete and must include the evaluation matrix containing all supporting evidence (data and information and their source).

- **PowerPoint presentation of the evaluation results.** The presentation will provide a clear overview of the key findings, conclusions and recommendations to be used for the dissemination of the final evaluation report.
- Based on these deliverables, the CPE Manager, in collaboration with the communication officer in the UNFPA Uganda CO will develop an:
- **Evaluation brief.** The evaluation brief will consist of a short and concise document that provides an overview of the key evaluation results in an easily understandable and visually appealing manner, to promote their use among decision-makers and other stakeholders. The structure, content and layout of the evaluation brief should be similar to the briefs that the UNFPA Independent Evaluation Office produces for centralized evaluations.

All the deliverables will be developed in English.

Quality Assurance and Assessment

The UNFPA Evaluation Quality Assurance and Assessment (EQAA) system aims to ensure the production of good quality evaluations at central and decentralized levels through two processes: quality assurance and quality assessment. Quality assurance occurs throughout the evaluation process, starting with the ToR of the evaluation and ending with the final evaluation report. Quality assessment takes place following the completion of the evaluation process and is limited to the final evaluation report to assess compliance with a certain number of criteria. The quality assessment will be conducted by the UNFPA Independent Evaluation Office (IEO).

The EQAA of this CPE will be undertaken in accordance with the guidance and tools that the IEO has developed (see https://www.unfpa.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance). An essential component of the EQAA system is the EQA grid, which defines a set of criteria against which the draft and final evaluation reports are assessed to ensure clarity of reporting, methodological robustness, rigor of the analysis, credibility of findings, impartiality of conclusions and usefulness of recommendations.

The CPE Manager is primarily responsible for quality assurance of the deliverables of the evaluation in each phase of the evaluation process. However, the evaluation team leader also plays an important role in undertaking quality assurance, as elaborated in the Handbook. The evaluation team leader must ensure that all members of the evaluation team provide high-quality contributions (both form and substance) and, in particular, that the draft and final evaluation reports comply with the quality assessment criteria outlined in the EQA grid[82] before submission to the CPE Manager for review.

[82] The evaluators are invited to look at good quality CPE reports that can be found in the UNFPA evaluation database, which is available at: https://www.unfpa.org/evaluation/database. These reports must be read in conjunction with their EQAs (also available in the database) in order to gain a clear idea of the quality standards that UNFPA expects the evaluation team to meet.

Using the EQA grid, the EQAA process for this CPE will be multi-layered and will involve: (i) the evaluation team leader (and each evaluation team member); (ii) the CPE Manager in the UNFPA Uganda CO, (iii) the regional M&E adviser in UNFPA ESARO, and (iv) the UNFPA Independent Evaluation Office, whose roles and responsibilities are outlined in section 11.

Indicative Timeframe and Work Plan

The table below indicates the main activities that will be undertaken throughout the evaluation process, as well as their estimated duration for the submission of corresponding deliverables. The involvement of the evaluation team starts with the design phase and ends after the reporting phase. The Handbook contains full details on the activities at each phase and must be used by the evaluators to guide completion of their detailed work plan in the design report.

Approximate timelines for main tasks and deliverables in each phase of the CPE[83]

Main tasks	Responsible entity	Estimated duration
Phase 1: Preparation		
CPE launch and orientation meeting for CO staff	CO Representative, CPE Manager and all CO staff	12 weeks
Establishing the evaluation reference group	CPE manager in consultation with the relevant government partner that coordinates the country programme and CO staff	
Evaluation questions workshop	CO Representative, CPE Manager and all CO staff	
Drafting the terms of reference	CPE manager	
Online document repository	CPE manager	
Mapping the CPE stakeholders	CPE Manager and relevant CO staff	
Recruiting the evaluation team	CPE Manager and CO operations team	
Phase 2: Design		
Induction meeting with the evaluation team	CPE Manager and evaluation team	2-3 weeks
Orientation meeting with the CO staff	CO Representative, CPE Manager, CO staff and RO M&E Adviser	
Desk review by the evaluation team and preliminary interviews, mainly with CO staff	Evaluation team	
Developing the evaluation approach	Evaluation team	
Stakeholder sampling and site selection	Evaluation team, CPE Manager and relevant CO staff	
Developing the field work agenda	Evaluation team, CPE Manager and relevant CO staff	
Developing the initial communications plan	CPE Manager and CO communications officer	
Drafting the design report version 1	Evaluation team	
Quality assurance of design report version 1	CPE Manager and RO M&E Adviser	

[83] For full information on all tasks and responsible entities, see the relevant chapters of the Handbook

ERG meeting to present the design report	Evaluation team, CPE manager, ERG members, RO M&E Adviser	
Drafting the design report version 2	Evaluation team	
Quality assurance of design report version 2	CPE Manager and RO M&E Adviser	
Phase 3: Fieldwork		
Preparing all logistical and practical arrangements for data collection	CPE Manager and relevant CO staff, supported by	3-4 weeks
Launching the field phase	Evaluation supported by CPE Manager and CO staff	
Collecting primary data at national and sub-national level	Evaluation team, supported by CPE Manager	
Supplementing with secondary data	Evaluation team, supported by CPE Manager	
Collecting photographic material	Evaluation team, supported by CO communications officer and CPE Manager	
Filling in the evaluation matrix	Evaluation team	
Conducting a data analysis workshop	CPE Manager and evaluation team	
Debriefing meeting and consolidating feedback for the debrief	ERG members, CO staff, evaluation team and CPE manager	
Phase 4: Reporting		
Brainstorming on feedback from the ERG and CO	Evaluation team, supported by CPE Manager	6 weeks
Additional data collection if required	Evaluation team, supported by CPE Manager	
Consolidating the evaluation matrix	Evaluation team	
Drafting the findings and conclusions	Evaluation team	
Identifying tentative recommendations using the recommendations worksheet	Evaluation team and CPE Manager	
Drafting CPE report version 1	Evaluation team	
Quality assurance of CPE report version 1 and recommendations worksheet	CPE Manager and RO M&E Adviser	
ERG meeting on CPE report version 1	CPE manager, ERG members, RO M&E Adviser, Evaluation team	
Recommendations workshop	Evaluation team, CPE manager, ERG members	
Revision of CPE report version 1	Evaluation team	
Drafting CPE version 2	Evaluation team	
Quality assurance of CPE report version 2	CPE Manager and RO M&E Adviser	
Final CPE report	Evaluation team, CPE Manager and RO M&E Adviser	

Management of the Evaluation

The **CPE Manager** in the UNFPA Uganda CO, in close consultation with the National Population Council that coordinates the country programme will be responsible for the management of the evaluation and supervision of the evaluation team in line with the UNFPA Evaluation Handbook. The CPE Manager will oversee the entire process of the evaluation, from the preparation to the dissemination of the evaluation results and facilitation of use. S/he will also coordinate the exchanges between the evaluation team and the ERG. It is the responsibility of the CPE Manager to ensure the quality, independence and impartiality of the evaluation in line with the UNEG norms and standards and ethical guidelines for evaluation. The full roles and responsibilities of the CPE Manager are provided in the Handbook for each phase of the CPE.

At all stages of the evaluation process, the CPE Manager will require support from staff of the UNFPA Uganda CO. In particular, the **country office staff** contribute to the preparation of the ToR and all its annexes, assist the evaluators to understand the country programme and its strengths and limitations, and assist with all logistics for the CPE. They also provide inputs to the management response and contribute to the dissemination of evaluation results. CPE Manager

The progress of the evaluation will be followed closely by the **evaluation reference group (ERG)**, which is composed of relevant UNFPA staff from the Uganda CO, ESARO, representatives of the national Government of Uganda, implementing partners, as well as other relevant key stakeholders (see Handbook, section 1.4). The ERG serves as a body to ensure the relevance, quality and credibility of the evaluation. It provides inputs on key milestones in the evaluation process, facilitates the evaluation team's access to sources of information and key informants and undertakes quality assurance of the evaluation deliverables from a technical perspective. The Handbook provides details of the roles and responsibilities of the ERG at different phases of the CPE.

The **regional M&E adviser** in UNFPA ESARO will provide guidance and backstopping support to the CPE Manager at all stages of the evaluation process. In particular, the regional M&E plays a crucial role in the evaluation quality assurance and assessment (EQAA) of the CPE. This includes quality assurance of the ToR, consultant recruitment and both the design and final evaluation reports. S/he also assists with dissemination and use of the evaluation results. The roles and responsibilities of the regional M&E adviser at all phases of the CPE are indicated in the Handbook in the respective chapters.

The UNFPA **Independent Evaluation Office IEO)** commissions an independent EQA of the final evaluation report. The IEO also publishes the final evaluation report, independent EQA and management response in the UNFPA evaluation database.

Composition of the Evaluation Team

UNFPA Uganda CO seeking to hire the services of a multi-disciplinary team of a evaluators, which will consist of: (i) an evaluation team leader with overall responsibility for carrying out the evaluation exercise, and (ii) team members who will provide technical expertise in thematic areas relevant to the UNFPA mandate (SRHR; adolescents and youth; gender equality and women's empowerment; and population dynamics). In addition to her/his primary responsibility for the design of the evaluation methodology and the coordination of the evaluation team throughout the CPE process, the team leader will perform the role of technical expert for one of the thematic areas of the 9th UNFPA country programme in Uganda.

The evaluation team leader will be recruited internationally (incl. in the region or sub-region), while the evaluation team members will be recruited locally to ensure adequate knowledge of the country context. Finally, the evaluation team should have the requisite level of knowledge to conduct human rights- and gender-responsive evaluations and all evaluators should be able to work in a multidisciplinary team and in a multicultural environment.

Roles and Responsibilities of the Evaluation Team

Evaluation team leader

The evaluation team leader will hold the overall responsibility for the design and implementation of the evaluation. S/he will be responsible for the production and timely submission of all expected deliverables in line with the ToR. S/he will lead and coordinate the work of the evaluation team and ensure the quality of all evaluation deliverables at all stages of the process. The CPE Manager will provide methodological guidance to the evaluation team in developing the design report, in particular, but not limited to, defining the evaluation approach, methodology and work plan, as well as the agenda for the field phase. S/he will lead the drafting and presentation of the design report and the draft and final evaluation report, and play a leading role in meetings with the ERG and the CO. The team leader will also be responsible for communication with the CPE Manager. Beyond her/his responsibilities as team leader, the evaluation team leader will serve as technical expert for one of the thematic areas of the country programme described below.

Evaluation team member: SRHR expert

The SRHR expert will provide expertise on integrated sexual and reproductive health services, HIV and other sexually transmitted infections, maternal health, and family planning. S/he will also provide expertise on youth friendly SRHR services, SRHR of young women and adolescent girls, and access to contraceptives for young women and adolescent girls. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the CPE Manager, UNFPA Uganda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Gender equality and women's empowerment expert

The gender equality and women's empowerment expert will provide expertise on the human rights of women and girls, the empowerment of women and girls, engagement of men and boys, as well as GBV and harmful practices, such as female genital mutilation, child, early and forced marriage. S/he will provide expertise on sexuality education, sexual and reproductive rights, leadership and participation of young people and women in evidence-based decision making and accountability. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings

with the CPE Manager, UNFPA Uganda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

Evaluation team member: Population dynamics expert

The population dynamics expert will provide expertise on population and development issues, such as census, ageing, migration, the demographic dividend, and national statistical systems. S/he will provide expertise on sexuality education, sexual and reproductive rights, leadership and participation of young people and women in evidence-based decision making and accountability. S/he will contribute to the methodological design of the evaluation and take part in the data collection and analysis work, with overall responsibility of contributions to the evaluation deliverables in her/his thematic area of expertise. S/he will provide substantive inputs throughout the evaluation process by contributing to the development of the evaluation methodology, evaluation work plan and agenda for the field phase, participating in meetings with the CPE Manager, UNFPA Uganda CO staff and the ERG. S/he will undertake a document review and conduct interviews and group discussions with stakeholders, as agreed with the evaluation team leader.

The modalities for the participation of the evaluation team members in the evaluation process, their responsibilities during data collection and analysis, as well as the nature of their respective contributions to the drafting of the design report and the draft and final evaluation report will be agreed with the evaluation team leader. These tasks will be performed under her/his supervision.

Qualifications and Experience of the Evaluation Team

Team leader

The competencies, skills and experience of the evaluation team leader should include:

- Master's degree in public health, social sciences, demography or population studies, statistics, development studies or a related field.
- 10 years of experience in conducting or managing evaluations in the field of international development.
- Extensive experience in leading complex evaluations commissioned by United Nations organizations and/or other international organizations and NGOs.
- **Demonstrated expertise in one of the thematic areas of the country programme covered by the evaluation (see expert profiles below).**
- In-depth knowledge of theory-based evaluation approaches and ability to apply both qualitative and quantitative data collection methods and to uphold high quality standards for evaluation as defined by UNFPA and UNEG.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Excellent management and leadership skills to coordinate the work of the evaluation team, and strong ability to share technical evaluation skills and knowledge.
- Experience working with a multidisciplinary team of experts.
- Excellent ability to analyze and synthesize large volumes of data and information from diverse sources.
- Excellent interpersonal and communication skills (written and spoken).

- Work experience in/good knowledge of the region and the national development context of Uganda.
- Fluent in written and spoken English.

SRHR expert

The competencies, skills and experience of the SRHR expert should include:

- Master's degree in public health, medicine, health economics and financing, epidemiology, biostatistics, social sciences or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international.
- Substantive knowledge of SRHR, including HIV and other sexually transmitted infections, maternal health, and family planning.
- Knowledge in youth friendly SRHR services, SRHR of young women and adolescent girls, and access to contraceptives for young women and adolescent girls.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Uganda.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English.

Gender equality and women's empowerment expert

The competencies, skills and experience of the gender equality and women's empowerment expert should include:

- Master's degree in women/gender studies, human rights law, social sciences, development studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development
- Substantive knowledge on gender equality and the empowerment of women and girls, GBV and other harmful practices, such as female genital mutilation, early, child and forced marriage, and issues surrounding masculinity, gender relationships and sexuality.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.

- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Uganda.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English.

Population dynamics expert

The competencies, skills and experience of the population dynamics expert should include:

- Master's degree in demography or population studies, statistics, social sciences, development studies or a related field.
- 5-7 years of experience in conducting evaluations, reviews, assessments, research studies or M&E work in the field of international development.
- Substantive knowledge on the generation, analysis, dissemination and use of housing census and population data for development, population dynamics, migration and national statistics systems.
- Ability to ensure ethics and integrity of the evaluation process, including confidentiality and the principle of do no harm.
- Ability to consistently integrate human rights and gender perspectives in all phases of the evaluation process.
- Solid knowledge of evaluation approaches and methodology and demonstrated ability to apply both qualitative and quantitative data collection methods.
- Excellent analytical and problem-solving skills.
- Experience working with a multidisciplinary team of experts.
- Excellent interpersonal and communication skills (written and spoken).
- Work experience in/good knowledge of the national development context of Uganda.
- Familiarity with UNFPA or other United Nations organizations' mandates and activities will be an advantage.
- Fluent in written and spoken English.

Budget and Payment Modalities

The evaluators will receive a daily fee according to the UNFPA consultancy scale based on qualifications and experience. The payment of fees will be based on the submission of deliverables, as follows:

Upon approval of the design report	20%
Upon submission of a draft final evaluation report of satisfactory quality	40%
Upon approval of the final evaluation report and the PowerPoint presentation of the evaluation results	40%

In addition to the daily fees, the evaluators will receive a daily subsistence allowance (DSA) in accordance with the UNFPA Duty Travel Policy, using applicable United Nations DSA rates for the place of mission. Travel costs will be settled separately from the consultancy fees. The provisional allocation of workdays among the evaluation team will be the following:

	Team leader	Thematic expert 1	Thematic expert 2	Total (Person-days)
Design phase	10-15	6-10	6-10	22-35
Field phase	23	21	21	54
Reporting phase	20-25	10-16	10-16	40-57
Dissemination and facilitation of use phase	2	1	1	1
TOTAL (Person daysdays)	55-65	38-48	38-48	90 - 105

Please note the numbers of days in the table are indicative. The final distribution of the volume of work and corresponding number of days for each consultant will be proposed by the evaluation team in the design report and will be subject to the approval of the CPE Manager.

Bibliography and Resources

The following documents will be made available to the evaluation team upon recruitment:

UNFPA documents

1. UNFPA Strategic Plan (2018-2021) (incl. annexes) https://www.unfpa.org/strategic-plan-2018-2021
2. UNFPA Strategic Plan (2022-2025) (incl. annexes) https://www.unfpa.org/unfpa-strategic-plan-2022-2025-dpfpa20218
3. UNFPA Evaluation Policy (2024) https://www.unfpa.org/admin-resource/unfpa-evaluation-policy-2024
4. *UNFPA Evaluation Handbook*
5. Evaluation of UNFPA support to population dynamics and data - available at: https://www.unfpa.org/evaluation
6. Mid Term Evaluation of Maternal Health Thematic Fund -- available at: https://www.unfpa.org/evaluation

Uganda national strategies, policies and action plans

7. National Poverty Reduction Strategy
8. National Development Plan III
9. United Nations Sustainable Development Cooperation Framework (UNSDCF) - 2021 - 2025
10. Uganda Demographic and Health Survey (2022)
11. National Health Policy
12. Health Sector Development Plan
13. National Population Policy

UNFPA Uganda CO programming documents

14. Government of Uganda/UNFPA 9th Country Programme Document 2021-2025
15. United Nations Common Country Analysis/Assessment (CCA)
16. Situation analysis for the Government of Uganda/UNFPA 9th Country Programme (2021-2025)
17. CO annual work plans
18. Joint programme documents
19. Mid-term reviews of interventions/programmes in different thematic areas of the CP
20. Reports on core and non-core resources
21. CO resource mobilization strategy
22. Relevant national policy documents for each programmatic area
23. Uganda Vision 2040
24. Implementing Partner Progress (Work plan) Reports
25. Joint Programme Documents
26. GoU/UNFPA 8th Country Programme Evaluation Report
27. Mid term evaluation report for the JPGBV
28. Endline evaluation report for JPGBV
29. Mid term evaluation report for the WAY
30. Endline evaluation report for WAY
31. Mid term evaluation report for ANSWER
32. Endline evaluation report for ANSWER
33. Endline evaluation of ADA
34. available
35. Documentation on donor coordination mechanisms
36. Donor reports
37. Uganda National Household Survey, 2018

UNFPA Uganda CO M&E documents

38. Government of Uganda/UNFPA 9th Country Programme M&E Plan (2021-2025)
39. Uganda Country Office Annual Results Plans (2020, 2021, 2023, 2024)
40. Uganda Country Office Annual Reports (COAR 2020, 2021, 2023)
41. GoU/UNFPA 9th Country Programme Document (2021-2025)
42. GoU/UNFPA 9th Country Programme Business Plan (2021-2025)
43. Previous evaluation of the Government of Uganda/UNFPA 8th Country Programme 2016 - 2020), available at: https://web2.unfpa.org/public/about/oversight/evaluations/

Other documents

44. Implementing partner annual work plans and quarterly progress reports
45. Implementing partner assessments
46. Audit reports and spot check reports
47. Meeting agendas and minutes of joint United Nations working groups
48. Donor reports of projects of the UNFPA Uganda CO
49. HRP- Humanitarian Response Plan and related reports https://response.reliefweb.int/ [optional: for CPE with a humanitarian component]
50. RRP- Refugee Response Plan and related reports https://www.unhcr.org/refugee-response-plans [optional: for CPE with a humanitarian component]
51. Evaluations conducted by other UN agencies
52. IAHE- Inter-Agency Humanitarian evaluations https://interagencystandingcommittee.org/inter-agency-humanitarian-evaluations

Annex A

Theory of change


5. UGA CPD9 ToC 220920_ Outcome 1.p


5. UGA CPD9 ToC 220920_ Outcome 1.p


5. UGA CPD9 ToC 220920_ SP OUTCOM

Annex B

Table 1

Donor	Implementing agency							Other partners							Rights holders	Other
	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
Strategic plan 2022-2025 outcomes Outcome 1: By 2025, the reduction in the unmet need for family planning has accelerated Outcome 2: By 2025, the reduction of preventable maternal deaths has accelerated Outcome 3: By 2025, the reduction in gender-based violence and harmful practices has accelerated																
Output: [insert relevant county programme output as per the Strategic plan 2022-2025] *If the CPD is not aligned with the Strategic Plan 2022-2025, please use the outcome and output areas of the 2018-2021 Strategic Plan*																

Output: [insert relevant county programme output as per the Strategic plan 2022-2025] *insert additional rows as applicable*

Table 2

For all entities/organizations identified in Table 1, please provide the following information:

Acronym	Name of the entity/organization	Role/responsibilities	Starting date of the collaboration with the CO	Contact person(s)			Reference staff in CO
				Name	Title/Function	E-mail	

*

ANNEXURE 2: LIST OF PERSONS/INSTITUTIONS VISITED

No	Names	Gender	Organisation /Location	Designation
1	Ms Annelie Areskär	F	Embassy of Sweden	National Programme Officer SRHR
2	Ms Agnes Gillian Ocitti	F	Embassy of Denmark	Senior Programme Officer
3	Ms Judith Elsie Adokorach	F	Netherlands Embassy	Policy Officer SRHR/Gender
4	Ms Perez Masinde	F	OUTBOX	Programme Director
5	Ms Gift Malunga	M	UNFPA Country Office	Representative
6	Mr Daniel Alemu	F	UNFPA Country Office	Deputy Representative
7	Ms Laura Lafuente	M	UNFPA Country Office	Programme Specialist: Gender & Youth
8	Mr Ayurzana Bayaraa	F	UNFPA Country Office	International Operations Manager
9	Dr John Odaga	M	UNFPA Country Office	Programme Specialist M&E
10	Ms Florence Mpabulungi Tagoola	M	UNFPA Country Office	Programme Specialist: Population and Data
11	Mr Chan Ju Park	F	UNFPA Country Office	Programme Specialist: Resource Mobilisation and Partnerships
12	Mr Francis Engwau	F	UNFPA Country Office	Programme Specialist: SRH-HIV
13	Ms Juliana Lunguzi	M	UNFPA Country Office	Program Specialist: SRH
14	Dr Rodgers Ampwera	M	Naguru Teenage Education Centre	Executive Director
15	Mr Paul Orikushaba	M	Lutheran World Foundation	Programme Director
16	Ms Camilla Buch von Schroeder	M	UNFPA Country Office	Programme Specialist: ANSWER
17	Dr Alex Chono	F	UNFPA Country Office	Regional Team Coordinator
18	Dr Sangaki Patrick	M	Amudat District	DHO
19	Politician		Amudat District	Politician
20	CAO		Amudat District	CAO
21	DCDO		Amudat District	DCDO
22	District Planner		Amudat District	District Planner
23	Senior CDO		Amudat District	Senior CDO
24	Kisembo Brian	M	Kyegegwa District	Acting Assistant District Health Officer MCH
25	Leonard	M	Kyegegwa District	District Health Educator
26	District Planner		Kyegegwa District	District Planner
27	Trevor Julius	M	Kyegegwa District	Field assistant Acord
28	Keiko Inoue	M	Peace Wings Japan	Country Representative
29	Timothy Kayondo	M	Peace Wings Japan	Project Officer
30	Police Officer		Police	Child and Family Protection Unit Officer

No	Names	Gender	Organisation /Location	Designation
31	Gloria Akayo	F	Kyegegwa District: OPM	Assistant Community Services Officer, GBV Focal person
32	Ms Belonde Agness.	F	Kyegegwa District	Senior Community Development Officer
33	Mr Lulu Henry Mekoha	M	Adjumani District	Assistant District Health Officer
34	Police Officer		Adjumani District	Child and Family Protection Unit Officer
35	DCDO		Adjumani District	District Community Development Officer
36	Deputy CAO		Adjumani District	Deputy CAO
37	Deputy LCV		Adjumani District	Deputy LCV
38	District Education Officer		Adjumani District	District Education Officer
39	Dr Dribareo Jovia Iya	M	Adjumani District	Medical Team (MTI)
40	Programme Director		Plan International	Programme Director
41	Principle Planner		Adjumani District	Principle Planner
42	Welfare OPM		Adjumani District	Welfare OPM
43	ADHO		Kamuli District	ADHO
44	Mr Denis Owor	M	Kamuli District-BRAC	Project Officer
45	Mr Ronald	M	Care International - Kamuli District	Project Officer
46	Programme Director		MARIESTOPES - Kamuli	Programme Director
47	Cultural Leader		Kamuli District	Cultural Leader
48	DEO		Kitgum District	District Education Officer (DEO)
49	Deputy CAO		Kitgum District	Deputy CAO
50	James Okello P'Okid	M	Kitgum District	DCDO
51	Chief Administrative Officer		Madi-Okollo District	Chief Administrative Officer
52	Assistant District Health Officer Maternal		Madi-Okollo District	Assistant District Health Officer Maternal & Child Health
53	District Community Development Officer		Madi-Okollo District	District Community Development Officer
54	District Health Officer		Madi-Okollo District	District Health Officer
55	LCV		Madi-Okollo District	LCV
56	Family And Child Protection Officer		Madi-Okollo District - Police	Family And Child Protection Officer
57	Probation Officer		Madi-Okollo District	Probation Officer
58	Acting District Health Officer		Moroto District	Acting District Health Officer
59	District Health Officer		Moroto District	District Health Officer
60	Kapchese Betty	F	Karamoja Women Umbrella Organization (KAWUWO)	Program Staff
61	Olaboro Lazarus	M		
62	Aluti Stella			
63	LCV Chair Person		Moroto District	LCV Chair Person
64	District Planner		Moroto District	District Planner Moroto
65	Mary Akit	F	Moroto District High Court	High Court Judge

ANNEXURE 3: EVALUATION MATRIX

Evaluation question 1 (EQ1): To what extent did the 9th Country Programme (CP) design and theory of change (ToC) respond to (i) national policies, strategies, and priorities; (ii) the strategic direction and objectives of UNFPA; and (iii) priorities articulated in international frameworks and agreements, particularly the ICPD Programme of Action and the SDGs? Additionally, how effectively did the CP adapt to contextual changes to achieve its intended results? [Relevance]			
Assumptions for Verification	**Indicators**	**Data Sources**	**Data Collection Methods**
Assumptions for verification 1.1: Assumptions for verification 1.1: The 9th CP design and ToC align with national policies, UNFPA objectives, and international frameworks, while adapting effectively to contextual changes.	**Alignment with National Policies and Priorities:** - Review and compare national policies, strategies, and priorities (e.g., NDP III (2020/21-2024/25), National Vision 2040, African Union Agenda 2063, United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025) with the CP9 design and ToC to assess alignment in Population and Development (PD). - Evidence of CP9's contributions to achieving national development priorities related to Population and Development. - Level of adherence to evolving national Population and Development needs and priorities during CP9 implementation, considering contextual changes. **Consistency with UNFPA's Strategic Direction:** - Assessment of CP9's alignment with the strategic direction and objectives of UNFPA, especially the Strategic	**Strategic Documents:** - GoU/UNFPA 9th CPD, NDP III (2020/21-2024/25), National Vision 2040, African Union Agenda 2063, United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025, and relevant Sector Strategic Plans (Health, Education, Gender, JLOS, NPA, and others as applicable). - Documents reflecting significant changes in context during the CP9 period. **National Level Stakeholders:** - UNFPA CO staff, Other UN Agencies, Implementing Partners (Head Offices), Donors, and Focal Point Persons from relevant government agencies: NPC, POPSEC, UBOS, NPA, MoH, MoLG, MGLSD, MoJCA (JLOS). **District Level Stakeholders:** - Chief Administrative Officers, District Health Teams (DHT), District Planners/Population	**Documents Review:** - Review updated strategic and contextual documents relevant to CP9. **Key Informant Interviews:** - Conduct interviews with a broad range of stakeholders involved in or affected by CP9. **Focus Group Discussions (FGDs):** - Organise FGDs with diverse target groups, focusing on their perceptions of CP9's relevance and adaptation to their needs. **Field Visits/Observations:** - Conduct field visits to observe the

	Plans (2018-2021, 2022-2025). - Consideration of how CP9 adapted to changes in UNFPA's global strategy and priorities over the programme period. **Integration of International Frameworks and Agreements:** - Examination of CP9's alignment with international frameworks and agreements, particularly the ICPD Programme of Action and the SDGs. - Analysis of how CP9 adapted its strategies and interventions to align with global shifts and emerging priorities in international agreements. **Adaptation to Contextual Changes:** - Evaluation of how effectively CP9's design and ToC were adjusted in response to significant contextual changes (e.g., political, economic, demographic) to achieve its intended results. - Exploration of the mechanisms used by CP9 to ensure continuous alignment with the evolving context and needs.	Officers, District Community Development Officers (DCDO), District Education Officers (DEO), JLOS representatives (Police-CFPU, Magistrates), Implementing Partners (IPs) in field sites, Relevant community structures (cultural and religious leaders, local council representatives, community activists, Male Action Groups, etc.), and relevant programme beneficiaries (including women, men, and young people).	implementation of interventions and their alignment with evolving priorities and needs.
Data Collected: **National Alignment and Strategic Contributions** • CP9 aligns with Uganda's Vision 2040 and the Third National Development Plan (NDP III), particularly the Human Capital Development Programme, through investments in health, education, and skills development. • The programme supports key national frameworks, including the Reproductive Health Commodity Security Strategic Plan, the draft National SRHR Policy Framework, and the Health Sector Development Plan (HSDP).			

- CP9 addresses critical health challenges such as high adolescent fertility, unmet family planning needs, and maternal mortality, contributing to Uganda's demographic dividend.
- CP9 strengthens data systems through contributions to the Uganda Demographic and Health Survey (UDHS) and the Census and promotes the inclusion of refugees in national statistical systems in collaboration with UNHCR.
- CP9 supports Uganda's commitments under the 2019 Nairobi Summit on ICPD25 and the Sustainable Development Goals (SDGs), contributing directly to SDG 3 (Good Health and Well-being), SDG 5 (Gender Equality), and SDG 10 (Reduced Inequalities).

Sub-National Alignment and Implementation

- CP9 aligns with District Development Plans (DDPs) to address localized health and demographic challenges in districts such as Kitgum, Madi-Okollo, and Adjumani.
- The programme integrates SRHR and GBV services in refugee-hosting districts like Adjumani and Kyegegwa, supporting Uganda's Comprehensive Refugee Response Framework (CRRF) and the Health Sector Integrated Refugee Response Plan (HSIRRP).
- In underserved regions, such as Karamoja and northern Uganda, CP9 addresses health disparities and promotes reproductive rights, focusing on vulnerable populations.

Thematic Contributions Across Key Areas

- CP9 facilitated the procurement of over $20 million worth of contraceptives and essential supplies through the Supplies Partnership, addressing unmet contraceptive needs and ensuring service continuity.
- Youth-focused interventions reduce teenage pregnancies and harmful practices, contributing to Uganda's demographic dividend and socio-economic growth.
- CP9's humanitarian response integrates SRHR and GBV services for refugees and host communities, strengthening local systems and promoting social cohesion.
- CP9 enhances Uganda's data-driven decision-making capacity through demographic health surveys and commodity gap quantifications.

Adaptation and Innovation During COVID-19

- During the COVID-19 pandemic, CP9 ensured continuity of essential services through innovations such as mobile health clinics and telehealth services, demonstrating adaptability and alignment with Uganda's evolving priorities.

Overall Contributions

- CP9 bridges national and sub-national priorities, addressing immediate health needs while strengthening systems for sustainable socio-economic transformation.
- The programme's strategic focus on SRHR, GBV prevention, and youth empowerment reinforces Uganda's progress toward an equitable and inclusive future.

Evaluation question 2 [EQ2]: To what extent did the 9th CP interventions incorporate cross-cutting issues and accelerators (as defined in the UNFPA Global Strategy) to respond to the diverse needs of marginalized and vulnerable populations, including people with disabilities (PWD), adolescents and youth, persons affected by humanitarian crises including refugees, key populations, and other vulnerable groups? [Relevance]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods

Assumptions for verification 2.1: The 9th CP interventions integrated cross-cutting issues and accelerators to address the diverse needs of marginalized and vulnerable populations, including PWD, youth, refugees, and key populations.	**Integration of Cross-Cutting Issues and Accelerators:** - Review how CP9 interventions in Population and Development integrated cross-cutting issues such as gender equality, human rights, and disability inclusion, as well as accelerators like data-driven programming, innovation, and partnerships. - Assessment of the strategies used to incorporate these cross-cutting issues and accelerators in addressing the needs of marginalized and vulnerable populations. **Targeting of Marginalized and Vulnerable Populations:** - Evaluation of the extent to which CP9 interventions specifically targeted marginalized and vulnerable populations, including PWDs, adolescents, youth, refugees, and key populations. - Examination of how the diverse needs of these groups were identified, prioritised, and addressed in CP9's design and implementation. **Evidence of Taking into Consideration Needs at National and Sub-National Levels:** - Assessment of the extent to which CP9 interventions considered the needs of target beneficiary institutions	**Strategic Documents:** - Review of CP9 project and programme documents, UNFPA Global Strategy, relevant policies on inclusion (e.g., disability inclusion, gender equality), humanitarian response plans, and sector-specific strategies (Health, Education, Gender, etc.). - Documents detailing the incorporation of cross-cutting issues and accelerators in CP9 interventions. **National Level Stakeholders:** - UNFPA CO staff, Implementing Partners, Government Agencies (e.g., MoH, MoE, MoGLSD), NGOs focused on vulnerable populations, and Donors. - Representatives from organisations or networks advocating for PWDs, youth, refugees, and other vulnerable groups. **Community-Level Stakeholders:** - Local organisations working with marginalized and vulnerable populations, community leaders, representatives of vulnerable groups (e.g., youth groups, disability advocacy groups), and beneficiaries of CP9 interventions. - Humanitarian actors involved in	**Documents Review:** - Detailed review of strategic and operational documents to assess the integration of cross-cutting issues and accelerators into CP9. **Key Informant Interviews:** - Conduct interviews with national and community-level stakeholders, including representatives from marginalized and vulnerable groups, to gather insights into the inclusivity and effectiveness of CP9 interventions. **Focus Group Discussions (FGDs):** - Organise FGDs with representatives from targeted vulnerable populations (e.g., PWDs, youth, refugees) to understand their perspectives on the responsiveness and inclusivity of CP9 interventions.

	and population groups, including Most-At-Risk Populations (MARPs), PWDs, refugees, and internally displaced persons (IDPs), both at national and sub-national levels. - Review of how these considerations were reflected in the programme's design and execution across different regions and contexts. **Responsiveness to Humanitarian Crises:** - Analysis of CP9's responsiveness to humanitarian crises, including how interventions were adapted to support populations affected by such crises (e.g., refugees, internally displaced persons). - Consideration of the effectiveness of CP9 interventions in Population and Development in maintaining or enhancing the resilience of vulnerable groups during and after crises. **Inclusivity and Participation:** - Assessment of the mechanisms used to ensure the participation of marginalized and vulnerable populations in the design, implementation, and monitoring of CP9 interventions. - Evaluation of the inclusivity of programme processes and whether they effectively addressed the barriers faced by these populations.	crisis response and support to affected populations.	**Field Visits/Observations:** - Conduct field visits to observe how CP9 interventions were implemented in areas with significant vulnerable populations and assess the inclusivity and impact of these interventions.

Data Collected:

Alignment with the Needs of Vulnerable Populations

- **Women and Adolescents:**
  - CP9 addresses significant gaps in SRHR and GBV services, focusing on high adolescent fertility rates, unmet family planning needs, and disparities in antenatal care.
  - Community-based SRHR education, youth-friendly health corners, and peer-led initiatives have empowered adolescents, reducing stigma and increasing access to family planning services in districts such as Adjumani and Kyegegwa.
  - Tailored GBV services, including safe spaces, legal aid, and health support, promote gender equity and social stability, particularly in rural and underserved areas.
- **Persons with Disabilities (PWDs):**
  - CP9 integrates disability-inclusive approaches, including collaborations with organizations of persons with disabilities (OPDs) and targeted SRHR outreach in districts like Adjumani.
  - Despite progress, gaps persist in disability-friendly healthcare, such as a lack of trained healthcare workers, assistive technologies, and sign language interpreters, highlighting the need for expanded capacity-building initiatives.
  - CP9's disability-focused efforts align with national strategies emphasizing inclusive healthcare and rights-based approaches for PWDs.
- **Indigenous and Remote Communities:**
  - Mobile health clinics and culturally sensitive programming have improved SRHR access in remote areas such as Karamoja and Amudat.
  - Community engagement, including partnerships with traditional leaders, has enhanced uptake of family planning services by aligning health interventions with local norms and practices.
- **Refugees and Host Communities:**
  - CP9 provides SRHR and GBV services in refugee settlements such as Kyaka II and Tika, improving access to family planning, menstrual hygiene, and GBV prevention.
  - CP9 supported the implementation of Minimum Initial Service Package (MISP) protocols, ensuring continuity of SRHR services during emergencies and strengthening integration into government systems.
  - Barriers such as language differences have been mitigated through hiring multilingual health workers and community outreach, aligning services with Uganda's Comprehensive Refugee Response Framework (CRRF).
- **LGBTQI+ Persons:**
  - Advocacy efforts have promoted inclusive healthcare, but systemic discrimination and stigma persist as major barriers to SRHR access.
  - Few LGBTQI+ respondents reported positive healthcare experiences, emphasizing the need for expanded sensitization of healthcare providers and non-discriminatory service delivery policies.

Impactful Practices and Innovations

- **Youth-Friendly Services:**
  - SRHR education in refugee-hosting districts has increased family planning awareness, addressing barriers such as stigma and limited knowledge.

- Peer-led education and health corners have proven effective in reducing judgmental attitudes and improving service accessibility for adolescents.

- **Culturally Sensitive Programming:**
  - In Karamoja and northern Uganda, involving traditional leaders in advocacy has increased trust and acceptance of SRHR services.
  - Tailored interventions for indigenous groups address geographic isolation and cultural barriers, fostering inclusivity in remote areas.
- **Emergency and Humanitarian Response:**
  - Distribution of Inter-Agency Reproductive Health (IARH) kits and integration of SRHR services within settlement facilities have enhanced healthcare delivery during emergencies.
  - Accreditation of refugee settlement facilities to national supply chains has ensured sustainable access to contraceptives and family planning resources.
- **Capacity Building and Resource Mobilization:**
  - CP9's collaboration with local health authorities and community organizations enhances the sustainability and reach of SRHR and GBV services.
  - Efforts to train healthcare workers and provide assistive technologies aim to reduce gaps in disability-inclusive care and improve service equity.

Overall Contributions

- CP9 demonstrates strong alignment with the needs of marginalized groups by prioritizing accessibility, inclusivity, and responsiveness to systemic barriers.
- The programme's efforts to leave no one behind (LNOB) are reflected in its community-driven approaches, tailored services, and integration of vulnerable populations into broader health systems.
- CP9 contributes to health equity and resilience by addressing the unique challenges faced by women, youth, refugees, indigenous groups, and other vulnerable populations, reinforcing Uganda's development priorities and global commitments.

Evaluation question 3 [EQ3]: To what extent are the interventions in the 9th CP inter-linked, well-integrated, complementary, and synergistic? [Coherence]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 3.1: The 9th CP interventions are inter-linked, integrated, and complementary, fostering coherence and synergy across thematic areas.	**Inter-Linkages and Integration of Interventions:** - Assessment of the extent to which the CP9 interventions in Population and Development are inter-linked and well-integrated across different components of the programme. - Review of how complementary and	**Strategic Documents and Reports:** - CP9 programme documents, government policy documents, UNSDCF (2021-2025), relevant sectoral strategies, and reports from other UN agencies, INGOs, and development partners.	**Documents Review:** - Review of strategic documents, programme reports, and partnership agreements to assess coherence and integration.

	synergistic the interventions are in contributing to overall programme goals. **Complementarity with Government Programmes:** - Evaluation of how CP9 interventions in Population and Development are aligned and complementary to existing government programmes and policies, particularly those related to population, health, education, and development. - Examination of how CP9 leveraged government resources, capacities, and structures to enhance programme effectiveness. **Synergy in Achieving Results:** - Analysis of how the integration of CP9 interventions with those of other actors contributed to achieving synergistic effects and enhanced impact. - Consideration of any gaps or overlaps in interventions that may have affected programme coherence.	- Documents and reports on joint initiatives, partnerships, and collaborative efforts during CP9. **National and District Level Stakeholders:** - UNFPA CO staff, Government Officials (e.g., MoH, MoE, MoLG, MGLSD), Representatives from other UN agencies, INGOs, development partners, and key national institutions involved in Population and Development. **Community-Level Stakeholders:** - Local government representatives, community leaders, representatives from local NGOs and community-based organizations (CBOs), and beneficiaries involved in joint or coordinated interventions.	**Key Informant Interviews:** - Conduct interviews with stakeholders at national and district levels, including UNFPA CO staff, government officials, and representatives from UN agencies, INGOs, and development partners to gather insights on coherence and integration. **Focus Group Discussions (FGDs):** - Organise FGDs with community-level stakeholders to understand the perceived coherence and integration of CP9 interventions at the local level. **Field Visits/Observations:** - Conduct field visits to observe the implementation of integrated and coordinated interventions, assessing

			how well they complement and synergize with other efforts.

Data Collected:

Coherence with Other Initiatives

- **Interagency Collaborations:**
  - CP9 collaborates with UN agencies (UN-Women, UNICEF, WHO, UNHCR, UNDP, UNAIDS, UN-Human Rights) to harmonize strategies and interventions for SRHR and GBV at national and sub-national levels.
  - Joint Programme on Gender-Based Violence (JPGBV) and the Spotlight Initiative exemplify synergy in planning, implementation, and monitoring, leveraging each agency's strengths to address harmful practices and strengthen GBV response systems.
  - In regions like West Nile and Acholi, CP9 contributes to joint annual workplans, improving coordination and minimizing duplication through United Nations Area Coordination (UNAC) meetings.
- **Integration in Humanitarian Settings:**
  - CP9 integrates SRHR and GBV services into refugee-hosting districts through partnerships with UNHCR, UNICEF, and UN-Women, aligning with the Comprehensive Refugee Response Framework (CRRF).
  - The WAY and ANSWER programmes address both refugee and host community needs, ensuring equitable access to SRHR and GBV services and fostering social cohesion.
  - CP9 supports health facilities in emergency settings with dignity kits, midwife recruitment, ambulance systems, and maternal health tents, enhancing coherence with national guidelines for SRHR/GBV service delivery.

Alignment with National Frameworks:

- CP9 aligns interventions with Uganda's health policies, including the Adolescent Health Strategy and School Health Policy, avoiding redundancy and streamlining SRHR service delivery for vulnerable populations, including refugees and adolescents.
- Participation in interagency sector working groups (e.g., National GBV Reference Group) ensures alignment with government and civil society actors, harmonizing approaches to SRHR and GBV prevention and response.

Leveraging Multi-Stakeholder Partnerships:

- Partnerships with USAID and the private sector (e.g., MTN) enhance SRHR service delivery by addressing supply chain gaps and equipping Health Centre IV facilities with critical resources, reducing duplication and improving infrastructure.
- Collaboration with CSOs through the Spotlight Initiative and ANSWER programme has reduced administrative costs and ensured co-funding for shared goals, such as disability inclusion and maternal health policies.

Local Synergies and Coordination:

- CP9 enhances coordination at district and sub-county levels through initiatives like the 3W Partner Matrix and joint planning meetings, ensuring activities complement existing health and social services.
- Regular partner meetings in districts like Kamuli, Kitgum, and Moroto have strengthened alignment with local government priorities, clarified roles, and minimized overlap in SRHR and GBV programming.

- In Kitgum, CP9 integrates SRHR and GBV activities with local health and education structures, expanding school-based and community sensitization efforts without creating parallel systems.

Integrated Approaches:

- CP9 advances an integrated approach to SRHR/HIV/GBV by aligning strategies and guidelines through programmes like JPGBV and ANSWER, enabling a holistic service package at health facilities and in communities.
- Joint review of policies, such as the Maternal and Perinatal Death Surveillance and Response (MPDSR) and Disability Inclusion Policy, demonstrates coherence in addressing cross-cutting health and equity challenges.

Promoting Efficiency and Accountability:

- CP9 supports quarterly sector meetings, such as Menstrual Health Management (MHM) Steering Committees, to streamline efforts, align standards, and harmonize implementation plans.
- In Moroto, budget conference meetings involving stakeholders ensure funding allocations and intervention priorities are aligned, preventing fragmentation and duplication.

Outcomes of Enhanced Coherence:

- CP9's coherence efforts have strengthened local capacity to implement SRHR and GBV interventions effectively while ensuring resources are optimized and aligned with existing systems.
- By fostering interagency collaboration, CP9 has expanded its reach and enhanced the impact of its initiatives, providing comprehensive support to vulnerable populations while adhering to national and global strategies.

Evaluation question 4 [EQ4]: To what extent have the strategies and interventions of the 9th CP delivered outputs and contributed to the achievement of the country programme outcomes, specifically: (i) increased access and use of integrated SRH services; (ii) empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights; (iii) advancement of gender equality and the empowerment of women and girls; (iv) increased use of population data in the development of evidence-based national development plans, policies, and programmes? Which specific programme models proved to be more effective in delivering results, and for whom? [Effectiveness]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 4.1: The 9th CP delivered outputs that increased access to integrated SRH services, empowered youth, advanced gender equality, and promoted the use of population data in evidence-based planning.	**Achievement of Country Programme Outcomes:** - Assessment of the extent to which CP9 interventions in Population and Development contributed to increased access and use of integrated SRH services. - Evaluation of the empowerment of adolescents and youth to access SRH information and services and exercise their sexual and reproductive rights.	**Strategic Documents and Reports:** - CP9 programme reports, outcome evaluation reports, sector-specific reports, national development plans, and relevant SRH, gender, and population data documents. - Documentation on programme models, implementation strategies, and effectiveness assessments.	**Documents Review:** - Review of programme and outcome reports, national development plans, and SRH, gender, and population data documents to assess effectiveness. **Key Informant Interviews:**

	- Analysis of the advancement of gender equality and the empowerment of women and girls through CP9 interventions in Population and Development. - Review of the increased use of population data in the development of evidence-based national development plans, policies, and programmes. **Effectiveness of Specific Programme Models:** - Identification of programme models in Population and Development that were more effective in delivering results across different population groups, including adolescents, youth, women, and those in remote areas. - Evaluation of the adaptability and replicability of these Population and Development programme models for wider application in future programming.	**National and District Level Stakeholders:** - UNFPA CO staff, government officials (e.g., MoH, MoE, MoLG, MGLSD), representatives from other UN agencies, implementing partners, and key institutions involved in SRH, youth empowerment, gender equality, and population data use. **Community-Level Stakeholders:** - Beneficiaries, community leaders, representatives from local NGOs and community-based organizations (CBOs), and field staff involved in implementing CP9 interventions.	- Conduct interviews with stakeholders at national and district levels, including UNFPA CO staff, government officials, and implementing partners, to gather insights on the effectiveness of CP9 interventions. **Focus Group Discussions (FGDs):** - Organise FGDs with beneficiaries and community-level stakeholders to understand their perspectives on the effectiveness of CP9 interventions and specific programme models. **Field Visits/Observations:** - Conduct field visits to observe the implementation of effective programme models, assess their impact, and identify best practices.

Evaluation question 5 [EQ5]: To what extent did the 9th CP deliver results for the most vulnerable and left-behind populations, including adolescents and youth, PWDs, key populations, refugees, and other populations affected by humanitarian crises, as well as those living in remote and underserved areas? [Effectiveness]			
Assumptions for Verification	**Indicators**	**Data Sources**	**Data Collection Methods**
Assumptions for verification 5.1: The 9th CP effectively delivered results tailored to the needs of the most vulnerable and left-behind populations, including adolescents, PWDs, key populations, refugees, and underserved communities.	**Reach and Impact on Vulnerable Populations:** - Evaluation of the extent to which CP9 interventions in Population and Development reached the most vulnerable and left-behind populations, including adolescents and youth, PWDs, key populations, refugees, and those affected by humanitarian crises. - Analysis of the impact of CP9 interventions in Population and Development on these populations, particularly in remote and underserved areas. - Identification of any barriers to access and participation for these populations and how CP9 addressed them. **Effectiveness of Targeted Interventions:** - Assessment of the effectiveness of specific interventions targeting vulnerable and left-behind populations. - Review of the strategies used to overcome challenges in reaching and delivering results to these groups.	**Strategic Documents and Reports:** - CP9 programme reports, humanitarian response plans, reports on vulnerable populations (e.g., adolescents, PWDs, refugees), and national development plans. - Documentation on targeted interventions, challenges faced, and solutions implemented. **National and District Level Stakeholders:** - UNFPA CO staff, government officials (e.g., MoH, MoE, MoLG, MGLSD), representatives from humanitarian agencies, implementing partners, and organizations advocating for vulnerable populations. **Community-Level Stakeholders:** - Representatives from vulnerable populations, community leaders, local NGOs, CBOs, and field staff involved in implementing targeted interventions.	**Documents Review:** - Review of programme reports, humanitarian response plans, and documentation on interventions targeting vulnerable populations to assess effectiveness. **Key Informant Interviews:** - Conduct interviews with stakeholders at national and district levels, including UNFPA CO staff, government officials, and representatives from humanitarian agencies and organizations advocating for vulnerable populations. **Focus Group Discussions (FGDs):** - Organise FGDs with representatives from vulnerable populations to gather their

			perspectives on the effectiveness of CP9 interventions in addressing their needs. **Field Visits/Observations:** - Conduct field visits to observe the implementation of interventions targeting vulnerable populations and assess their impact on these groups.
Evaluation question 6 [EQ6]: To what extent were the investments in innovations effective and contributed to the achievement of results? How effectively were innovations developed, tested, documented, disseminated, and scaled-up? Did the 9th CP introduce innovative approaches that could be scaled up for a wider impact? [Effectiveness]			
Assumptions for Verification	**Indicators**	**Data Sources**	**Data Collection Methods**
Assumptions for verification 6.1: The 9th CP investments in innovations were effectively developed, tested, and scaled-up, contributing significantly to the achievement of programme results and wider impact.	**Effectiveness of Innovations:** - Evaluation of the effectiveness of investments in innovations in contributing to the achievement of CP9 results related to Population and Development. - Assessment of the processes used to develop, test, document, disseminate, and scale-up innovations in Population and Development. - Identification of specific innovations introduced by CP9 that could be scaled up for wider impact. **Impact of Innovative Approaches:** - Analysis of the impact of innovative	**Strategic Documents and Reports:** - CP9 programme reports, innovation strategies, documentation on innovation processes (development, testing, documentation, dissemination, scaling-up), and outcome evaluation reports. - Reports on the impact of innovative approaches in Population and Development. **National and District Level Stakeholders:** - UNFPA CO staff, innovation	**Documents Review:** - Review of programme reports, innovation strategies, and documentation on innovation processes to assess effectiveness and impact. **Key Informant Interviews:** - Conduct interviews with stakeholders involved in innovation projects, including UNFPA CO staff,

	approaches on programme outcomes, particularly in Population and Development. - Review of the scalability of these innovations and their potential for broader application in future programming.	teams, government officials (e.g., MoH, MoE, MoLG, MGLSD), representatives from research institutions, and implementing partners involved in innovation projects. **Community-Level Stakeholders:** - Beneficiaries, local NGOs, CBOs, and field staff involved in implementing and testing innovations.	government officials, and representatives from research institutions and implementing partners. **Focus Group Discussions (FGDs):** - Organise FGDs with beneficiaries and community-level stakeholders to understand their experiences with innovations introduced by CP9. **Field Visits/Observations:** - Conduct field visits to observe the implementation and impact of innovative approaches, assess their scalability, and identify best practices for wider application.
Evaluation question 7 [EQ7]: What are the key lessons learned and best practices that can contribute to the knowledge base of UNFPA and its partners, and be applied in future programme and policy development to accelerate results? [Effectiveness]			
Assumptions for Verification	**Indicators**	**Data Sources**	**Data Collection Methods**
Assumptions for verification 7.1: The 9th CP identified and documented key lessons and best practices that are replicable and contribute to	**Identification of Key Lessons Learned:** - Analysis of key lessons learned in the implementation of CP9	**Strategic Documents and Reports:** - CP9 programme documents, quarterly and annual reports, field	**Documents Review:** - Review of programme documents, reports, and documentation of best

improving future programme and policy development for accelerated results.	interventions in Population and Development, particularly those that contributed to or hindered the achievement of programme outcomes. - Documentation of challenges encountered and how they were addressed, with a focus on potential applications in future programming. **Documentation of Best Practices:** - Identification and documentation of best practices in Population and Development that emerged during CP9 implementation, especially those that demonstrated effectiveness, efficiency, or innovation. - Assessment of how these best practices can be scaled up or adapted for broader application in future programmes and policy development. **Innovative Approaches:** - Review of innovative approaches in Population and Development introduced during CP9, their outcomes, and lessons learned from their implementation. - Evaluation of the potential for these innovations to be replicated or expanded in future programming.	and progress reports, documentation of good practices, evaluation reports, and special studies. - Documentaries or multimedia that capture programme impacts and lessons learned. **National Level Stakeholders:** - UNFPA staff (leadership, programme, finance, and administrative staff), other UN agencies, implementing partners (IPs) at the head office level, and relevant government bodies (NPC/POPSEC, UBOS, NPA, Academia, MoLG, MGLSD, MoH). - Academia, particularly institutions like Makerere University Centre for Population and Development, EPRC, and other research entities. **District Level Stakeholders:** - Chief Administrative Officers, District Health Teams (DHT), District Planners/Population Officers, District Community Development Officers (DCDO), District Education Officers (DEO), field-level IPs, and programme beneficiaries. - Community structures, including cultural and religious leaders, local council representatives, and other relevant community members.	practices to identify key lessons learned and innovative approaches. **Key Informant Interviews:** - Conduct interviews with national and district-level stakeholders, including UNFPA staff, government officials, and implementing partners, to gather insights into lessons learned and best practices. **Focus Group Discussions (FGDs):** - Organise FGDs with beneficiaries, community leaders, and field-level IPs to capture their perspectives on effective strategies, lessons learned, and best practices. **Field Visits/Observations:** - Conduct field visits to observe and document best practices and

			innovative approaches in action, and gather direct feedback from implementers and beneficiaries.

Data Collected:

Contribution to Planned Outputs and Outcomes

- **Provision of SRHR Services:**
  - The percentage of primary service delivery points with no 'stock-out' of contraceptives increased from 73.6% in 2020 to 85.9% in 2024, surpassing the target of 78.7%.
  - Outputs for policies, laws, strategies, and regulations promoting gender equality and equitable SRHR access were exceeded, with 62 achieved against a target of 36 by 2024.
  - Despite progress, only 12% of health facilities in target districts met readiness standards for emergency obstetrics and newborn care (target: 57.6%), and only 224 health facilities achieved 80% of SRH/HIV/GBV integration standards (target: 701).
- **Utilization of SRHR Services:**
  - The number of Couple Years of Protection (CYP) dispensed rose from 5.05 million in 2021 to 6.47 million in 2024, approaching the 6.62 million target.
  - The unmet need for family planning decreased significantly, from 30% in 2021 to 22% in 2022.
  - Marginalized adolescent girls reached by life skills programmes increased from 80,466 in 2021 to 126,418 in 2024, surpassing targets for all years.
  - SRHR service utilization improved, with increased family planning users (719,725 in 2023 vs. 416,882 in 2022), fourth antenatal care visits (146,239 in 2023 vs. 137,872 in 2022), and institutional deliveries (195,008 in 2023).
- **Gender Equality and Women Empowerment:**
  - Women's control over earnings increased from 36.8% in 2022 to 79.1% in 2024 (target: 50%). Participation in household decision-making also rose from 31.6% to 69.4%.
  - The number of districts making public declarations against harmful practices increased from 46 in 2021 to 97 in 2024 (target: 89).
  - Multi-sectoral coordination structures for GBV/SRH/FGM were consistently functional, meeting bi-annually in all targeted districts.
- **Data and Leadership:**
  - Functional national and district data management systems increased from 2 in 2021 to 5 in 2024, meeting the target.
  - In-depth analytical reports on SRHR and youth-related themes exceeded targets, with 26 reports produced by 2024 (target: 14).
  - Platforms for young people and women to participate in policy development expanded from 5 in 2021 to 64 in 2024, significantly surpassing the target of 17.

Reaching Intended Populations and Areas

- **Adolescents and Refugees:**

- Refugee settlements such as Kyaka II and Adjumani benefited from targeted SRHR interventions, including family planning and adolescent health programmes, improving access to critical services.
- In districts like Moroto, CP9 reached underserved populations, though logistical and transportation barriers limited outreach to remote areas.
- Marginalized populations, including individuals with disabilities, were less consistently reached, highlighting a need for enhanced inclusivity in program planning and execution.

- **Women and Marginalized Groups:**
  - Community-based initiatives engaged men, women, and youth to improve SRHR awareness, gender equity, and GBV prevention. Examples include safe spaces for GBV survivors and accessible family planning services in communities.
  - Efforts in districts such as Kitgum and Madi-Okollo supported adolescent girls and young mothers, fostering economic and social empowerment through training and access to health resources.

Integration of HIV, SRHR, and GBV Service Delivery

- **Health Facility Capacity:**
  - Only 32% of health facilities in the assessed districts met the basic integration standards for SRHR/HIV/GBV service delivery (target: 80%).
  - Service gaps included low rates of CQI projects (34%) and inadequate functionality of Health Unit Management Committees (HUMC, 51%).
  - Positive indicators included availability of HMIS tools (100%), community linkage (90%), and trained staff with multiple skills in focus areas (87%).
- **Recommendations for Improvement:**
  - Strengthen CQI projects through training and mentorship to enhance integration of HIV/SRH/GBV services.
  - Improve HUMC functionality by building capacity through periodic supervision and adherence to Ministry of Health guidelines.
  - Conduct accessibility audits to ensure compliance with disability inclusion standards, including ramps, sign language interpreters, and assistive technologies.

Outcomes of Effectiveness:

- CP9 has significantly improved SRHR service availability and utilization, surpassing targets in areas such as contraceptive availability, family planning, and policy development.
- Gender equality and women's empowerment outcomes exceeded expectations, with transformative impacts on control over earnings, decision-making, and asset ownership.
- The integration of SRHR, HIV, and GBV services remains a challenge, with critical gaps in facility readiness and data utilization requiring further investment.
- CP9 effectively reached high-priority populations, including refugees and adolescents, though logistical challenges and inclusivity gaps suggest opportunities for enhanced targeting and resource allocation.

Evaluation question 8 [EQ8]: To what extent have resources (human, financial, and administrative), policies, procedures, tools, and delivery modalities of the 9th CP contributed to the effective and timely delivery of services and the achievement of the outputs and outcomes defined in the country programme? [Efficiency]			
Assumptions for Verification	**Indicators**	**Data Sources**	**Data Collection Methods**
Assumptions for verification 8.1: The 9th CP resources, policies, and delivery modalities were adequate and efficiently utilised to support timely service delivery and achievement of programme outputs and outcomes.	**Adequacy and Utilisation of Resources:** - Assessment of the adequacy of resources (human, financial, and administrative) allocated for the delivery of CP9 outputs and outcomes in the Population and Development component. - Evaluation of how efficiently these resources were utilized to achieve the programme's objectives. **Effectiveness of Policies, Procedures, and Tools:** - Review of the policies, procedures, and tools employed in CP9 to ensure effective management and administration of resources. - Analysis of how these mechanisms contributed to the timely delivery of services and the achievement of defined outputs and outcomes. **Delivery Modalities and Partnerships:** - Examination of the delivery modalities used in CP9, including partnerships with implementing partners (IPs), government agencies, and other stakeholders.	**Relevant Programme, Administrative, and Financial Management Documents:** - Annual Work Plans (AWPs), project progress reports, financial reports from Implementing Partners (IPs) and UNFPA (Atlas reports), audit reports for IPs, and field monitoring visit reports. **National Level Stakeholders:** - UNFPA staff (programme, finance, and administrative departments), representatives of IPs (head offices), donors, other UN agencies (UNCT, UNDP, UN Women, UNICEF), and relevant government agencies (NPC/POPSEC, UBOS, NPA, MoLG, MGLSD, MoH, MoES). **District Level Stakeholders:** - Chief Administrative Officers, heads of district-level government departments (Health, JLOS, Education, Planning), and other local government representatives involved in CP9 implementation.	**Documents Review:** - Review of AWPs, progress reports, financial reports, audit reports, and field monitoring visit reports to assess resource utilization, efficiency, and effectiveness. **Key Informant Interviews:** - Conduct interviews with national and district-level stakeholders, including UNFPA staff, government officials, and representatives of IPs and donors, to gather insights into the efficiency of resource use and delivery modalities. **Focus Group Discussions (FGDs):** - Organise FGDs with stakeholders involved in the implementation

	- Evaluation of how these modalities facilitated or hindered the efficient delivery of services and the achievement of programme results. **Risk Management and Control Measures:** - Assessment of the mechanisms in place to control waste, fraud, and inefficiencies in the use of resources. - Evaluation of the effectiveness of risk management strategies in ensuring the optimal use of resources.		of CP9 to discuss the efficiency of resource use and the effectiveness of policies, procedures, and tools. **Field Visits/Observations:** - Conduct field visits to observe the implementation of CP9 interventions, assess resource utilization on the ground, and identify any bottlenecks or inefficiencies in service delivery.

Data Collected:

Efficiency in Resource Utilisation

- **Funding Efficiency:**
  - Budget utilization rates remained consistently high, increasing from 90.4% in 2021 to 92.1% in 2022 and stabilizing at 92.0% in 2023, reflecting robust financial management.
  - Adaptive budgeting during the COVID-19 pandemic ensured uninterrupted SRHR and GBV services through the reallocation of funds to high-priority areas such as maternal health, telehealth support, and mobile clinics.
  - Remote training and virtual meetings saved costs, allowing resources to be redirected to underserved areas, contributing to an estimated 45% reduction in travel expenses between 2020 and 2021.

Leveraging Partnerships for Cost-Effectiveness

- **Collaborations with Stakeholders:**
  - Partnerships with local NGOs and refugee-focused organizations optimized resource utilization in districts such as Adjumani and Kyegegwa, where pooled resources supported both host and refugee populations under the Comprehensive Refugee Response Framework (CRRF).
  - Integration of Village Health Teams (VHTs) into SRHR outreach programs minimized operational costs while empowering local health systems to sustain services beyond CP9's direct funding.

- Joint initiatives with UN agencies (e.g., UNICEF and WHO) reduced administrative and operational costs through shared platforms for data management and combined monitoring visits.

Community-Based Approaches and Local Empowerment:

- **Capacity Building for Local Structures:**
  - VHTs were cross-trained in SRHR and GBV prevention, creating a cost-effective, versatile workforce capable of addressing multiple community needs simultaneously.
  - Deployment of locally trained midwives in districts such as Kamuli improved antenatal care coverage, reducing reliance on external staffing and increasing sustainability.
  - Community-based models enhanced resource efficiency by embedding skills and health service delivery capacity within local systems.

Innovation and Digitization

- **Digital Solutions for Efficiency:**
  - E-health platforms streamlined health worker scheduling and reporting, reducing data management delays and operational costs.
  - Regional hubs for contraceptive supply distribution reduced logistical expenses while ensuring consistent availability of family planning commodities, particularly in remote areas.

Administrative Efficiency:

- **Cost Savings Through Collaboration:**
  - Collaborative data management with UNICEF and shared logistics for monitoring visits with WHO significantly lowered software and transport costs.
  - Joint planning with local NGOs allowed for the rapid deployment of resources, such as menstrual hygiene kits, to meet urgent community needs.

Adaptation During Emergencies:

- **Agile Resource Allocation:**
  - CP9 demonstrated flexibility by reallocating resources during emergencies, such as the COVID-19 pandemic, to sustain critical services like maternal health and HIV prevention.
  - Mobile health units and telehealth innovations minimized disruptions, enabling continued access to SRHR and GBV services in high-need areas.

Challenges and Areas for Improvement:

- **Logistical Constraints:**
  - Delays in resource delivery to remote districts, such as Moroto and Kitgum, were caused by supply chain bottlenecks and limited transport capacity.
  - High demand in refugee-hosting districts often outpaced available resources, underscoring the need for strengthened supply chain frameworks and expanded outreach models.
  - Accessibility audits and enhanced transport logistics are needed to address gaps in service delivery for underserved and marginalized groups.

Timeliness of Resource Allocation:

- **Strengths and Opportunities:**
  - Rapid fund reallocation during emergencies demonstrated CP9's adaptability and ensured continuity of essential services.
  - However, district-level feedback revealed mixed results, with some delays in resource delivery to underserved areas. Strengthening logistical frameworks is critical to ensuring timely and equitable access across all target regions.

Outcomes of Efficiency Measures:

- **Sustained Impact and Resource Optimization:**
  - By leveraging partnerships, prioritizing local capacity building, and integrating digital tools, CP9 minimized costs while maintaining impactful service delivery.
  - The adoption of innovative approaches, such as mobile health units and cross-trained VHTs, ensured efficient resource use, particularly in geographically challenging regions.
  - Addressing logistical gaps and expanding supply chain capabilities will enhance CP9's ability to sustain long-term impact in Uganda's underserved areas.

Evaluation question 9 [EQ9]: To what extent has the programme been able to support the government, implementing partners, and rights-holders (notably, women, adolescents, and youth) in developing capacities and establishing mechanisms to ensure the durability of effects? [Sustainability]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 9.1: The 9th CP effectively strengthened capacities and mechanisms among stakeholders to sustain programme benefits and ensure long-term impact.	**Capacity Building for Sustainability:** - Assessment of how CP9 has supported the government, implementing partners, and rights-holders (women, adolescents, and youth) in developing capacities to maintain the benefits of programme interventions related to Population and Development. - Review of capacity development initiatives in Population and Development, including training and technical assistance provided to partners and beneficiaries. **Established Sustainability Mechanisms:** - Examination of the sustainability	**Relevant Documents:** - Sectoral policies and strategic plans, Annual Work Plans (AWPs) for Implementing Partners (IPs), country programme reports, CPAP, IP progress reports, and relevant sector strategic plans. - Annual review reports, standard progress reports, special study reports, mid-term review reports, and strategic plan evaluations for sectors such as health, education, and community services. **National Level Stakeholders:** - UNFPA staff, government officials, IP staff, district leaders, and heads of departments (Health, Education, Community Services,	**Documents Review:** - Review of sectoral policies, strategic plans, AWPs, programme reports, and sustainability plans to assess the establishment of sustainability mechanisms and capacity development efforts. **Key Informant Interviews:** - Conduct interviews with national and district-level stakeholders, including UNFPA staff,

	mechanisms established under CP9, including systems, structures, and processes designed to continue programme benefits beyond the programme period. - Evaluation of the likelihood that these mechanisms and benefits will be sustained in the long term. **National and Community Ownership:** - Analysis of the extent to which CP9 promoted national and community ownership of supported interventions in Population and Development, including financial and resource commitments from government and local stakeholders. - Review of partnerships and collaborative efforts in Population and Development that contributed to ownership and sustainability. **Sustainability Plans and Strategies:** - Review of the existence and implementation of sustainability plans, strategies, and scale-up initiatives related to Population and Development developed during CP9. - Assessment of the readiness of partner organizations and communities to sustain and scale up successful interventions.	Planning). - Representatives from partner organisations involved in sustainability planning and implementation. **Community-Level Stakeholders:** - Programme beneficiaries, including women, young people, men, and relevant community structures (local councils, cultural and religious leaders, community activists, Male Action Groups).	government officials, IPs, and community leaders, to gather insights into the sustainability of CP9 interventions. **Focus Group Discussions (FGDs):** - Organise FGDs with programme beneficiaries, community leaders, and partner organizations to discuss the durability of programme effects and the effectiveness of sustainability mechanisms. **Field Visits/Observations:** - Conduct field visits to observe the implementation of sustainability mechanisms, assess their effectiveness, and evaluate the level of ownership by local stakeholders.
Data Collected:			

Working Within Existing National Frameworks, Structures, and Systems

- **National-Level Integration:**
  - CP9's integration into Uganda's national health, legal, and psychosocial systems ensured that SRHR and GBV services will continue beyond the program's lifespan.
  - Development and dissemination of policies, plans, and guidelines created a robust legislative environment for SRHR and gender equality.
  - Investments in data systems, such as the Uganda Demographic Health Survey (UDHS) and the National GBV database, enable long-term monitoring, planning, and data-driven policy-making.
- **Subnational Engagement:**
  - Collaboration with District Health Offices, Community Development Offices, and Civil Society Organizations (CSOs) strengthened local capacity to implement and monitor SRHR and GBV interventions.
  - District-level bylaws and ordinances on SRHR promotion and GBV prevention were established with CP9 support, fostering local ownership.
  - District stakeholders expressed confidence in the durability of program outcomes, citing sustained technical and policy support at the district level.
- **Community-Level Integration:**
  - Use of existing community structures, such as health facilities, schools, religious and cultural institutions, ensured continuity in service delivery.
  - Disability-inclusive practices were embedded in national frameworks to promote long-term inclusivity in SRHR and GBV services.

Partnerships and Collaborations

- **National-Level Partnerships:**
  - CP9 established strong collaborations with ministries, including the Ministry of Gender, Labour and Social Development (MGLSD), Ministry of Health (MoH), and the Ministry of Education and Sports (MOES).
  - Partnerships with entities such as the Uganda Bureau of Statistics (UBOS) and National Planning Authority (NPA) ensured alignment with national development goals.
- **Subnational and Community Partnerships:**
  - Engagement with District Local Governments, NGOs, and cultural and religious leaders fostered localized ownership and continuity in SRHR and GBV service delivery.
  - Partnerships with private sector actors, such as telecommunication companies, supported innovative and sustainable solutions for service provision.
- **Role of Multi-Sectoral Collaboration:**
  - Coordinated efforts among ministries, CSOs, FBOs, and private sector actors leveraged complementary strengths, creating cost-efficient and sustainable interventions.
  - Regular review meetings among partners facilitated adaptive responses to emerging challenges, strengthening the sustainability of CP9 outcomes.

Capacity Building

- **Health System Strengthening:**
  - CP9's training programs equipped healthcare providers, community leaders, and peer educators with skills to address SRHR and GBV needs independently.
  - Integration of SRHR, HIV, and GBV services into existing health facilities created a sustainable framework for comprehensive service delivery.
- **Cascading Training Models:**
  - National and district trainers provided mentorship to local health workers, teachers, and community leaders, embedding skills within local systems.
  - Religious and cultural leaders, trained as change agents, continue to promote SRHR and gender equality within their communities.
- **Disability Inclusion:**
  - Capacity-building efforts emphasized disability-inclusive practices, ensuring that the needs of persons with disabilities (PWDs) are integrated into long-term service delivery frameworks.

Summary of Sustainability Insights

- **Alignment with National Goals:**
  - UNFPA's focus on strengthening local systems and aligning CP9 initiatives with Uganda's development goals ensures the program's legacy in advancing SRHR, maternal health, and gender equality.
  - Robust data systems and stakeholder capacity-building efforts position Uganda to independently sustain progress achieved under CP9.
- **Challenges and Recommendations:**
  - Resource limitations in refugee-hosting areas, such as Moroto and Adjumani, highlight the need for continued logistical and financial support.
  - Expanding capacity-building initiatives, particularly in logistical planning and resource mobilization, can further enhance sustainability.

Outcomes of Sustainability Measures:

- CP9's integration into existing structures, strategic partnerships, and focus on capacity building have created a strong foundation for sustained impact in SRHR, GBV prevention, and youth empowerment.
- Continued support for resource-constrained areas and further strengthening of local capacities will ensure long-term benefits across diverse communities.

Evaluation question 10 [EQ10]: To what extent did the governance structures (DaO, partnership strategy, execution/implementation arrangements, joint programme modality) foster or hinder the achievement of the programme outputs? [**Coordination]**

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 10.1: Governance structures under the 9th CP facilitated coordination and collaboration, fostering the achievement of programme outputs.	**Effectiveness of Governance Structures:** - Assessment of how the Delivering as One (DaO) approach, partnership strategy, and	**Relevant Documents:** - Minutes of UNCT working groups, programming documents regarding UNCT joint initiatives, monitoring/evaluation reports of	**Documents Review:** - Review of minutes, programming documents, monitoring/evaluation

	execution/implementation arrangements contributed to or hindered the achievement of CP9 programme outputs related to Population and Development. - Review of how joint programme modalities and governance structures facilitated effective coordination and resource sharing among partners. **Role of UNFPA in Coordination Mechanisms:** - Analysis of UNFPA's role in leading or participating in coordination mechanisms at national and sub-national levels, particularly in areas related to Population and Development. - Evaluation of UNFPA's contributions to joint initiatives, planning, monitoring, and evaluation efforts in collaboration with other UN agencies and partners. **Impact of Coordination on Programme Outputs:** - Examination of how effective coordination influenced the achievement of programme outputs in Population and Development, including the identification of any gaps or overlaps in coordination that impacted programme effectiveness. - Review of the alignment between UNFPA's coordination efforts and the	joint programmes and projects. - Minutes of Humanitarian Country Team (HCT) and related humanitarian coordination mechanisms, minutes and relevant documents on UN and national-level coordination mechanisms for SRH, GBV, and HIV integration. - UNSDCF (2021-2025) progress reports on coordination mechanisms, minutes, and reports of relevant DLG coordination structures for thematic areas/issues. **National Level Stakeholders:** - UNFPA country office staff, other UN agencies, representatives from the UN Resident Coordinator's Office (UNRC), and partners involved in coordination mechanisms. - Government officials and representatives of implementing partners involved in joint programming and coordination efforts. **Community-Level Stakeholders:** - Representatives from local government coordination structures, community leaders, and local partners engaged in coordinated interventions.	reports, and UNSDCF (2021-2025) progress reports to assess the effectiveness of coordination mechanisms and governance structures. **Key Informant Interviews:** - Conduct interviews with UNFPA country office staff, UNRC, other UN agencies, and partners involved in coordination to gather insights into the effectiveness of governance structures and their impact on programme outputs. **Focus Group Discussions (FGDs):** - Organise FGDs with stakeholders involved in coordination mechanisms at the community level to discuss their experiences and perspectives on the effectiveness of these structures.

	broader goals of CP9 and the UNSDCF (2021-2025).		**Field Visits/Observations:** - Conduct field visits to observe the implementation of coordinated interventions and assess how well governance structures facilitated or hindered programme outputs.

Data Collected:

Contributions to the Consolidation of UNCT Mechanisms

- **National-Level Coordination:**
  - UNFPA strengthened UN Country Team (UNCT) mechanisms by leading and participating in Results Groups (e.g., RG1 under UNSDCF) and developing Joint Workplans (JWPs) for harmonized planning and resource mobilization.
  - Collaboration with UN-Women, UNICEF, and UNDP facilitated joint monitoring and implementation of key initiatives such as the EU Spotlight Initiative and JPGBV Programme.
  - UNFPA actively engaged in inter-agency task forces on SRHR, GBV, and HIV, ensuring alignment with the mandates of MDAs like MoH, MGLSD, and OPM.
  - Functional national coordination platforms, including the National GBV Reference Group and Medical Legal Task Force, were supported through technical and financial inputs, fostering multi-sectoral integration and expanded membership (e.g., inclusion of JLOS actors and OPM).
- **District-Level Coordination:**
  - Institutionalized multi-sectoral coordination at district levels through regular planning and review meetings improved stakeholder accountability and streamlined service delivery.
  - Dissemination of tools like the 3W Matrix clarified roles, reduced duplication, and enhanced coordination among implementing partners and local governments.
  - Field Officers increased on-the-ground presence, facilitating bi-monthly site visits and district-level coordination to align government, community, and IP activities.
  - In refugee-hosting districts (e.g., Adjumani, Kyegegwa), structured platforms integrated SRHR and GBV services into humanitarian frameworks, benefiting both refugee and host communities.
- **Community-Level Coordination:**

- Collaboration with community structures, such as cultural and religious leaders, peer educators, and Village Health Teams (VHTs), ensured grassroots integration of SRHR and GBV interventions.
- GBV working groups and child protection platforms established at settlement levels empowered community members to lead in addressing social norms and fostering shared responsibility for family and community health.

Improvements in Coordination Mechanisms

- **Reduced Duplication and Fragmentation:**
  - Coordination at all levels minimized overlapping interventions, ensuring equitable distribution of resources and covering underserved areas.
  - Multi-sectoral approaches harmonized actions across government, civil society, and humanitarian actors, optimizing service delivery efficiency.
- **Accountability and Alignment:**
  - Regular coordination meetings ensured alignment with national and sector-specific priorities, such as SRHR, gender equality, and youth empowerment.
  - Community and district-level stakeholders consistently reported improved clarity on roles and responsibilities, fostering a unified approach to addressing gaps.
- **Learning and Adaptation:**
  - Joint planning meetings provided platforms to reflect on successes and challenges, promoting iterative improvements in service delivery and coordination strategies.
  - Enhanced capacity for partner engagement allowed for more integrated and context-specific responses, particularly in regions like Moroto and Kamuli.

Challenges and Areas for Improvement:

- **Sub-County and Community-Level Gaps:**
  - While district-level coordination improved, inconsistencies were noted at the sub-county and community levels. Efforts to actively support these structures with resources, work plans, and lesson-sharing are required.
  - Logistical and resource constraints occasionally limited the regularity of meetings and full engagement at lower administrative levels.
- **Coordination in Remote and Refugee Areas:**
  - High demand for services in refugee-hosting districts often outpaced coordination capacity, emphasizing the need for expanded logistical and resource support in regions like Kyegegwa and Adjumani.

Outcomes of Coordination Mechanisms:

- **Enhanced Integration:**
  - UNFPA's leadership in coordinating GBV and SRHR interventions contributed to aligning programmatic efforts with Uganda's national health and development goals.
  - Improved collaboration among UN agencies, government actors, and IPs fostered coherence in delivering transformative outcomes for vulnerable populations.
- **Empowered Local Structures:**

- Strengthened community engagement and capacity building at district and settlement levels ensured local ownership and sustainable delivery of services.
- Partnerships with local government and civil society actors facilitated gender equality and youth empowerment initiatives aligned with contextual needs.

Summary:
UNFPA's coordination mechanisms under CP9 effectively unified multi-sectoral and inter-agency efforts, reducing duplication and enhancing alignment across sectors. However, addressing gaps at sub-county and community levels and improving resource allocation for underserved regions will further strengthen coordination outcomes and ensure equitable service delivery.

Evaluation question 11 [EQ11]: To what extent have UNFPA humanitarian interventions systematically reached all geographic areas where affected populations (women, adolescents, and youth) reside? [Coverage]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 11.1: Humanitarian interventions under the 9th CP systematically reached all geographic areas with affected populations, ensuring equitable access to services.	**Geographic Reach of Interventions:** - Assessment of the extent to which UNFPA humanitarian Population and Development interventions covered all geographic areas where affected populations, particularly women, adolescents, and youth, reside. - Identification of any gaps in coverage, including underserved or hard-to-reach areas that were not adequately covered by interventions. **Target Population Reach:** - Evaluation of the extent to which Population and Development interventions specifically reached the targeted populations, including women, adolescents, and youth, in all identified geographic areas. - Analysis of the effectiveness of strategies used to ensure the inclusion of these populations in the	**Relevant Documents:** - Geographic and demographic data on affected populations, humanitarian response plans, programme implementation reports, and monitoring and evaluation reports. - Maps and spatial analysis documents showing the geographic distribution of interventions and affected populations. **National Level Stakeholders:** - UNFPA humanitarian staff, government officials, and representatives from humanitarian agencies and partners involved in the response. - UN agencies, INGOs, and local NGOs engaged in humanitarian coordination and implementation. **Community-Level Stakeholders:**	**Documents Review:** - Review of geographic and demographic data, programme implementation reports, and spatial analysis documents to assess the coverage of humanitarian interventions. **Key Informant Interviews:** - Conduct interviews with UNFPA humanitarian staff, government officials, and representatives from humanitarian agencies and partners to gather insights into the geographic reach and challenges of the

	humanitarian response. **Barriers to Coverage:** - Identification of barriers or challenges that may have hindered the full geographic coverage of humanitarian interventions, such as logistical, security, or resource constraints. - Review of how these barriers were addressed or mitigated during the programme period.	- Beneficiaries, community leaders, and representatives from affected populations, particularly women, adolescents, and youth in targeted areas.	interventions. **Focus Group Discussions (FGDs):** - Organise FGDs with beneficiaries and community leaders in various geographic areas to understand their experiences and perspectives on the coverage of humanitarian interventions. **Field Visits/Observations:** - Conduct field visits to observe the implementation of interventions in different geographic areas, particularly in underserved or hard-to-reach locations, and assess the effectiveness of coverage strategies.

Data Collected:

Extent of Coverage Across Intended Populations and Areas

- **Broad Geographic and Demographic Reach:**
  - CP9 provided SRHR and GBV services to over 2.5 million people by 2023, representing approximately 5.5% of Uganda's mid-2023 population.
  - In refugee-hosting districts, interventions reached 24,518 young people aged 10–24, and SRHR outreach covered an estimated 15% of women of reproductive age in targeted regions.

- Districts like Kitgum, Amudat, and Madi-Okollo saw significant expansion of SRHR, GBV prevention, and maternal health services, addressing gaps in areas with limited health infrastructure.

- **Targeted Populations:**
  - Refugee-hosting districts, such as Adjumani and Kyegegwa, received tailored services benefiting both refugees and host communities (70% host, 30% refugee populations), fostering social cohesion while addressing distinct health needs.
  - Adolescent-focused interventions were prioritized, including youth-friendly health services and peer-led initiatives in underserved rural and refugee areas.
  - Coverage extended to women, refugees, and rural populations, with specific efforts to include marginalized groups, although challenges persisted for persons with disabilities and adolescent boys.
- **Logistical Challenges and Gaps:**
  - Geographic isolation, transportation barriers, and limited health worker availability restricted CP9's reach in remote sub-counties, particularly in Moroto and Kitgum.
  - Cultural and language barriers in refugee settlements, such as Tika in Madi-Okollo, hindered comprehensive SRHR delivery, emphasizing the need for culturally sensitive approaches, including South Sudanese-speaking staff.

Identification and Response to Significant Gaps in Coverage

- **Gap Identification:**
  - CP9 utilized data-driven strategies to prioritize underserved areas, focusing on adolescents, women, and rural populations with high unmet SRHR needs.
  - Findings from the Gap Analysis highlighted persistent barriers for marginalized groups, including persons with disabilities and adolescent boys, who remain underserved in traditional SRHR programming.
  - Evaluations such as the ADA project and WAY programme emphasized gaps in reaching remote regions and addressing cultural barriers in refugee settings.
- **Targeted Responses:**
  - Mobile health units and partnerships with Village Health Teams (VHTs) enhanced outreach to hard-to-reach populations in regions like Karamoja and northern Uganda.
  - Peer-led networks and youth-friendly health services expanded access for adolescents, though additional focus is needed to include adolescent boys and disabled youth.
  - CP9's integration of culturally sensitive approaches, such as employing multilingual health workers, addressed some language barriers in refugee-hosting areas.
- **Persistent Challenges:**
  - Logistical constraints, including transport limitations and supply chain issues, hindered consistent service delivery in isolated areas.
  - Limited funding prevented comprehensive coverage, particularly for populations with disabilities and adolescent boys, who remain underrepresented in outreach efforts.

Summary of Coverage Insights

- **Achievements:**

- CP9 effectively expanded SRHR and GBV services to Uganda's high-need populations, including adolescents, women, refugees, and rural communities.
- Tailored strategies, such as mobile health units and community-based outreach, enabled significant geographic and demographic reach in underserved regions.

- **Opportunities for Improvement:**
  - Expanding logistical support and fostering partnerships can improve coverage in remote areas.
  - Inclusive strategies targeting persons with disabilities and adolescent boys are essential for ensuring equitable access to SRHR and GBV services.
  - Enhancing cultural sensitivity in refugee settings and improving data-driven planning will further strengthen CP9's coverage.

Outcomes of Coverage Efforts:

- CP9's adaptive and targeted approaches addressed critical gaps in health service delivery, particularly in underserved rural and refugee-hosting areas.
- Continued investment in inclusivity, logistics, and tailored outreach will be crucial to achieving comprehensive coverage and equitable health access for Uganda's diverse populations.

Evaluation question 12 [EQ12]: To what extent has the UNFPA humanitarian response taken into account longer-term development goals articulated in the results framework of the country programme? [Connectedness]

Assumptions for Verification	Indicators	Data Sources	Data Collection Methods
Assumptions for verification 12.1: The 9th CP's humanitarian response was aligned with and contributed to longer-term development goals outlined in the country programme results framework.	**Integration of Humanitarian and Development Goals:** - Assessment of the extent to which the humanitarian response was designed and implemented with a view to contributing to longer-term development goals. - Review of the alignment between humanitarian interventions and the longer-term development objectives articulated in the CP9 results framework. **Sustainability of Humanitarian Interventions:** - Evaluation of how humanitarian interventions were planned and	**Relevant Documents:** - CP9 results framework, humanitarian response plans, programme implementation reports, and strategic documents outlining the integration of humanitarian and development goals. - Partnership agreements, coordination meeting minutes, and progress reports on joint initiatives between humanitarian and development actors. **National Level Stakeholders:** - UNFPA humanitarian and development staff, government officials, representatives from UN	**Documents Review:** - Review of CP9 results framework, humanitarian response plans, and strategic documents to assess the integration of humanitarian and development goals. **Key Informant Interviews:** - Conduct interviews with UNFPA staff, government officials, and representatives from humanitarian and

	executed to ensure that their benefits could contribute to or be sustained within broader development initiatives. - Analysis of the mechanisms put in place to transition from humanitarian assistance to development programming, ensuring continuity and lasting impact. **Linkages with Development Partners:** - Review of the collaboration between humanitarian actors and development partners, including government agencies, UN agencies, and NGOs, to ensure that humanitarian actions supported longer-term development goals. - Identification of any synergies or gaps in the coordination between humanitarian and development efforts.	agencies, INGOs, and NGOs involved in both humanitarian response and development programming. **Community-Level Stakeholders:** - Beneficiaries and community leaders who have experienced both humanitarian interventions and development programmes, particularly in areas where transitions from humanitarian to development assistance occurred.	development partners to gather insights into the connectedness of interventions. **Focus Group Discussions (FGDs):** - Organise FGDs with beneficiaries and community leaders to understand their perspectives on how humanitarian interventions have supported or transitioned into longer-term development goals. **Field Visits/Observations:** - Conduct field visits to observe the implementation of interventions with a focus on areas where humanitarian actions are linked with or have transitioned into development programming.
Data Collected: **Connections Between CP9 Interventions and Broader Development/Humanitarian Goals** • **Alignment with National and Global Frameworks:**			

- CP9 interventions are strategically integrated into Uganda's Vision 2040, the National Development Plan (NDP), and the Sustainable Development Goals (SDGs), specifically SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality).
- Efforts to reduce maternal mortality and support SRHR contribute directly to Uganda's demographic dividend strategy, enhancing human capital and economic growth prospects.

- **Integration with Humanitarian Priorities:**
  - In refugee-hosting districts, such as Adjumani and Madi-Okollo, CP9's SRHR and GBV services foster social cohesion and inclusivity, addressing immediate humanitarian needs while supporting long-term community resilience.
  - The program's adherence to Uganda's Comprehensive Refugee Response Framework (CRRF) promotes equitable health access for both refugees and host communities, enhancing shared development goals.
- **Impact on Broader Socio-Economic Goals:**
  - SRHR and GBV interventions, particularly those targeting women and adolescents, align with Uganda's economic development priorities by empowering vulnerable populations, reducing early marriages, and increasing workforce participation.
  - In districts like Kitgum and Kamuli, CP9's focus on adolescent health and family planning reduces teenage pregnancies and fosters educational and economic opportunities for young women.
- **Targeted Programming in Underserved Areas:**
  - CP9 prioritizes health equity through SRHR and GBV services in rural regions such as Karamoja and northern Uganda, addressing critical gaps in underserved communities.
  - Interventions support Uganda's SDG agenda by improving health indicators and addressing social determinants of health, such as gender inequities and geographic disparities.

Linkages Between Immediate Interventions and Long-Term Objectives

- **Building Sustainable Health Systems:**
  - CP9's support for national data systems, such as the Uganda Demographic Health Survey (UDHS), provides a foundation for data-driven planning and policymaking aligned with Uganda's long-term development objectives.
  - Integration of SRHR services into existing community health structures ensures continuity of health services and promotes local ownership, even in resource-constrained areas.
- **Empowering Communities for Long-Term Impact:**
  - Youth-focused SRHR education fosters lasting behaviour change, reducing teenage pregnancies and enabling informed decision-making for Uganda's demographic dividend.
  - In refugee-hosting areas, culturally sensitive GBV interventions and community-based programming create structural shifts in social norms, aligning with Uganda's Vision 2040 goals for inclusivity and resilience.
- **Data-Driven Decision-Making:**
  - CP9's investments in demographic data collection and analysis enhance Uganda's capacity to monitor health trends, allocate resources effectively, and address demographic challenges.
  - Collaboration with government and local stakeholders ensures that health and gender equality gains are sustained beyond the program's lifespan.

Summary of Connectedness Insights

- **Achievements:**
  - CP9 effectively links immediate health interventions with Uganda's broader development and humanitarian objectives, including Vision 2040, the NDP, and SDG commitments.
  - Investments in youth empowerment, gender equality, and local health system strengthening align with Uganda's long-term socio-economic and demographic strategies.
- **Challenges and Opportunities:**
  - Expanding reach to remote and marginalized areas is critical to maximizing CP9's contributions to national development goals.
  - Continued integration of disability-inclusive programming and tailored interventions for underserved groups will enhance CP9's long-term impact.

Outcomes of Connectedness Efforts:

- CP9's holistic approach addresses Uganda's immediate SRHR and GBV needs while building sustainable systems for long-term health, social equity, and economic development.
- Through alignment with national priorities and global goals, CP9 reinforces Uganda's capacity to achieve resilient and inclusive progress in health and gender equality.

LESSONS LEARNT AND GAPS:
What lessons were learned, and what gaps remain from CP9 implementation?

Lessons Learned
Sexual and Reproductive Health and Rights (SRHR)
Key Lessons and Best Practices:

1. **Community-Based Approaches Drive Impact:**
   - Village Health Teams (VHTs) significantly improved access to SRHR services in underserved and remote areas by leveraging local trust and cultural understanding.
   - Community-embedded initiatives ensured continuity of services beyond CP9's direct funding cycle.
2. **Mobile Clinics Ensure Service Continuity:**
   - Mobile clinics proved effective during emergencies and in hard-to-reach areas, providing uninterrupted SRHR services like family planning and maternal health.
   - Integration with community outreach enhanced efficiency by addressing multiple health needs simultaneously.
3. **Peer-Led Education Fosters Long-Term Behaviour Change:**
   - Adolescents and youth benefitted from relatable peer educators, which reduced stigma and increased the uptake of contraceptives and SRHR services.
   - Sustained behaviour changes were observed, particularly in reducing teenage pregnancies and unsafe practices.
4. **Capacity Building Strengthens Sustainability:**

- Training healthcare workers and equipping health facilities reinforced the resilience of community health systems, ensuring the continuity of SRHR services post-programme.

Identified Gaps:

1. **Inclusivity Challenges Persist:**
   - Adolescent boys and persons with disabilities were underrepresented in SRHR programming due to structural barriers and social stigmas.
2. **Cultural and Social Barriers:**
   - Resistance from religious and community leaders hindered family planning uptake and other SRHR services among marginalized groups.
3. **Insufficient Mechanisms for Cross-Learning:**
   - Limited documentation and sharing of successful practices reduced opportunities for scaling peer-led models and youth engagement strategies.

Transferable Insights for Future Programming:

1. **Scale Up Mobile Clinics:**
   - Integrate mobile clinics into long-term SRHR outreach strategies, particularly for remote and underserved populations.
2. **Expand Peer-Led Models:**
   - Formalize and scale up peer-led education initiatives to address stigma and enhance youth engagement.
3. **Prioritize Cultural Sensitivity:**
   - Engage religious and cultural leaders as advocates for SRHR practices to reduce resistance and improve community acceptance.
4. **Tailored Outreach for Underserved Groups:**
   - Design inclusive services addressing the specific needs of adolescent boys and persons with disabilities.

Gender Equality and Women's Empowerment (GEWE)

Key Lessons and Best Practices:

1. **Community Engagement Enhances Outcomes:**
   - Collaborations with local leaders and cultural institutions reduced stigma and fostered ownership of GBV prevention initiatives.
2. **Safe Spaces Build Trust:**
   - Safe spaces for women and girls provided psychological support and secure environments for GBV survivors to access services.
3. **Policy Alignment Strengthens Impact:**
   - Integration with Uganda's gender policies and SDG 5 facilitated cross-sectoral collaboration, amplifying the reach of GBV and gender equality interventions.
4. **Economic Empowerment Drives Change:**
   - Empowering women financially enhanced their resilience, increased participation in GBV prevention, and strengthened advocacy for their rights.

Identified Gaps:

1. **Resistance to Norm Change:**
   - Entrenched cultural resistance to addressing harmful gender norms persisted, requiring sustained advocacy and tailored strategies.

2. **Inconsistent Accessibility of Safe Spaces:**
    - Uneven availability of safe spaces across districts limited their impact, particularly in rural and refugee-hosting regions.

Transferable Insights for Future Programming:

1. **Integrate GBV Services with SRHR Initiatives:**
    - Deliver GBV and SRHR services through integrated programming to provide comprehensive support for women's health and empowerment.
2. **Scale Up Safe Spaces:**
    - Expand safe spaces in underserved districts to ensure consistent availability and reliability of GBV services.
3. **Tailored Engagement with Men and Boys:**
    - Develop targeted interventions involving men and boys to challenge harmful gender norms and foster long-term behavior change.
4. **Broaden Economic Empowerment Initiatives:**
    - Scale up vocational training and microfinance initiatives to provide sustainable financial independence for women.

Population and Data Systems

Key Lessons and Best Practices:

1. **Data-Driven Decision-Making Enhances Program Effectiveness:**
    - Use of data from the Uganda Demographic Health Survey (UDHS) and the national census ensured equitable resource allocation and targeted service delivery.
2. **Adaptive Responses Enabled by Data:**
    - Real-time data informed resource reallocation during crises, such as the COVID-19 pandemic, maintaining service continuity for SRHR and maternal health.
3. **Capacity Building Strengthens Local Decision-Making:**
    - Training district officials in data analysis improved local planning and accountability, aligning interventions with district-specific needs.

Identified Gaps:

1. **Limited Integration Across Systems:**
    - Fragmentation among data systems in health, education, and population sectors hindered coordinated decision-making.
2. **Variable Data Utilization at Sub-National Levels:**
    - Inconsistent application of data by district officials highlighted the need for ongoing mentoring and technical support.

Transferable Insights for Future Programming:

1. **Invest in Integrated Data Systems:**
    - Establish harmonized data systems across sectors for seamless information sharing and improved program efficiency.
2. **Strengthen Adaptive Planning Mechanisms:**
    - Leverage robust data systems for rapid adjustments in programming during emergencies, ensuring resilience and relevance.
3. **Sustain Capacity Building:**
    - Continue training and mentoring district officials to embed data-informed decision-making as a routine practice.

Summary:
The lessons from the 9th CP underscore the importance of community engagement, inclusive programming, and capacity building for achieving sustainable impact in SRHR, GEWE, and population data systems. Addressing identified gaps - such as inclusivity challenges, cultural barriers, and fragmented data systems - will be essential for maximizing the effectiveness of future programming.

ANNEXURE 4: DATA COLLECTION TOOLS

UNFPA Uganda - Population and Development (PD)

Key Informant Interview Guide for Implementers of the PD Component

Key Informants

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

General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the Government of Uganda (GoU)/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential interview aimed at understanding how well UNFPA has positioned itself with the communities and national partners to add value to the country's development results. We seek to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders, including beneficiaries, and visiting districts including Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."

Core Interview Objectives and Sample Questions

1. **Relevance to National Government and UNFPA Policies**
    - To what extent is the 9th Country Programme (CP9) aligned with national priorities (including Vision 2040, National Development Plan (NDP) III (2020/21-2024/25, United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025, African Union Agenda 2063))?
    - How well does CP9 align with sectoral priorities and the needs of target groups, including the SDGs and the ICPD Programme of Action?
2. **Coherence with Other Initiatives**
    - How well does CP9 ensure synergy and avoid duplication with other interventions and initiatives by UN agencies, the government, or other stakeholders in Uganda?
    - Are there any conflicting policies or strategies within the programme that might affect its coherence?
3. **Effectiveness of Approaches/Programmes/Interventions**
    - To what extent did UNFPA-supported interventions contribute to the achievement of planned results under CP9? Were the intended geographic areas and target groups successfully reached?
    - What lessons and best practices can be applied in future programme and policy development?
4. **Efficiency of Use of UNFPA Resources**
    - How has the Country Office optimised its resources (funding, personnel, administrative arrangements, etc.) in the achievement of CP9 results?

- Did the intervention mechanisms foster or hinder the achievement of the programme outputs, particularly those related to advancing gender equality and human rights?

5. **Sustainability of Benefits**
   - How likely are the benefits from UNFPA support to continue after CP9?
   - To what extent have partnerships built by UNFPA promoted national ownership of the supported interventions?
6. **Coordination Mechanisms within and Across Sectors**
   - How has the UNFPA Country Office contributed to the functioning and consolidation of United Nations Country Team (UNCT) coordination mechanisms under CP9?
7. **Coverage of Targeted Populations and Areas**
   - How comprehensive was the reach of CP9 activities across the targeted populations and geographic areas?
   - Were there any significant gaps in coverage, and if so, how were they addressed?
8. **Connectedness to Broader Development Goals**
   - How well were CP9 activities linked to broader development and humanitarian initiatives in Uganda?
   - Were there effective linkages between immediate interventions and long-term development objectives?
9. **Interviewee Recommendations**

UNFPA Uganda – Sexual Reproductive Health and Rights (SRHR)
Key Informant Interview Guide for Implementers of the SRHR Component
Key Informants

- **UNFPA SRHR staff; UNFPA Humanitarian Team; Office of the Prime Minister (OPM); Ministry of Health; Ministry of Gender, Labour and Social Development; Ministry of Education and Sports; Ministry of Justice & Constitutional Affairs; NPC, NPA, UBOS, Makerere University School of Public Health (SPH); Inter-Religious Council of Uganda; and Heads of Relevant DLG Departments (Health, Community Services, Planning & Education, Police, Judicial Officers & Probation Officers)**

General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential interview aimed at understanding how well UNFPA has positioned itself with the communities and national partners to add value to the country's development results. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."

Core Interview Objectives and Sample Questions

1. **Relevance to National Government and UNFPA Policies**
    - How aligned is CP9 with national policies and priorities, including responses to changing contexts, such as humanitarian emergencies?
2. **Coherence with Other Initiatives**
    - To what extent are SRHR activities under CP9 coordinated with other health and development programmes in Uganda to ensure coherence?
    - How does CP9 address any potential overlaps or contradictions with other programmes or policies?
3. **Effectiveness of Approaches/Programmes/Interventions**
    - How well have UNFPA's SRHR interventions met the expected outcomes under CP9? Were key geographic areas and target populations reached?
4. **Efficiency of Use of UNFPA Resources**
    - How effectively has UNFPA utilised its resources in achieving SRHR outcomes?
    - How did partnerships and implementation arrangements impact the achievement of SRHR results?
5. **Sustainability of Benefits**
    - What measures are in place to ensure that SRHR interventions supported by UNFPA will continue beyond the completion of CP9?
    - How has UNFPA fostered national ownership of SRHR initiatives?

6. **Coordination Mechanisms within and Across Sectors**
    - To what extent has UNFPA contributed to SRHR coordination among stakeholders at the district and national levels?
7. **Coverage of Targeted Populations and Areas**
    - Did the SRHR component of CP9 effectively reach all intended groups, particularly the most vulnerable populations?
    - Were any populations or areas underserved, and how were these gaps addressed?
8. **Connectedness to Broader Development Goals**
    - How well did the SRHR interventions under CP9 integrate with other health and development efforts to ensure that immediate needs were addressed alongside long-term goals?
9. **Interviewee Recommendations**

UNFPA Uganda – Sexual Reproductive Health and Rights (SRHR)
Key Informant Interview Guide for Other Key Players
Key Informants

- **UN Agencies, Donors, and Organizations that are not implementing the programme but are key players in the sector (Resident Coordinator, others in humanitarian assistance)**

General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential interview aimed at understanding how well UNFPA has positioned itself with the communities and national partners to add value to the country's development results. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."

Core Interview Objectives and Sample Questions

1. **Relevance to National Government and UNFPA Policies**
    - How relevant do you perceive UNFPA's work to be regarding national objectives and priorities, including the humanitarian situation for refugees?
    - How well does the UNFPA activities/work support the national structures that are in place?
2. **Coherence with Other Initiatives**
    - How well is CP9 coordinated with other humanitarian and development efforts in the region?
    - Are there overlaps or gaps in services that could be better addressed through improved coherence?
3. **Effectiveness of Approaches/Programmes/Interventions**
    - To what extent did the SRHR interventions contribute to the achievement of intended outcomes under CP9?
    - Were the planned geographic areas and target groups effectively reached?
4. **Efficiency of Use of UNFPA Resources**
    - How effectively has UNFPA utilised its resources (funding, personnel, etc.) in achieving the SRHR outcomes?
    - Were there any challenges in the allocation and use of resources that affected the programme's efficiency?
5. **Sustainability of Benefits**
    - What measures have been taken to ensure the sustainability of SRHR interventions beyond CP9?
    - How has UNFPA built capacity among local partners to maintain these efforts?
6. **Coordination Mechanisms within and Across Sectors**
    - How well has UNFPA engaged with other UN agencies and partners to ensure effective coordination of SRHR activities?
    - Are there existing coordination mechanisms that have facilitated or hindered the programme's success?
7. **Coverage of Targeted Populations and Areas**
    - Did the SRHR component of CP9 adequately cover the intended populations, especially in remote or underserved areas?
    - What strategies were employed to ensure comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How were SRHR interventions linked to broader development goals in the region?

- Were there effective linkages between immediate humanitarian needs and long-term development strategies?

9. **Interviewee Recommendations**

UNFPA Uganda – Gender Equality
Key Informant Interview Guide for Implementers of the Gender Equality Component
Key Informants

- **UNFPA Gender Equality staff; Ministry of Gender, Labour and Social Development; Ministry of Health; Ministry of Education and Sports; Ministry of Justice & Constitutional Affairs; Directorate of Public Prosecution; Justice Law Order Sector (JLOS); Police Child and Family Protection Units; & Heads of Relevant DLG Departments including Health, Community Services, Planning & Education, Police, Judicial Officers & Probation Officers**
- **CSO/NGO IPs (ACORD, BRAC, CARE, IRC, LWF, RAHU, RHU)**

General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential interview aimed at understanding how well UNFPA has positioned itself with the communities and national partners to add value to the country's development results. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."

Core Interview Objectives and Sample Questions

1. **Relevance to National Government and UNFPA Policies**
    - How relevant are the gender equality initiatives under CP9 to the national objectives and priorities, particularly in the context of refugee and humanitarian situations?
2. **Coherence with Other Initiatives**
    - To what extent are gender equality initiatives under CP9 coherent with other initiatives, avoiding duplication and ensuring complementarity?
    - Are there any policy or programme conflicts that may affect the coherence of the gender equality interventions?
3. **Effectiveness of Approaches/Programmes/Interventions**
    - How effective have the gender equality interventions been in achieving the intended outcomes under CP9?
4. **Efficiency of Use of UNFPA Resources**
    - How efficiently has UNFPA employed its resources in advancing gender equality under CP9?
    - What were the impacts of the partnership and implementation strategies on the gender equality outcomes?
5. **Sustainability of Benefits**
    - What is the likelihood that the benefits of gender equality initiatives will continue after CP9?
    - How has UNFPA contributed to building sustainable partnerships in the gender equality space?
6. **Coordination Mechanisms within and Across Sectors**
    - How well has UNFPA integrated with other stakeholders in coordinating gender equality efforts at both district and national levels?
7. **Coverage of Targeted Populations and Areas**
    - Did gender equality initiatives under CP9 effectively reach the intended beneficiaries, including marginalized groups?
    - How were any gaps in coverage addressed?
8. **Connectedness to Broader Development Goals**

- How well were the gender equality initiatives under CP9 connected to broader development and humanitarian goals?
- How effectively were short-term gender equality interventions linked to long-term development strategies?

9. **Interviewee Recommendations**

UNFPA Uganda - Reproductive Health and Rights (SRHR)
Focus Group Discussion for Adolescents and Youth
General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential discussion aimed at understanding how effectively UNFPA has supported adolescents and youth in understanding and addressing health issues. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."
Core Interview Objectives and Sample Questions

1. **Rationale for the Project and Activities Undertaken**
    - What were, and are your priority needs as far as adolescent sexual and reproductive health is concerned?
2. **Relevance of the Project/Activities to National Government and UNFPA Policies**
    - How well does the activity/work of UNFPA fit with the needs of adolescents and youth in this district?
    - What effect do you think the work should have on different groups?
3. **Efficiency of Use of UNFPA Resources**
    - Did your work receive the needed support from UNFPA?
    - Did the youth network receive any other support in connection with the UNFPA work? If so, who provided this support?
4. **Effectiveness of Approaches/Programmes/Interventions**
    - Can you provide examples of success from the activities (e.g., box game, peer counseling) both long-term and short-term?
    - How useful are these activities in communicating reproductive health messages?
5. **Sustainability of Benefits**
    - Can the youth networks carry on the work without UNFPA support?
    - What will help the youth networks to continue the SRHR work on their own?
6. **Coordination Mechanisms within and Across Sectors**
    - Do you work with other UN agencies? How well are the activities coordinated? Are there overlaps or gaps?
7. **Coverage of Targeted Populations and Areas**
    - Were all the intended groups, particularly the most vulnerable, effectively reached through the interventions?
    - Were there any challenges in ensuring comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How well were the activities linked to broader development and health goals in your community?
    - How were immediate needs and long-term goals balanced in these interventions?
9. **Focus Group Discussion Recommendations**

UNFPA Uganda - Reproductive Health and Rights (SRHR)
Focus Group Discussion for Women of Reproductive Age (15-54 years) / Girls
General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential discussion aimed at understanding how effectively UNFPA has supported women/girls in understanding and accessing sexual and reproductive health (SRH) and family planning (FP) services. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."
Core Interview Objectives and Sample Questions

1. **Rationale for the Project and Activities Undertaken**
    - What were, and are your priority needs as far as sexual and reproductive health and rights are concerned?
2. **Relevance of the Project/Activities to National Government and UNFPA Policies**
    - How well does the activity/work of UNFPA fit with the needs of women/girls in this district?
    - What effect do you think the work should have on different groups?
3. **Efficiency of Use of UNFPA Resources**
    - Did the women/girls or your groups receive the needed support from UNFPA?
    - Did your groups receive any other support in connection with the UNFPA work? If so, who provided this support?
4. **Effectiveness of Approaches/Programmes/Interventions**
    - Can you provide examples of success from the activities (e.g., box game) both long-term and short-term?
    - How useful are these activities in communicating SRH messages?
5. **Sustainability of Benefits**
    - Can the women/girls or your groups carry on the work without UNFPA support?
    - What will help the groups to continue the SRH work on their own?
6. **Coordination Mechanisms within and Across Sectors**
    - Do you receive support from other UN agencies? How well are the activities coordinated? Are there overlaps or gaps?
7. **Coverage of Targeted Populations and Areas**
    - Were all intended groups, particularly vulnerable women/girls, effectively reached through the interventions?
    - Were there any challenges in ensuring comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How well were the activities linked to broader development and health goals in your community?
    - How were immediate needs and long-term goals balanced in these interventions?
9. **Focus Group Discussion Recommendations**

UNFPA Uganda - Reproductive Health and Rights (SRHR)
Focus Group Discussion for Men and Men Action Groups (MAGs)
General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential discussion aimed at understanding how effectively UNFPA has supported men and MAGs in understanding and accessing sexual and reproductive health (SRH) and family planning (FP) services. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."
Core Interview Objectives and Sample Questions

1. **Rationale for the Project and Activities Undertaken**
    - What were, and are your priority needs as far as sexual and reproductive health and rights are concerned?
2. **Relevance of the Project/Activities to National Government and UNFPA Policies**
    - How well does the activity/work of UNFPA fit with the needs of men and MAGs in this district?
    - What effect do you think the work should have on different groups?
3. **Efficiency of Use of UNFPA Resources**
    - Did the men or MAGs receive the needed support from UNFPA?
    - Did the men and MAGs receive any other support in connection with the UNFPA work? If so, who provided this support?
4. **Effectiveness of Approaches/Programmes/Interventions**
    - Can you provide examples of success from the activities (e.g., box game) both long-term and short-term?
    - How useful are these activities in communicating SRH messages?
5. **Sustainability of Benefits**
    - Can the men and MAGs carry on the work without UNFPA support?
    - What will help the men and MAGs to continue the SRH work on their own?
6. **Coordination Mechanisms within and Across Sectors**
    - Do you receive support from other UN agencies? How well are the activities coordinated? Are there overlaps or gaps?
7. **Coverage of Targeted Populations and Areas**
    - Were all intended groups, particularly vulnerable men, effectively reached through the interventions?
    - Were there any challenges in ensuring comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How well were the activities linked to broader development and health goals in your community?
    - How were immediate needs and long-term goals balanced in these interventions?
9. **Focus Group Discussion Recommendations**

UNFPA Uganda - Reproductive Health and Rights (SRHR)
Focus Group Discussion for Refugees (Women or Men)
General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential discussion aimed at understanding how helpful this work has been for your community, including services such as dignity kits, psychosocial counseling, SRH/HIV and FP services, and ambulance referral service. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."
Core Interview Objectives and Sample Questions

1. **Rationale for the Project and Activities Undertaken**
    - What were, and are your priority needs?
    - How well have you been consulted about your needs?
2. **Relevance of the Project/Activities to National Government and UNFPA Policies**
    - Did you help plan the services you have received?
    - What effect do you think the work should have on different groups?
3. **Efficiency of Use of UNFPA Resources**
    - Did you receive the services when you needed them? Were there delays?
    - Did you receive what you expected? Were you consulted afterwards about your use of the items and services?
4. **Effectiveness of Approaches/Programmes/Interventions**
    - Can you provide examples of success from the services or activities?
    - How do you think the activities can be improved?
    - What was helpful for you regarding your health (psychosocial support, learning, access to contraceptives, birth spacing)?
    - Will the activities/services be useful in the future?
5. **Sustainability of Benefits**
    - Can you carry on the work without UNFPA support?
    - What will help you carry on the SRH work on your own?
6. **Coordination Mechanisms within and Across Sectors**
    - Do you receive support from other UN agencies? How well are the activities coordinated? Are there overlaps or gaps?
7. **Coverage of Targeted Populations and Areas**
    - Were all intended refugee groups effectively reached through the interventions?
    - Were there any challenges in ensuring comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How well were the activities linked to broader development and health goals in your community?
    - How were immediate needs and long-term goals balanced in these interventions?
9. **Focus Group Discussion Recommendations**

UNFPA Uganda – Gender Equality

Focus Group Discussion for Beneficiaries (Separately for Women, Men, and Young People, Community Structures including Community Activists, Male Action Groups)

General Introduction - Purpose of the Evaluation "I am (we are) part of a three-person team to evaluate the GoU/UNFPA's 9th Country Programme (2021-2025). This evaluation will assist UNFPA in planning the next country programme. It is an independent evaluation, and this is a confidential discussion aimed at understanding how effectively UNFPA has helped you understand issues related to gender equality, empowerment, gender-based violence, and harmful practices. We will be talking to many stakeholders, including beneficiaries, and visiting districts such as Kampala, Iganga, Adjumani, Arua, Kitgum, Amudat, Moroto, and Kyegegwa."

Core Interview Objectives and Sample Questions

1. **Rationale for the Project and Activities Undertaken**
    - What were, and are your priority needs as far as gender equality and empowerment?
2. **Relevance of the Project/Activities to National Government and UNFPA Policies**
    - How well were you consulted about your needs? How were you involved in the development of the programme?
3. **Efficiency of Use of UNFPA Resources**
    - Were you receiving services in a timely manner/whenever you needed them?
    - Did the agency/institution seek your feedback on the services/activities being implemented? How well did the agency/institution use this feedback to improve services/activities?
4. **Effectiveness of Approaches/Programmes/Interventions**
    - How well has the programme managed to support your gender equality and women empowerment needs? What changes has this programme brought about in your lives?
    - What are the key lessons learned and best practices that can contribute to the knowledge base of UNFPA and partners and be applied in future programme and policy development?
    - Are there any changes that should have been made in order to improve services or activities?
5. **Sustainability of Benefits**
    - Are you engaged in gender equality and women empowerment activities by other agencies or individuals? Do they work together?
6. **Coordination Mechanisms within and Across Sectors**
    - How well has the programme been able to work within existing community structures?
    - Do you think the existing structures are able to take on the work/part of the work that is being implemented?
7. **Coverage of Targeted Populations and Areas**
    - Were all intended groups, particularly vulnerable women/men/youth, effectively reached through the interventions?
    - Were there any challenges in ensuring comprehensive coverage?
8. **Connectedness to Broader Development Goals**
    - How well were the gender equality initiatives linked to broader development goals in your community?
    - How were immediate needs and long-term goals balanced in these interventions?
9. **Focus Group Discussion Recommendations**

Observation Guide

This observation guide is designed to help the Evaluation Team to systematically assess key aspects of the environment, facilities, and services provided under the UNFPA Uganda 9th Country Programme (CP9). The observations will focus on various factors that influence the effectiveness, efficiency, and accessibility of services, as well as the overall experience of beneficiaries. The following key issues should be closely observed and documented:

- **External environment** (brief description)
- **Youth Friendly Spaces** (Safety, Recreation Facilities, Games/Sports, TV)
- **Ease of access to services** (location, transport access, surroundings, etc.)
- **Standard Operating Procedures (SOPs)**
- **Availability of Information, Education, and Communication/Behaviour Change Communication (IEC/BCC) materials** (e.g., variety, numbers, documents to take away, language, attractiveness, relevance, range)
- **Availability of stocks for family planning commodities** (including observing stock in and stock outs, medical kits)
- **PEP Kits**
- **Sufficiency of facilities** (size, counselling/consultation rooms, crowdedness, equipment, whether all equipment is working, what sort of condition the rooms and equipment are in, etc.)
- **Functional sanitation services that offer privacy**
- **Referral Directories and forms**
- **Minutes of coordination meetings**
- **Club activities** (e.g., ELA Clubs activities, Activities of Male Action Groups)
- **Evidence of trainings** (e.g., Training materials in life skills, vocational skills, livelihood skills)
- **Income Generating Activities (IGAs)**
- **Training equipment**
- **Implementing Partners (IPs) reports and other relevant materials**
- **Services provided to beneficiaries.**
- **Counselling rooms at Health Facilities and Police**
- **Police Forms and other Administrative Records**
- **Interactions between staff and clients**
- **Waiting times and streamlined flow of service provision/staff-to-client ratio.**

ANNEXURE 5: STAKEHOLDER MAPPING

Stakeholder map

Table 1

	Donor	Implementing agency							Other partners							Rights holders	Other
		Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other	Gov	Local NGO	Int. NGO	Women's rights org.	Other UN	Academia	Other		
	Strategic plan 2022-2025 outcomes																
	Outcome 1: By 2025, the reduction in the unmet need for family planning has accelerated																
	Outcome 2: By 2025, the reduction of preventable maternal deaths has accelerated																
	Outcome 3: By 2025, the reduction in gender-based violence and harmful practices has accelerated																
	CPD Outcome 1: Maternal Health																
	Output 1. Primary health care system at national and subnational level has increased capacity to provide universal access to and coverage of high-quality integrated sexual and reproductive health and rights, HIV, and gender-based violence services, particularly for the most vulnerable women and young people, including in humanitarian settings																
	Output 2. Women and young people, including those in hard-to-reach communities and those most at risk, are empowered to make informed choices and utilize high-quality, integrated sexual and reproductive health and rights information and services																
	CPD Outcome 2:Gender equality and women's empowerment																
	Output 1. National, subnational, and community capacities strengthened to prevent and respond to sexual and gender-based violence and other harmful practices, including female genital mutilation and child marriage, in all settings																
	CPD Outcome 3: Population dynamics																
	Output 1. National population data systems strengthened to address inequalities, advance the commitments of the ICPD Programme of Action to inform rights-based policies, programmes and accountability																
	: [insert relevant county programme output as per the Strategic plan 2022-2025] *If the CPD is not aligned with the Strategic Plan 2022-2025, please use the outcome and output areas of the 2018-2021 Strategic Plan*																
1	Republic of Austria	National Population Council		CARE International	Marie Stopes U	UNWomen	Makerere Univeristy School of Public Health	Naguru Teenage Education Centre		Nabagereka Foundation	Jhipaego				Acholi Ker Kwar		
2	Kingdom of Denmark	Ministry of Health		Action Aid		UNDP		AfriYAN		Miss Uganda Foundation							
3	Republic of Iceland	Ministry of Local Government		Safe the Children		UNHCR		InterReligious Council of Uganda									
4	Japan	Ministry of Gender		Plan International		UNICEF											
5	Netherlands	National Planning Authority		Lutherlan World Federation		Unwomen											
6	Kingdom of Norway	Uganda Bureau of Statistics				WHO											
	Strategic Investiment Facility	Ministry of Justice Const. Affairs				UNAIDS											
		Ministry of Defence & Vet. Affairs															
		Ministry of Education & Spots															
		Uganda HR Commission															
7		Uganda Aids Commission															
	Output: [insert relevant county programme output as per the Strategic plan 2022-2025] *insert additional rows as applicable*																

STAKEHOLDER MAPPING (CONT'D...)

Table 2

For all entities/organizations identified in Table 1, please provide the following information:

Acronym	Name of the entity/organization	Role/responsibilities	Starting date of the collaboration with the CO	Contact person(s)			Reference staff in CO
				Name	Title/Function	E-mail	
ATA18	Austrian Embassy						Laura Lafuente
DKA37	Embassy of Denmark						Laura Lafuente
ICA17	Embassy of Iceland						Chan Ju
JPD63	Embassy of Japan						Chan Ju
NOA95	Norwegian Embassy						Juliana Lunguzi
NLA95	Netherlands Embassy						Camilla

ANNEXURE 6: COUNTRY PROGRAMME EVALUATION AGENDA

This comprehensive evaluation agenda outlines the detailed schedule for the evaluation process, reflecting the timelines and activities for the Country Programme Evaluation of the 9th Country Programme.

Date	Activity/Institution	People to Meet	Location	Link with the CP	Justification
Phase 2: Design					
Week 1					
Day 1 (Thu. 1st Aug. 2024)	Document review and preliminary CO interviews, interrogation, and reconceptualisation of Theory of Change (ToC)	Evaluation team	Remote (Online)	N/A	Begin document review and interviews with CO staff to gather preliminary data and interrogate the ToC.
Day 2 (Fri. 2nd Aug. 2024)	Continued document review and ToC interrogation	Evaluation team	Remote (Online)	N/A	Ongoing document review and ToC interrogation to align with CP9 objectives.
Day 3 (Mon. 5th Aug. 2024)	Continued document review and ToC interrogation	Evaluation team	Remote (Online)	N/A	Continue with document review and reconceptualisation of ToC based on insights gathered so far.
Day 4 (Tue. 6th Aug. 2024)	Continued document review and ToC interrogation	Evaluation team	Remote (Online)	N/A	Ongoing document review, refining the ToC to ensure alignment with CP9 objectives.
Day 5 (Wed. 7th Aug. 2024)	Continued document review and ToC interrogation	Evaluation team	Remote (Online)	N/A	Continue refining the ToC and document review to ensure comprehensive coverage.
Day 6 (Thu. 8th Aug. 2024)	Continued document review and ToC interrogation	Evaluation team	Remote (Online)	N/A	Finalising document review and ToC interrogation, preparing for the design report drafting.
Day 7 (Fri. 16th Aug. 2024)	Induction meeting with the evaluation team	Evaluation team, Evaluation Manager	Virtual (Online)	N/A	Orientation and discussion on roles, responsibilities, and

Date	Activity/Institution	People to Meet	Location	Link with the CP	Justification
					the evaluation process.
Week 2					
Day 8 (Sat. 17th Aug. 2024)	Begin drafting Design Report version 1	Evaluation team	Remote (Online)	N/A	Start drafting the initial design report based on the findings from document review and interviews.
Day 9 (Sun. 18th Aug. 2024)	Continued drafting Design Report version 1	Evaluation team	Remote (Online)	N/A	Continue refining and drafting the design report, incorporating team feedback.
Day 10 (Mon. 19th Aug. 2024)	Continue drafting Design Report version 1	Evaluation team	Remote (Online)	N/A	Further drafting of the design report, integrating feedback from team discussions.
Day 11 (Tue. 20th Aug. 2024)	Internal review of Design Report version 1	Evaluation team internal meeting	Remote (Online)	N/A	Internal review of the first draft, gathering team feedback for revisions.
Day 12 (Wed. 21st Aug. 2024)	Revise Design Report version 1	Evaluation team	Remote (Online)	N/A	Revise the design report based on internal feedback and prepare for the next draft.
Day 13 (Thu. 22nd Aug. 2024)	Finalise Design Report version 1	Evaluation team	Remote (Online)	N/A	Complete the first draft of the design report for internal review.
Day 14 (Fri. 23rd Aug. 2024)	Final internal review and preparation for ERG meeting	Evaluation team	Remote (Online)	N/A	Final internal review and preparation of presentation materials for the ERG meeting.
Week 3					
Day 15 (Fri. 30th Aug. 2024)	Drafting Design Report version 2	Evaluation team	Remote (Online)	N/A	Start drafting the second version of the design report, incorporating feedback from the ERG.

Date	Activity/Institution	People to Meet	Location	Link with the CP	Justification
Day 16 (Tue. 3rd Sep. 2024)	ERG meeting to present the Design Report	ERG members, Evaluation Manager	Remote (Online)	N/A	Present the design report to the ERG for review and feedback.
Day 17 (Fri. 6th Sep. 2024)	Final submission of the Design Report	Evaluation Manager	Remote (Online)	N/A	Submit the final design report to the CO.
Phase 3: Fieldwork					
Week 4					
Day 18 (Mon. 9th Sep. 2024)	Preparing logistical arrangements for data collection	Evaluation Manager, CO Staff	Physical presence	N/A	Develop a logistics plan for national and sub-national data collection.
Day 19 (Tue. 10th Sep. 2024)	Finalisation of logistical arrangements	Evaluation Manager, CO Staff	Physical presence	N/A	Ensure all logistics are in place for fieldwork.
Day 20 (Thu. 12th Sep. 2024)	Collecting primary data at the national level	CO staff, Government officials, UN partners, and other stakeholders	Physical presence (On-ground visits)	Linked to specific CP outcomes	Gather primary data to assess programme implementation and impact at the national level.
Week 5					
Day 21 (Mon. 16th Sep. 2024)	Continue collecting primary data at the national level	CO staff, Government officials, UN partners, and other stakeholders	Physical presence (On-ground visits)	Linked to specific CP outcomes	Ongoing data collection focusing on the national level.
Day 22 (Fri. 27th Sep. 2024)	Final day of national-level data collection	CO staff, Government officials, UN partners, and other stakeholders	Physical presence (On-ground visits)	Linked to specific CP outcomes	Wrap up national-level data collection and prepare for sub-national fieldwork.
Week 6					
Day 23 (Mon. 30th Sep. 2024)	Begin collecting primary data at the sub-national level	District officials, Implementing partners, Beneficiaries	Physical presence (On-ground visits)	Linked to specific CP outcomes	Start fieldwork at the sub-national level in key districts.
Day 24 (Mon. 7th Oct. 2024)	Continue collecting primary data at the sub-national level	District officials, Implementing partners,	Physical presence (On-ground visits)	Linked to specific CP	Ongoing sub-national data collection in selected districts.

Date	Activity/Institution	People to Meet	Location	Link with the CP	Justification
		Beneficiaries		outcomes	
Day 25 (Fri. 14th Oct. 2024)	Final day of sub-national data collection	District officials, Implementing partners, Beneficiaries	Physical presence (On-ground visits)	Linked to specific CP outcomes	Complete data collection at the sub-national level and prepare for data analysis.
Week 7					
Day 26 (Tue. 15th Oct. 2024)	Data analysis workshop	Evaluation team	Physical presence	N/A	Begin analysing collected data in a structured workshop format.
Day 27 (Wed. 16th Oct. 2024)	Continue data analysis workshop	Evaluation team	Physical presence	N/A	Ongoing data analysis with the evaluation team.
Day 28 (Thu. 17th Oct. 2024)	Final day of data analysis workshop	Evaluation team	Physical presence	N/A	Finalise data analysis and prepare for debriefing.
Day 29 (Mon. 21st Oct. 2024)	Debriefing meeting with CO and ERG	Evaluation team, CO staff, ERG members	Physical presence	N/A	Present preliminary findings and gather feedback from CO and ERG.
Phase 4: Reporting					
Week 8					
Day 30 (Tue. 22nd Oct. 2024)	Consolidation of evaluation matrix	Evaluation team	Physical presence	N/A	Compile findings into the evaluation matrix for comprehensive reporting.
Day 31 (Fri. 25th Oct. 2024)	Final day of evaluation matrix consolidation	Evaluation team	Physical presence	N/A	Ensure the evaluation matrix is complete and accurate.
Week 9					
Day 32 (Mon. 28th Oct. 2024)	Draft CPE report version 1	Evaluation team	Remote (Online)	N/A	Begin drafting the first version of the CPE report.
Day 33 (Fri. 1st Nov. 2024)	Continue drafting CPE report version 1	Evaluation team	Remote (Online)	N/A	Continue refining the draft report.
Day 34 (Mon. 4th Nov. 2024)	Finalise draft CPE report version 1	Evaluation team	Remote (Online)	N/A	Complete the first draft of the CPE report.
Week 10					

Date	Activity/Institution	People to Meet	Location	Link with the CP	Justification
Day 35 (Tue. 5th Nov. 2024)	Quality assurance/review of draft report	Evaluation team, External reviewers	Remote (Online)	N/A	Conduct quality assurance and review of the draft report.
Day 36 (Thu. 7th Nov. 2024)	Finalise QA review	Evaluation team, External reviewers	Remote (Online)	N/A	Incorporate QA feedback into the draft report.
Week 11					
Day 37 (Fri. 15th Nov. 2024)	ERG meeting on draft report	ERG members, Evaluation Manager	Physical presence	N/A	Present and discuss the draft report with the ERG.
Day 38 (Mon. 18th Nov. 2024)	Recommendations workshop	Evaluation team, ERG members, CO staff	Physical presence	N/A	Facilitate a workshop to develop recommendations based on the evaluation findings.
Day 39 (Tue. 19th Nov. 2024)	Drafting CPE report version 2	Evaluation team	Physical presence	N/A	Begin drafting the second version of the CPE report, incorporating recommendations.
Day 40 (Wed. 20th Nov. 2024)	Continue drafting CPE report version 2	Evaluation team	Physical presence	N/A	Continue refining the draft report.
Day 41 (Fri. 22nd Nov. 2024)	Finalise draft CPE report version 2	Evaluation team	Physical presence	N/A	Complete the second draft of the CPE report.
Day 42 (Mon. 25th Nov. 2024)	Internal review of CPE report version 2	Evaluation team internal meeting	Physical presence	N/A	Internal review and finalisation of the CPE report.
Day 43 (Tue. 26th Nov. 2024)	Final preparation for report submission	Evaluation team	Physical presence	N/A	Prepare the final CPE report for submission.
Day 44 (Wed. 27th Nov. 2024)	Final CPE report submission	Evaluation Manager	Physical presence	N/A	Submit the final CPE report to CO.

ANNEXURE 7: BIBLIOGRAPHY/ LIST OF DOCUMENTS CONSULTED

No.	Document Title	Source
1	Annual Reports 2021; 2022 & 2023	UNFPA Uganda
2	CEDAW Report	Uganda
3	Final MTE NSCMTP Report, April 2020	UNFPA Uganda
4	Final Consultancy Report on the Application of the Integrated RMNCAH & SRH/HIV/GBV integration standards scorecards for program results in the UNFPA ANSWER program districts.	Ministry of Health/ UNFPA Uganda
5	Final Evaluation Handbook - 2024	UNFPA
6	Final Report on AR&WP 2023-24	UNFPA Uganda
7	GPECM 2020-2023 Evaluation	UNFPA Uganda
8	Ministry of Health, 2021; The National Quality Improvement Framework and Strategic Plan (NQIP & SP) 2020/21 – 2024/25	Ministry of Health
9	National Development Plan III, 2020-2021-2024-2025	Government of Uganda
10	National Development Plan II, 2020-2021-2024-2025	Government of Uganda
11	Stakeholder Map	UNFPA Uganda
12	UDHS 2022	Uganda Bureau of Statistics
13	Uganda Common Country Analysis, Updated December 2021	UNFPA Uganda
14	Uganda National ICPD Progress Report	UNFPA Uganda
15	Uganda UN Sustainable Development Cooperation Framework 2021-2025	United Nations
16	Uganda UPR 2022	Government of Uganda
17	Uganda CPD, Final Report	UNFPA Uganda
18	Uganda's VNR Report 2024 WBV	UNFPA Uganda
19	UNFPA Strategic Plan 2022-2025	UNFPA
20	2023 UNFPA Programme Overview & UCO Districts	UNFPA Uganda
21	2023-12-22 WAY Endline Evaluation Report	UNFPA Uganda
22	Uganda National CDF Review, 2022	Government of Uganda
23	Final Evaluation of UNFPA Country Programme 2016-2020	UNFPA Uganda
24	UNFPA Uganda Country Programme Action Plan 2021-2025	UNFPA Uganda
25	Health Facility Assessment Checklist	Ministry of Health, Uganda
26	Uganda Population Census Report 2024	Uganda Bureau of Statistics
27	Uganda Health Sector Strategic Plan 2020-2025	Ministry of Health, Uganda
28	UNFPA Uganda Gender Equality Strategy 2021-2025	UNFPA Uganda
29	UNFPA Uganda Youth Empowerment Strategy 2021-2025	UNFPA Uganda
30	UNFPA Uganda GBV Strategy 2021-2025	UNFPA Uganda

No.	Document Title	Source
31	Uganda National Population Policy 2024	Government of Uganda
32	Uganda Education Sector Strategic Plan 2020-2025	Ministry of Education, Uganda
33	Uganda National Family Planning Costed Implementation Plan 2021-2025	Ministry of Health, Uganda
34	Uganda National Gender Policy 2021-2025	Ministry of Gender, Labour, and Social Development, Uganda
35	Uganda National Youth Policy 2021-2025	Ministry of Gender, Labour, and Social Development, Uganda
36	Uganda National GBV Policy 2021-2025	Ministry of Gender, Labour, and Social Development, Uganda
37	Uganda Vision 2040	Government of Uganda

ANNEXURE 8: RECONSCTRUCTED THEORY OF CHANGE

(a) Outcome 1: Sexual and Reproductive Health and Rights (reconstructed)

UGANDA CPD 9 THEORY OF CHANGE: OUTCOME 1 – INTEGRATED SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

National priority (NDPIII): Increased Household Incomes and Improved Quality of Life of Ugandans:
Obj. 5: Strengthen the role of the state in guiding and facilitating development
Obj. 4: Enhance the productivity and social wellbeing of the population

UNSDCF Outcome 3.1: By 2025, people, especially the vulnerable and marginalized, have equitable access to and utilization of quality basic social and protection services

Every woman, adolescent and youth everywhere, especially those furthest behind, has utilized integrated sexual and reproductive health services and exercised reproductive rights, free of coercion, discrimination and violence

Outcome Indicators:

- Proportion of women of reproductive age who have their need for family planning unmet with modern methods disaggregated by age: *Baseline*: 28% (2016); *Target*: 10%
- Proportion of births attended by skilled personnel: *Baseline*: 73% (2016); *Target*: 80%
- Number of functional national and subnational platforms for dialogue on reproductive rights, fully engaging civil society, including faith-based and state actors: *Baseline:* 5 *Target*: 20
- Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by age and place of occurrence: *Baseline*: 39.6% (2016); *Target*: 30%

OUTPUT 1: National health care facilities and providers have increased capacity to provide universal access to and coverage of high quality integrated SRH/GBV/HIV services, particularly for the most vulnerable women and young people, including in humanitarian settings

Indicators:

Percent of primary service delivery points with no 'stock-out' of contraceptives in the last three months
Baseline: 73.6% (2018); Target: 80%
Percent of health facilities in target districts with capacity and readiness to provide emergency obs[illegible] and new-born care services
Baseline: 7.8% (2019); Target: 80%
Number of health facilities providing integrated SRH/HIV/ GBV services (HCIII and above that meet at least 80% of the basic integration score) Baseline: 467 (2020); Target: 701
Number of policies, guidelines, and strategies supported by UNFPA that address SRH rights, gender equality, the needs of adolescents and youth, and population dynamics
Baseline: 20 (2019); Target: 40

Strategic Interventions

Advocacy and policy dialogue:
Support advocacy for and implementation of policies and strategies for access of in and out-of-school young people to integrated SRH information and services;
Advocate for sustainable and innovative financing and financial protection to support the provision of integrated HIV, sexual and reproductive health and rights, and gender based violence services
Support government in the implementation of sexual and reproductive health and rights and gender based violence policies and strategies
Knowledge generation and sharing:
Provide technical support and scale up maternal and perinatal death reviews at national and sub-national levels
Capacity building
Provide support to strengthen midwifery training, associations, and regulatory frameworks for improving skilled attendance at birth;
Build the capacity of health service providers to deliver rights based family planning, emergency obstetric care, and reproductive health including the minimum initial services package, including within the context of COVID-19
Service delivery
Support availability as well as monitor, track, and report on reproductive health commodities, supplies, and contraceptives
Support and scale up maternal and perinatal death reviews

OUTPUT 2: Women and young people, including those in hard to reach communities and those most at risk, are empowered to make informed choices, and utilize high quality, integrated, sexual and reproductive health and rights, information, and services

Indicators:

- Number of CYP dispensed with support from UNFPA
  Baseline: 5,049,302 (2019); *Target*: 7,010,229
- Percent of women (15-49yrs) in programme districts make own decisions on SRHR
  Baseline 58.5% (2016); Target 75%
- Percent of affected population reached with integrated SRH/HIV/GBV services in humanitarian settings
  Baseline: 15% (2017); *Target*: 75%

Strategic Interventions

Advocacy and policy guidance
-Advocacy for and implementation of sexuality education for in and out-of-school young people;
Knowledge generation and sharing:
-Support innovative approaches focused on HIV prevention among young people, key, and most-at-risk populations including scaling up initiatives for young people to access reproductive health services
- Use innovative approaches to ensure women and girls have access to information and services on menstrual health and hygiene including continued support for developing eco-friendly and reusable sanitary
pads
Capacity building
-Support for the empowerment and livelihoods for adolescents' clubs to build adolescent girls' health, social, and economic
assets;
Service delivery
-Support community outreach initiatives including pregnancy mapping to stimulate demand for maternal health service;
Partnership and coordination
-Enhance partnerships with government, religious, cultural, and civil society and youth led organizations to sustain the provision of integrated sexual and reproductive health and rights information and services

Risks & Assumptions

Risks:

1. **Political shifts reducing SRHR prioritisation**
2. **Donor funding gaps for SRHR interventions**
3. **Social norms hindering SRHR uptake**
4. **Inadequate budget for SRHR programmes**
5. **Health crises disrupting implementation**
6. **Institutional capacity challenges for SRHR**

Assumptions:

1. **Government commitment to SRHR goals**
2. **Consistent donor support for SRHR programmes**
3. **Stakeholder active participation in SRHR**
4. **Advocacy effectively shifts SRHR norms**
5. **Community demand for SRHR services**
6. **Institutions sustain SRHR programme integration**

Interlinkages with other SP outcomes:

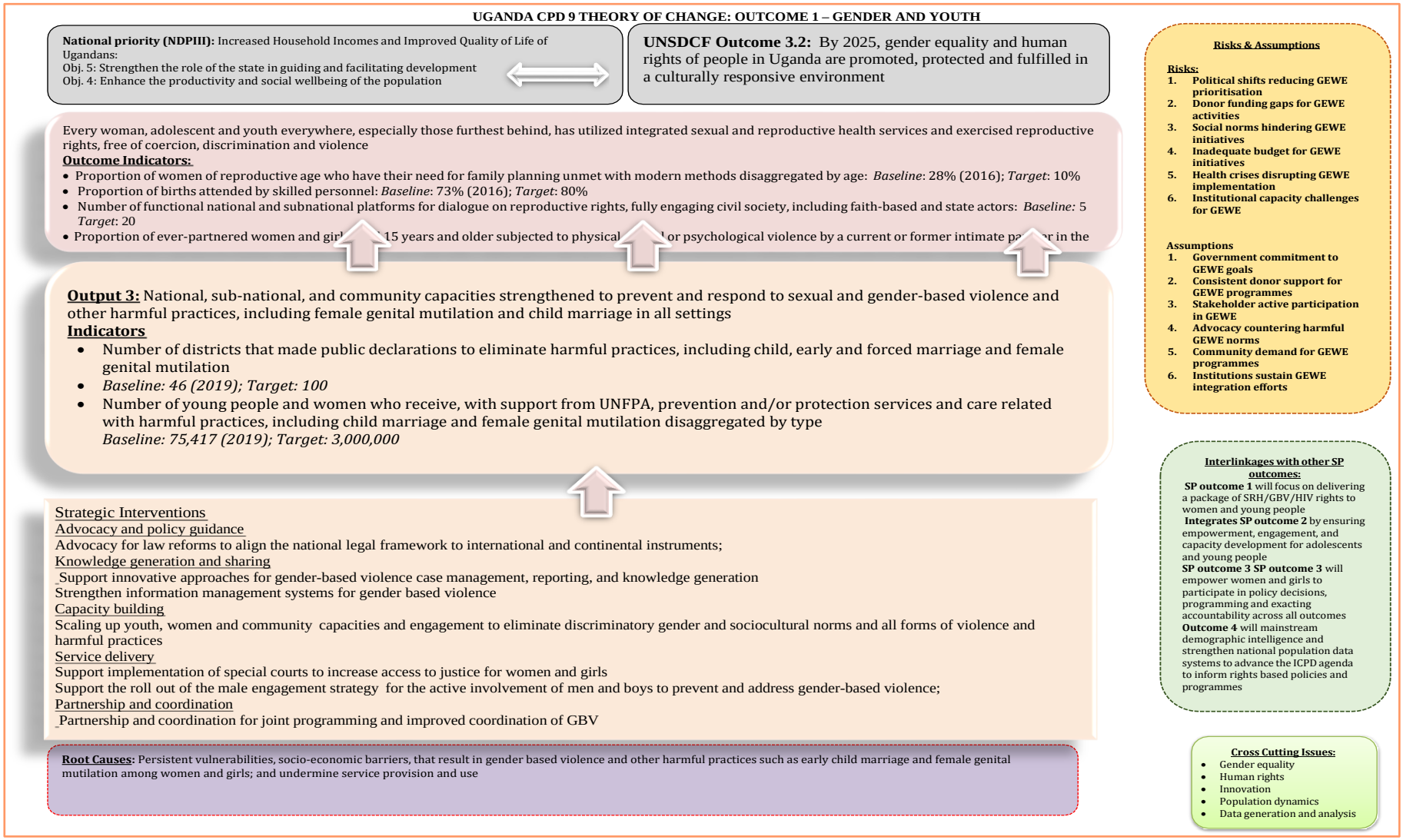
SP outcome 1 will focus on delivering a package of SRH/GBV/HIV rights to women and young people
Integrates SP outcome 2 by ensuring empowerment, engagement, and capacity development for adolescents and young people
SP outcome 3 SP outcome 3 will empower women and girls to participate in policy decisions, programming and exacting accountability across all outcomes
Outcome 4 will mainstream demographic intelligence and strengthen national population data

Cross Cutting Issues:

- Gender equality
- Human rights
- Innovation
- Population dynamics
- Data generation and analysis

Core Problem: high teenage pregnancies, high school dropout rates, and poor reproductive health outcomes among young people and women, as a result of the inadequate integration of and limited health services, and weak implementation of policies and laws

(b) **Outcome 2: Gender and Women's Empowerment** (reconstructed)



(c) Outcome 3: Population Dynamics (reconstructed)