Endline Evaluation of the Advancing Sexual Reproductive Health and Rights in the West Nile and Acholi Sub Regions in Uganda (ANSWER) Programme

May 2024

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Acronyms and abbreviations

ADH	Adolescents Health
ANC	Antenatal Care
ANSWER	Advancing Sexual and Reproductive Health and Rights in the West Nile and Acholi Sub Regions of Uganda Programme
AYSRH	Adolescents and Youth Sexual and Reproductive Health
CCA	Common Country Assessment/Analysis
CEI	Client Exit Interview
CIP	Cost Implementation Plan
CIS	Community Information System
CO	Country Office
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CQI	Continuous Quality Improvement
CSO	Civil Society Organizations
DCDO	District Community Development Officer
DD	Demographic Dividend
DEC	District Executive Committee
DEO	District Education Officer
DHIS	District Health Information System
DHO	District Health Officer
DHMT	District Health Management Team
DID	Difference-in-Difference
DLG	District Local Governments
DSA	Daily Subsistence Allowance
DTPC	District Technical Planning Committee
ELA	Empowerment and Livelihoods for Adolescents
eLMIS	Electronic Logistics Management Information System
EQ	Evaluation Question
EQA	Evaluation Quality Assessment
EQAA	Evaluation Quality Assurance and Assessment
ERG	Evaluation Reference Group
ESARO	UNFPA East and Southern Africa Regional Office
EU	European Union
FDG	Focus Group Discussion
FGM/C	Female Genital Mutilation / Cutting
FP	Family Planning
GDP	Gross Domestic Product
GBV	Gender-Based Violence
GoU	Government of Uganda
HFA	Health Facility Assessment
HP	Harmful Practices
HRBA	Human Rights-Based Approach
ICPD	International Conference on Population and Development
IDI	In-depth Interview
IRB	Institutional Review Board
IRCU	Inter-Religious Council of Uganda
JMS	Joint Medical Stores
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LC	Local Council
MAG	Male Action Group
mCPR	Modern Contraceptive Prevalence Rate

MDA	Ministries, Departments and Agencies
MGLSD	Ministry of Gender, Labor, and Social Development
MIS	Management Information System
MOES	Ministry of Education and Sports
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NCDC	National Curriculum Development Centre
NDP III	Third Uganda National Development Plan
NGBVD	National GBV Database
NGO	Non-Governmental Organisation
NMS	National Medical Stores
NPA	National Planning Authority
NPC	National Population Council
OECD/DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PIASCY	Presidential Initiative on AIDS Strategy for Communication to Youth
PWD	People living with Disabilities
RA	Research Assistant
RGA	Rapid Gender Assessment
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RNE	Royal Netherlands Embassy
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SO	Special Olympics
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
ToTs	Training of Trainers
TWG	Technical Working Group
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNHCR	United Nations High Commission for Refugees
UNEG	United Nations Evaluation Group
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNESCO	United National Educational, Scientific and Cultural Organization
UNICEF	United National Children's Fund
UNFPA	United Nations Population Fund
UNFPA CO/CO	United Nations Population Fund (Uganda) Country Office
UNSCT	Uganda National Council for Science and Technology
UNSDCF	United Nations Sustainable Development Cooperation Framework
VHTs	Village Health Teams
VSLA	Village Savings and Loans Associations

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EXECUTIVE SUMMARY

In October 2019, UNFPA and the Government of Uganda, with funding from the Royal Netherlands Embassy (RNE), initiated a 4-year (2019-2023) Programme on Advancing Sexual Reproductive Health and Rights in the West Nile and Acholi Sub-Regions in Uganda (ANSWER). The programme was implemented in 15 districts in West Nile (12) and Acholi (3) sub-regions in Northern Uganda, in partnership with key national ministries, departments, and agencies (MDAs), district local governments (DLGs), civil society organisations (CSOs), and religious and cultural institutions.

The ANSWER programme was designed to address key Sexual and Reproductive Health and Rights (SRHR) and Gender-Based Violence (GBV) issues and respond to contextual challenges. Specifically, the programme aimed to address health systems bottlenecks to improve the availability and coverage of high-quality SRHR and GBV services; empower young people, women, and men to claim their sexual and reproductive rights and demand and access SRHR services; and transform negative social and gender norms that exacerbate gender inequalities at the community and individual levels, preventing women and young people from accessing SRHR and GBV services.

UNFPA separately contracted consultants to conduct an independent external endline evaluation of the programme, covering the period from its inception in 2019 through September 2023.

The evaluation aims to ensure independent monitoring and quality assurance of programme delivery, documentation of lessons learned, and robust tracking of results, providing an assessment of the effectiveness of official development assistance (ODA) funds.

An endline evaluation was carried out between July and December 2023 to generate findings, conclusions, and recommendations for future programming. This report is based on data collection and analysis conducted between July and October 2023, including 215 key informant interviews (KIIs) and focus group discussions (FGDs) with UNFPA and key stakeholders. A Knowledge, Attitudes, and Practices (KAP) survey was conducted with over 5,000 in and out-of-school youth, and a health facility assessment (HFA) was conducted at 125 sites. Various sources of secondary data (e.g., project documents, policies, etc) were reviewed. An Evaluation Reference Group (ERG), composed of external stakeholders and representatives of the RNE and UNFPA, was established to provide technical oversight and feedback on the inception report in August and the draft final report during an ERG meeting in December 2023.

Evaluation Findings

The following are the findings against the evaluation criteria.

Relevance: Given the strong partnership with the Government of Uganda, the ANSWER Programme remains highly relevant to the objectives of the Government of Uganda over the course of its implementation. The ANSWER Programme also actively supported the localisation of national policies and/or priorities such as a focus on human capital development. With implementation during the COVID-19 pandemic, ANSWER adeptly responded to the issues and needs of the districts. Additionally, at midterm, UNFPA pivoted the Theory of Change (ToC) to align activities and interventions. The programme responded to the needs of primary beneficiaries, particularly women of reproductive age and young people. However, activities supporting refugees and people with disabilities were not prioritized at the beginning of the programme. Further, some national level activities and strategies required further tailoring to the sub-national context before scaling.

Effectiveness: Significant improvements have been made across key SRHR indicators in the West Nile and Acholi regions between 2018 and 2023, with parallel improvements in the outcome indicators of the ANSWER Programme. These changes are reflected in the analysis of the programme's HMIS data. Overall, the ANSWER programme made significant achievements in strengthening SRHR services at the facility and community levels. However, the achievements related to addressing social and gender norms, knowledge, attitudes, practices, and creating a supportive policy environment were more mixed and were significantly affected by the COVID lockdowns and shorter implementation period. A key finding is that there is strong evidence that the ANSWER programme contributed to achieving key

outcomes: (1) reducing maternal deaths in West Nile and Acholi sub-regions by strengthening the capacity of the health system to provide quality maternal health services through training, continuous quality improvement, and MPDSR, and (2) increasing family planning uptake through outreach services, work around social norms, and sexuality education. The ANSWER programme achieved these outcomes by strengthening the supply and service provision of maternal health, family planning, and GBV services, while also removing social, gender, and personal barriers, improving knowledge and attitudes of young people, and enhancing the policy context and public discourse around SRHR.

Efficiency: UNFPA implemented the programme efficiently and promptly with appropriate structures, implementation modalities, competent staff, and implementing partners (IPs). However, the impact of COVID-19 caused a significant reduction in the implementation period and disrupted programme activities. The programme was also spread too thinly across a large geographic area, limiting its impact. Despite this, the ANSWER programme leveraged additional resources, such as funds for SRH in some districts and radio talk time for youth and leaders to discuss SRHR issues. The "I dare the challenge" initiative garnered interest from district authorities willing to invest in SRHR services, although there was limited funding from the central government. UNFPA effectively coordinated the programme, and results were efficiently measured and reported.

Sustainability: The ANSWER Programme was well-designed and implemented with sustainability in mind. The programme adopted approaches that promote sustainability and ownership, including supporting government initiatives, working within government policies and frameworks, and developing institutional, health facility, and community capacities. Sustainability considerations were embedded in the programme strategy and implementation plans. However, challenges remain, such as the lack of local resources to sustain the programme's benefits once project funding ends. Some practices, like paying participants to engage in the programme, may have the potential to undermine sustainability and require further examination. Additionally, community structures (e.g., SASAs, MAGs) and interventions (e.g., generational dialogues) may not have had the chance to mature and may not be sustained without external support.

Coherence: Mechanisms were established at all levels to ensure high internal coherence, and synergies between activities and strategies within UNFPA, including between the ANSWER and other UNFPA programmes. UNFPA has taken a proactive role in coordinating activities with other partners. Strong coordination with and ownership by national and district local government agencies and various inter-development partner platforms ensured external coherence with the government and SRHR and GBV programmes implemented by other development actors. However, further efforts are needed to strengthen the coordination between development actors around thematic areas, and UNFPA has actively promoted and coordinated such platforms.

Conclusions

The conclusions are derived from the findings and categorized into strategic-level (related to overall relevance, efficiency, coherence, and sustainability) and program-level conclusions.

Strategic Conclusions:

- Conclusion 1: The ANSWER programme aligns well with international frameworks and national priorities, addressing SRHR needs of targeted populations, particularly adolescents and young people, while responding appropriately to changing contexts and demands. However, the needs of people living with disabilities were not fully addressed, and there was limited engagement with beneficiary groups during the design and inception phase.

- Conclusion 2: Despite facing significant implementation challenges, the ANSWER programme achieved many of its expected results, notably in maternal health, family planning and GBV

services, and youth-friendly services. However, some outputs related to post-abortion care, HIV testing, and changing social norms were not fully achieved.

- Conclusion 3: The theory of change underlying the ANSWER programme's results chain logic was sound and remains relevant. The programme effectively addresses both supply and demand factors, focusing on policy and social environment improvements to address poor SRHR outcomes in Acholi and West Nile Region. However, investments were uneven, with more significant investments in supply-side factors. Initial integration issues were addressed with the 2022 review, strengthening internal coherence and integration.
- Conclusion 4: Efforts were made to address gender equality and disability inclusion in select activities, but these were not systematically or consistently mainstreamed across all programme activities.
- Conclusion 5: UNFPA and its implementing partners provided timely and quality financial and technical support, using appropriate implementation modalities. The programme structure, coordination, and collaboration mechanisms were efficient, but human resources at the field level were spread too thin for optimal impact. Changes to IP deployment in 2022 improved coordination and efficiency but impacted the programme's implementation midstream.
- Conclusion 6: UNFPA established effective programme coordination mechanisms and a robust monitoring and evaluation framework, capturing appropriately disaggregated data (including adolescents, young people, gender, PWDs, and refugees). However, data integrity and reliability at the collection stage, particularly for GBV and other services, remain challenging.
- Conclusion 7: Sustainability was well-designed and implemented, including support for government initiatives, alignment with policies and frameworks, and building institutional and local technical capacities. Some results may be sustained beyond the programme's closure, but challenges include inadequate government resources, limited implementation time due to COVID-19, and adaptations introduced in the second half of the Programme.
- Conclusion 8: The programme significantly strengthened the health system's capacity at various levels to deliver quality SRHR and GBV services, achieving many planned targets despite COVID-19 challenges. However, inherent health system challenges and upstream issues beyond the programme's control affected the effectiveness of certain interventions.
- Conclusion 9: UNFPA's implementation of sexuality education in schools enhanced SRHR and GBV knowledge and attitudes among learners. However, social and political challenges slowed progress and prevented the initiative from gaining substantial traction in the school system.
- Conclusion 10: Interventions to engage out-of-school youth improved SRHR knowledge among this group, marking a significant achievement.
- Conclusion 11: The programme successfully enhanced community structures and resource persons' skills to shift social and gender norms. However, issues with fidelity, intensity, and reach of these activities suggest they were too dispersed over a large geographic area to achieve desired and sustained impact.
- Conclusion 12: The programme increased resources and created technical guidance and tools to strengthen capacity around the demographic dividend at national and district levels. However, it set unrealistic expectations about district-level leadership's ability to change policy priorities and budget allocations.

Recommendations

The following are 12 recommendations categorized into strategic and programmatic levels.

Strategic Level

- Recommendation 1: UNFPA should continue to harness its strong relationship and alignment with existing structures at the national, district, and community levels. Future work needs to be more intentional in engaging target beneficiaries from the design phase to ensure their needs and inputs shape the design, implementation, and monitoring of the Programme.

- Recommendation 2: The Theory of Change remains relevant. Interdependent components of the programme should be appropriately resourced and implemented to ensure their respective contributions work together to deliver holistic and optimal results.
- Recommendation 3: Cross-cutting issues at the heart of the ANSWER programme should be consistently integrated.
- Recommendation 4: In future large-scale, multi-component programming, adequate time, resources, and flexibility should be allocated for the inception phase to allow for more detailed consultations, co-creation, and planning, especially with beneficiaries, implementers, and stakeholders in the districts. Additionally, programmes should plan and allocate resources to fully implement the comprehensive package of related and interdependent interventions over a smaller geographical scope for the desired impact that aligns with the theory of change.
- Recommendation 5: UNFPA and other partners should allocate adequate resources and effort into improving data capture, analysis, and reporting.
- Recommendation 6: UNFPA should continue and learn from its already effective approaches to sustainability, while continually assessing and addressing sustainability challenges.

Programmatic Level

- Recommendation 7: To strengthen health systems, UNFPA and partners should attend to upstream issues by continuing ongoing advocacy efforts and systems-strengthening interventions to address identified challenges to ensure optimal results from implementing activities at the district level.
- Recommendation 8: The ANSWER Programme focused primarily on improving access to quality SRHR services for youth and adolescents within health facilities and in communities. However, access to these services within health facilities remains inadequate. UNFPA should work with the Ministry of Health to further strengthen the implementation of youth-friendly services in health facilities.
- Recommendation 9: It is necessary to re-envision interventions to reach more schools with age-appropriate sexuality education, including menstrual hygiene management, and supplement what they learn in school with other community approaches.
- Recommendation 10: While there is a need to reach more out-of-school youth with SRHR information and services and behaviour change interventions, there is also a need for more emphasis on their livelihood empowerment.
- Recommendation 11: On gender and social norms change interventions, more effort and resources are needed to fully implement selected approaches and to scale up interventions with more community and financial resources for organized diffusion to achieve the desired impact.
- Recommendation 12: UNFPA should build on its successful work to raise awareness and capacity around the demographic dividend at the national level and focus on further strengthening district-level actors to move this agenda forward.

1. INTRODUCTION

This report outlines the results of the final evaluation of the Advancing Sexual Reproductive Health and Rights in the West Nile and Acholi Sub Regions in Uganda (ANSWER) programme implemented by UNFPA. The evaluation aims to assess the relevance and performance of the ANSWER programme and analyse various facilitating and constraining factors influencing the programme's delivery and the achievement of intended results. Specifically, the endline evaluation will assess the relevance, effectiveness, efficiency, sustainability, and coherence of the ANSWER Programme based on the OECD/DAC criteria[1], UN Evaluation Group (UNEG) guidelines for evaluation[2], and UNFPA global evaluation standards and guidelines.[3]

1.1. Purpose and objectives of the evaluation

The endline evaluation of the Advancing Sexual Reproductive Health and Rights in the West Nile and Acholi Sub Regions in Uganda (ANSWER) Programme has two specific objectives:

1. To provide an independent assessment of the relevance and performance of the ANSWER programme and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results.

2. To broaden the evidence base to inform the design of future SRHR programmes in Uganda.

The endline evaluation will also draw key lessons and conclusions and provide a set of strategic, actionable recommendations for decision-makers in UNFPA (at the country office and relevant regional and global units), the Kingdom of the Netherlands Embassy (RNE) and other key stakeholders in the SRHR space, particularly around district ownership and multi-sectoral approach at district and community level.

1.2. Scope of the evaluation

The endline evaluation covers the period from October 2019 to September 2023. It includes the thematic areas covered by the ANSWER programme in 15 districts in West Nile and Acholi sub-regions where UNFPA implemented the ANSWER programme, including Madi-Okollo, Yumbe, Koboko, Adjumani, Obongi, Terego, and Lamwo, Arua (Arua City), Zombo, Nebbi, Maracha, Moyo, Pakwach, Amuru, and Agago, and at the national level.

1.3. Evaluation approach

The changes being evaluated are complex; numerous interlocking activities. Many other actors and external factors influence these changes, and various activities and actors contribute to each desired outcome.[4] Therefore, the evaluation's analytical approach focus on understanding the ANSWER programme's contribution to these complex change processes and results in advancing SRHR in the West Nile and Acholi Sub Regions, rather than on attribution. Central to this evaluation is the Theory of Change (ToC), which outlines how the programme intended to bring about change, and this evaluation tests the validity of the ToC for the ANSWER programme. The methodology used to assess

[1] For detailed definitions of the OECD/DAC criteria, please see: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

[2] http://www.unevaluation.org/document/detail/1914

[3] https://www.UNFPA.org/admin-resource/evaluation-quality-assurance-and-assessment-tools-and-guidance ; https://www.UNFPA.org/admin-resource/evaluation-handbook-how-design-and-conduct-country-programme-evaluation-UNFPA-2019

[4] Mayne, J (2012a). *Making Causal Claims*. Brief 26, Institutional Learning and Change (ILAC) Initiative

the ToC draws on the principles of contribution analysis (CA) to evaluate the contribution of different strategies to advancing SRHR in the West Nile and Acholi sub-regions.[5],[6]

The evaluation used the standard criteria from the United Nations Evaluation Group (UNEG) and the Organization for Economic Cooperation and Development (OECD/DAC). The evaluation team was also guided by the UNEG norms and standards of evaluation[7], Ethical Guidelines for Evaluation[8], Code of Conduct for Evaluation in the UN System[9], and Guidance on Integrating Human Rights and Gender Equality (HRGE) in Evaluations[10], UNFPA Evaluation Handbook,[11] and Guidance on Disability Inclusion in UNFPA Evaluations.[12] The cross-cutting themes of human rights, gender equality and disability inclusion were also assessed.

1.3.1. Evaluation questions

The following 11 evaluation questions were used for the endline evaluation.

Relevance

1. To what extent was the ANSWER programme relevant to the SRHR needs of the target population (including women, adolescents, people with disabilities and refugees) and relevant government agencies at national and district levels? (Relevance Q1)
2. To what extent was the ANSWER programme aligned with priorities set by the relevant national and district policies and strategies related to SRHR and GBV, the GOU-UNFPA 9th Country Programme and the Multi-Annual Country Strategy of the Netherlands Embassy? (Relevance Q2)
3. To what extent was the ANSWER programme able to respond to changes in the national and district context, including COVID-19, the evolving SRHR landscape, and the socio-political environment during the implementation period? (Relevance Q3)

Effectiveness

4. To what extent have the programme outputs been achieved and are likely to contribute to achieving programme outcomes? How adequate is the theory of change underlying the results chain logic? (Effectiveness Q4)
5. To what extent has the Programme integrated the cross-cutting issues of gender equality, disability inclusion and human rights-based approaches? (Effectiveness Q5)
6. What were the unforeseen consequences (negative or positive) of the Programme? (Effectiveness Q6)

Efficiency

7. To what extent has UNFPA made good use of its human, financial, technical and administrative resources and appropriate combination of policies, procedures, tools, innovative approaches

[5] Mayne, J (2018) Revisiting Contribution Analysis. 34. 10.3138/cjpe.68004.

[6] Mayne, J., (2008). Contribution analysis: An approach to exploring cause and effect. International Learning and Change (ILAC) Brief, 16.

[7] http://www.unevaluation.org/document/detail/1914

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

[9] http://www.unevaluation.org/document/detail/100

[10] http://www.unevaluation.org/document/detail/980

[11] https://www.UNFPA.org/admin-resource/evaluation-handbook-how-design-and-conduct-country-programme-evaluation-UNFPA-2019

[12] Guidance on disability inclusion in UNFPA evaluations | United Nations Population Fund

and implementation modalities to achieve the programme's outputs and outcomes? (Efficiency Q7)
8. Did UNFPA resources have a leveraging effect? (Efficiency Q8)
9. Were the progress and the results of the programme effectively and efficiently measured and reported? (Efficiency Q9)

Sustainability

10. To what extent have UNFPA-supported interventions promoted national, district and community ownership and contributed to the capacity development of the implementing partners and the communities (in terms of policies, increased capacity and budgetary allocation)? (Sustainability Q10)

Coherence

11. How effectively did the Programme coordinate and achieve synergies with other UNFPA programmes? How well does the UNFPA collaborate with other UN agencies, development partners, NGOs and partners, and what are opportunities for increasing this coordination? (Coherence Q11)

The ERG and CO management reviewed the evaluation matrix, questions, and tools to ensure their relevance, appropriateness, and comprehensiveness to ensure the evaluation's quality and usefulness.

Methods for data collection and analysis

The evaluation employed a mixed-method design consisting of both quantitative and qualitative instruments.[13] It also used a theory-based approach to ensure robust analysis and understanding of the programme logic underpinned by the theory of change. The evaluation covered 15 districts where the programme was implemented (and three non-intervention districts) with detailed case studies using qualitative data collection methods in eight districts.

Primary data was collected through five methods: (1) a survey of knowledge, attitude and practices (KAP) among young people; (2) a health facility assessment (HFA); (3) focus group discussions (FGD) with rights-holders (notably women, adolescents and youth); (4) semi-structured key informant interviews (KIIs) and group interviews with stakeholders at national and district levels, and (5) direct observations during visits to study communities, health facilities and schools. The KAP survey and HFA used the same protocols and sampling strategy at baseline to allow for comparability. Observational data from four activities was collected in the eight selected districts, and this allowed us to capture a broader understanding of the context and implementation of the activities in the programme.

Secondary data was collected through desk review of relevant reports, operations and policy documents, reports from other relevant studies, among others; data from the KAP and HFA baseline studies, the mid-term review of the ANSWER programme and demographic dividend (DD) compliance assessments; and administrative data from the health management information system (HMIS) and national GBV database (NGBVD), and budget and expenditure tracking data on investments in the DD. Table 1 provides an overview of the data collection tools.

[13] For detailed guidance on the different data collection methods typically employed in UNFPA programme evaluations, see Handbook, section 3.4.2, pp. 65-73.

Table 1: Overview of data collection tools

Data Types	Types of data collection tool	Data collection tool
Primary	Quantitative	KAP
		Health facility assessment
	Qualitative	In-Depth Interviews
		Focus Group Discussions
		Observations
Secondary	Intervention mapping	
	Documents - annual reports and work plans, quarterly reports, IP reports, baseline documents, background documents, MSU youth-friendly readiness assessment	
	HMIS, DHIS	
	Demographic dividend (DD) compliance tool	

*Stakeholders – see list in the sampling methods section

Qualitative Data Analysis:

Over 215 interviews and focus group discussions (FGDs) were conducted. The interviews and FGDs were recorded, then transcribed and translated as necessary. The distribution of the sample is described in Table 2 and Table 3 below. The evaluation matrix was used to develop the coding framework for summarizing and analysing data. The FGDs, IDIs, groups, or KIIs were audio-recorded unless the respondent or respondents declined. All transcripts were iteratively coded and thematically analysed based on the domains found in the evaluation framework. Key themes were identified based on the evaluation questions and an initial reading of the interview transcripts, and the transcripts were coded using these themes. Once entered and coded, the data and content were analysed for patterns, frequency of occurrence, similarities, differences, and linkages, and triangulated with the available quantitative data. The links between an intervention and its results were explained, and any unintended outcomes were highlighted.

Table 2: Distribution of the samples of FGDs, IDIs, and KIIs at community and health facility level

Study population	Total no.
Focus Group Discussion	
Beneficiaries	8
Peer educators	1
SASA! Facilitators	3
MAG facilitators	1
Caregivers	3
Teachers	4
Learners	24
Non-beneficiaries	5
Key Informant Interviews	
PWDs	8
Cultural and religious leaders	24

Community leaders (LCs, RWCs)	18
Matrons/patrons of school clubs	1
Teachers	4
KIIs at the health facility	17
FGDs with VHTs	8

We collected data over a set period with several days dedicated to each site. In some cases, we were not able to achieve the desired samples.

Observation data was collected at health facilities and sessions of the PIASCY training. However, this data was not included in the report. There was a high degree of the Hawthorne effect here, so we felt this data was biased.

Table 3: Distribution of the sample of KIIs at the district and national level

District-level respondents	Number
UNFPA regional/district staff (KIIs)	2
Implementing partners (Save the Children, Marie Stopes Uganda, Plan International.)	11
District officials, community, local leaders, cultural leaders, and religious leaders	56
Representative of humanitarian programme or other UNFPA programme	5
National-level stakeholders	
UNFPA	7
Ministries (MoH, MoES)	4
Royal Netherlands Embassy	2
Other stakeholders	3

Knowledge, Attitudes, and Practices (KAP) Quantitative Survey Data Analysis:

The baseline sample for the KAP survey included 8,020 young individuals, with 6,211 from the intervention districts and 1,809 from the comparison districts. At the endline, the sample included 872 young people from the comparison districts and 4,494 from the intervention districts. See Table 4 for the sample of the KAP survey at baseline and endline.

Table 4: Sample of KAP survey

In-School Young people	**Baseline**			**Endline**		
	Acholi - intervention	Acholi-control	WN	Acholi - intervention	Acholi-control	WN
	575	789	1,933	327	286	1,431
Out-of-school young people	**Baseline**	**Endline**		**Baseline**	**Endline**	
	Acholi - intervention	Acholi-control	WN	Acholi - intervention	Acholi-control	WN
	887	1020	2816	606	637	2031

Descriptive and inferential analyses were conducted to generate the same indicators at the baseline, as guided by the evaluation matrix.

In the descriptive analysis, all relevant KAP indicators were generated as proportions based on categorized data elements and composite scores using standard summation and alpha factoring procedures. Composite scores of knowledge, attitudes, practices, and self-efficacy were categorized based on Bloom's categorization of knowledge scores. For example, based on Bloom's cut-off point for knowledge (Bloom BS, 1956), each respondent's comprehensive knowledge of SRHR was categorized as:

i. Good if the percentage score is at least 80 percent,
ii. Moderate (50-79 percent), and
iii. Poor (49 percent or less).

Estimates were generated for different sub-populations, including regional level estimates (West Nile vs Acholi), in-school vs out-of-school young people, sex-specific, age-group-specific, Ugandan vs refugee, and disability status. All analyses were sample survey weighted.

In inferential analyses, the baseline values of the key indicators were compared with the endline values using a regression model-based F-test. In addition to this correlational analysis of changes in indicators between the baseline and endline, causal analysis based on the difference-in-difference (DID) estimation regression model was conducted at two levels:

a) Comparing indicators from data from all 15 intervention districts against data from the three non-intervention districts,
b) Comparing indicators from data from the 3 Acholi sub-region intervention districts against data from the three non-intervention districts.

Output indicators' values were compared against the program targets set in the results framework. The RAG colour scheme was used to highlight the level of achievement against the set targets.

Health Facility Assessment (HFA) of Youth Friendly Services Data Analysis

The HFA survey covered 125 of the 127 sampled health facilities, with a minimum of 7 health facilities taken from each of the 15 ANSWER programme districts (see Table 5). Within each health facility, semi-structured questionnaire interviews were conducted with senior health workers responsible for SRH service delivery and with the facility in-charge (see Table 6). Additionally, client exit interviews were conducted with young people (10-24 years) exiting the facility after receiving SRH services or information. To adhere to the WHO and UNAIDS (2015) manual on the assessment of adolescent and youth-friendly health service standards, a minimum of six exit interviews were conducted in each health facility. These also included sit-in clinical observations.

Table 5: Health facilities sampled by level

		Level of the facility			
	n	**HCII**	**HCIII**	**HCIV**	**Hospital**
Baseline	129	**33**	82	10	**4**
Endline	**125**	**16**	**85**	**15**	**9**

Table 6: Distribution of the number of health worers interviewed by cadre

	Acholi	**West Nile**	**All**	**Percentage**
No. of HFs	**25**	**100**	**125**	**100.0**
Cadre of staff				
Medical Officer	**2**	10	**12**	9.6
Clinical Officer	**9**	39	**48**	38.4
Nursing Officer-Nursing	**4**	10	**14**	11.2
Nursing Officer-Midwifery	**3**	5	**8**	6.4
Enrolled Nurse	**6**	14	**20**	16.0
Enrolled Midwife	**0**	12	**12**	9.6
Other	**1**	10	**11**	8.8

Quantitative data was summarized into key indicators as at the baseline (and as in the log frame) and according to the WHO's Global Standards for Quality Health-Care Services for Adolescents and the MoH's Health Facility Quality of Care Assessment Programme (HFQAP) Tool. Both descriptive and inferential analyses were conducted. In inferential analysis, comparisons were made to the baseline data and tested for statistical significance using an F-test.

Data source mapping

Table 7 below outlines how the data sources map to the evaluation criteria.

Table 7: Data sources mapping to the evaluation criteria

Evaluation Criteria	Data Sources used
Relevance	Programme reporting documents, interviews with institutional stakeholders & community
Effectiveness	
Health Facility	Programme reporting documents, HMIS, HFA, interviews with stakeholders & community
Sexuality Education	Programme reporting documents, KAP and community interviews
Social and Gender Norms	Programme reporting documents, community interviews
Demographic Dividend	Programme reporting documents, reports and interviews with stakeholders and community
Efficiency	Financial information and interviews with IPs, stakeholders and community members
Coherence	Interviews with IPs, stakeholders and community members
Sustainability	Design of the programme, programme reports (e.g. capacity building), interviews with IPs, stakeholders and community members

Demographic Dividend

To assess the work related to the demographic dividend, the team reviewed the annual reports and documents produced as part of the project, including the data collected for the demographic dividend (DD) compliance and the DD budget analysis. This assessment included the DD budget analysis at both the national and local levels, along with a review of the district-level policy documents available online.

Data validation

Data validation was a continuous and iterative process throughout the different evaluation phases. Data was checked for validity and robustness of findings at each stage of the evaluation, assessing whether certain specific hypotheses (related to the evaluation questions) should be explored further. Several strategies were used to ensure the validity of the information and data collected[14] , including but not limited to:

- Systematic triangulation of data sources and data collection methods and tools.
- Regular exchange with the UNFPA evaluation manager and programme staff at the CO.
- Internal evaluation team meetings to corroborate data and information to analyse assumptions, formulate emerging findings, and define preliminary conclusions.
- Discussion of the emerging findings during a debriefing meeting with the UNFPA team.
- Draft findings and conclusions are validated when the evaluators present the draft evaluation report (ERG meeting).

[14] For more detailed guidance see Handbook, section 3.4.3, pp. 74-77

We state the strength of the evidence supporting each contribution statement under the causal pathways. The strength of the evidence was assessed based on the level of triangulation and the quality of the sources used. Table 8 presents how we ranked the strength of evidence used throughout the reporting of the findings. Where there are significant differences between sources, we have stated this clearly.

Table 8: Strength of evidence

Weak evidence	Evidence comprises of limited evidence, a single source or unreliable evidence.
Moderate evidence	Evidence comprises of multiple data sources of lesser and decent quality (good triangulation).
Strong evidence	Evidence comprises of multiple data sources of high quality (good triangulation)

Limitations encountered during evaluation

Table 9 below highlights the limitations encountered during the endline evaluation and the mitigation measures taken. However, the limitations were insufficient to invalidate this evaluation's conclusions.

Table 9: Limitations encountered, and mitigation measures taken

Limitation	Risk	Mitigation Response
Challenges in scheduling of interviews due to distance to be covered.	Changes or delays in data collection result in data not being collected within the time frame.	Undertook data collection in waves to allow for multiple data collection and fill any data gaps.
Challenges in scheduling appointments with key stakeholders for secondary data acquisition and programme reports (absence from office due to other commitments)	This can potentially lead to sample bias regarding the coverage of stakeholders.	Allow sufficient time for the recruitment of respondents.
School holidays during the data collection phase	This may make it hard to collect the information for the KAP survey in school settings and not achieve the desired sample size.	A final stage of school data collection was added to the work plan.
Accessibility and quality of HMIS data at the district	Some data elements may not be clean, and it might not be possible to get insights	Recognised this in the limitations
Information is self-reported (exit surveys, KIIs) and thus may suffer inaccuracy arising from social desirability bias.	The research assistant makes stereotypical statements during the interview that may elicit biased responses.	All research assistants are trained to avoid passing stereotypical statements during the interview that may elicit biased responses.
No collection of qualitative data collection in the control districts	There is no account of the interventions and programmes in the control district	Recognised this in the limitations
Funds are not released to pay the data collection and evaluation team on time.	Data collectors and data analysis delayed in undertaking their work.	Repeated and consistent pressure to ensure the release of funding to pay the team.
Not all members of the evaluation team were available due to unexpected bereavement.	Insufficient staff to oversee and manage the evaluation process.	The deputy team lead takes on the leadership role as co-team lead to ensure continuity.
Quality of observation data	When collecting observation data, there was a high degree of the Hawthorne effect and bias.	Observational data has recognised limitations, including the Hawthorne effect. However, mitigation strategies were limited as we needed to plan the

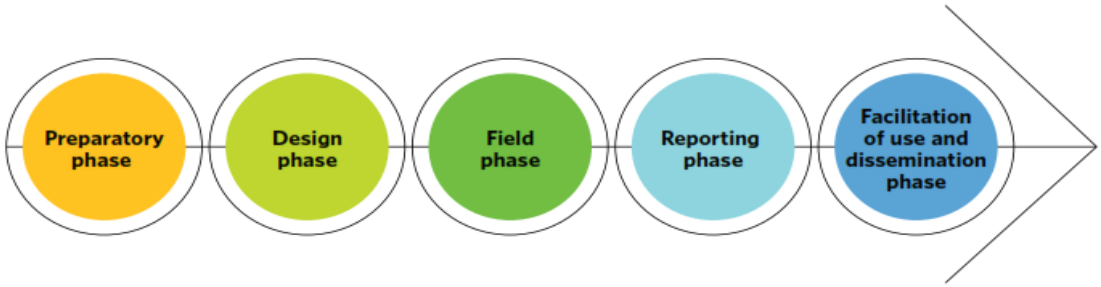
Limitation	Risk	Mitigation Response
		timing of the observation and then obtain consent for the observations, which made the respondents aware of what was happening. A mystery client approach would have been more appropriate.
Missing data from key respondents	Not having complete coverage of the diverse range of respondents introduces bias.	The interviews were planned for several weeks to ensure we could secure time with the relevant respondents. In addition, the team allowed for several days of data collection and staggered data collection over time to provide sufficient interview time.
We collected data over a set period and certain days dedicated to the sites. In some cases (refugees and PWDs), we could not achieve the desired samples despite the mobilization efforts.	Missed some voices	Analysis based on the few participants from these two subpopulations has been included in the synthesis of the findings.

The limitations in data collection can inevitably lead to bias in several ways, possibly resulting in skewed or inaccurate representations. Given we only collected data from a handful of sites involved in the ANSWER programme, we may have sampling bias, e.g., the sample population used for data collection is not representative of the entire population of interest. As many respondents have benefited from the presence of the ANSWER programme, respondents may provide misleading information due to social desirability bias or recall bias between the different programmes being implemented.

Process Overview

The evaluation process followed the UNFPA Country Programme Evaluation (CPE) Handbook guidelines.[15] The evaluation was conducted in five phases, as depicted in the figure below:

Figure 1: The phases of the evaluation



Source: UNFPA Evaluation Handbook (Revised 2019)

Phase 1 was the **preparatory phase,** which included establishing the evaluation manager (EM), the evaluation reference group (ERG), recruiting consultants, preparing the draft stakeholder map, and making available key documents to the consultants.

[15] Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA. Revised May 2019.

The consultants conducted the following phases with technical, logistical, and administrative support from the UNFPA CO, primarily through the EM.

Phase 2 was the **inception phase**, and the main objective was to produce the inception report that structured the evaluation process. The report ensured a common understanding within the evaluation team and between the evaluation team, the UNFPA CO Team, and the ERG on the processes and methods guiding this evaluation towards producing a final report. Activities include orientation of the consultant team, desk review, stakeholder selection for interview and focus group discussions; development of the evaluation matrix, finalising evaluation questions, and developing the data collection tools; planning for data collection and analysis; and production of a comprehensive work plan for the field, analysis and synthesis and reporting phases of the evaluation. During this time, the UNFPA CO prepared the fieldwork logistics according to the agreed stakeholder selection.

Phase 3 was the **fieldwork phase**. The consultant team undertook data collection activities, utilizing and continuing the document review from Phase 2, conducted the KAP and HFA surveys, key informant and in-depth interviews, group discussions, and focus group discussions.

Phase 4 was the **synthesis and reporting phase** of data collation, triangulation, and analysis, as well as developing the draft and final evaluation reports and presenting them for critique and validation. The EM and the ERG reviewed the draft report and provided feedback on revising it. This iterative process allows for repeated clarification and validation of the findings, conclusions, recommendations, and lessons learned.

Phase 5 is the **facilitation of use and dissemination phase**. During this phase, the EM shared the report with country stakeholders, the RNE and the UNFPA headquarters, and relevant external stakeholders. The evaluation manager and the UNFPA CO then prepared a management response to the evaluation recommendations.

2. COUNTRY CONTEXT

2.1. Development challenges and national strategies

Ensuring universal access to sexual and reproductive health and rights (SRHR) as part of universal health coverage aligns with the 2030 Agenda for Sustainable Development. It continues to be a global and national challenge in Uganda despite some progress being made in SRHR.[16] Uganda has one of the highest fertility rates globally, with a total fertility rate (TFR) of 5.2 in 2022.[17] Nonetheless, there have been some declines in TFR recorded over the last ten years, from 6.7 in 2006 and 6.2 in 2011 to the most recent estimate of 5.2 in 2022. The maternal mortality ratio has declined from 336/100.000 live births in 2016 to 189 in 2022, thanks to increased skilled birth attendance from 91 per cent (UDHS, 2022) to 74 per cent (UDHS, 2016). Unsafe abortion contributes to the maternal mortality ratio, with 8 per cent of maternal deaths due to unsafe abortion.[18] There has been a significant decline in the unmet need for family planning among married women in Uganda, from 34 per cent to 26 per cent from 2016 to 2020,[19] though it remains higher than the target of 10 per cent. This disproportionately affects Uganda's young population, with 30-year-olds and below making up 76 per cent of the population.[20]

Adolescents (10-19 years) and youth (15-24 years) are seen as underserved and at-risk populations. Among them, out-of-school girls are particularly vulnerable, as they experience limited agency in SRH decision-making and in translating their intentions into practice[21], which exposes them to issues of unplanned pregnancy, child marriage[22], and gender-based violence (GBV), among others.[23] Forty-three (43) per cent of women marry before the age of 18 years.[24] While early childbearing (age group 15-19 years) has progressively declined from 43 per cent in 1995, 31 per cent in 2001, and 25 per cent in 2006 and in 2016,[25] Uganda has not registered any significant declines in the last ten years, despite the social and behaviour change communication (SBCC) campaigns and strategic programming efforts by multiple actors. Twenty-six (26) per cent of maternal mortality is attributed to adolescent childbirth.

Moreover, modern contraceptive use among young people remained as low as 30.3 per cent among all women and 42.7 per cent among sexually active unmarried girls in 2016.[26,27] Over 40 per cent of pregnancies among women below age 20 are unintended.[28] Moreover, HIV prevalence among young women aged 15-24 years is up to three times that of males (0.8 per cent in males compared to 3.3 per cent in females) and accounts for over 70 per cent of new infections.[29] This contributes to school

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[16] Baseline assessment for the ANSWER programme in the West Nile and Acholi sub-regions in Uganda (2021)

[17] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 202022 – Key Findings.

[18] Prada E et al., Incidence of induced abortion in Uganda, 2013: new estimates since 2003, PLoS ONE, 2016, 11(11):e0165812, doi:10.1371/ journal.pone.0165812.

[19] PMA2020, Performance Monitoring and Accountability 2020 (PMA2020) Survey Round 6, PMA2018/Uganda

[20] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[21] Kisaakye, P., Bukuluki, P., Wandiembe, S. P., Kiwujja, V., Kajungu, C., Mugwanya, W., ... & Kaikai, F. (2023). How Self-Efficacy and Agency Influence Risky Sexual Behavior among Adolescents in Northern Uganda. Adolescents, 3(3), 404-415.

[22] Bantebya, G.K., Muhanguzi, F.K. and Watson, C., 2014. Adolescent girls in the balance: changes and continuity in social norms and practices around marriage and education in Uganda. London: Overseas Development Institute.

[23] Bukuluki, P., Kisaakye, P., Houinato, M., Ndieli, A., Letiyo, E., & Bazira, D. (2021). Social norms, attitudes and access to modern contraception for adolescent girls in six districts in Uganda. BMC Health Services Research, 21(1), 1-14.

[24] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[25] ibid

[26] ibid.

[27] ibid.

[28] ibid

[29] Uganda Population-Based HIV Impact Assessment. 2016-2017. ICAP/CDC/MOH, 2017

dropouts and negative SRH outcomes, including high unplanned pregnancies, unsafe abortions, and maternal morbidity/mortality. If the unmet need for modern family planning methods was satisfied in Uganda, maternal mortality would drop by 40 per cent, and unplanned births and induced unsafe abortions would decline by 85 per cent.[30]

Recent studies (UNFPA's Cost of Inaction) found that 64 per cent of adolescent mothers are at risk of not completing primary education, and an estimated 60 per cent of adolescent mothers will end up in subsistence agriculture work.[31] This implies that the Government of Uganda will incur a very high economic cost on healthcare for teen mothers and, in the long and medium term, on education for their children. Hence, there is a need to extend voluntary family planning services to young people to support human capital development and harness the demographic dividend. Notwithstanding, most young people in Uganda face challenges in accessing family planning services, and several gaps on the demand and supply side exist in delivering these services to young people.[32]

The high burden of diseases, particularly the prevalence of sexually transmitted infections (STIs), especially HIV, is a threat to achieving universal access to SRHR and overall universal health coverage. In Uganda, over 1.4 million people are living with HIV, and about 53,000 new infections are reported annually.[33,34] Vulnerable populations, including refugees, young people, and PWDs, face both the risk of HIV infection and barriers to HIV counselling and testing.[35] Generally, barriers to the utilisation of HIV healthcare services are associated with stigma, cost, manpower, quality of services, distance to health service centres, and health literacy.

Gender-based violence (GBV) has been conceptualised as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[36] GBV is considered a human rights violation with far-reaching negative consequences for survivors as well as their families and children[37]. Due to its dire consequences, GBV has been declared a global pandemic – with negative implications for the health and well-being of individuals.[38] For this evaluation report, GBV refers to violence against women and girls[39] , and these may manifest in different ways relative to various contexts of gender relations between men and women as well as girls and boys. GBV has several consequences, including undermining the health, security, and autonomy of the survivors. Yet, it remains shrouded in a culture of silence and rooted in deeply entrenched gender-inequitable norms. Survivors of violence can suffer SRH consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections, including HIV, and even death. The rates of different forms of intimate partner violence are high in Uganda; emotional violence is the most common, followed by physical violence: About 1 in 3 women (29 per cent) and men (29 per cent) experienced emotional violence from a current or most recent spouse/partner in the 12 months before the survey. Twenty-two (22) per cent of women and 12 per cent of men experienced spousal physical violence in the past 12 months, and 16 per cent of women and 6 per cent of men experienced spousal sexual violence during that period. Among specific kinds of non-emotional

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30 Guttmacher Institute. Unintended Pregnancy and Induced Abortion in Uganda, 2006.

31 UNFPA and UNICEF (2021) The cost of inaction: teenage pregnancy in Uganda https://uganda.UNFPA.org/en/publications/teenage-pregnancy-uganda-cost-inaction

32 Government of Uganda, Ministry of Health (2020). The Family Planning Research and Learning Agenda for Uganda 2021–2025: Promoting Scale, Quality, and Equity

33 Avert (2018). HIV and AIDS in Uganda. from https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda.

34 UNAIDS (2020b). Uganda Overview

35 Naswa S, & Marfatia YS (2010) Adolescent HIV/AIDS: Issues and challenges. Indian Journal of STDs and AIDS, 31(1), 1 10. doi: 10.4103/0253-7184.68993.

36 United Nations (1993) Declaration on the Elimination of Violence against Women Proclaimed by General Assembly resolution 48/104 of 20 December 1993 https://www.un.org/ genocideprevention/documents/atrocity-crimes/Doc.21_declaration percent20elimination percent20vaw.pdf en/

37 Sri AS, Das P, Gnanapragasam S, Persaud A. COVID-19 and the violence against women and girls: 'The shadow pandemic'. Int J Soc Psychiatry. 2021;67(8):971–3

38 Sánchez OR, Vale DB, Rodrigues L, Surita FG. Violence against women during the COVID-19 pandemic: an integrative review. Int J Gynecol Obstet. 2020;151(2):180–7

39 Dlamini NJ. Gender-based violence, twin pandemic to COVID-19. Crit Sociol. 2021;47(4–5):583–90.

violence ever experienced with a current or most recent husband/partner, women are most likely to report being slapped (35 per cent), being physically forced to have sex when they did not want to (21 per cent), being pushed or shaken or having something thrown at them (19 per cent).[40]

More than 1 in 5 women aged 15-49 years (22 per cent) report that they have experienced sexual violence at some point in time (from any person). One in four women report that their first sexual intercourse was forced against their will. Fifty-six per cent of ever-married women and 44 per cent of ever-married men have experienced physical, sexual, or emotional violence by their current or most recent spouse/partner.

Unequal gender relations underpin the widespread tolerance for GBV, harmful practices (HP) and denial of access to SRHR. Five out of ten women (49 per cent) and four out of ten men (41 per cent) aged 15-49 agree with at least one justification for GBV; these proportions declined from 77 per cent of women and 64 per cent of men in 2000-01.[41] This may lead to inhibition of the use of contraception, child and forced marriages, and girls dropping out of school, resulting in deprivation of enjoyment of their rights and wellbeing. The linkages between gender inequality, GBV, maternal morbidity and death, HIV and STIs, child marriage and adolescent birth and imbalances in power and decision-making have been studied and documented (UBOS, 2017). This demonstrates the importance of focusing on social and gender norms and other structural factors influencing SRHR and GBV-related behaviour.[42,43]

Uganda has an evolving policy environment for SRH (including gender-based violence) and health overall. Driven mainly through its Vision 2040, the current National Development Plan (NDP) III 2020/21-2024/25 focuses on easing the living conditions and overall quality of life of the people of Uganda, shows that access to and utilization of health and education services has significantly increased – among other services and key sectors. Different policies and frameworks guiding SRHR and GBV include the national GBV policy, [44] national SRH policy, national health policy, health sector development plan, and RMNCAH sharpened plan. In 2021, the Ministry of Health released its family planning research and learning agenda[45]. For adolescent health, there are several relevant policies and strategies, including the Uganda National Adolescent Health Policy (2004), Adolescent Health Policy and Service Standards (2012), the National-Adolescent-Health-Strategy-2011-2015 and the National Sexuality Education Framework (2018). In March 2023, the Ugandan parliament passed the Anti Homosexuality Bill, which the President of Uganda assented to the 2023 Anti-Homosexuality Act (AHA) on the 29th of May 2023. The AHA criminalises all forms of consensual same-sex relations and the "promotion of homosexuality".[46] This is likely to have negative implications and social sanctions for the ability of the marginalised groups, especially the LGBTQ, to seek prevention and care services ranging from HIV to SRH services.[47] It also has the potential to increase backlash, especially stigma and discrimination for LGBTQ. It is at variance with the attaining Universal Health Coverage (UHC)

[40] All statistics presented here are extracted from the Uganda Demographic and Health Survey, 2016; National GBV Policy, Uganda 2016

[41] ibid.

[42] Bukuluki P, Kisaakye P, Wandiembe SP, Musuya T, Letiyo E, Bazira D (2021) An examination of physical violence against women and its justification in development settings in Uganda. PLoS ONE 16(9): e0255281.

[43] Bukuluki, P., Kisaakye, P., Houinato, M., Ndieli, A., Letiyo, E., & Bazira, D. (2021). Social norms, attitudes and access to modern contraception for adolescent girls in six districts in Uganda. BMC Health Services Research, 21(1), 1-14.

[44] All statistics presented here are extracted from the Uganda Demographic and Health Survey, 2016; National GBV Policy, Uganda 2016

[45] Government of Uganda, Ministry of Health (2020). The Family Planning Research and Learning Agenda for Uganda 2021–2025: Promoting Scale, Quality, and Equity.

[46] This broadly covers advocacy, funding, or even identifying as LGBTQ+, with up to 20 years of imprisonment. Government of Uganda:The Anti-Homosexuality Act, 2023

[47] Minor Peters, M. (2016). 'They wrote "gay" on her file': transgender Ugandans in HIV prevention and treatment. Culture, health & sexuality, 18(1), 84-98.

and the popular notion of "leaving no one behind".[48] It has also been criticised for not aligning with human rights-based approaches.[49]

On GBV, the Government of Uganda has enacted several legal and policy instruments that address the experience of violence. The constitution of Uganda under Article 33 provides for equal dignity of women and prohibits any form of law or practice that undermines women's dignity.[50] Similarly, the Constitution of the Republic of Uganda (1995) prohibits discrimination based on sex, guarantees the rights and equality of women to men, and provides for affirmative action in favour of marginalised groups, including those based on gender. It also prohibits "laws, customs, cultures or traditions" that are against women's interests or welfare. The other critical legal instruments include:[51]

- The Penal Code Act criminalises rape (forced sex of adult women over 18) and defilement (sexual intercourse with a minor), and the 2007 amendment allows Chief Magistrates to hear these cases; the Domestic Violence Act (2010) makes domestic violence a punishable offence (provisions for fines, imprisonment) and recognises physical, psychological and economic abuse;
- The FGM Act prohibits Female Genital Mutilation and provides for the prosecution and punishment of offenders and the protection of victims as well as girls and women under the threat of FGM/C and provides for the protection of females who refuse to undergo FGM/C;
- The Prevention of Trafficking in Persons Act (2010) aims to prevent and eliminate trafficking, including sexual exploitation and prescribes punishments and victim compensation;
- The Employment Act recognises sexual harassment in employment and calls for employers to put in place positive measures in workplaces to prevent sexual harassment;
- The 2004 amendment to the Land Act 1998 includes provisions to increase the protection of the rights of women to own, use and inherit land. It provides for spousal and children's consent before the disposal, transfer or mortgaging of family land;
- The Public Finance and Management Act (2015) includes enforcing gender and equity-responsive budgeting across Government Ministries, Departments and Agencies (MDAs).

In addition, several policies, such as the National Policy on the Elimination of Gender-Based Violence, encourage stakeholders to increase and expand their programmatic efforts in preventing and responding to GBV.[52]

The Uganda Gender Policy (2007) provides a framework for identifying, implementing, and designing interventions to promote gender equality and women's empowerment.[53] The National Referral Pathway for Prevention and Response to GBV Cases in Uganda (2013) aims to assist victims or survivors of GBV.[54] It is also worth noting that the Minister of Finance, in consultation with the Equal Opportunities Commission, has the mandate and can issue a gender and equity certificate to government MDAs whose Budget Framework Paper is 'gender and equity responsive'. Similarly, the development of the Strategy to End Child Marriage (ECM) and Teenage Pregnancy in Uganda 2022/23-2026/27 demonstrates the Government of Uganda's commitment to revert the current negative

[48] Human Rights Watch, (2023). Uganda: New Anti-Gay Bill Further Threatens Rights Follows Broader Crackdown on LGBT-Rights Groups, Civil Society in General. Available at: https://www.hrw.org/news/2023/03/09/uganda-new-anti-gay-bill-further-threatens-rights

[49] Dasandi, N. (2022). Foreign aid donors, domestic actors, and human rights violations: the politics and diplomacy of opposing Uganda's Anti-Homosexuality Act. Journal of International Relations and Development, 25(3), 657-684.

[50] Government of Uganda (1995) Constitution of Uganda

[51] These are further elaborated in the "Lyndsay McLean and Paul Bukuluki 2016. National GBV Diagnostic. World Bank and MGLSD Report

[52] Government of Uganda (2016) The National Policy on Elimination of Gender-Based Violence in Uganda

[53] Government of Uganda (2007) The Uganda Gender Policy.

[54] Government of Uganda (2013) National Referral Pathway Guideline for Prevention and Response to GBV.

trend of ECM and teenage pregnancy. It further shows commitment to influencing changes in social and cultural norms that drive and perpetuate ECM and teenage pregnancy.[55]

Despite the country's policies and strategies, major challenges remain around implementation, follow-up, and assessment, rooted in systemic, socio-cultural, political, and economic factors. In addition, some policies, including some relevant to SRHR and GBV, have been criticised for failure to address issues of marital rape, providing clear guarantees for access and utilization of contraceptives for adolescents, among others. For example, representatives of young people in Uganda have reported on some platforms that they are experiencing pushback and backlash regarding their sexual and reproductive health and rights (SRHR), particularly regarding sexuality education, contraception, and gender equality.[56]

2.2. Brief Overview of the Acholi and West Nile context

Three of the ten poorest districts per capita are in Northern Uganda, and all districts in Northern Uganda have not yet attained the current national GDP. The two sub-regions of West Nile and Acholi have some of the worst SRHR indicators in the country. For example, the Northern region has the highest percentage of adolescent girls (15-19 years) ever giving birth (26.6 per cent). Similarly, although the Health Sector Development Plan of the Northern Region aimed to reduce teenage pregnancy to 14 per cent by 2025, the onset of COVID-19 aggravated the situation. It contributed to an unprecedented surge in teenage pregnancies by up to 365 per cent in some age categories[57], with the Northern and West Nile regions coming among those with the highest rates. Young people aged 10 to 24 years, persons with disabilities (PWDs), refugees, and the geographical sub-regions of West Nile and Acholi experience disproportionate inequities in access to and the utilisation of SRHR and GBV services and information in Uganda.

Regional total fertility rates show that Acholi has a total fertility rate (TFR) of 5.2 in 2022 and a maternal mortality ratio of 368 per 100,000 live births, close to the national average.[58] The unmet need for family planning is 39 per cent compared to the national average of 28 per cent, and the contraceptive prevalence rate is 30.2 per cent, like national levels. The rate of teenage pregnancies in the Acholi region is 23.8 per cent. The proportion of women who had experienced spousal violence in Acholi was 39 per cent in 2016[59]. The school drop-out rate is 60 per cent for girls in the Northern region.

[55] Government of Uganda (2022) The Strategy to End Child Marriage and Teenage Pregnancy in Uganda 2022/23-2026/27

[56] UNFPA-ESARO (2019). "Trust and empower us" – young Ugandans on their sexual and reproductive health and rights "Available at: https://esaro.UNFPA.org/en/news/trust-and-empower-us%E2%80%9D-%E2%80%93-young-ugandans-their-sexual-and-reproductive-health-and-rights Accessed January 2024

[57] UNICEF, 2021

[58] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.

[59] ibid

Figure 2: Map of Uganda showing West Nile and Acholi sub-regions

West Nile region had a total fertility rate (TFR) of 5.1 in 2022, and the unmet need for family planning is 43 per cent compared to the national average of 28 per cent. The contraceptive prevalence rate among married women is 19 per cent, far below the national average of 39 per cent.[60] Teenage pregnancies in the West Nile region are 22 per cent, as compared to the national average of 25 per cent. The proportion of women who had experienced gender-based violence in the region was 43 per cent in 2016. The school drop-out rate is 60 per cent for girls in the Northern region.

The two regions are also home to high numbers of refugees. Uganda's open-door approach to hosting refugees has received international acclaim, with its refugee policy described as the most progressive[61] [62] and "the world's most compassionate refugee policy".[63] The nation is among the world's top three refugee-hosting nations and the largest in Africa, currently hosting approximately 1.5 million refugees and asylum seekers, mainly from South Sudan. The refugees are spread out in 12 districts, and over 67 per cent live in the West Nile region.[64] Uganda has no refugee camps; refugees live in gazetted settlements or wherever they choose within the wider society.[65] This is in line with the government's policy of service integration, which states that refugees share all services with the host community.[66] Registered refugees can be employed, engage in agriculture or business and access all services, including healthcare. A recent World Bank (2018) study revealed that while all refugee settlements in Uganda have lower-level health facilities, these facilities are also used by the local host communities integrated within or surrounding the settlements.[67] Health facilities in refugee settlements follow the national referral pathway, requiring more complex cases from lower-level facilities to be managed at higher-level facilities.[68]

[60] Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.
[61] Seruwagi G, Nakidde C, Otieno F, Kayiwa J, Luswata L, Lugada E, Ochen EA, Muhangi D, Okot B, Ddamulira D, Masaba A and Lawoko S (2021) Healthworker preparedness for COVID-19 management and implementation experiences: a mixed methods study in Uganda's refugee-hosting districts. BMC *Conflict & Health* 15: 79 (2021). https://doi.org/10.1186/s13031-021-00415-z
[62] World Bank Group. An assessment of Uganda's progressive approach to refugee management. World Bank; 2016.
[63] Hattem J. Uganda at breaking point as Bidi Bidi becomes world's largest refugee camp. The Guardian. 2017.
[64] UNHCR. Uganda: Refugees and asylum-seekers. UNHCR Representation in Uganda. 2021
[65] Golooba-Mutebi F, Bukenya B, Seruwagi GK. The political economy of refugee-hosting districts in Uganda: A case study of Arua, Moyo and Yumbe districts. 2018.
[66] Government of Uganda. Local Governments Act. 1997
[67] World Bank. Informing the refugee policy response in Uganda: results from the Uganda refugee and host communities 2018 household survey. 2018
[68] Ministry of Health (MoH) Uganda Hospitals. 2023. https:// www. health. go.ug/ hospitals/

2.3. COVID-19 and its impacts on GBV and SRHR programming

In response to the COVID-19 pandemic, Uganda implemented strict control measures, including public and private transportation, schooling, and business shut-downs, that resulted in youth migrating from urban schools and workplaces to rural home villages.[69] The COVID-19 pandemic adversely affected Uganda's SRHR and GBV situation. Control measures including lockdowns, increased risks and vulnerability to GBV as well as for most of the SRH outcomes, especially teenage pregnancy and GBV.[70] [71] [72] Like other contexts experiencing epidemics and other complex emergencies, there has been a disproportionate impact on women and girls, increasing their vulnerability to gender-based violence (GBV).[73] Several studies have found that during COVID-19, access to information and/or education concerning sexual and reproductive health (SRH) was disrupted and/or reduced.[74,75] The reported impacts on SRH ranged from severe infection and complications due to delayed care seeking and increases in youth STIs, pregnancy, and abortion.[76] In Uganda, 3,280 cases of GBV were reported to police in April 2020 in comparison to a monthly average of 1,137 cases in 2019.[77] Data from the Rapid Gender Assessment (RGA) survey conducted during COVID-19 revealed that those with low socio-economic status and education and those who needed help or medical support as a prevention measure against GBV were more at risk of gender-based violence.[78]

A study conducted by Save the Children (2023) found that the COVID-19 measures and restrictions (a) increased household-level socio-economic stress, (b) led to closures of school and youth activities, (c) reduced access to SRH information, and (d) removed social structures that work to limit sexual activity.[79] Furthermore, there have been rising cases of GBV in Uganda as services (e.g., prevention, shelters, and legal services) were reduced as they were classed as non-essential and impacted women with disabilities in particular.[80] [81] The provision of multi-sectoral GBV services was not spared from initial lockdown restrictions, and this led to the disruption of critical GBV services such as clinical management of rape, legal and judicial services, psychosocial services, availability of shelters, and community-based prevention activities. Similarly, curfews, stay-at-home orders, and public and private transportation restrictions further diminished service access.[82]

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[69] Khan S, Kemigisha E, Turyakira E, Chaput K, Kabakyenga J, Kyomuhangi T, Manalili K, Brenner JL. Dramatic effects of COVID-19 public health measures and mass reverse migration on youth sexual and reproductive health in rural Uganda. Paediatr Child Health. 2022 May 3;27(Suppl 1):S40-S46. doi: 10.1093/pch/pxab107. PMID: 35620554; PMCID: PMC9126275.

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[82] John, N.A., Bukuluki, P., Casey, S.E., Chauhan, D.B., Jagun, M.O., Mabhena, N., Mwangi, M. and McGovern, T., 2023. Government responses to COVID-19 and impact on GBV services and programmes: a comparative analysis of the situation in South Africa, Kenya, Uganda, and Nigeria. Sexual and Reproductive Health Matters, 31(1), p.2168399.

3. The ANSWER Programme

The UNFPA Uganda Country Office (CO) and the Government of Uganda (GoU) are currently implementing the Ninth (9th) Country Programme (CP) for the period 2021-2025 across more than 56 districts in Uganda. The overall vision of the programme is to ensure universal access for women and young people in Uganda to quality, integrated sexual and reproductive health and rights (SRHR) information and services. This effort supports the attainment of the three transformative results in the UNFPA Strategic Plan 2018-2021: ending unmet need for family planning, ending preventable maternal deaths, and ending gender-based violence (GBV), as well as the East and Southern Africa regional priority of ending new HIV infections.

Under the framework of the 9th Country Programme 2021-2025, the UNFPA Uganda Country Office (CO) is committed to addressing national development needs and priorities articulated in the third Uganda National Development Plan (NDPIII) 2020/2021-2024/2025, National Vision 2040, African Union Agenda 2063, the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021-2025, and the UNFPA Strategic Plan 2018-2021. The 9th Country Programme is funded through UNFPA core funds, global thematic and trust funds, and in-country bilateral donors.

In October 2019, UNFPA and the GoU, with funding from the Royal Netherlands Embassy (RNE), began implementing a four-year (2019-2023) Programme on Advancing Sexual Reproductive Health and Rights in the West Nile and Acholi Sub-Regions in Uganda (ANSWER). This programme is implemented in 15 districts in Northern Uganda, with 12 districts in West Nile and three in Acholi. It is implemented in partnership with key national ministries, departments, and agencies (MDAs), district local governments (DLGs), civil society organisations (CSOs), and religious and cultural institutions.

3.1 Overview of the ANSWER Programme

The ANSWER programme was designed to address key SRHR and GBV issues and respond to contextual challenges. Specifically, the programme aimed to tackle health system bottlenecks to enhance the availability and coverage of high-quality SRHR and GBV services. It also sought to empower young people, women, and men to assert their sexual and reproductive rights and advocate for access to SRHR services. Additionally, the programme aimed to transform negative social and gender norms that contribute to gender inequalities at both the community and individual levels, hindering access to SRHR and SGBV services for women and young people.

The programme's overall goal was to contribute to universal access to SRHR for women, girls, boys, and men, as well as refugees and PWDs in Uganda. The Programme had the following objectives:

1. Enhanced access to and utilisation of quality SRH services (family planning, maternal health, post-abortion care, HIV testing and post- GBV) by 1,057,177 women, girls, boys and men, including refugees and PWDs, in West Nile and Acholi sub-regions by 2023, and
2. Strengthened multi-disciplinary leadership for improved implementation and accountability towards the national Demographic Dividend Road Map by 2023.

The approaches and interventions that underpin ANSWER are drawn from evidence-based interventions identified at the start of the programme.

Under Objective 1, the approaches and interventions were expected to increase the availability, accessibility, and utilisation of SRHR services by focusing on the supply side (strengthening the health system) and the demand side (schools and the community) components.

The outputs under this objective included:

1) Strengthening the health system in the targeted districts to increase the availability, accessibility, and quality of SRHR services.

2) Support adolescents in schools with sexuality education and implement relevant policies to improve SRHR and prevent and respond to GBV.
3) Support out-of-school girls and boys adolescents with age-appropriate, correct and comprehensive SRHR information to enable increased utilization of services.
4) Community members (host and refugees) are empowered to transform negative gender and social norms and thus reduce GBV, teenage pregnancy and child marriage while increasing acceptance of modern contraceptive methods and timely referral for post-GBV health services.

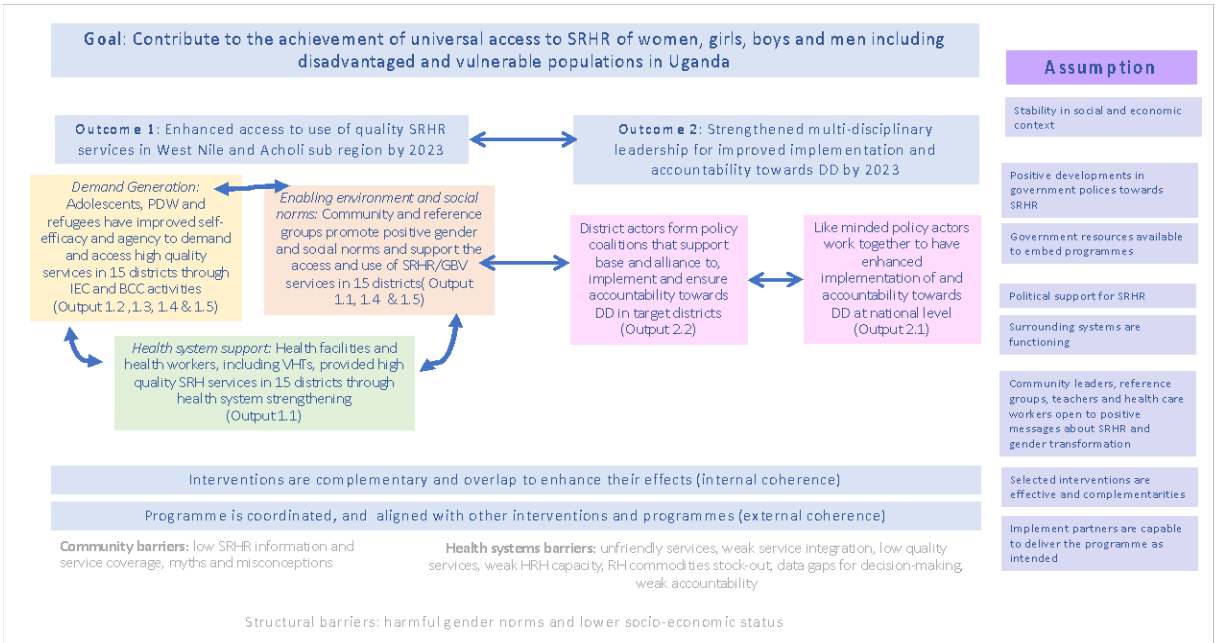
Under Objective 2, the approaches and interventions were expected to strengthen the integration of population dynamics into the larger development agenda at the national and district level and advocate for increased resource allocation for the Demographic Dividend (DD) strategic areas. This was expected to increase public expenditure on family planning, adolescent SRH, GBV and maternal health.

The following were the outputs and interventions: (1) enhanced implementation of and accountability towards the demographic dividend (DD)priorities nationally and (2) enhanced implementation of and accountability towards the demographic dividend (DD) priorities in the targeted districts in West Nile and Acholi sub-regions.

3.2 Analysis of the Theory of Change

Overall, the programme interventions' logic is still considered appropriate by the donor, key government agencies, and implementation partners for achieving the expected results. At the core of the theory of change is the recognition of the need for multiple complementary programme strategies to enhance the supply of SRH services and address the barriers hindering women, girls, adolescents, young people, and other vulnerable groups from seeking SRH services, at the intrapersonal, interpersonal, community, and structural levels. These approaches are complemented by broader actions aimed at ensuring a supportive policy and regulatory environment prioritizing this work, as depicted in Figure 3. The theory of change operates on the premise that these strategies are interconnected and complementary within a specific context over an extended period to achieve optimal coverage and results.

Figure 3: Refine theory of change



The unforeseen impacts of COVID-19 on the prevalence of GBV and unintended pregnancy further cemented the relevance of the ANSWER programme and the need for an integrated approach. However,

the underlying Theory of Change has not been thoroughly tested due to the constraints imposed by responding to COVID-19, limiting the extent to which the programme could be implemented, and curtailing many activities for a shorter period than intended. Additionally, the programme's delivery in numerous districts and sub-counties by multiple implementing partners during the first two years meant that programme strategies were not necessarily synergistic, leveraging, and amplifying each other as intended in the ToC. This issue was rectified after the mid-term review in 2022. Following the changes in 2022, the programme strategies aligned with the Theory of Change. Nonetheless, there remained a disproportionate investment in programme strategies aimed at strengthening service delivery compared to those supporting demand generation for SRHR services.

While many program elements were implemented, the level of intensity varied. For instance, resources allocated to health facilities outweighed those dedicated to demand generation and addressing social norms. Furthermore, certain populations received more attention than others; for example, persons with disabilities (PWDs) received minimal focus in the initial years of programming.

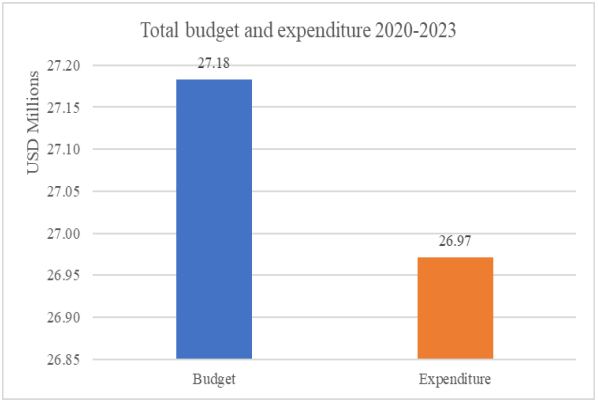
During the evaluation, many assumptions were scrutinized, revealing their broad nature. For instance, while factors like lack of stability (e.g., COVID-19) and a conducive environment for SRHR (e.g., human capital development) were identified, these assumptions failed to capture the complicated context where the program was implemented. Government policies exhibited a range of positive elements (e.g., human capital development) and negative approaches (e.g., promoting abstinence-only sex education). Support for government policies varied depending on the SRHR area, with maternal health and adolescent health receiving more positive reception than adolescent sexuality and abortion. Also, although resources may be available at the national level, they were not adequately reflected in the budget allocated to districts, indicating the need for more refined and contextualised assumptions.

While outcomes 1 and 2 were theoretically interconnected in the program's logic, this did not translate during implementation.

3.3. The Financial Structure of the ANSWER Programme

The Programme is fully funded by the Royal Netherlands Embassy (RNE). The total budget for the Programme was USD 27,182,636. The total expenditure for the period (including provisional amounts for 2023) is USD 26,971,171. The overall absorption rate is 99.2 per cent.

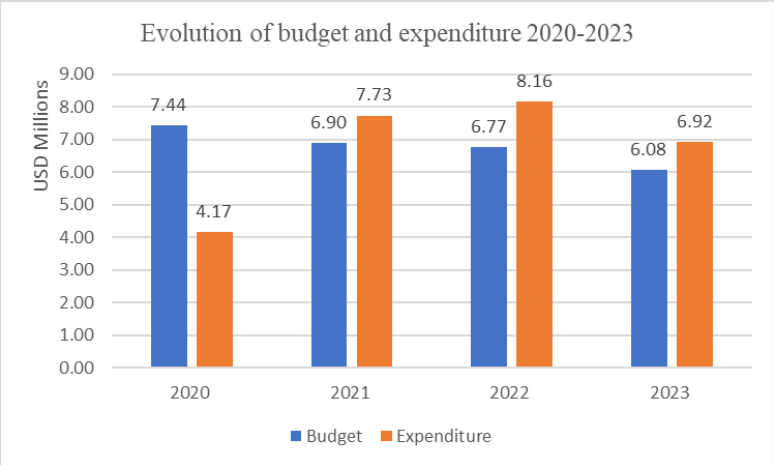
Figure 4: The total budget and expenditure 2020 - 2023



(Source: UNFPA Uganda CO)

The budget (original budget) and expenditure figures for 2020 to 2023 are shown in Table 5 below.

Figure 5: The evolution of budget and expenditure from 2020 to 2023

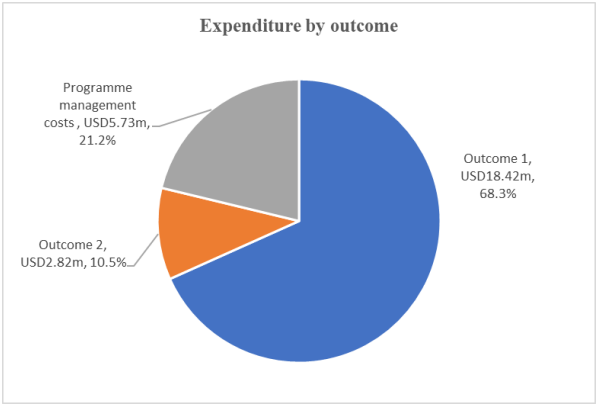


Year	2020	2021	2022	2023	Total
Budget[83]	7,437,736	6,896,872	6,769,788	6,078,240	27,182,636
Expenditure	4,166,158	7,729,615	8,158,786	6,916,613	26,971,171
Absorption rate	56.0%	112.1%	120.5%	113.8%	99.2%

(Source: UNFPA Uganda CO)

The absorption rates are provided in the table below the graph. The low absorption rate of 56.0 percent in 2020 is due to the COVID-19 lockdowns that significantly restricted activities in the Programme's first year. The higher absorption rates in 2021, 2022, and 2023 indicate accelerated activities to compensate for the first-year challenges.

Figure 6: Budget and expenditure per Programme outcome



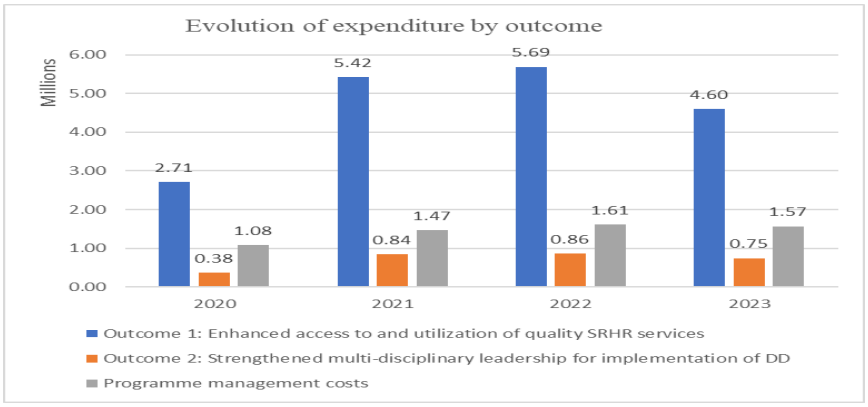
(Source: UNFPA Uganda CO)

The expenditure per outcome is shown in Figure 6. Outcome 1 had the highest proportion at 68.3 per cent. Outcome 2 received 10.5 per cent of total spending, while management costs accounted for 21.2 per cent of the total expenditure.

[83] Budgets used are as per Programme document

The evolution of expenditure by outcome is shown in Figure 7 below. The figure shows low expenditure for the two outcome areas in year 1 of the Programme. However, programme costs are substantial compared to the level of activities, indicating a lower efficiency level in utilizing funds.

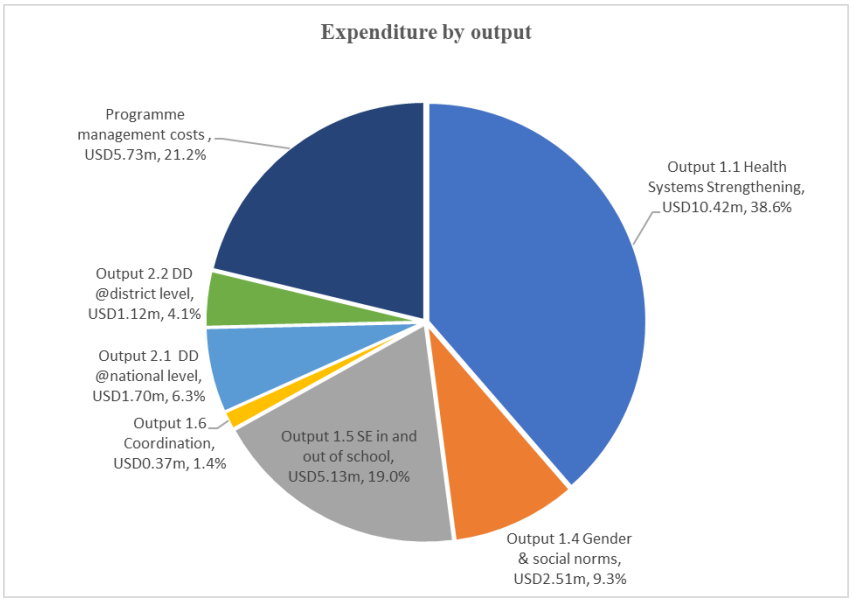
Figure 7: Evolution of expenditure by outcome



(Source: UNFPA Uganda CO)

Expenditure by output is shown in Figure 8 below. Output 1 on health systems strengthening had the highest spending at 38.6 per cent, followed by output 1.5 on sexuality education for in and out-of-school adolescents and young people at 19.0 per cent.

Figure 8: Expenditure by output



(Source: UNFPA Uganda CO)

4. Findings

This chapter addresses the questions and explores assumptions in the evaluation matrix based on analysis, triangulation, and data synthesis from multiple sources, as described in the methodology section above.

4.1. Relevance

Summary of Findings

- The ANSWER programme remains highly relevant to the objectives of the Government of Uganda and was particularly adept at responding to the issues and needs faced by the target population, particularly young people.
- The programme supported strengthening or localising national policies and/or priorities, such as focusing on demographic dividend and human capital development.
- There was a deep appreciation of the ANSWER programme's quick adaptations to the COVID-19 pandemic, and the support received at the time was noted.
- The interventions and activities that took place with the district partners could have benefited from more refinement, tailoring to local circumstances and needs, and piloting before scaling.

EQ1: To what extent was the ANSWER programme relevant to the SRHR needs of the target population, including (women, adolescents, people with disabilities and refugees), and relevant government agencies at national and district levels?

The ANSWER programme is relevant to the SRHR needs of the target population, particularly young people, and relevant government agencies at national and district levels.

The ANSWER programme set out to address five major issues: high maternal mortality rate, high unmet need for family planning, stagnant rates of teenage pregnancy and early marriages, high occurrence of SGBV and poor uptake of SGBV services, and inequality in access to SRHR services for vulnerable groups such as adolescents, refugees, and persons with disabilities. The major bottlenecks contributing to the poor performance of these indicators range from substantive weaknesses within the public health system on the supply side to socio-cultural barriers in communities on the demand side. The main health systems (supply-side) barriers identified during the design phase included lack of integration in SHR service delivery, poor quality of SRHR services, commodity stockouts, limited health care provider skills, and limited client-centeredness in the delivery of services. Negative social norms (due to culture and religion) that perpetuate SGBV, promote gender inequality and hinder uptake of available services, financial barriers and constraints, myths and misconceptions and lack of information.

The ANSWER programme proposed and implemented three major categories of intervention aimed at addressing the identified barriers:

a) Interventions to strengthen the health system, including Continuous Quality Improvement approaches, strengthening commodity security for SRHR including, family planning, SRHR voucher system of adolescents, strengthening adolescent and youth friendliness/responsiveness of SRHR services, and strengthening health worker knowledge and skills in family planning and maternal health/SGBV/PAC/HIV through training and mentorship; PWD responsiveness.
b) Interventions to address socio-economic barriers, mainly gender transformative approaches (SASA! MAGs); sexuality education, community empowerment models for out-of-school adolescents and youth; engaging cultural and religious leaders.
c) Strengthening the enabling environment (leadership, governance, and innovation). These approaches and interventions were selected based on the evidence of effectiveness and alignment with priorities identified in the situational analysis that took place at the start of the programme. There was an appreciation of the range of programme strategies, for example, aimed at changing social norms around reproduction and how to manage menstruation. However, over the course of the programme, some activities were not implemented,

discontinued, or adapted to respond to emerging contextual changes.

The programme was particularly adept at responding to the issues and needs faced by young people – this included making SRH services more youth-friendly, creating a supportive environment to talk about sexual and reproductive health with teachers, parents and community leaders and ensuring young people are engaged in planning processes through youth leadership to discuss the issues affecting the youth, e.g., drug abuse, unemployment, teenage pregnancy. The interventions supported by UNFPA were seen to lay the groundwork for supporting young people moving forward.

Activities targeting people living with disability were limited at the start of the programme, and there does not appear to have been technical expertise within UNFPA and implementing partners to support this work. After engaging a partner with this expertise, UNFPA only focused on activities for people with disabilities in late 2022 and 2023, when UNFPA introduced a dedicated work package that explicitly targeted people with disabilities. As a global strategic partner to UNFPA, Special Olympics in Uganda was engaged to work with several implementing partners in 5 districts to build the capacities of the VHTs, peer educators, health workers and teachers to support young people with intellectual and other disabilities.

The programme was designed to work closely with the district leadership and technical personnel and intended to be district-led to ensure alignment with district priorities. However, several participants in district leadership felt the programme did not undertake any specific needs assessments or priority settings in the programme sites to ensure the interventions were tailored to the local situations. The respondents felt the needs assessments were more general and based on nationally available data sets or evidence. Hence, they felt that key activities were missing, such as supporting the judicial system to support reported cases of GBV. Some suggested starting with a programme pilot to learn key implementation lessons before scaling would make sense.

Moreover, there was little community engagement in the project's design, activities, and mapping out of vulnerable communities. This meant that the activities were not sufficiently tailored to the specific needs of communities or key dimensions of target populations were not considered (e.g. income levels). According to the team at UNFPA, the selection of sites (e.g., the sub-counties, schools and facilities) was done in consultation with the district leadership at the start of the programme. Yet, respondents in the district leadership did not understand the rationale for selecting sites for the programme and often felt the coverage of the interventions and staff supporting them were too thin on the ground to have a realistic impact. For example, there were too few peer educators to cover their allocated areas. This suggests there has been turnover in the district teams, which might not be familiar with the decisions made at the beginning of the programme.

EQ2: To what extent was the ANSWER programme aligned with priorities set by the relevant national and district policies and strategies related to SRHR and GBV, the GOU-UNFPA 9th Country Programme and the Multi-Annual Country Strategy of the Netherlands Embassy?

The ANSWER programme was purposefully designed to contribute to UNFPAA's global goal of universal access to SRHR, which was later crystallised in the UNFPA and Government of Uganda Ninth Country Programme (2021-2025).

As outlined in the programme proposal and the midterm review, the ANSWER programme is well aligned with the national priorities, partnership, and overall vision of ensuring universal access for women and young people in Uganda to high-quality, integrated sexual and reproductive health and rights information and services as outlined in Uganda Vision 2040.

In 2020, the Government launched the third National Development Plan (NDP III) outlining 18 national programmes central to achieving the Uganda Vision 2040. The outcomes of the ANSWER programme neatly align with the NDP III objective to increase the population's productivity, inclusiveness, and well-being. Moreover, the specific aims around improving services, removing social and personal barriers to accessing information and services and changing harmful gender norms at the heart of the ANSWER programme align with the 2020 Human Capital Development Implementation Action Plan (PIAP) that aims to address a range of SRH and education outcomes. Therefore, the

ANSWER programme remains closely aligned with the Government's priorities. Given that the NDPIII was used to structure the district development plans for 2020/21-2024/25, a sample of publicly accessible district development plans (e.g. for Amuru, Lamwo, Moyo, Obonji and Yumbe) prioritise human capital development, including a focus on maternal mortality, access to contraception, reducing adolescent pregnancy and addressing gender inequity.

This programme was designed to contribute towards reducing the unmet need for family planning in Uganda and reducing unintended pregnancies and maternal deaths. Participants believe that the programme is still relevant as there is still much to be done for the SRH of young people, unmet need for contraceptives, and prevention of and response to GBV, particularly in Acholi and West Nile. Moreover, the idea is that an increase in the utilisation of services cannot happen unless you address issues with demand for services, and these two elements are interconnected.

The ANSWER programme actively worked with relevant government ministries and departments at the national and sub-national levels, including districts, sub-counties and parishes, enabling them to realise their mandates. For instance, many of the programme strategies were designed to strengthen existing structures in the health systems, such as commodity security, the CQI, and the nationally endorsed sexuality education curriculum, PIASCY. The partnerships with the National Population Council (NPC) built on existing work on the Demographic Dividends (DD) and with the National Planning Authority (NPA) ensured harmonisation with budgeting and planning to realise Uganda's national development.

Objective two of the ANSWER was particularly well aligned with the NDP III component of Quality of Life (QoL), Human Capital Development (HCD) and the Demographic Dividend (DD) Roadmap. The MTR found that the multi-sectoral ANSWER programme approach aligned with Human Capital Development (HCD) to ensure consistent programming across the supply and demand for SRH care. A key part of this work was supporting the domestication of the national policies at the district level by cascading national conversations about human capital and demographic dividends downwards. For instance, the "I dare the challenge" explicitly benchmarked interventions with existing government policies, e.g. DD, V2040, NDPIII.

In addition, the ANSWER programme is aligned with the Ministry of Foreign Affairs of the Kingdom of The Netherlands' Multi-Annual Country Strategy 2023-2026 Uganda strategic results area on sexual and reproductive health and rights, particularly focusing on young people and marginalised groups. The ANSWER programme contributed to RNE priorities to increase access to SRHR information and SRHR commodities and quality SRH services (public and private). Yet there was less alignment on improving comprehensive sexuality education, the SGBV prevention and response, and contributing to an enabling environment at social, cultural and political levels, both in terms of sustainable social behavioural change

EQ3: To what extent was the ANSWER programme able to respond to changes in the national and district context, including COVID-19, the evolving SRHR landscape, and the socio-political environment during the implementation period?

The ANSWER programme quickly and adequately responded to changes in the national and district context, including COVID-19, the evolving SRHR landscape, and the socio-political environment during the implementation period.

The ANSWER programme was forced to make dramatic changes to the planned activities due to factors beyond their control, namely the impact of COVID-19. The impact of the response to COVID-19 meant that service provision had to be re-designed for the first year and a half. This included providing support to ambulance drivers and midwives to ensure that mothers access SRH services and referrals at health facilities and support to District Local Governments and health facilities to ensure that the health workers were mentored and supported to provide SRH services during the COVID-19 pandemic, including provision of personal protective equipment (PPE) and information on COVID-19 prevention to young people. Over three years later, this support at a time of an emergency was warmly remembered:

> *"…when COVID-19 came in, it of course disorganised the whole system... Each time I got stuck; I would only make a phone call asking for support. The next minute, you [UNFPA] called with offers of fuel, a*

car or sanitiser, or whatever they had. And life was very easy. They are very flexible and would immediately sit, discuss and give you feedback. UNFPA, Marie Stopes and IDI were always with us, and they indeed supported us in one way or another." - Assistant District Health Officer, Zombo District.

"They hired ambulances for Amuru to serve the whole district, and it did its purpose, having referrals for our mothers who are to deliver, and we highly appreciated that. We needed to reach out to the people, and they helped us through the project to make community outreach. However difficult it was, they came in, and that counted a lot for us than leaving us when it is in hard times, and then they come back when COVID-19 has gone when it has subsidized." - Chief Administrative Officer, Amuru District.

The extended closure of schools resulted in the activities around sexuality in-school being delayed by two years; some of the activities were re-designed to be implemented at the community level.

The ANSWER programme also had to adapt to unanticipated policy shifts. When the programme was initially designed, it was understood that the Government of Uganda was moving towards institutionalising sexuality education in line with the 2018 National Sexuality Education Framework. At the time, earlier reservations surrounding sexuality education appeared to be progressing. The programme was intended to support the development of operational guidelines and reader guides for sexuality education and teacher training. However, at the beginning of the programme's implementation, there were expectations that this framework would be approved shortly. Still, there has been minimal progression in operationalising the National Sexuality Education Framework. The programme used the existing extracurricular model - the Presidential Initiative on AIDS Strategy to Youth (PIASCY) as this is the only curriculum endorsed and permitted by the Ministry of Education and Sports (MoES). The mid-term review (MTR) found that while adopting the PIASCY curriculum has advanced the reach of elements of sexuality education among young people and other stakeholders, it has several gaps, including not being age-segmented or able to promote transformative sexual education with young people satisfactorily. Yet their information and service needs are evolving, complex, and require bespoke service delivery, which can only be partially achieved under PIASCY. PIASCY curriculum uses abstinence-only content and limits the provision of comprehensive information on sex, sexuality and reproduction and does not adhere to the internationally agreed normative guidance on sexuality education. Moreover, this curriculum was not oriented to sexually active individuals. To mitigate the risks associated with the curriculum, the ANSWER programme supplemented it by linking adolescents to health facilities, and health workers from the nearest health facilities were regularly called upon to offer sessions to the young people.

In addition to the unanticipated shift in sexuality education policy, there was also a shift in government planning and budgeting. The Third National Development Plan (NDPIII) was adopted in 2020 and instigated a shift from sector-based to programme-based budgeting to optimise budget planning, transparency and accountability. This reform was accompanied by the introduction of the Parish Development Model in October 2021, which moves budgeting from the national development planning authorities to the grassroots. Each parish develops a Parish Development Plan (PDP) through a consultative process that includes the community and outlines the key development priorities and strategies for achieving them. These changes in budgeting and planning in the programme were both an opportunity and a challenge to which the programme adequately responded. Many of the tools developed under Outcome 2 were redesigned to suit programme budgeting and PDM. The shift in approach presented an opportunity to engage and support stakeholders through training and other resources. The district leadership positively regarded the tools and resources shared, which adapted to these new modalities.

4.2. Effectiveness

Summary of findings

- Significant improvements have been made across key SRHR indicators in the Western Nile and Acholi regions between 2018 and 2023. These are paralleled by concurrent improvements in the outcome indicators of the ANSWER programme. These changes are reflected in the analysis of the programme's HMIS data.
- Overall, the ANSWER programme made significant achievements in strengthening SRHR care. Yet, the achievements related to addressing social norms and knowledge, attitudes and practices, and creating a supportive policy environment were more mixed.
- There is strong evidence that the ANSWER programme contributed to reducing maternal deaths in the West Nile and Acholi sub-region by strengthening the capacity of the health system to provide quality maternal health services through training and mentorship: continuous quality improvement, MPDSR, and provision of essential reproductive health equipment. The programme also contributed to increased family planning uptake through outreach services, VHT activities, and work around social norms and sexuality education. There was a significant increase in the number of women and girls served with maternal health services at the ANSWER-supported health facilities.
- Causal Pathway 1: There is moderate to strong evidence that the ANSWER programme strengthened the service provision and access to maternal health, youth-friendly services, family planning and GBV services, but not in post-abortion care and HIV testing.
    - There is strong evidence that the ANSWER programme improved the capacity of supported health facilities to provide maternal health services.
    - There is strong evidence that the ANSWER programme supported increased attendance at antenatal and postnatal services.
    - There is strong evidence that the ANSWER programme improved the capacity of health facilities to provide family planning services.
    - There is strong evidence that the ANSWER programme improved access to SRHR services through outreaches and VHT activities (including pregnancy mapping, administration of family
    - planning methods, referrals, and vouchers for young pregnant mothers)
    - There is limited evidence to suggest that the ANSWER Programme improved services for GBV survivors at health facilities.
    - Evidence suggests that the ANSWER programme strengthened the capacity of health facilities to deliver quality SRH information to adolescents and youth (HFA survey). However, some health system barriers are still prevalent.
- Causal Pathway 2: There is moderate to strong evidence that the ANSWER programme intentionally removed social and personal barriers and improved the knowledge and attitudes of young people to enable demand and access to SRHR services.
    - Moderate evidence indicates the ANSWER programme strengthened cultural and religious leaders' engagement in SRHR.
    - There is moderate evidence that the ANSWER programme contributed to scaling up community support for SRH.
    - There is limited evidence that the ANSWER programme shifts in individual and couple attitudes around ANC, contraceptive use, teenage pregnancies and early/child marriage.
    - There is moderate evidence that the ANSWER programme shifted and created new norms around gender and GBV.
    - There is strong evidence that the ANSWER programme partly contributed to enhancing SRH knowledge of young people in school settings.
    - There is strong evidence that the ANSWER programme contributed to improving the knowledge, attitudes and practices of out-of-school young people.
    - There is strong evidence that the ANSWER programme contributed to positively changing the gender attitudes of in and out-of-school youth.
    - There is strong evidence that the ANSWER programme contributed to positively influencing confidence and self-efficacy among in and out-of-school youth.
- Causal Pathway 3: There is moderate evidence that the ANSWER programme improved the policy context and public discourse around the value of SRHR and investing in this as part of wider societal progress in SRHR services in Western Nile and Acholi at this stage, but not in changing allocation of resources.
    - There is moderate evidence that the ANSWER programme contributed to strengthening governance and accountability for DD.
    - There is moderate evidence that the ANSWER programme contributed to strengthening the evidence base around the demographic dividend.
    - There is moderate evidence that the ANSWER programme contributed to supporting In-house technical capacity to operationalise the demographic dividend.
- There is moderate evidence that the programme integrated gender equity and disability inclusion into some interventions (e.g. social norms and sexuality education and service delivery). Yet, these were not systematically included in the programme. There is no evidence of integrating a human rights approach.

EQ 4: To what extent have the outputs of the Programme been achieved and are likely to contribute to the achievement of Programme outcomes? How adequate is the theory of change underlying the results chain logic?

There has been an overall improvement in the outcome indicators of the ANSWER Programme in the two sub-regions of West Nile and Acholi in the project period, except for post-abortion care.

Table 10: Outcome 1 indicators, baselines, targets and achievements

Outcome indicators related to supply	Region	Baseline	Target (4 Yr)	Achieved (From the start of the programme to June 2023)
1.1 Institutional Maternal Mortality Ratio at the ANSWER-supported health facilities	West Nile	104	72	86
	Acholi	45	31	47
	Overall	**94**	**65**	**79**
1.2 Number of new users of modern contraceptives (disaggregated by age (10-19,20-24 and 25+), type of method, district and specific groups refugees, PWDs) at the ANSWER-supported facilities	West Nile	48,966	264,747	299,992
	Acholi	14,942	78,329	85,710
	Overall	**63,908**	**343,076**	**385,702**
1.3 Number of women and girls provided with maternal health services (disaggregated by age, location, PWDs, refugees) at the ANSWER-supported facilities	West Nile	93,793	479,200	313,400
	Acholi	19,958	98,639	62,085
	Overall	**113,751**	**577,839**	**375,485**
1.4 Number of GBV survivors provided with post-GBV health services (disaggregated by age, sex, location, and specific groups (refugees, PWDs)) at the ANSWER-supported facilities	West Nile	2,354	18,212	14,916
	Acholi	636	4,053	3,324
	Overall	**2,990**	**22,265**	**18,240**
1.5 Number of women and girls provided with post-abortion care (disaggregated by age, location, PWDs, refugees) at the ANSWER-supported health facilities	West Nile	4,312	19,994	12,520
	Acholi	1,427	5,880	1,560
	Overall	**5,739**	**25,874**	**14,080**
1.6 Number of people provided with HIV Testing services from the supported health facilities (disaggregated by sex, age, location, and specific groups (PWDs, refugees)) at the ANSWER-supported facilities	West Nile	170,205	719,485	525,630
	Acholi	52,967	211,742	146,690
	Overall	**223,172**	**931,227**	**672,320**

Deep Green is for results whose targets were achieved 100% or above.
Light green for results that are between 70% to 99.9% achieved
Yellow for results that are between 40% to 70% achieved
Orange is used for results between 1% and 40% achieved.
Red for results/indicators that worsened below baseline values or did not improve at all.

A review of the outcome indicators shows progress against five of the six program targets. Given the impact of COVID-19 on the first two years of implementation, the targets for the programme were revised mid-way. Nonetheless, when the baseline and endline figures are compared, clear staggering progress is observed across the board. The percentage change in the number of people seeking and utilising service dramatically increased in Western Nile and Acholi regions over the project period.

These changes are reflected in the analysis of the HMIS date for the region.

- The institutional maternal mortality ratio (IMMR) at the ANSWER-supported health facilities in the two subregions reduced by 16 per cent (from 94 to 79 per 100,000 deliveries) compared to a marginal reduction of 1.8 per cent (from 92 to 90.3) nationally.[84] However, this achievement was only 52% of the programme target. Further, this reduction in IMMR was due mainly to the reduction in IMMR for the West Nile region, otherwise, the IMMR in the Acholi region increased from 45 per 100,000 deliveries at the baseline to 47 per 100,000 deliveries at the endline.
- The number of new users of modern contraceptives at the ANSWER-supported facilities increased by 134 per cent from 63,908 in 2018 to 141,988 in 2022 in the two sub-regions combined, in West Nile by 133 per cent and Acholi by 136 per cent. Overall, the planned results -number of new users - were achieved way and above (112 per cent).
- The uptake of maternal health services among girls and women in the ANSWER-supported facilities increased by 10.0 per cent from 113,751 in 2018 to 125,157 in 2022. The programme increased the utilisation of maternal health services in the health facilities. However, it did not meet its target. Overall, 65 per cent of the planned results were achieved.
- The number of GBV survivors served in the ANSWER-supported health facilities increased by over 100 per cent from 2,990 in 2018 to 6,027 in 2022 (HMIS). The programme increased the utilisation of SGBV services but did not meet its target. Overall, 65 per cent of the target was achieved. Secondly, linking this to the indicator of timely reporting by SGBV survivors also did not improve, dropping below the baseline indicator.
- The two lagging indicators were women and girls served with post-abortion health services (PAC) and the number of people provided with HIV testing services in ANSWER-supported health facilities.
- PAC services decreased by 26.3 per cent from 5,739 in 2018 to 4,227 in 2022 (HMIS). The programme did not meet its service target for PAC, only 54.4% achieved.
- The number of people provided with HIV Testing services at the ANSWER-supported facilities decreased marginally from 223,172 in 2018 to 222,328 in 2022 (HMIS). The programme did not meet this target, only 72% achieved.

There is strong evidence that the ANSWER programme contributed to reducing maternal deaths in West Nile and Acholi by strengthening the capacity of the health system to provide quality MH services through training, continuous quality improvement, MPDSR, etc. The Programme also significantly increased family planning uptake through outreach services, work around social norms and sexuality education. There was a significant increase in the number of women and girls served with maternal health services at the ANSWER-supported health facilities.

The institutional maternal mortality ratio (IMMR) at the ANSWER-supported districts in the two subregions reduced by 16.0 per cent (from 94 / 100,000 deliveries in 2018 to 79 / 100,000 deliveries) compared to a marginal reduction of 1.8 per cent (from 92 to 90.3) nationally indicating that supported districts did better than the national average.[85] However, while IMMR in the West Nile sub-region reduced by 17.3 per cent (from 104 to 86), that of the Acholi sub-region increased by 4.4 per cent (from 45 to 47).[86] (HMIS, UNFPA) Also, nationally and for the two regions combined, the achievement falls short of the MoH target of 70/100,000 deliveries.[87] The institutional mortality ratio for the two sub-regions of West Nile and Acholi and nationally is provided in Figure 9 below.

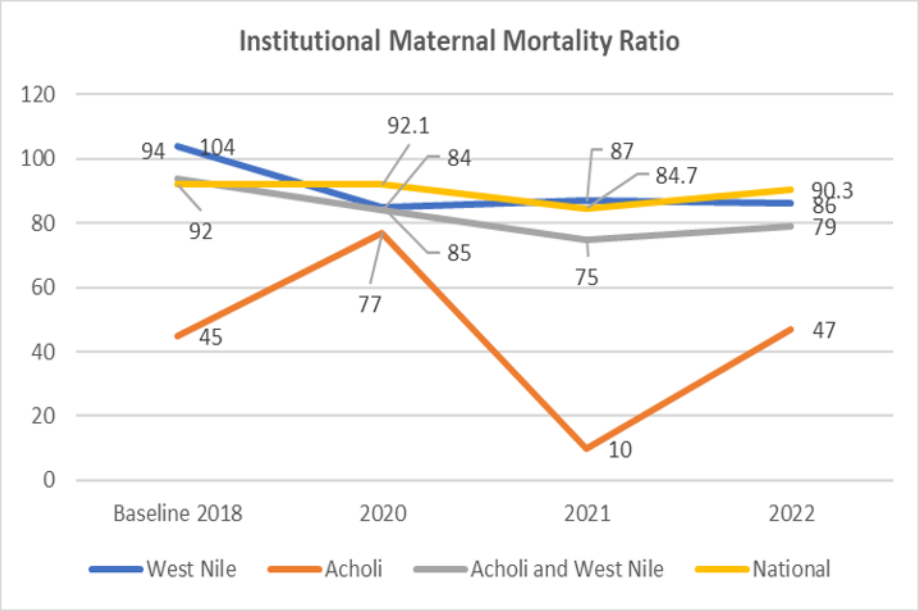
[84] Ministry of Health, Uganda. September 2023. National Annual Maternal and Perinatal Death Surveillance and Response (MPDSR) Report FY 2022/2023

[85] Ministry of Health, Uganda. September 2023. National Annual Maternal and Perinatal Death Surveillance and Response (MPDSR) Report FY 2022/2023

[86] It is worthy to note that the Acholi sub region has maintained a much lower IMMR than the national average. (HMIS, UNFPA).

[87] MoH. July 2022. Reproductive, Maternal, Newborn, Child, Adolescent and Healthy Aging Sharpened Plan for Uganda 2022/23–2027/28

Figure 9: Institutional maternal mortality ratio



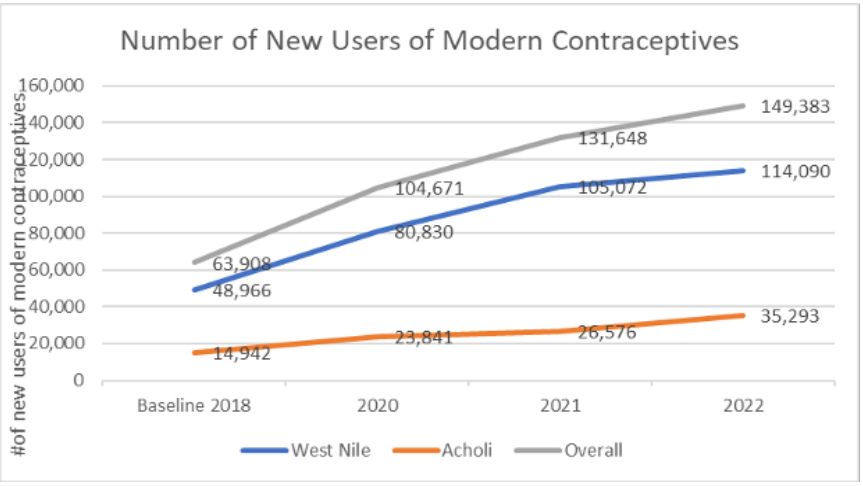
(Source: HMIS)

The Programme was also linked to the emergence of pockets of excellence. According to Adjumani District health officials, there has been a significant drop in IMMR, from 11 in 2016/7 to 2 in 2022/3, directly attributed to CQI interventions supported by the ANSWER Programme. In the last three years, health facilities delivered 35,531 but lost only seven mothers (this translates to an IMMR of 20 per 100,000 live births).

During the period, the number of women and girls provided with maternal health services in the ANSWER-supported health facilities annually increased by 10 per cent, from 113,751 in 2018 to 125,157 in 2023. (HMIS). The number of young people provided with maternal health services through differentiated delivery points was 180,858 by 2023 (HFA Endline Report). In particular, the strict adherence to maternal death notifications and MPDSR reviews, better management of deliveries in the hospitals, more efficient referrals and the projects implemented in health facilities to address identified gaps in maternal health services were the critical components of what made the difference.

There is also strong evidence that the ANSWER Programme contributed significantly to the increased uptake of family planning methods in the supported districts of West Nile and Acholi sub-regions. The uptake of modern family planning in West Nile and Acholi sub-regions increased substantially during the ANSWER implementation, as shown in Figure 10 below.

Figure 10: Number of new users of modern contraceptives



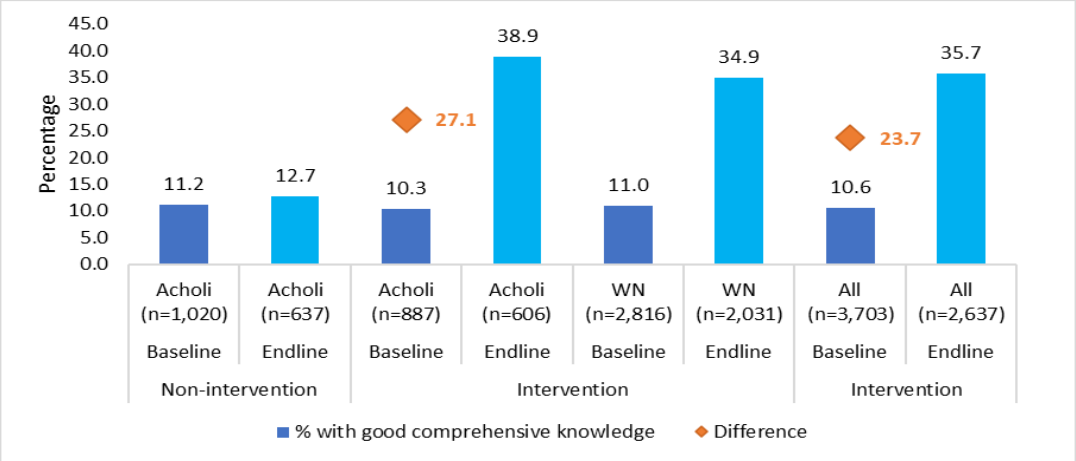
(Source: HMIS)

The number of new users of modern contraceptives at the ANSWER-supported facilities increased by 134 per cent from 63,908 in 2018 to 149,383 in 2023. (HMIS). ANSWER contributed to the increase in family planning uptake through support to interventions focused on strengthening the capacities at the 210 ANSWER-supported health facilities to provide family planning services, the sensitization of communities, including the adolescents and youth undertaken (through sexuality education for in and out-of-school young people), and the family planning services provided through integrated SRHR outreaches, and the extension of family planning services to communities through VHTs. (KIIs with district health officials, health facility in charge, representatives of IPs and UNFPA).

Of those reached with family planning services, 58 per cent were young people aged between 10 and 24 years, 19 per cent were PWDs, and 6 per cent were refugees (HMIS, UNFPA). During the period, 253,051 young people were provided with family planning services through differentiated delivery points. The number of revisits for modern contraceptives increased by 77.2 per cent from 40,665 in 2018 to 72,041 in 2022. (HMIS, UNFPA).

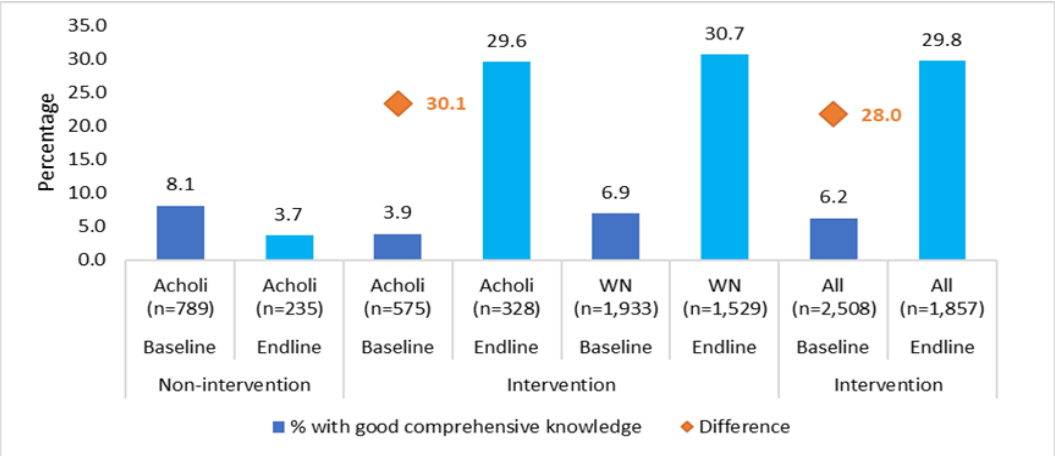
There is strong evidence that the ANSWER programme increased the use of family planning by young people in and out of school, and it suggests that community and school-level programming was instrumental. Figures 11 and 12 below illustrate the positive changes in knowledge and practices related to family planning among young people in and out of school in the ANSWER target districts. At the same time, there have been limited improvements in the control districts.

Figure 11: Percentage distribution of out-of-school young people with good knowledge on prevention of pregnancy, contraception, their use and sources, and prevention of HIV and STIs at baseline and endline



(Source: KAP Endline Survey)

Figure 12: Percentage of in-school young people with good knowledge of prevention of pregnancy, contraceptives and their uses and sources, and prevention of HIV and STIs



(Source: KAP Endline Survey)

The proportion of out-of-school young people currently using modern contraceptives in the two sub-regions increased from 33.7 per cent (35.1 per cent in West Nile and 29.4 per cent in Acholi) at baseline to 70.1 per cent (70.8 per cent in West Nile and 68.0 per cent in Acholi) by 2023. An absolute increase of 20.9 per cent in Acholi was attributed to the interventions. Similarly, the proportion of in-school young people currently using contraceptives (mainly condoms and moon beads) more than doubled from 32.4 per cent (35.1 per cent in West Nile and 23.9 per cent in Acholi) at the baseline to 61.0 per cent (63.6 per cent in West Nile and 47.1 per cent in Acholi) at endline. The interventions denoted a 17.4 per cent absolute increase in both regions (Source: KAP Endline Survey).

Output indicators

Drawing on information collected from the Knowledge, Attitude and KAP survey and the HFA, the level of achievement of the output indicators in the Theory of Change (supply, demand, and policy) is illustrated in the following table.

Table 11: Domains of theory of change (TOC)- summary of performance

Domain of TOC	Summary of Performance
Supply	The achievement of the outputs related to strengthening SRHR care was positive. There targets were reached in the five reported outputs.
Demand	The achievement of the outputs related to removing personal and social barriers to SRH care was mixed. Six output targets were reached, five targets were not reached but did improve over the baseline, and two outputs did not improve over the baseline.
Enabling Environment	The achievement of the outputs related to creating a supportive policy environment is mixed. Two output targets were reached, two targets were not reached but did improve over the baseline, and one output did not improve over the baseline.

Table 12: Summary of supply output indicators

Supply Output indicators	Region	Baseline	Target (4 Yr)	Achieved (from Oct 2019 to June 2023)
1.1.1 Percent of target health facilities with capacity to provide quality GBV/HIV/family planning/MH	Family planning	68.8%	78.8%	88.0
	Maternal Health	42.6%	61.6%	66.7
	PAC	59.4%	69.4%	86.0
	GBV	49.6%	64.6%	82.8
	HIV	81.3%	89.3%	83.2
1.1.2 Percent of health facilities experiencing no stock-outs of at least three modern family planning methods over three consecutive months.	Acholi	81.5%	89.0	76.0
	Western Nile	65.8%	75.8%	62.0
1.1.3 Number of young people provided with maternal health services through differentiated points of delivery	Overall	0	107,273	73,642
1.1.4 Number of young people provided with family planning services through differentiated points of delivery	Overall	0	165,493	151,508
1.1.5 Number of revisits for modern contraceptives (disaggregated by age (10-19,20-24 and 25+), type of method, district and specific groups refugees, PWDs)	Western Nile	31,949	210,302	52,788
	Acholi	8,715	61,656	19,253
	Overall	40,665	271,958	72,041
1.1.6 Percentage of clients at the supported health facilities who are satisfied or very satisfied with family planning/MH/HIV/ GBV services (disaggregated by gender, age, disability, refugee and service)	Family planning	73.1%	83.1%	70.3%
	Maternal Health	68.7%	77.7%	66.7%
	Post Abortion care	66.7%	74.7%	70.0
	GBV	77.3%	85.3%	74.1
	HIV	69.4%	77.4%	71.8
1.1.7. Number of people referred to access quality SRHR services (FP, Maternal health, PAC, HIV Testing and Post GBV from the community).	**Overall**	**0**	87,302	99,156

Deep Green is for results whose targets were achieved 100% or above.
Light green for results that are between 70% to 99.9% achieved
Yellow for results that are between 40% to 69.9% achieved
Orange is used for results between 1% and 40% achieved.
Red for results/indicators that worsened below baseline values or did not improve at all.

Table 13: Summary of demand output indicators

Demand Output indicators	Region	Baseline	Target (4 Yr)	Achieved (From the start of programme to June 2023)
1.4.1 Number of community members reached (per year) through different strategies with a standard package of information on SRHR/GBV	Overall	0	866,415	838,632
1.4.2 # and type of community actions taken to contribute to the reduction of SGBV, teenage pregnancy and child marriage.	Overall	0	48.0	42
1.4.3 Percentage of SGBV survivors (rape and defilement) reporting timely (within 72hrs) for post-SGBV services at health facilities.	West Nile	63.8%	70.8%	61.8%
	Acholi	63.0%	70.0%	60%
	Overall	63.7%	70.3%	61.5%
1.4.4 Number of people engaging as community resource persons, including activists on GBV, teenage pregnancy, child marriage, and family planning (Disaggregated by age, sex, district and specific groups (refugees and PWDs)).	Overall	0	1,964	2,345
1.5.1 Number of schools providing sexuality education Programme	Overall	0	450	421
1.5.2 Number of young people in school (students and pupils) reached with comprehensive age-appropriate information on SRHR and GBV (	Overall	0	315,000	181,448
1.5.3 Percentage of young people in school (students and pupils) with comprehensive correct information on sexuality, HIV/STIs, pregnancy, and	West Nile (10-14)	24	4.1	34.9
	Acholi (10-14)	6.8	4.1	6.8
	West Nile (15-19)	7.4	8.7	33.1
	Acholi (15-19)	3.6	6.1	40.0
	West Nile (20-24)	12.5	13.8	53.8
	Acholi (20-24)	11.5	14.0	31.6
1.5.4 Number of young people reached with age-appropriate information on SRHR and GBV through various strategies	Overall	0	542,612	292,555
11.5.5 Percentage of sexually active in school (students and pupils) young people (15-24 years) who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner)	West Nile	56.9	61.0	75.5
	Acholi	53	60.9	38.5
1.5.6 Percentage of sexually active in school (students and pupils) young people (15-24 years) who use modern contraception	West Nile	35,1	39.2	63.6
	Acholi	29.4	37.3	47.1
1.5.7 Number of young people out of school reached with comprehensive, age-appropriate correct information on SRHR/GBV (i.e., good knowledge of prevention of pregnancy, contraceptives and their user and sources, and prevention of HIV and STIs)	?	0	22,320	18,505
1.5.8 Percentage of young people out of school with comprehensive correct knowledge of sexuality, HIV/STIs, pregnancy and contraception	West Nile (10-14)	2.6	3.9	2.1
	Acholi (10-14)	1.3	3.8	1.2
	West Nile (15-19)	6.7	8.0	31.1
	Acholi (15-19)	5.8	8.3	32.4
	West Nile (20-24)	15.4	16.7	42.6
	Acholi (20-24)	15.2	17.7	47.7
1.5.9 Percentage of sexually active out-of-school young people 15-24 years) who used a condom at last high-risk sex	Acholi	75.4	83.3	68.0
	WN	75.4	79.5	70.8
1.5.10 Percentage of sexually active out-of-school young people (15-24 years) who use modern contraception	Acholi	32.4	40.3	48.5
	WN	32.4	36.5	37.2

Deep Green is for results whose targets were achieved 100% or above.
Light green for results that are between 70% to 99.9% achieved
Yellow for results that are between 40% to 69.9% achieved
Orange is used for results between 1% and 40% achieved.
Red for results/indicators that worsened below baseline values or did not improve at all.

Table 14: Summary of enabling environment output indicators

Enabling Environment Output Indicators	Region	Baseline	Target (4 Yr)	Achieved (From the start of the programme to December 2022)
2.1.1 Percentage of sector (health, education, gender) budget released to districts (disaggregation by sector)	Overall	40.9%	43.0%	NA
2.1.2 Budget execution on demographic dividend (DD)priorities within the sectoral plans/family planning (disaggregation by sector)	Overall	72.1%	80.0%	NA
2.1.3 Number of targeted sectors (Health, education, gender, Lands and urban development, Water, Agriculture) with annual plans and budgets compliant with demographic dividend indicator requirements at a minimum of 80%, by 2023.	Overall	0	0	NA
2.1.4 Number of motions on relevant SRH, DD, family planning, and GBV issues presented on the floor of parliament and commitment passed and implemented.	Overall	0	5	2
2.2.1 Percentage of district-approved budget (education, health & gender) allocated on demographic dividend (DD)priorities (disaggregation by district)	Overall	63.9%	69.0%	66.7%
2.2.2 Budget execution on demographic dividend (DD)priorities within the district plans/family planning (disaggregation by district and department)	Overall	87%	95%	89.7%
2.2.3 Average demographic dividend (DD)Compliance Score for ANSWER Targeted Districts.	Overall	55.2%	70%	64.6%
2.2.4 Number of ordinances/by-laws related to Adolescent SRHR, Maternal health, DD, family planning, and GBV issues presented to the district council, passed and implemented.	Overall	0	24	3

Deep Green is for results whose targets were achieved 100% or above.
Light green for results that are between 70% to 99.9% achieved
Yellow for results that are between 40% to 69.9% achieved
Orange is used for results between 1% and 40% achieved.
Red for results/indicators that worsened below baseline values or did not improve at all.

Causal Pathways

According to the theory of change, there are three main causal pathways by which the ANSWER Programme contributed to the improved outputs and outcomes. The three causal pathways include (1) strengthening the supply and service provision of SRHR services in Western Nile and Acholi, (2) intentionally removing social and personal barriers to accessing services and enabling demand for SRHR services in Western Nile and Acholi, and (3) improving the policy context and public discourse around the value of SRHR and investing in this as part of wider societal progress in SRHR services in Western Nile and Acholi. The activities and strategies that helped achieve these causal pathways are described in the text below, including activities that do not necessarily contribute to these causal pathways.

Causal Pathway 1: There is moderate to strong evidence that the ANSWER programme strengthened the service provision and access to maternal health, youth-friendly services, family planning and GBV services, but not in post-abortion care and HIV testing.

There is strong evidence that the ANSWER Programme improved the capacity of supported health facilities to provide maternal health services.

Despite the limited programme implementation period due to COVID-19 disruptions (effectively two years), which affected the results of the Programme, the proportion of target health facilities with the capacity to provide maternal health services increased from 42.6 to 66.7 per cent. The improvement was from 35.7 per cent to 45.6 per cent in Acholi and from 44.0 per cent to 59.1 per cent in West Nile.

The quality of services improved, but the percentage of clients at the supported health facilities who were satisfied or very satisfied with maternal health services remained the same at 66.6 per cent in both subregions. (HFA Endline Report).

Several interventions contributed to improving the capacity of the health facilities: supporting capacity building of health personnel and support supervision (mainly through district health teams and midwives from UPMA), support for CQI processes at health facility and district level, provision of RH equipment (where this was established as a gap), and support for anaesthetic officers/assistants. For example, the Programme supported capacity building and the set up and operations of the CQI committees in the 15 supported districts and at the 210 supported health facilities. The district and health facility teams were supported to undertake MPDSR reviews and develop and implement projects aimed at addressing the gaps that caused a maternal death or a near miss. The district health authorities and the health facility personnel linked the success of this initiative (and therefore the reduction in IMMR) to the support from the ANSWER Programme:

> *"ANSWER Programme supported facilities sit for MPDSR reviews every month. The Programme has built the capacity and facilities to meet whether there are prenatal or maternal deaths. If no deaths have occurred, they sit down as a team to review the good practices that have made them not register any deaths."* Interview with a district mentor

> *"There is great improvement in CQI capacity in almost all the facilities, and we are offering quality of care services that we did not offer before. For example, we are now offering post-partum family planning and post-abortion care. In my facility, where we did not offer postpartum family planning, we are now at 76 per cent of the mothers offered this service after delivery."* Interview with a health worker.

A good story

In 2021, as a result of the national weekly MPDSR meetings, it was discovered that almost 50 per cent of the maternal deaths that occurred in Nebbi Hospital in 2020/21 were due to postpartum haemorrhage. The hospital is a central referral point for the Zombo, Madi-Okollo, Pakwach, and Buliisa districts. Through ANSWER Programme support, a blood fridge and an assortment of blood processing equipment were procured to enable Nebbi Hospital to become a regional blood collection and distribution site. In FY 2020/21, 8 out of 13 maternal deaths that occurred in Nebbi Hospital were due to postpartum haemorrhage and lack of blood for transfusion. According to the MPSDR report for FY 2022/23, only six maternal deaths were reported in Nebbi Hospital. The intervention also reduced referrals in and out of the hospital for transfusion services, saving patient and hospital costs.

There is strong evidence that the ANSWER Programme supported increased antenatal and postnatal services attendance.

Due to ANSWER Programme interventions, the district health personnel noted increased attendance at antenatal and postnatal clinics and deliveries at health facilities.

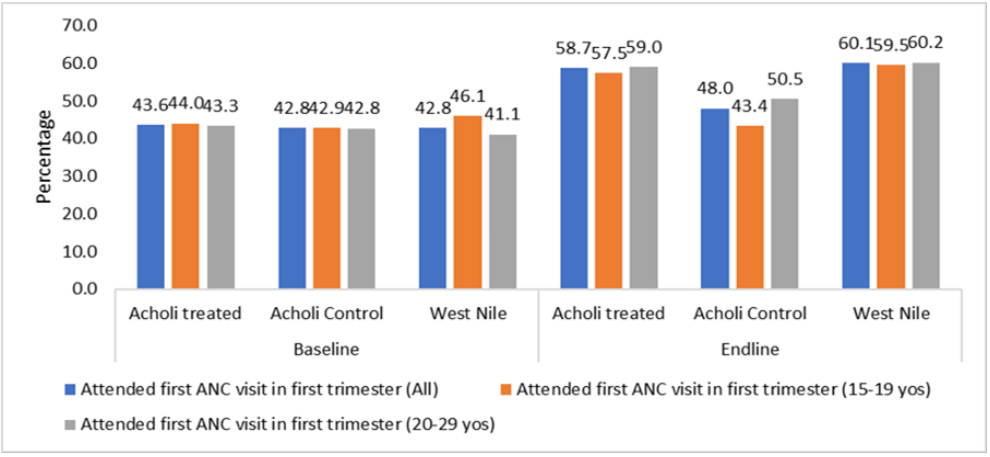
> *"One example is a Health Center II in Yumbe where deliveries have increased from 2-3 / month and now conducts over 30 / month. In Obongi, after UNFPA recruited a midwife[88] and the government provided one, Aliba Health Center III has seen improvement in ANC attendance from 70 to 87 per cent, while Iboa Health Center II is at 96 per cent. This hard-to-reach area was underperforming, with skilled birth deliveries at less than 50 per cent. Overall, in the district in 2022/23, ANC 4 had increased to 42.6 per cent from 37 per cent, ANC 1 to 58.4 per cent from 54.0 per cent, and deliveries in health facilities to 45.1 per cent from 38 per cent." DHO, Obongi District.*

This increase in the uptake of ANC services is reflected in the KAP data. The increase in ANC attendance is significantly higher in the programme sites than in the control districts. For the Acholi sub-region, the attendance for the first ANC in the first trimester and at least 4 ANC visits increased by 34.6 per cent compared to an increase in the control district of 12.1 per cent. The increase in the West Nile sub-region was 40.4 per cent, again, significantly higher than the increase in the control districts. The same applies to the attendance to at least 4 ANC visits.

[88] The midwife was recruited under the Emergency response fund not ANSWER which is an indication of the complementarity between programmes implemented by UNFPA

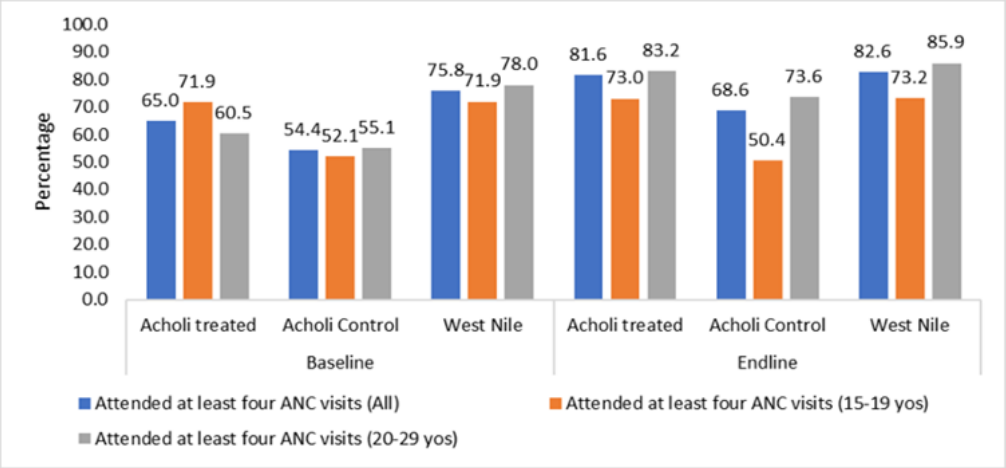
Figures 13 and 14 illustrate the increased attendance to ANC in the target districts compared to control districts.

Figure 13: Percentage distribution of respondents by attendance of 1st ANC in 1st trimester and at least 4 ANC visits



(Source: KAP Endline Report)

Figure 14: Percentage distribution of respondents by attendance of at least 4 ANC visits



(Source: KAP Endline Report)

There is strong evidence that the ANSWER Programme improved the capacity of health facilities to provide family planning services

The proportion of target health facilities that can provide family planning services in the two regions increased by 27.9 per cent from 68.8 at baseline to 88.0 per cent in 2023. However, satisfaction with the quality of services seems to have decreased, with the proportion of clients at the supported health facilities who are satisfied or very satisfied with family planning services reducing from 73.1 per cent to 70.3 per cent overall. (HFA Endline Report).

The ANSWER programme strengthened the capacity of the supported health facilities in the delivery of a range of contraceptive methods, especially long-acting family planning (LAFP) methods. Overall, they mentored and improved the skills of 514 health workers, and 1,431 clients received services, with 704 clients using family planning methods when the mentors were onsite in health facilities. The mentors themselves improved their skills and learnt new approaches.

The lack of critical equipment for the provision of RH services was identified early as an issue. In 2021, the programme addressed the issue through the procurement and delivery of the equipment to supported health facilities. However, the limited stock of some family planning commodities (and basic

supplies such as drapes, iodine for disinfection, surgical gloves, and faulty sterilisers) and lack of training materials hampered the ability to demonstrate and mentor effectively. Redistribution of commodities between facilities and emergency orders helped.

> *"The significance of the change in regard to family planning has made me able to manage my family in that by providing for the family food, school fees and also how to look my family and I look very healthy and good we don't look like a family with a lot of problems, but we look a responsible family."* FGD with beneficiaries in Adjumani

According to district health personnel interviewed, the ordering and management of commodities in health facilities has improved and moved from manual to electronic systems. The interventions included an annual contribution to the national RH commodity budget, the implementation of RH SPARS and the eLMIS. This also included facilitating the redistribution of commodities between facilities, thereby mitigating the challenge of stockouts and reducing incidences of expired commodities. UNFPA also supported emergency orders from JMS. (Document review of UNFPA and IP reports, KIIs with district health officials). However, RH commodity security deteriorated, with the proportion of health facilities experiencing stockouts of at least three modern family planning methods over three consecutive months increasing from 34.2 per cent to 38.0 per cent in West Nile and from 18.5 per cent to 24.0 per cent in the Acholi sub-region. (HFA Endline Report). This limited result resulted from upstream challenges with NMS commodities distribution.

> *"We have a committee led by the inventory officer, which includes ADHO. Every quarter, we go to all the ANSWER-supported health facilities with a checklist, which includes cleanliness, setting, safety, etc. We pick commodities and redistribute them. We were first trained under medicine management by MoH, where the ANSWER programme picked from and dealt with the gaps."* Interview with a DHO

> *"The interventions are likely to achieve results of NMS supplies resuming without further interruptions. According to MoH, the electronic system experienced a breakdown in 2022, disrupting supplies. This problem has been solved."* Interview with MoH

The inadequate availability of RH commodities may have contributed, among other factors, to less than optimum achievement of higher quality of services in the targeted health facilities.

There is strong evidence that the ANSWER programme improved access to SRHR services through outreaches and VHT activities (including pregnancy mapping, administration of family planning methods, referrals, and vouchers for young pregnant mothers)

The programme also supported the extension of SRHR services into communities through outreaches, and village health teams (VHTs) contributed significantly to the results. The work of the VHTs and outreaches supported by the ANSWER Programme contributed significantly to improved MH and family planning services uptake.

With Programme support, 722 VHTs were trained by district trainers on pregnancy mapping, provision of short-term family planning methods (e.g. Sayana Press), the issuance of vouchers for access to RH services for teenage mothers and young vulnerable girls, and referral (for cases they are not able to handle or services that are only available in health facilities).

> *"The increase in uptake of family planning is because of the constant health education by the VHTs, the health workers, and sometimes, the politicians. And then services were taken nearer to them through outreaches."* Interview with an in charge of an ANSWER-supported health facility.

> *"Pregnancy mapping by VHTs played a vital role in improving the proportion of pregnant women who had their first ANC in the first trimester from 16 to 30 per cent. They not only do pregnancy mapping; they also follow up with the women on their journey through the health system."* Interview with a district health official.

There were challenges: VHTs are voluntary and have other responsibilities besides community health; reporting and supervision are weak, and social norms continue to restrict access to SRH services. Many VHTs talked about providing family planning services in secret, where women and young girls would sneak out to access the services. Below (group discussions with district youth leaders, FGDs with

VHTs, and KIIs with district and family health personnel, document review). This is illustrated in the quote.

> *"I've found it difficult to disseminate information about family planning. Most of our communities are established in the Catholic faith, and most of them don't support family planning. We find it difficult to talk to people openly, so I said we talk to them in secrecy. We select them randomly and talk to them. Since the church is against us, we find it difficult to speak to people publicly, and this has been our greatest challenge."* FGD with VHTs.

The Programme supported the implementation of integrated SRHR outreaches aimed at improving the accessibility and availability of services for young people in hard-to-reach areas every month:

> *"Outreaches help a lot because most of these targeted clients are far from the facility. We take services near them. We start with health education. Remember, it is integrated, so everybody comes. Family planning services, such as malaria testing and treatment, immunization, nutrition assessment, and all those things, are provided. By providing integrated services, many people are coming, which would not be the case for specific outreaches. However, sometimes we have challenges with inadequate commodities."* Interview with the Health facility in charge.

The number of people, including the young people, exceeded the targets by a wide margin. The number in 2021 was 121,622, 217 per cent of the target (with 86,238 young people reaching 192 per cent of the target). The number reached in 2022 was 263,212, 470 per cent of the target, among them 192,053 young people. The overachievement is explained by the high number of outreaches and more intensive community mobilisation. Also, to address demand-side barriers, the voucher scheme targeted pregnant teenage girls to access maternal health services and 162,092 vouchers were issued, with 50 per cent being utilized for family planning and the other 50 per cent for maternal health services.

There is evidence to suggest that the ANSWER programme strengthened the capacity of health facilities to deliver quality SRH information to adolescents and youth (HFA survey). However, some health system challenges still prevail.

There was an improvement in the capacity and systems of health facilities to ensure that adolescents and young people receive quality SRH information. A remarkable increase was noted, from 32.6% at the baseline to 78.4% at the endline. Improvements in health worker competence underpinned this positive transformation and the availability of educational materials, outreach plans, and the delivery of age-appropriate health education. It is worth noting that both the Acholi and West Nile sub-regions demonstrated substantial improvements in the capacity and systems of their health facilities, with the overall average score for this enhancement being 71.4% and 61.9% for the West Nile and Acholi sub-regions, respectively (HFA report). Also, the young people's satisfaction with health workers' attitudes showed notable progress for all services received. Overall, client satisfaction with health workers' friendliness, non-judgmental attitude, respect, and dignity increased significantly, with 70.9% of clients expressing satisfaction at the endline.

In summary, the assessment shows significant improvements in health systems have been made to deliver adolescent and youth friendly SRHR and GBV services within the supported health facilities. These improvements include enhanced capacity and increased competence and attitudes among health workers. Some of these capacity improvements include an increase in the proportion of health facilities: with "with all inputs and processes" necessary to serve adolescents and youth from 32.6 per cent to 78.3 per cent; offering age-appropriate health education and counselling from 18.9 per cent to 76.2 per cent; with up-to-date informational materials in waiting areas from 8.1 per cent to 71 per cent; and readiness with the required SRH equipment from 24.3% to 70.8%, indicating an increased level of preparedness in this aspect. There was also an increase in the proportion of health facilities where adolescents always receive private and confidential healthcare during service provision from 63.5 per cent to 87.2 per cent. (HFA Endline Report)

There is limited evidence to suggest that the ANSWER Programme improved services for GBV survivors at health facilities.

The number of GBV survivors served in the ANSWER-supported health facilities increased by over 100 per cent from 2,990 in 2018 to 6,027 in 2022 (HMIS). This is partly attributed to the sensitization of communities through referrals from community structures (SASA activities, peer educators, and VHTs). The number served in the four years of ANSWER implementation to June 2023 was 18,240 (2023). While the readiness of facilities to provide SGBV services improved significantly from 49.6 per cent to 82.8 per cent, there was a general decrease in the percentage of SGBV survivors reporting within 72 hours and client satisfaction with GBV services. (HFA Endline Report).

There is moderate evidence to suggest that the ANSWER Programme did not improve access to post-abortion care and HIV testing.

There are two areas where the ANSWER programme's efforts to improve SRH services are notable: the provision of post-abortion care (PAC) and HIV testing services in ANSWER-supported health facilities. PAC services decreased by 26.3 per cent from 5,739 in 2018 to 4,227 in 2022 (HMIS). The total number served to June 2023 is 14,080 (HMIS), which means the Programme did not meet the target of 25,874. The availability of PAC services slightly improved from 84.5 to 87.2 per cent, with the Acholi region showing significant improvement from 71.4 per cent to 89.0 per cent, with West Nile remaining steady at 84 per cent. (HFA Endline Report). It is important to study the reasons behind this decline in access to PAC services and to determine if increased access to family planning services may have resulted in more women and girls avoiding unplanned pregnancies and resultant abortions.

The number of people provided with HIV testing services at the ANSWER-supported facilities decreased marginally from 223,172 in 2018 to 222,328 in 2022 (HMIS). The overall number reached with these services to June 2023 is 672,320 (HMIS), which failed to meet the target (931,*227*). The availability of HIV Care, Prevention, and Antiretroviral Therapy (ART) services increased from 79.8 per cent to 88.8 per cent, with West Nile improving from 85.1 per cent to 90.0 per cent. Screening and treatment services for STIs/STDs have achieved near-complete coverage, with an overall availability of 99.2 per cent. Regarding facility capacity and preparedness for HIV/STI services, there has been a slight overall increase, from 81.4 to 83.2 per cent, with the capacity in the Acholi sub-region increasing substantially from 71.4 to 84.0 per cent. (HFA Endline Report). It is important to study the reasons for this decline, including the level of service availability and the resources deployed for integrated SRHR services, including outreaches.

Causal Pathway 2: There is moderate to strong evidence that the ANSWER programme intentionally removed social and personal barriers and improved the knowledge and attitudes of young people and access to SRH services.

There is moderate evidence that indicates the ANSWER programme contributed to strengthening cultural and religious leaders' engagement in SRHR.

Religious leaders play a significant role in shaping the choices of young people by equipping them with the values and skills to transition into adulthood. The ANSWER programme worked with religious leaders through their consortium – the Inter-Religious Council (IRCU), and though the partnership with IRCU phased out at the end of 2021, the evaluation team found that its activities were still quite visible and impactful. However, it suffices to note that religious leaders were among the actors that exhibited backlash on the Sexuality Education Framework. Some argued that sexuality education was against the faith norms and values.[89] Therefore, although religious leaders provide a platform for social norm change, they do this selectively on topics they perceive to align with their faith norms and values. This

[89] The Independent, (2019). Sexuality education still eludes Uganda as church, gov't differ. Available at: https://www.independent.co.ug/sexuality-education-still-eludes-uganda-as-church-govt-differ/

has implications for the effectiveness of SBC interventions in Schools founded on faith values and norms.[90]

The Programme also worked closely with cultural leaders to shift social and gender norms related to SRHR and GBV. For example, later in the programme, in close collaboration with the Ministry of Gender, Labour, and Social Development, the ANSWER programme engaged cultural leaders in Lugbara Kari, Ker Kwaro Acholi, and Alur chiefdoms in intergenerational dialogues [1] to promote positive social norms that drive GBV, teenage pregnancies, and child marriage. IGDs involve facilitating discussions between young people and elders or cultural leaders separately and then organising joint dialogues between young people and cultural leaders' local officials to discuss issues and jointly develop solutions. Programme documents show that these engagements contributed to the Kampala Declaration – where leaders outlined their actions to address teenage pregnancy and other SRHR/GBV issues; revised the Acholi Marriage Principle, which condemns all underage marriage; and disseminated parenting guidelines focusing on child protection.

> *"They came together for generational dialogue, so the cultural leaders presented that, after the consultation, we found that these are the issues affecting the girls, boys, men, and women, so they were brought together for generational dialogue if it is, for example, teenage pregnancy, what do you think we as parents, the women, the men can do to support our young girls from getting pregnant, what do you think you can do to ensure that you don't get pregnant again for the boys, how can you support the young girls, what should we do to ensure that the boys or the men stop impregnating young girls who are still in school to stop dropping out of school".* (Interview with Save the Children, Amuru)

Respondents clearly stated that the ANSWER programme leveraged the influence of cultural leaders as custodians of traditions, values, and beliefs who are respected and preside over traditional ceremonies and played a significant role in engaging community members on gender and social norms transformation. For example, the annual report for 2021 reported that Acholi implemented seven community actions generated through two commitments: (1) "Ker Kwaro Acholi stands firm on eliminating obstacles that contribute to teenage pregnancy and child marriage" and (2) "We re-commit to fight GBV within our communities and ensure that the GBV survivors receive the required services."

In addition, programme documents show that three by-laws were developed and presented to the Sub-County councils. in Maracha and Koboko districts. In the Yumbe district, all the sub-counties were recommended to adopt the by-law.

> *It was successful because many by-laws were passed due to the meeting, especially the first dialogue. After all, now the public meeting is when we prevented it, and now the third was like a follow-up. We had three sets of dialogue, and from there, we came into a public meeting that involved the whole community, the local leaders, and the district officials where we had a presentation of what the issues of concern of the community came with the way forward of what the field should be done to stop the issues of concern in the community.* (IDI with CSO staff save the children, Amuru)

Apart from the feedback from respondents, there is limited evidence to assess whether the ANSWER Programme succeeded in shifting social/gender norms amongst religious leaders and contributed to social norm change in the community. There is limited information on the engagement of religious leaders, and monitoring and quality assurance of their activities and messages are unclear. However, the IGDs process that led to the proposal and adoption of new by-laws in four districts does signal changes in attitudes among those who participated in the dialogues and the wider community as the by-laws were adopted.

There is moderate evidence that the ANSWER programme contributed to scaling up community support for SRHR.

The ANSWER programme implemented several evidence-based community mobilization approaches to change social and gender norms, namely the SASA! and Male Action Groups (MAGs) approaches. By mid-point, the ANSWER Programme had trained and mentored 1,335 SASA activists (80%) of its

[90] Ninsiima, A. B., Coene, G., Michielsen, K., Najjuka, S., Kemigisha, E., Ruzaaza, G. N., ... & Leye, E. (2020). Institutional and contextual obstacles to sexuality education policy implementation in Uganda. Sex education, 20(1), 17-32.

target and had actively engaged 282,339 individuals (158,481 males and 123,858 females) on social norm change around gender, GBV, family planning, maternal health, HIV, teenage pregnancy and child marriage. Respondents indicate that SASA activists have been proactively engaging with communities to mobilize, sensitize and conduct community dialogue and home visits on GBV prevention and response, SRHR, teenage pregnancy, and child marriages. Furthermore, SASA activists have also been responding to GBV cases through timely reporting, referring GBV survivors, and even escorting them to access services such as health, justice, and psychosocial support (PSS).

> *"If the CBT or CDO discovered a case of early marriage, they would want to know whether we've been handling such cases, and if yes, they would want us to tell them how we did it. In the training, they explained to us the meaning of SASA and trained us in line with our duty. Firstly, they told us how to aid support in homes with violence, what kind of support we can give, and what actions we can take."* FGD Structures combined with Yumbe

A rapid assessment survey[91] conducted by Save the Children (2022) in the eight programme districts found that the trained SASA activities had shifted social and gender norms around violence against women. For example, over 75 per cent of the respondents reported that violence against women is not normal in relationships. In contrast, over 85 per cent of the respondents asserted that a woman could refuse her partner if she doesn't want to have sex. Though this suggests that the SASA activists positively changed norms around violence against women, some harmful norms persist. One hundred per cent of the respondents in Lamwo and Amuru assert that disciplining women makes families stronger (87.5 % in Maracha, 79.2% in Arua and 40.3% in Agago)

Though showing promising results, implementing partners and local officials were concerned about the limited coverage of the SASA activists, particularly because there were not enough SASA activists for the geography they covered nor the logistical support to enable them to increase coverage through community dialogues and home visits. Additionally, there were concerns that government institutions, such as the CFPU, often lack the resources to follow up on GBV cases that were referred to them. At the same time, health facilities ran out of essential medicines and supplies needed to conduct medical examinations for survivors, among other issues. Social and economic barriers, such as poverty, also continue to affect the gains of the interventions.

Building on lessons and success from the WAY programme[92] on male engagement, the ANSWER Programme established and trained Male Action Groups (MAGs) to challenge regressive social and gender roles, norms, and power relations. By 2021, the ANSWER Programme had successfully trained and supported 501 MAGs activists on GBV, teenage pregnancy, child marriage, and family planning. That reached 66,581 household members (30,435 males and 36,146 females) with key messages and mentoring. The sessions focused on their achievements, challenges, reporting, and linkages of GBV cases through referral pathways.

> *"We even do individual counselling sessions, too. So, the teachings are dependent on the different topics and scenarios. For example, if in a family, there is violence because the man over-drinks alcohol, we shall go to advise and sensitize the couple on domestic violence and the dangers of excessive alcohol or alcohol abuse"* (FGD with structures, Lamwo)

However, discussions with stakeholders revealed that MAGs were more responsive to GBV incidents than other areas, such as prevention. It was also noted that although MAGs are an excellent strategy for promoting male involvement in changing social norms and GBV, informants reported male involvement to be limited. It would, therefore, be important to have a well-intentioned strategy for male involvement in family planning and other RH matters in the communities. The reach of the MAGs was relatively low compared to other interventions. UNFPA's efforts to engage men took a multi-pronged approach that focused on disseminating the National Male Involvement Strategy for the Prevention and Response to GBV, which served as an important tool for implementing interventions at the national level.

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[91] Save the Children International (2022). SASA Rapid Assessment Report

[92] The WAY programme was a 6-year SRHR programme implemented by UNFPA with funds from Danida from 2018-2023. It was implemented in 10 out of the 15 ANSWER districts. The ANSWER programme was designed to be complementary to the existing WAY programme.

Per the standard SBBC programme, the diffusion strategies are not elaborated on and understood by participants at the local government and community level interviewed during this evaluation, especially the community resource persons at the operational core of social norm-shifting activities. It is therefore not clearly articulated how organized the wider diffusion, which is key in norms shifting strategies, is operationalized. There is also limited evidence on the deliberate follow-up and mentorship provided to community resource persons to ensure that information is moving out to the community and address pushback they may be experiencing against the social norm change structures. Similarly, those implementing the programme did not provide sufficient mechanisms to ensure and monitor fidelity and ensure quality in the implementation of models.

Overall, despite the severe delays associated with COVID-19, the ANSWER programme trained over 1,964 community resource persons and reached 838,632 community members through different behaviour change strategies. The ANSWER programme successfully recruited and trained cultural resource persons, partly contributing to community social norm change. Apart from the SASA that was evaluated as it was being implemented (each phase) and showed contribution to changing social norms, there is no evidence to assess the implementation of the other structures, such as model parents MAGs. There is insufficient evidence to assess the contribution more robustly outside of KAP for within and out-of-school students. However, each SASA activist, on average, seems to have reached more people than the MAG model.

There is limited evidence that the ANSWER programme contributed to shifts in individual and couple attitudes around ANC, contraceptive use, teenage pregnancies and early/child marriage.

Changes have been reported, especially increased male participation/involvement in supporting their wives (spouses) in attending ANC and delivery at the health facility. This reflects a shift in norms; previously, ANC was considered something for women, and it was not typical to see or even expect men to accompany their spouses to ANC. Several beneficiaries and health workers observed more male engagement in ANC. During FGDs, it was observed that the norms related to the delivery of babies have changed. It is becoming a new norm for mothers to deliver at the health facilities under skilled care rather than at home. The increase in attendance of ANC and the support from male spouses is associated with now making it typical or a norm for mothers to deliver at health facilities.

> *The expectant mothers are no longer delivering from home; this is because we teach them that when you have attended ANC 8 times, you have to produce from the hospital. Since it will be a qualified doctor attending to you. So now, most mothers no longer deliver from home. (FGD with VHTs Host Community Padibe, Lamwo)*

The respondents stated that before the programme, the couple attitudes around contraceptive use were largely negative, and the negative connotations would discourage many women from attending contraception services. Participants observed that they have seen shifts in these norms due to the ANSWER programme activities. For example, there are now more conversations between couples and in the community about contraceptive use. There is also more appreciation of the need for child spacing by couples. Participants also noted a new norm of joint decision-making about contraceptive use among the couples.

> *For me, I've got a lot of changes. My husband accepted me to use family planning. His perception also changed because he heard positive things about family planning and told me when I chose to go for it. He was like now, after this child, you know we should not produce every year. I'm waiting for three years after three years when my child is older". (FGD Caregivers – Obongi)*

Changes in norms have been observed at the community level and among health workers. It was noted that before interventions by the ANSWER programme, some health workers were reluctant to provide contraceptive services to unmarried women, especially adolescents, but this norm has now shifted. Before the ANSWER programme, health workers were mirroring the same norms that were prevalent in the community and were also afraid of social sanctions that would accrue to them if they provided contraceptives to adolescents. However, this has changed after the ANSWER programme interventions; health workers now do not discriminate against adolescents who need contraception to prevent pregnancy and continue with their education.

Below are some of the views shared by participants in relation to the shift in norms and experiences that indicate a reduction in teenage pregnancies and early/child marriage. Some participants, especially health workers, attributed the reductions in teenage pregnancies and school dropout to community engagement and working together with peer educators and VHTs during outreaches to do community mobilization and community dialogue that address both negative norms as well as bridge information and knowledge gaps about SRHR and take services close to the users.

> *Yes, Teenage pregnancy before was high, but after these outreaches with Peer educators, it is reducing. Also, dropouts from school have reduced, and the uptake of family planning has increased. The youth know what to use because they are knowledgeable about sexual reproductive health services, and they're now making contraceptive choices. (KII with health worker Aliba HC III, Obongi)*

There is moderate evidence that the ANSWER programme shifted norms around gender and GBV.

A change has been reported in perceptions and norms related to gender roles and decision-making at the household and community levels. This was particularly attributed to community dialogue meetings and home visits by SASA activists. Participants observed that before the ANSWER programme supported activities conducted by SASA activists and Model Parents, all the domestic and unpaid care work would have been left for the women. However, this is changing with continued community engagement by community resource persons, especially SASA activists and model parents. The community resource persons serve as role models who lead by example in encouraging the redistribution of gender roles by sharing tasks traditionally ascribed to women and encouraging women's participation in decision-making. This reflects a significant shift in norms related to gender roles and shows recognition and redistribution of roles, including unpaid care work at the family and community level.

> *My husband used to refuse to take part in washing, bathing the child, and cooking food for the child, but since SASA came, if I'm not at home, he washes the kids, cooks for them on time, and if the child is sick, he carries the child and takes him to the hospital and now at home we're able to do work concurrently. With my husband, I used not to talk much, but these days, we talk better. We sit and have meetings on how to improve our family. (FGD with female beneficiaries, Apo Sub- County, Yumbe)*

The ANSWER programme has disseminated information about GBV through different community structures through community dialogue and sensitization by SASA, Peer educators, and MAGs. This has enabled changes in the community, as more GBV cases are being reported compared to before the intervention when it was considered taboo and would be handled privately in the home. Traditional norms that GBV is a private matter and a family affair have been challenged, and it is a new norm among community members to be willing and to feel confident to report GBV cases. The programme also facilitated good relationships between couples, reducing incidences of GBV, and is attributed to the ANSWER Programme norm-shifting activities through the community structures.

> *My husband is very respectful of me now; he listens to my opinion as opposed to the past when we had not received the training. They also taught us about GBV, how to avoid it and where to report. My life changed, especially when they taught us about domestic violence. I used to be a very violent person. I never spoke to my husband calmly; I thought fighting and being harsh with him was the way to go. But after the training, I learned that it doesn't always have to be fights and violence. A misunderstanding can be handled without being physical. (FGD refugee women beneficiaries 20-29, Lamwo)*

Beyond success registered in changes in norms shared through FGDs by young people, results from the KAP survey show that there was an improvement in comprehensive knowledge on GBV, including knowing at least four forms of GBV and where to report, and need for HIV PEP within 72 hours for rape or forced sex survivors. For example, Comprehensive knowledge of GBV among in-school young people/learners increased from 11.5% at baseline to 21.8% at the endline, compared to comparison communities (Figure 3.25 in the Annexes).

However, the evaluation team noted relatively limited investment in GBV response activities at all levels. Yet, a balance is required between interventions on response and prevention of GBV. Interviews with the Police, especially the Child and Family Protection Units and Community

Development Officers at the district and sub-county level, demonstrated that the programme made very limited investments in GBV response activities to complement the GBV prevention activities at the community level. Limited investment in GBV response, especially investments in an effective referral pathway and skilling of service providers in applying the survivor-centred approach was perceived by some of the duty bearers to have affected the demand and utilisation of GBV response services. This is likely to have affected the timely seeking of GBV response services by GBV survivors along the referral pathway.

There is strong evidence that the ANSWER programme partly contributed to enhancing SRH knowledge of young people in school settings.

The proportion of in-school young people with good comprehensive knowledge of SRHR[93] increased from 6.2% (3.9% in Acholi and 6.9% in West Nile) at the baseline to 29.8% (29.6% in Acholi and 30.7% in West Nile). The proportions of in-school young people with comprehensive knowledge of contraceptives increased from 28.5% at the baseline to 39.8% (45.0% in Acholi and 38.5% in West Nile) by the endline. The proportion of young people with knowledge of at least one method in each short, medium and long-term contraceptive category increased from 28.3% at the baseline to 39.3% at the endline. Knowledge of prevention of pregnancy, risks of teenage pregnancy and dangers of unsafe abortion practices improved significantly among both the out-of-school and in-school young people. In addition, the percentage of in-school young people in intervention communities who had positive attitudes toward (justified) early or teenage pregnancy reduced from 35.5% at the baseline to 19.2% (16.4% in Acholi and 20.0% in West Nile). However, the percentage of young people with positive attitudes toward modern contraceptive use and access and use of condoms remains below 50% among both out-of-school and in-school young people.

By June 2023, sexuality education had been introduced in 421 schools, 93% of the 450, and the activities reached 154,383 learners with SRH and GBV information of the targeted 315,000 (less than 49%). However, targets related to knowledge, attitudes and behaviours for this output were, overall, achieved. However, the indicators have not been achieved in the knowledge of the 10-14 years about pregnancy, contraception, and HIV/AIDS (Annex 7 presents the achievements under this output).

A closer review of the activities provides insights into the mixed results. The first-year activities were adjusted in response to the pandemic, and the activities were re-focused on a community-based process that enabled young people to access sexuality education. This facilitated the interaction and participation of parents who are relevant in sexuality education, GBV and SRH for adolescents and older youth (including radio shows, community drive-throughs, spot messages and DJ mentions). The school-based activities only started in earnest in 2022 after the lifting of the lockdown, which delayed the work around sexuality education dramatically. The 2022 Mid Term Review found that the two implementing partners responsible for community and school interventions made good progress in implementing the activities (e.g. training of teachers, establishing clubs, support matrons and patrons, peer education, and sessions with health care workers).

The curriculum and modality of delivery are likely to have affected the number of students reached. UNFPA and the implementing partners adopted a curriculum approved by the Ministry of Education and Sports called the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY) as the key instructional material of the programme. The PIASCY curriculum and model is based on trained teachers setting up School Families of 40 students annually. Further,1,400 teachers per school were trained and supervised by the District Education Officers. The model meant limited coverage with the student body from the included schools where the programme was active. Several respondents were concerned about the model's heavy reliance on teachers already overburdened with catching students over 18 months behind with the standard curriculum. Some of the teachers were trained earlier in the programme when the schools were closed, which may have affected their recall for implementation. In addition, few teachers were trained, and some received insufficient training (only two days in some cases), which affected their performance. The training was provided by nationally accredited trainers

[93] Comprehensive knowledge: prevention of pregnancy, contraception uses and sources, and prevention of HIV and sexually transmitted infections (STIs) (KAP survey p. 13. ff)

from the Ministry of Education. Peer education activities and activities with local health workers are included. Still, the frequency of these activities and whether they were dedicated to the whole study body or just club members are not well documented. Therefore, we anticipate that the reach would be limited.

Observation data of the delivery of sessions in the school found that the PIASCY was delivered as intended, including the core abstinence messages. A learner under 19 years of age in Yumbe District who participated in the sessions stated reflected the dangerous narratives associated with abstinence-only sexuality education:

> *In that session, we were taught about the dangers of early sex, early marriages, and early pregnancies, and we have also shared these with our friends and now they are fearing to face those dangers and are now abstaining from sex.*

Some teachers also reflected the abstinence-focused messaging:

> *"We have not been encouraging the use of contraception a lot in our sessions. We have been encouraging abstinence. But what we know is that some learners are using contraceptives because some categories cannot live without sex".* Interview with a teacher in Yumbe District

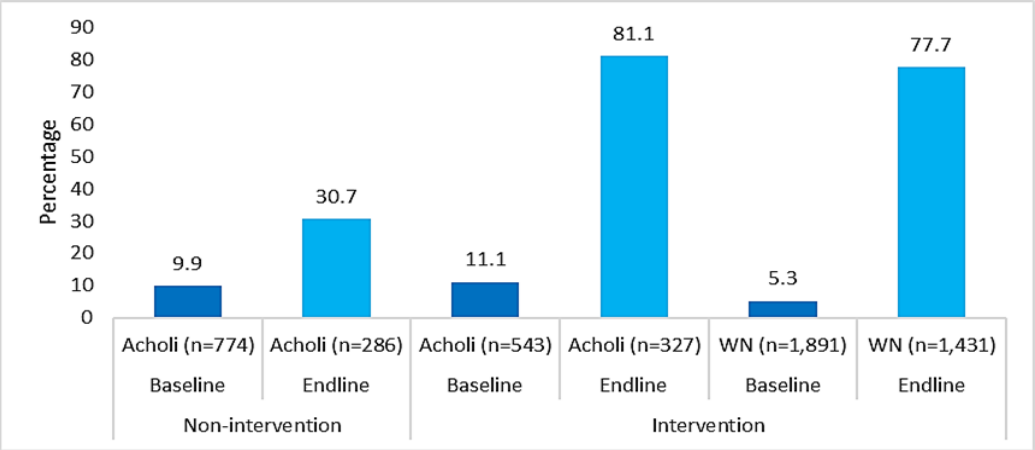
> *"While the health workers encourage the use of contraceptives, for us, we advise abstinence. So, it might be difficult for us to ascertain whether or not a girl is using contraceptives unless it is discovered."* Interview with a teacher in Maracha District

At the programme's start, UNFPA and the implementing partners identified gaps in the curriculum related to information on menstrual hygiene management and GBV. Additional modules on menstrual hygiene management (MHM) and GBV were implemented alongside the standard curriculum. In the school setting, the additional modules around MHM were highly valued interventions. This work was done through the targeted clubs for MHM interventions, which are existing "health and sanitation" clubs. Reusable sanitary pads and materials for making them were procured and distributed to 18,500 girls, and 153,446 young people were reached with MHM IEC materials from across the 15 districts by the end of 2022. This increased knowledge about menstruation and puberty is borne out in the KAP survey. See the Figure 15 below:

Menstrual hygiene has succeeded, especially in schools. Boys were involved in making reusable pads as issues around menstrual hygiene are discussed. This has changed the norm of menstrual hygiene being a women's issue as both males and females freely discuss and offer supportive environments for girls during menstruation while at school. The girls have also been guided on how best to manage their menstruation during the implementation of the programme activities, especially in schools. The Programme supplied 20,000 schoolgirls to the health and sanitation clubs at the 1,700 targeted public primary and secondary schools every year. The Programme also supports printing IEC materials and teaching aids, transport for outreach staff, and the orientation of 2 teachers from each school on reusable AFRIPads. Both boys and girls in the clubs receive information on menstrual hygiene and making reusable pads, which has been very significant in reducing stigma and changing norms on menstruation, especially in schools. It was also noted boys have been very supportive, especially to girls, during their menstruation, unlike before the programme when the boys would shame the girls. As explained, this has created a good environment that reduces absenteeism during menstruation.

> *"Boys used to laugh at girls whenever they learned that a girl was on her period, but these days, the boys are helping and supporting the girls by advising them on proper menstrual hygiene. Sometimes, when a girl has messed up her uniform, a boy can go to the senior female teacher to seek help for the girl. I like that the boys are also helping us make reusable sanitary pads. Even at home, my brother helps me make it sometimes, which is really good".* FGD with girls 15-19 Refugee Maji secondary school, Adjumani

Figure 15: Percentage distribution of in-school 10–14-year-old young people with knowledge of puberty and sexuality



There is strong evidence that the ANSWER programme contributed to improving the knowledge, attitudes and practices of out-of-school young people.

Overall, misconceptions about modern contraceptives were reduced, and comprehensive knowledge about contraceptive use among out-of-school young people increased from 48.6% at the baseline to 59.9% by the endline. The proportions of in-school young people with comprehensive knowledge of contraceptives also increased from 28.5% at the baseline to 39.8% (45.0% in Acholi and 38.5% in West Nile) by the endline. The interventions significantly accounted for a 27.8% absolute increase in the proportion of young people who improved their knowledge about contraceptives ($p<0.001$). However, the knowledge of long-term methods remained low. The proportion of young people with knowledge of at least one method in each of the short, medium, and long-term contraceptives categories increased from 28.3% at the baseline to 39.3% at the endline. Among contraceptive methods, male condoms were the most recognized method by young people. However, the knowledge of long-term methods remained low. Knowledge of pregnancy prevention, risks of teenage pregnancy and dangers of unsafe abortion practices improved significantly among both the out-of-school and in-school young people. An effect size of 20.6%, increasing from 47.2% at baseline to 56.2% at endline. The ANSWER interventions accounted for a 14.7% absolute improvement in the proportion of young people with comprehensive knowledge about pregnancy ($p < 0.001$).

By June 2023, the knowledge, attitudes and behaviours about pregnancy and HIV/AIDS were, overall, achieved except for 10-14 years and around contraception. Yet, with increased knowledge about condoms, there was a decrease in the percentage of sexually active, out-of-school young people (15-24 years) using condoms.

Out-of-school activities started in year two due to a late change in the identified implementing partner. Year 2 Plan Intl set up the Village Savings and Loans Association (VSLA) model as an entry platform for integrating SRH and GBV information, linkages, and referrals to service points, including health facilities for post-GBV treatment and contraceptive services. The ANSWER Programme set up 288 groups, 144 of which were existing groups. In Year 3, the VSLA members were offered training courses, start-up incentives, and apprenticeships. The programme supported 108 selected groups with income-generating activities in pre-identified enterprises that the district marketing and production department guided. In addition, some VSLA groups were supported to be formally registered through the local council register, and others were linked to district local government to benefit from available government initiatives. Also, 286 groups were registered with the local government, and 204 were linked to government programmes.

> *"The time we joined, we didn't have money, and neither did our parents, but because of the little savings, we are able to help our parents. This programme has brought me good luck. I now run a small-scale business selling tomatoes to silverfish. I used to be very stubborn and never made any right decisions, but joining this group has really groomed me.*

My father has been very helpful, and we can now support each other financially. This is the goodness I have got." FGD with 20–29-year-old female beneficiary in Madi Okollo District.

"Youth who have dropped out of school struggle to make ends meet and survive. When we develop some hands-on skills, we train people on tailoring. We can easily reach out to the youth in that way. We can bring many programs like tailoring, hairdressing and other things that would put food on their table. Being out of school is already painful, so when we give a way of survival, it would be a good opportunity to engage them." KII with a Youth leader in Zombo District.

Of the 8,558 VSLA members, 5,582 attended at least 80% of the SRH/GBV sessions. In addition, 1,171 peer educators were identified from the VSLA and trained as peer educators on SRHR, GBV, adolescent life skills, and facilitation skills. Further, 7,705 young people out of school were reached with SRH and GBV information through peer educators, and of those, close to 50% (8,072) were referred for SRH and GBV services. Adolescent health forums targeted out-of-school young people with SRHR and GBV information and services were attended by 15,063 (9270 females and 5793 males).

According to respondents, the sexuality education provided to those out of school was found to be richer and more comprehensive than the sexuality education in schools. This is reflected in the feedback from the participants themselves.

"I space my children because I know about the various types of contraceptives and their effects. Before joining this project, I used to think that contraceptives were meant for the old, not the unmarried, but after participating in this project, I realised unmarried girls and boys can equally use contraceptives. I used to fear taking emergency pills, thinking that it's not healthy for us, but now I know that contraceptives are very healthy and safe for us to use. I heard that some contraceptives, like injectables, can disappear from our bodies, which scared me so much, but after participating in this project, I now know that's not true. My friends used to tell me when you use contraceptives, you will have abnormal kids, but participating in this project made me realize that their safety measures when followed correctly, you won't have abnormal kids." (KII with a 15-19-year-old female beneficiary)

"Before this programme, I was always scared to advise my boyfriends on issues related to sex. I mean, I always break up with them whenever they want to have sex with me, but ever since I joined this programme, I have learnt not to run away from them but rather advise them to abstain from sex. Before participating in this programme, I thought as soon as you reach 18 years old, you must get married, but that changed when I joined this programme, and now I know I have to take my time to get married. It doesn't matter how old I am. Before participating in this project, I thought that as soon as a girl starts experiencing her menstrual period, she should get married. However, that changed when I learnt that having a menstrual period only causes you to become mature and not ready to get married. That's through the use of condoms that will protect us from getting pregnant and even getting sexually transmitted diseases." (FGD with 15-19-year-old female beneficiaries, Adjumani District)

There is strong evidence that the ANSWER programme contributed to positively changing the gender attitudes of in and out-of-school youth.

Moreover, there were notable changes in gender norms. In out-of-school settings, there was a small increase in young women's attitudes towards equal roles of men and women (from 6% at baseline to 6.4% at endline) and a significant increase among young men from 0.5% at baseline to 8.4% at endline. The same pattern is observed among out-of-school youth aged 20-24 (2.9% baseline vs 8.9% endline). There is a similar trend in schools. Overall, more positive attitudes towards gender equality were observed at the endline compared to the baseline among in-school respondents in the treatment arm, irrespective of age, disability status, or history of ever having sex.

Findings from qualitative data from FGDs and IDIs also demonstrate similar changes in gender norms related to gender roles and decision-making.

"This has changed as we now work together. I attribute it to the fact that I lacked knowledge. We now share roles in our homes, for example, cooking, maintaining our children's hygiene, and fetching water, among others. In the past, when we returned from the garden, the wife should again do all the housework e on how to handle family issues". FGD with Male Beneficiaries aged 20-29 in -Amuru District

"Yes, these days, boys also help girls in doing housework. Before, people said cooking was the work of women and girls, fetching water, sweeping the compound, and actively helping girls with all these responsibilities. In the past, boys were more protected than girls; even in a family meeting, a boy would decide that everyone would go by, and a woman's voice was never heard, but this is not the case these days' girls also make decisions take an example of

our head girls whenever she takes a decision people follow it". Refugee girls 15-19-year-old FGD Refugee Maji secondary school, Adjumani District

There are also differences between the baseline and endline regarding how out-of-school young people think of gender - see Tables 14 and 15. Irrespective of sex, there was an increase in the proportion of boys (62.2% at baseline vs 79.0% at endline) and girls (77.0% at baseline vs 81.1% at endline) who thought girls were as smart as boys. The proportion of young in-school females who think girls are as smart as boys are higher at the endline (79.1%) than at baseline (77.7%) in the treatment arm, although this pattern differs for males.

Table 15: Distribution of out-of-school young people's positive scores on the GEM Scale

	Baseline				Endline				difference	
	WN	Acholi – treated	All treated	Acholi – control	WN	Acholi – treated	All treated	Acholi - control	Acholi	All
All	57.2	54.2	56.5	61.2	63.1	57.0	61.8	55.0	9.0	11.5
Sex										
M	52.0	51.4	51.8	61.6	62.4	58.1	61.5	54.0	14.3	17.3
F	62.6	56.4	60.9	60.7	63.5	56.6	61.9	55.4	5.5	6.3
Age group										
10-14	56.3	56.0	56.2	64.5	60.5	55.0	59.5	51.8	11.7	16.0
15-19	56.8	52.9	55.8	60.0	60.1	53.2	58.8	54.0	6.3	9.0
20-24	58.0	54.5	57.2	60.6	65.1	58.6	63.5	56.0	8.7	10.9

Table 16: Distribution of in-school young people's positive scores on the GEM Scale

	Baseline				Endline				Effect size	
	WN	Acholi – treated	All treated	Acholi - control	WN	Acholi – treated	All treated	Acholi - control	Acholi	All
All	59.6	55.1	58.5	62.6	64.1	54.6	62.4	54.4	7.7	12.1
Sex										
M	55.1	51.2	54.3	61.2	63.7	54.0	62.1	52.0	12.0	17.0
F	64.2	58.2	62.7	63.9	64.4	54.8	62.5	55.4	5.1	8.3
Age group										
10-14	60.1	55.5	59.1	63.9	61.8	59.9	61.5	52.5	15.8	13.8
15-19	58.8	53.7	57.6	60.8	64.7	53.1	62.4	55.5	4.7	10.1
20-24	59.8	56.1	58.8	63.0	66.2	51.8	64.9	56.7	2.0	12.4

There was a significant decrease in the proportion of out-of-school young people at the endline compared to baseline who do not believe that men make the final decision in the household. For example, in the interviews, male spouses have started involving their wives in making decisions about how to use funds from the sale of crops after harvest.

"We now make decisions together but not in all. He decides for children and their education, feeding, and family planning, and I decide. John might say they want to separate his home, I don't need to change my behaviour to please people, and however much the people talk, he will not get tired of helping his wife". FGD with male beneficiaries aged 20-29 years old in Madi Okollo District.

Like out-of-school young people, the results shown in Table 3.57 in the annexe indicate a similar pattern. Overall, there was a decline in the proportion of young in-school people at the endline who think that the husband makes a final decision and should be obeyed when compared to the baseline.

This pattern is observed among all in-school young people irrespective of sex, age, disability status or history of sexual intercourse.

There is strong evidence that the ANSWER programme contributed to positively influencing confidence and self-efficacy among in and out-of-school youth.

As part of the KAP, we also assessed changes in the life skills of young people relating to their ability to have great SRHR focused on confidence, self-efficacy, and decision-making for SRHR/GBV services and information. In general, there are marked improvements in out-of-school and in-school settings related to three out of four of the self-efficacy indicators in the ANSWER sites compared to the Acholi control group, where there was a downward trend overall.

Table 17: Changes in self-efficacy in out-of-school and in-school settings[94]

Out of School	All treated		Acholi control	
	Baseline	Endline	Baseline	Endline
Percentage distribution of young people with Self-confidence/life skills in general	10	6.6	9.6	9.6
Percentage distribution of young people with Self-efficacy to refuse or negotiate for safer sex	61.8	80.8	72	61.5
Percentage distribution of young people who Can negotiate for safe sex	79.6	84.8	89.7	67.5
Percentage distribution of young people who Have confidence in seeking contraceptives from health workers/VHTs	46.7	74.3	55.1	56.4
In-School	All treated		Acholi control	
	Baseline	Endline	Baseline	Endline
Percentage distribution of young people with Self-confidence/life skills in general	11.6	6.5	10.5	5.7
Percentage distribution of young people with Self-efficacy to refuse or negotiate for safer sex	49.5	66.4	51.7	35.2
Percentage distribution of young people who Can negotiate for safe sex	82.4	87.6	87.4	68.3
Percentage distribution of young people who Have confidence in seeking contraceptives from health workers/VHTs	49.5	66.4	51.7	35.2

Causal Pathway 3: There is moderate evidence that the ANSWER programme improved the policy context and public discourse around the value of SRHR and investing in this as part of wider societal progress in SRHR services in Western Nile and Acholi at this stage, but not in changing allocation of resources.

There is moderate evidence that the ANSWER programme contributed to strengthening governance and accountability for demographic dividends.

This work built on a longstanding partnership between UNFPA, the National Population Council and the National Planning Authority had worked together with the publication of the "Harnessing the Demographic Dividend: Accelerating Socioeconomic Transformation in Uganda" in 2014, followed by a series of joint publications that outlined how to harness the demographic dividend in the Uganda context. [built up political support for this work] The work planned under this objective is an extension of this work with the aim for improved implementation of and accountability towards the demographic dividend road map by 2023 at the national and district levels. Overall, the outcomes, indicators and activities set out in the Results Framework at the start of the project have remained relevant. Many of these indicators were achieved. However, the indicators related to sectoral spending (2.1.1., 2.1.2., and

[94] Key item responses included: a) I have little control over things that happen in my life, b) I cannot do much to change things in my life, c) I believe things happening in my life are mostly determined by me, d) I am confident if I did not want to have sex, I would be able to refuse sex with a person who has power over me, like a teacher, employer, relative, etc., e) I am confident I can get the person with whom I have sex to use a condom, even if he/she doesn't want me to use a condom, f) I am confident If my partner and I do not have a condom, I can say no to sex, g) I am confident if I did not want to have sex, I would be able to refuse sex with a person who has power over me, like a teacher, employer, relative, etc., h) I am confident I can get the person with whom I have sex to use a condom, even if he/she doesn't want me to use a condom, and i) I am confident If my partner and I do not have a condom, I can say no to sex. Life skills for correct SRHR decisions included all items (a) – (h) to capture confidence, efficacy and decision making while self-efficacy to negotiate safe sex included only (e)-, (f), (h) and (i).

2.1.3) are no longer relevant, as was a shift from sector to programme-based budgeting by the Government of Uganda halfway through the project.

The planned activities for the ANSWER programme built on the ongoing collaboration between NPC, NPA and UNFPA and focused on government strengthening and accountability, one of the key interventions previously identified as a priority for harnessing the demographic dividend (DFID and UNFPA 2019). The NPA's demographic dividend certificate of compliance (2018) and the NPA (2020) MDA and Local Government Dividend Compliance Tool are central to the accountability. These tools were developed to ensure that all public sector institutions implement the agreed-on key interventions to harness the demographic dividend (DD) and assess that national and district strategic plans, work plans and budgets conform with demographic dividend (DD)plans. Under the Programme, UNFPA also supported NPC and NPA in revising the compliance tools to ensure they align with current development plans (NDPII and the National Population Policy) and programme-based planning and budget approach.

In addition, UNFPA provided technical and financial support to the Partners in Population and Development Africa Regional Office (PPD ARO), in partnership with the NPC, to conduct a budget analysis to assess the trends in budgetary investments towards demographic dividend (DD)pillars at local government levels in 31 districts, 15 of these districts were supported by the ANSWER programme over three years. This was critical to monitoring the commitments to the priority interventions and budget allocations at the district level when working with district partners.

There is moderate evidence that the ANSWER programme contributed to strengthening the evidence base around the demographic dividend.

Building on earlier research and work to prioritise the demographic dividend in policy debates, the programme also supported key studies to garner further support for the demographic dividend (DD)and the development of key communications materials and dissemination events. Over the programme period, the programme supported over 13 publications to raise awareness of the benefits of demographic dividend (DD) and to support stakeholders in operationalising demographic dividend (DD)in their work.

In addition, the programme supported the Parliamentary Research Department in conducting studies on teenage pregnancy, maternal health, and GBV. The supported studies focused on the accountability role of Parliament and the key legislative, budgetary and oversight actions required to address the issues. Using the key findings, two motions were tabled on teenage pregnancy and GBV. Parliamentary engagements on maternal health led to the signing of a commitment to improve maternal health in the country.

There is moderate evidence that the ANSWER programme contributed to supporting In-house technical capacity to operationalise the demographic dividend.

The implementing partners for this activity, the National Population Council (NPC) and National Planning Authority (NPA), are the key institutions for developing and implementing population and demographic policies in Uganda. The success of advancing the demographic dividend priorities into policies, plans, and budget depends on the capacity of these two agencies to undertake their mandate and, hence, UNFPA's strategic investment in support of in-house technical capacity at the NPC and NPA throughout the programme. This additional technical support was critical in supporting the following activities:

- Analytical work to finalize the demographic dividend (DD)roadmap, including re-configuring compliance tools with programme-based planning and budgeting.
- Drafting, reviewing and finalizing of the National Population Policy;
- Drafting the milestones for harnessing Uganda's demographic dividend (DD) with specific indicators and targets set for 2025-2050.
- Development of the NPC and NPA Population Programme Research Agenda.
- The mid-term review of the third National Development Plan (NDP III) and end-evaluation of the second National Development Plan (NDP II) to ensure that the integration of population

dynamics, sexual and reproductive health, and GBV issues are also part of the review under the cross-cutting themes.

- Preparation of the State of Uganda's Population Report (SUPRE).
- The population dynamics, sexual reproductive health, and GBV issues are included in the development frameworks in the Parish Development Model.

With this in-house technical support, the NPC and NPA were able to integrate demographic dividend in the National Development Plan III, specifically the Human Capital Development programme and the district development plans. Through the relevant sectors and district support, Demographic Dividend (DD)/Family Planning was fully embedded in the following strategic areas within the NDPIII, Human Capital Development Programme (HCDP) and the Programme Implementation Action Plan (PIAP): improve maternal, adolescent and child health services at all levels of care; increase access to SRHR with special focus on family planning and strengthening population planning and development. At the district level, discussions were held with the various districts on integrating DD/family planning into the district development plans.

The NPA reviewed the budgets to assess investments in demographic dividend (DD)based on budget-related documents, which included Ministerial Policy Statements, Approved Estimates of Revenue and Expenditure (Recurrent and Development), and Annual Budget Performance Reports. From the analysis of the 2020/21 FY and 2021/22 FY, there is a marked increase in budget allocation for demographic dividend (DD)in 25% (2020/21), 29% (2021/22) and 35% (2022/23 FY). The budget release also increased from 22% to 28%, while expenditure increased from 22% to 27% in 2020/21 and 2021/22, respectively.

Harnessing the demographic dividend (DD)at the district level was the second output under this objective. The focus of the work at the district level was to support district authorities in harnessing the youth bulge through investments in education, health, skills, and access to jobs. The ANSWER programme supported district political and technical leadership prioritising human capital development interventions. The project supported activities that (1) build capacity to generate and analyze data to enhance capacity in providing evidence of the integration of population and development factors for improved planning and budgeting and (2) advocacy to raise political priority and financial investment in key areas of the DD. The evaluation found that the results of these activities at the district level have been mixed.

The ANSWER programme supported activities to strengthen district governments' understanding and prioritization of demographic dividend (DD)capacity. These activities included supporting district planners in undertaking a gap analysis with RAPID and guiding district leadership through District Development Planning and the demographic dividend (DD)compliance and tools. Workshops on budget allocations were hosted with the ULGA executive board, secretariat, district local chairpersons, CAOs, and planners who reviewed and synthesized budget allocation and releases for districts and drafted commitments to realize the demographic dividend (DD)(2022). In addition, in 2022, the ANSWER programme supported a coordination platform between the different sectors, such as health, education, community development and the planning departments at the district level. The purpose of the platform was to exploit synergies, leverage resources, minimise duplication and discuss the Human Capital Development pillar with the political leadership, technical planning committee, development partners, implementing partners, religious and cultural leaders, PWDs, youth council leadership and sub-county stakeholders to improve SRHR/GBV/demographic dividend (DD)programme efficiency and effectiveness at the district level. In addition, there was ongoing support throughout the programme to strengthen the district statistical committees (2021-2022). All districts now have statistics committees, and 221 members of the statistical committees are oriented on the harmonised data visualisation portal, preparing statistical abstracts. Each of the 15 ANSWER districts received data management equipment, including computers, accessories, projectors and internet broadband boosters. District leaders were also trained on data harmonisation - metadata, and how to assess, analyse and document data. Together, these skills would help to integrate demographic dividend (DD)into the DDP.

> *"Now, coming back to demographic dividend compliance. The available data has played a big role in guiding what is right and what is wrong. We know education cannot go well given our population in the district; actually,*

as Amuru district, our last population was 223,800. So, given that population, if they are not healthy, you can sense that the population will not be okay. If they are not educated, you also know that the district will have a lot of issues to address, which means that the resources in the district might not be put in the right place and whether it is put in the right place, the population is not educated, you know what type of a population you have in the district. So, this knowledge of demographic dividends helps us a lot as a district to advocate for the community and tell them what needs to be done regarding our population. It would be hard for us to control the population, but what do we need to do now that we have it? We need to ensure that the population is healthy and educated and the level of teenage pregnancies in the district is reduced. Actually, in 2020, the district was rated among those with the highest levels of teenage pregnancies in the country, but with this concern on demographic dividend, I remember you were on our case. It gave us, the district and the councillors, a lot of tasks; it became the day's topic in every meeting, and at least something had to be mentioned about teenage pregnancy. and as I talk now, statistics show that we are reducing, at least we are faring so far, at least not badly, not like before." Interview with the District planner, Amuru

Despite these investments, the impacts are below expected compared to the surrounding districts. Analysis of budget data shows that the share of the district budget allocated to demographic dividend (DD)activities increased by 25.6% in the non-ANSWER districts compared to 14.8% in ANSWER districts between 2018 and 2022. Moreover, the performance in moving from budgeting to spending on demographic dividend (DD)was 73.2 in ANSWER districts compared to 75 in non-ANSWER districts. See Annex 5.

At the time, the programme was focused on supporting district-level work on DD, but there have been some notable gains. The table below shows that in two years, there has been an increased percentage of districts approved and executed budgets for DD priorities and an increased average compliance score.

Table 18: Short-term changes in the implementation and accountability towards DD priorities at the targeted districts

Indicators	Region	YEAR	
		2019/20	2021/22
Percentage of district-approved budget (education, health & gender) allocated on DD priorities (disaggregation by district)	Western Nile	66.5 %	105.3 %
	Acholi	67.3 %	120.9 %
	Overall	66.7 %	108.3%
Budget execution on DD priorities within the district plans/BFPs (disaggregation by district and department)	Western Nile	92.8%	82.6 %
	Acholi	76.8%	81.1 %
	Overall	89.7%	82 %
Average DD Compliance Score for ANSWER Targeted Districts	Western Nile	64.2%	69.3 %
	Acholi	65.9%	73.1 %
	Overall	64.6%	69.3 %

Commentators suggested that investments in the demographic dividend (DD)roadmap were not happening. Firstly, district leaders had limited ability to allocate resources to set priorities locally. Some issues with the activities were related to how they were funded. Respondents suggested that the financial support for this work was not timely; funds were disbursed late and often came towards the end of the quarter. The teams had to rush to accomplish the task before the end of the quarter. In addition, initially, NPC was supposed to dispense the money to districts that would participate in implementation, yet this was not possible. Therefore, NPC implemented activities that were not often coordinated with the districts. Activities that conflicted with district schedules were planned, and the NPC/UBOS plan may not align with district priorities.

In 2021, in response to the gaps in domestic resources, the 'Yes, I Can Dare Challenge' initiative is supported by the programme to influence districts to plan, budget and implement activities with locally generated resources. The key strategy is to lobby district leadership to prioritize and increase investment in reproductive health for young people. Multi-sectoral district working groups

established during the development of the District Costed Implementation Plans supported the rollout of the "Yes, I Dare the Challenge project", and 12 districts expressed interest. By the end of December 2021, four districts (Agago, Amuru, Pakwach and Lamwo) had committed resources, matched by the ANSWER Programme, which concluded in 2022. While districts were encouraged to identify high-impact activities, most districts prioritised the activities already identified in their District family planning Costed Implementation Plan. The ANSWER programme also supported strengthening data management at the district level by harmonising existing data management systems to collect disaggregated GBV/Harmful Practices and SRHR data across government sectors to help generate, analyse, and use real-time data. Uganda Bureau of Statistics (UBOS) was supported in developing an online interactive geospatial data visualisation module on GBV and a parish community information system linked to census mapping of areas of inequality, available service delivery points, and other indicators. GBV/SRHR community information data was collected in Amuru, Arua, Obongi, Madi-Okollo and Arua City. The survey produced quality data on the prevalence, type, severity and consequences of GBV, levels of knowledge and awareness about SRHR, and information on the availability and access to SRH services. While the information gathered through the tools developed by UBOS was useful, they differed from what was being used by the e district community department, which was dealing with the GBV database system built by the Ministry of Labour and Gender. In effect, two databases were being used and did not reflect the same data, creating confusion and possible contradictions in the data.

EQ5: To what extent has the Programme integrated the cross-cutting issues of gender equality, disability inclusion and human rights-based approaches?

There is moderate evidence that the programme integrated gender equity and disability inclusion into some interventions (e.g., social norms and sexuality education and service delivery). Yet, these were not systematically included in the programme. There is no evidence of integrating a human rights approach.

The ANSWER Programme focused on integrating a strong youth focus in its work around the demographic dividend. At a national level, it set up the Adolescent Health Working Group (ADH WG) at the Ministry of Health as a key platform mandated to analyse and review adolescent health issues. In 2021, with a contribution of funding from the ANSWER programme, the platform was instrumental in shaping key strategies and interventions in the Health Sector Development Plan, the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) plan; reviewing and approving the Adolescent Health Policy, the Adolescent Health Strategy, and the National Menstrual Health Plan; and developing a Policy Brief on Adolescent Consent to SRH care as a barrier to access. In addition, youth parliamentarians participated in the NDPIII development that engaged communities, youth leaders, schools, etc, in 2022 and 2023. The ADH WG drove the scaling up of coordination structures at the district level. By the end of 2021, 31 districts had a District Committee on Adolescent Health (DICAH) to steer the implementation of adolescent health plans for improved health service delivery; community-level support was put in place and contributed to adolescent health-specific road maps, successfully advocated for budgets. District youth leaders, councillors, and young parliamentarians were oriented on NDPIII and PDM. There does not seem to be monitoring this as an outcome, and assessing performance in this area is impossible.

Some activities were implemented focusing on these groups, including disability assessment in 2020 and training of health workers and VHTs on providing respectful service to the PWDs, adolescents, youth and refugees. The programme also supported policy review on disability inclusion at the national level. It is also worth noting that PWDs and refugees were reached with services, and disaggregated data is available. Young people (<24 yrs) reached consistently above 50 per cent of the total, PWDs around 20 per cent, and refugees less than 10 per cent. However, while strong on plans and support for policy review, the Programme demonstrated weak attention and implementation of interventions focusing on PWDs. The lack of capacity to deal competently with PWDs may have contributed. The enrolment of Special Olympics close to the end of the Programme indicates a recognized need for specialized technical expertise to provide adequate attention to this area. In

integrating Human Rights-Based Approaches (HRBA), the disability assessment conducted in 2020, which identified barriers to access to SRHR services by PWDs, was a good attempt. However, there is a need to see a more pronounced involvement and participation of these groups in the planning and determination of what services they need. For example, while involved in the implementation, youth leaders did not seem to be fully engaged in shaping the Programme, as it should be, as it is focused on issues that affect the youth.

Young people were assessed for vulnerability in out-of-school work using the Vulnerability Assessment Tool (VAT). The assessment findings were instrumental in realigning 2022 interventions, adapting financial literacy in the VSLA model, briefing government stakeholders on the main issues and challenges, and advocating for increased youth participation in government youth programmes. For example, after the mid-term revision, vulnerable youth (e.g. living with disability, orphaned, etc.) were selected for vocational training in Moyo District in tailoring, building/brick laying, carpentry, and mechanics.

There were some commendable efforts towards gender transformative programming, especially in the area of social norm change. A notable contribution of the programme is related to gender and menstrual hygiene. Respondents frequently mentioned that boys who had been previously stigmatising menstruation after the MHM module had become more supportive. A young woman from Adujami explained:

> *"By then, boys used to laugh at girls whenever they learned that a girl was on her period or had messed up her uniform. Instead of helping her, they would laugh at her, but these days, the boys are helping and supporting the girls by advising them on proper menstrual hygiene. Sometimes, when a girl has messed up her uniform, a boy can go to the senior woman teacher to seek help for the girl."*

A 15–19-year-old girl from a refugee school in Adjumani District said:

> *"These days, boys are also involved in making sanitary pads, and they are better than girls because they concentrate on learning it, and now, they are also teaching other girls to make sanitary pads even at home and in the school personal hygiene, menstrual hygiene management, making of reusable sanitary pads. We learned how to make reusable sanitary pads, which were taught to us by our senior woman and man teachers.*

A teacher in the Madi-Okollo District observed:

> *"I think the boys can now understand that menstruation is normal. They have stopped the acts of maybe teasing these girls and so on during this process."*

In contrast, there was no clear gender analysis in the demographic dividend (DD)work. Only one respondent commented that only a few women are involved in budget planning, so more gender-related issues are not included. Similarly, issues around human rights, diversity and inclusions were not included in the design and implementation of this area of work. There was limited evidence that the entire programmatic activities of the programme were engendered. Engaging the entire programme from design and implementation would have been crucial to reaching a critical mass with gender-transformative interventions. In other words, all programme interventions must be done from a gender transformative lens at all levels, both at the community and institutional level. For example, working with health providers should focus more on gender transformation and change in provider social norms.

EQ6: What were the unforeseen consequences (negative or positive) of the Programme?

There were limited unforeseen consequences of the programmes.

One unforeseen consequence of the Programme was the interaction of VHTs with the community in the provision of family planning services. A significant contributing factor to the increased uptake of family planning methods was the opportunity for young people and women to seek to obtain these services

privately from a VHT without the knowledge of their relatives, including parents and partners. However, this also caused conflict and enmity with neighbours when it was discovered (FGD with VHTs).

Overall, no reported unforeseen consequences of the demographic dividend (DD) work at the national or district level were reported. However, planned activities did have to adapt to changing circumstances. Activities were subject to COVID-19 disruptions, which affected the ability to undertake advocacy activities and secure investments for demographic dividend (DD)work when national and local governments were responding to the pandemic. The impact of COVID-19 is not detailed in the documentation. The activities also had to be adapted to introduce programme-based planning and the Parish Development Model. For example, two activities (2.1.1. and 2.1.2.) were no longer relevant, and delays were caused by the need to adapt programmatic tools.

4.3 Efficiency

Summary of Findings

UNFPA provides quality technical and financial support to partners and stakeholders at ministerial departments and agencies (MDAs) and the district level. The staff of UNFPA and the IPs were considered committed, transparent, and responsive.

- Implementation modalities employed in the Programme were appropriate and efficient overall. However, challenges existed in channelling funds and implementing activities through central-level MDAs to District Local Governments.
- The leadership, coordination, and guidance by national and district authorities, as well as the use of local resources, contributed to efficiency in implementation.
- The impact of the COVID-19 pandemic was significant. The lockdowns not only reduced the effective implementation period but also adversely affected the implementation of activities and caused inefficiencies in the use of resources in the first year of the programme.
- The ANSWER Programme implementation structure, which includes UNFPA, IPs, and technical specialists, seems optimal and efficient. The changes in IPs in 2022 allowed for a more integrated and holistic package of interventions to be carried out more efficiently and at reduced costs. However, to some extent, it caused a temporary loss of momentum and delays in implementing some of the activities, adversely impacting efficiency. The field staff were also spread too thin for optimal impact.
- The programme employed effective coordination mechanisms and an elaborate monitoring and evaluation framework that allowed for the appropriate disaggregated data collection, analysis, and reporting. However, there were challenges to data collection capacity and integrity in the national systems.

EQ7: To what extent has UNFPA made good use of its human, financial, technical and administrative resources and appropriate combination of policies, procedures, tools, innovative approaches and implementation modalities to pursue the achievement of the outputs and outcomes of the programme?

UNFPA implemented the programme efficiently and promptly with appropriate structures, implementation modalities, competent staff, and IPs. However, the impact of COVID-19 caused a significant reduction in the implementation period while disrupting Programme activities. The Programme is also spread too thin (in many districts and sub-counties) across a large geographic area for its package of complementary interventions to achieve optimum impact.

UNFPA was efficient, providing timely financial and technical support to the government agencies and beneficiaries at national, district and community levels. The staff of UNFPA and the IPs were committed, transparent and responsive. The competency, commitment, and responsiveness of specific staff members are highly regarded by national, district, and local stakeholders and are attributed to the effectiveness and efficiency of implementation.

The fact that the implementation was under the guidance, leadership and coordination of Ministerial Departments and Agencies (MDAs) and District Local Governments (DLGs)enhanced efficiency in implementation, including efficient coordination of activities. Stakeholders in national and district offices highly value this. Using local resources, including national, regional and district officials and community resource persons (e.g. UPMA, VHTs, peer educators) as agents of change contributed significantly to the efficiency of implementation. They not only fully understood the context, the issues they were dealing with, and the change they aimed to see, but the approach was also cost-effective.

The following are five considerations related to efficiency.

1. *The impact of the COVID-19 Pandemic was significant.* The lockdowns resulting from the pandemic affected programme implementation in several ways. First, it reduced the implementation period by at least one and a half years. This caused significant delays in implementing many of the interventions, with many starting or restarting in the third quarter of 2021 and in-school sexuality education only in early 2022. The pandemic and the uncertainty involved with the intermittent lockdowns greatly impacted staff and stakeholders, their movements, and their ability to meet and work. Some lost loved ones. Thirdly, it resulted in inefficient use of financial and technical resources. UNFPA and IP staff and structures were already in place and receiving salaries, yet the implementation of activities was interrupted or significantly slowed down, especially at the community level. This is shown by a disproportionate level of expenditure on Programme Management costs compared to the level of absorption related to programme activities. Fourth, the disruption and the limited time may have affected the fidelity of some of the interventions (e.g. SASA!, Intergenerational Dialogues, and health systems strengthening interventions). Fifth, the monitoring and coordinating activities in the field were highly restricted. This implies that any reasonable assessment of the effectiveness and efficiency of implementation must consider the disruption caused by COVID-19.

2. *Programme organisation.* The ANSWER programme implementation structure seems optimal and efficient. It consisted of a core of management and professional staff specialising in key disciplines related to programme interventions in the Kampala office (e.g., SRHR, RH commodity security, adolescent and youth SRHR, DD, M&E, etc.), UNFPA coordination staff at the regional level, and competent field officers at the district level. The IPs were selected according to their competencies and mandates to implement key programme components, and NGOs were contracted to handle very specialised technical areas (e.g., UPMA, Special Olympics). UNFPA staff were well facilitated and received appropriate capacity-building support including through online training resources. This is an efficient structure that allows for efficient coordination and flow of information and handling issues by escalating them upwards.

   The changes in IPs in 2022 were considered timely and necessary by UNFPA programme staff, IPs and stakeholders after extensive consultations. They allowed for a more integrated and holistic package of interventions to be carried out more efficiently by fewer IPs and at reduced costs. The transition process was also managed efficiently by UNFPA, including building the capacity of IPs in the new areas assigned to them. As put very well by one of the district stakeholders:

   > *"Initially, five IPs were in the district. They used to bombard the same people and waste time and resources. We raised the issue in a national review in 2021, and UNFPA listened."* Interview with a District Health Officer

   The changes improved coordination between UNFPA and IPs, as well as with district authorities. However, the Programme lost some time, once again, because of this transition. There was a loss of momentum in early 2022 as the IPs started new tasks in areas they had not handled before, and in some, they needed to learn new skills, which took time as there is always a learning curve. The implementation of the SASA interventions was not optimally efficient and may have

interfered with the fidelity of the approach). According to UNFPA, this was a calculated risk based on thorough analysis in consultation with IPs. The transition was planned and carefully managed by UNFPA in close collaboration with IPs to jointly assess the risks and mitigation measures, minimise the delay and slowdown, and ensure an acceleration of the activities in Q3 and Q4 (UNFPA Uganda CO). The bottom line is this is a good learning point that will contribute to having the right structure of IPs from the beginning for more efficient implementation in the future. (KIIs with UNFPA, IPs, and district officials).

3. *Programme visibility*. Although well appreciated for doing a good job, IP staff were also spread too thinly on the ground, which limited their demonstration of the Programme's footprint in some areas, with coordination and representation on district platforms suffering in some instances. The IPs also showed weakness in providing visibility for UNFPA, the Netherlands Embassy and the ANSWER Programme in the field. (KIIs with other UN and government agencies).

4. *Implementation modalities:* To a great extent, UNFPA used an appropriate mix of implementation modalities. The flow of resources through carefully selected IPs and government agencies is appropriate and has largely worked well. However, when resources were channelled through national government agencies (case in point: National Population Council) for onward transmission to the districts, they faced bureaucratic challenges and issues with the iFMIS that delayed the implementation of activities. There were also issues with coordinating and scheduling activities between national-level ministries and district local governments that adversely affected implementing activities. Another key challenge was the financial years between UNFPA, some IPs and government agencies. For example, when money is released in June, it is towards the end of the government's financial year and runs the risk of being returned. In some cases, this also delays activities. (KIIs with IPs, UNFPA and government agencies in the districts). A careful review of this issue and exploration of options should inform more efficient arrangements in future programmes.

5. *Programme's strategic focus – spread versus depth.* The Programme appears to have spread too thin over a wide geographical area. While this may be demonstrated by looking at most interventions, a few examples may suffice. In the gender and social norms change component, there appeared to be too few change agents (SASA activists, MAGs, model parents, etc.) to reach a threshold of people necessary to motivate change faster at the community level. It would also have been more desirable to have more schools within districts to achieve better coverage and thus better diffusion and impact on the whole youth population and community. On the GBV interventions, aspects were missing in addressing the plight of survivors – support for the victims, facilitation for access to justice, recovery, etc. It is more desirable to focus resources, allowing the programme to provide a comprehensive, integrated package of interventions within a more limited geographic area and optimise impact in fewer districts and sub-counties to achieve demonstrable results and generate useful lessons faster.

6. *Upstream versus downstream focus.* UNFPA has elaborate and mature collaborations with national ministries, departments and agencies (MoH, NPA, NPC, UBOS, MoES, MoGLSD) and district governments. However, some interventions perform less optimally even when appropriately implemented because of challenges upstream. The challenges in the National Medical Stores (NMS) caused stockouts of commodities in supported health facilities to continue even when interventions related to RH commodity security, including RH SPARS and eLMIS, were well implemented. The computerisation of the harmonised national GBV database (NGBVD) appears to be in confusion, and nothing much may be achieved until the upstream issues related to the coordination of this effort at the national level are addressed. UNFPA could focus programmatic attention further on strengthening upstream barriers related to the supply chain management and the NGBV database, including through intensified advocacy, to ensure issues that affect implementation in the field receive due attention.

EQ8: Did ANSWER Programme resources have a leveraging effect? (Efficiency Q8)

ANSWER Programme resources had limited leveraging effect.

This is where the programme results in additional funds and other resources from other actors (e.g. government) being made available to achieve the Programme's aims. Examples include the additional funds for SRH in some districts and the allocation of radio talk time for youth and other leaders to talk about issues affecting the youth, including SRHR issues. The "I dare the challenge" also elicited a lot of interest from district government authorities who were willing to put in some money for SRHR services, but there was limited funding from the central government, which limited the implementation of the intervention.

EQ9: Was the progress and results of the programme effectively and efficiently measured and reported?

UNFPA effectively coordinated the Programme, and results were effectively and efficiently measured and reported.

The Programme had a good regional, regional, and national coordination framework. This involves both UNFPA structures and the national and district authorities. For example, the MoH coordinates all interventions on health at the national level, while the DHO coordinates district-level interventions.

There were coordination meetings at all levels and, lately, at the sub-county level. In the field, UNFPA coordinated IPs and met monthly. There were biweekly integrated field support meetings chaired by the UNFPA national programme coordinator and quarterly national UNFPA meetings. UNFPA field staff and IPs coordinated with district officials, while national UNFPA staff coordinated with national government agencies. There were also regular coordination meetings with the government and other actors at the district level.

However, there were weaknesses in district-led coordination of interventions and the IPs, some of which were beyond the control of the ANSWER Programme management. Sometimes, the district officials were too busy to attend to all the actors and issues that required their attention. Some of the coordination activities, e.g., meetings of the gender technical working groups, did not happen as regularly, while some of the actors failed to attend.

The Programme had a well-defined and elaborate monitoring and evaluation framework, implemented from community-level activities to the national level. The data was appropriately disaggregated for adolescents and young people, gender, PWDs and refugees. The reporting framework was also elaborate, from community change agents to the district, IPs and UNFPA at district, regional and national levels. However, information available in IP reports should be more standardised and informative. Overall, the reports need to tell a clear story. (Document review, interviews with UNFPA, IPs and district stakeholders).

However, challenges exist in data capture in the field. For example, collecting and reporting data by VHTs was voluntary. The district health team's supervision of VHT is weak; therefore, the data collected may lack integrity. Sometimes, the reporting tools are in short supply (KIIs with district authorities).

4.4 Sustainability

Summary of Findings

The ANSWER Programme was well-designed and implemented to promote sustainability through effective approaches, including:

- Supported government initiatives - worked within the policies and frameworks of the government, through and within government structures, and developing institutional and community capacities.
- Supported the development and review of policies, plans and guidelines at national and devolved levels.
- In implementation, worked with and through government and community structures and using local technical resources (e.g., district ToTs) and institutions.
- However, sustainability challenges included inadequate local resources to sustain benefits, practices with potential to undermine sustainability, and new structures (e.g., SASAs, MAGs) that may not be sustained without outside support. The level of maturity of implemented interventions was also a factor in sustaining their benefits (e.g., intergenerational dialogues).

EQ10: To what extent have UNFPA-supported interventions promoted national, district and community ownership and contributed to capacity development in its implementing partners and communities (regarding policies, increased capacity and budgetary allocation)?

The ANSWER Programme was well-designed and implemented with sustainability in mind. While the level of sustainability of the different interventions varies, the Programme adopted approaches that facilitated and promoted sustainability and ownership. This includes supporting government initiatives, working within the policies and frameworks of the government, working through and within government structures, and developing institutional, health facility and community capacities.

Supporting government policies and initiatives. The ANSWER Programme supported government policies and ongoing initiatives, thereby promoting ownership and sustainability. These include the CQI focused on MCH at the national, district, and health facility levels, digitising medicines management, and using the PIASCY curriculum for school sexuality education. The training of peer educators also follows government training materials. This means there is motivation for the government to sustain the effort using its own funds or focusing partners' resources to continue the implementation (document review, KIIs with UN FPA, national and district stakeholders).

Working through government and community structures. The Programme worked closely in collaboration with and through established structures at national, district and community levels. This included working with and through national ministries and agencies (e.g. MoH, MoES, NPC, NPA), district local governments (e.g. DHOs, DCDOs and DEOs), and community structures such as cultural and religious institutions and VHTs. The Programme further placed the leadership and coordination of interventions in the hands of government agencies at national and district levels, thereby ensuring ownership and efficiency in coordination and implementation.

> *"We strive to make the district leadership own the process and the issue. We take pride in the people doing the work themselves, owning the process, and getting excited with the results*." Interview with an IP field officer

Building institutional capacity and working with local resources. The ANSWER Programme built the capacity of national, regional and district trainers (ToTs), who then cascaded the training to lower levels and the final change agents and beneficiaries at the community level. These included training district health, community, and education officials as ToTs. The Programme facilitated capacity building for district teams (e.g. DHTs, statistical committees) and local structures (e.g. health facilities, schools,

cultural and religious leaders, SASA activists, model parents, and peer educators) to provide services and roles as change agents. The skills gained, and capacities developed will remain within those structures and the communities beyond the closure of the ANSWER programme.

Even without external resources and support, some agencies have adequate capacity to continue the initiatives (e.g., MoH, NPA, NPC). Some of people who were trained are constantly engaged with their constituents and may continue impacting the knowledge gained, e.g. religious and cultural leaders, teachers, and health workers. Building the capacity and working with local NGOs supported sustainability (e.g., UPMA, Special Olympics, etc).

This is the case for more established and existing institutions. New structures established through the Programme (e.g., SASA activists, MAGs, etc.) are less likely to be sustained, as they depended solely on Programme facilitation. Of course, the skills gained by individual change agents have the potential of continuing being useful for them and those they interact with directly (document review, KIIs with national and district stakeholders).

Support for the development and review of policies and plans. The programme emphasised supporting the development and review of policies and plans and advocacy materials to facilitate policy change. These included embedding Demographic Dividends in national plans (e.g., NDPIII). Advocacy materials supported by the Programme with the potential to create clarity and catalyse action on youth SRHR issues include the "Cost of Inaction" and "Young People out of School" (document review, KIIs with UNFPA, national and district stakeholders).

Designed for financial sustainability. The "I dare the challenge" initiative, where UNFPA would provide matching funds to district authorities for SRHR budgets, with the districts fully taking over after three years, was designed to facilitate sustainability. (document review, KII with UNFPA, IPs)

Inadequate funds in government budgets. Some interventions will be sustained as part of government operations, although the intensity is likely to reduce. For example, there is an expectation that health facilities will continue offering services at the facility level, while funds from the government budget may be inadequate to sustain integrated SRHR outreaches. District health authorities indicated the intention to continue with sexuality education, including integrating it into the routine management and supervision of schools. UPE (Universal Primary Education) Fund, where 15 per cent is supposed to be used on the girl child, may be used to buy materials for making reusable sanitary pads (KIIs with district officials).

However, the government may not have adequate funds to sustain some interventions. For example, in the assessment to establish the requirements for the implementation of eLMIS, existing computers in health facilities were found not to be working due to lack of maintenance – not serviced, no internet, no power, and software that was not working as it had not been attended to (document review).

Facilitation. The Programme facilitated activities including providing transport, offering biscuits and sodas for community members attending dialogue meetings, and providing stipends for programme-related activities, e.g., sexuality education teachers (matrons and patrons), SASA! activists, peer educators, VHTs, etc. Once the Programme ends, these people's efforts and impact will likely diminish. However, this is common practice (and a challenge) for all development and humanitarian actors in the field (KIIs with community structures).

The level of implementation of interventions. When an intervention is not fully implemented, it is unlikely to achieve the desired impact or to be sustained. For example, inter-generational dialogues were only implemented in the last year of the programme, which did not leave sufficient time for the impact to be realised. However, the first full cycle of programme implementation had been completed. It has less likelihood of sustaining its benefits (KIIs with community structures).

The table below indicates the likelihood of the interventions supported by the ANSWER programme to be sustained beyond its end:

Table 19: Interventions sustainability matrix

Outcome 1: Enhanced access to and utilization of quality SRHR services (FP, Maternal health, Post abortion Care, HIV Testing and Post GBV) by 1,057,177 women, girls, boys and men, including refugees and PWDS in West Nile and Acholi sub-regions, by 2023.			
Output 1.1: 210 public health facilities in West Nile and Acholi sub-regions offer quality, equitable SRHR services (FP/Maternal health/Post-abortion Care, HIV testing and Post GBV) that are responsive to the needs of women, girls, boys and men, PWDs and refugees, by 2023.			
Sustainability	Likely	Somehow likely	Unlikely
1.1.1 Improve availability of FP method mix at service delivery points and scale-up last mile access to new contraceptive technologies		x	
1.1.2 Support to functionalize logistics management information systems and a web-based real-time monitoring system	x		
1.1.3 Strengthen capacity for forecasting, quantification, procurement, storage and distribution to the last mile (SPARS)	x		
1.1.4. Delivery of the 3-Phase CQI Approach for SRHR services, including for vulnerable populations	x		
1.1.5 Pre-service training for anaesthetist assistants as critical carders for comprehensive SRH service delivery		x	
1.1.6 Support development/review and printing of GBV referral pathways		x	
1.1.7 SRHR outreaches for hard-to-reach populations			x
1.1.8 Voucher system for teenagers			x
1.1.9 Roll out the GetIN program.			x
1.1.10 Ensure SRH in covid	N/A	N/A	N/A
Output 1.4: 866,415 community members (host and refugees) empowered 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 by 2023.			
1.4.1 Strengthen cultural, religious and community leaders' engagement		x	
1.4.2 Male Action Groups			x
1.4.3 Scale up the tested community mobilization approach SASA			x
1.4.4.2 Support community platforms to deliver an integrate community mobilization and gender transformative approach to individuals, families, and communities		x	
Output 1.5 Girls and boys (10- 14, 15-19 yrs) and older youth (20-24 yrs) in West Nile and Acholi regions, including refugees, are provided with age-appropriate, correct and comprehensive SRHR information to create demand for SRHR services including contraceptives by 2023			
1.5.1. Development of the School Health policy operational guidelines	x		
1.5.2.2. Support teacher-led school health clubs for primary learners to provide integrated SRHR and life skills sessions, menstrual health (MH sessions, distribution of AfriPads, production of reusable pads), gender roles and positive masculinity, and girls' empowerment, including distribution of IEC materials.		x	
1.5.3.2 Support peer education clubs at community and secondary schools to provide integrated SRHR and life skills sessions, menstrual health (MH sessions, distribution of reusable Pads, production of reusable pads), gender roles and positive masculinity, and girls' empowerment, including distribution of IEC materials.		x	
1.5.4.1 Procurement and distribution of reusable pads for young people in schools		x	
1.6 ANSWER Coordination meetings at district and sub-district level referrals and linkages			

1.6 ANSWER Coordination meetings at sub-district level referrals and linkages	N/A	N/A	N/A
OUTCOME 2			
Output 2.1: Enhanced implementation of and accountability towards the DD priorities at the national level.			
2.1.1. Enhance advocacy for resource allocation to DD strategic areas			
2.1.2. Strengthen NPC capacity to provide leadership, advocacy and coordination of population and development in the country.		x	
2.1.3. Strengthen NPC capacity to coordinate a multi-sectoral team to implement the DD roadmap		x	
2.1.4. Strengthen the research capacity of the Parliamentary Research Department to provide required evidence for decision-making, especially on SRH, GBV and Population Dynamics.		x	
2.1.5 Support to the newly established structures at MOH specifically dedicated to adolescent health (ADH): the ADH division at the ministry, the ADH technical working group, and the ADH think tank.		x	
2.1.6 Improve coordination and scale up advocacy for leadership and accountability for the national family planning programme	x		
Output 2.2: Enhanced implementation of and accountability towards the DD priorities at the targeted districts in West Nile and Acholi Sub regions by 2023			
2.2.1. Multisectoral coordination of platforms that advocate for increased investment in adolescents and youth within development and health policies and programmes at the district level.		x	
2.2.2 Support quarterly combined meetings for the district executive committees (DEC) and the district technical planning committees (DPTC)			x
2.2.3 Support the functionality of the District Medicines and Therapeutic Committees		x	
2.2.4. The I Can Dare Challenge		x	
2.2.5 Facilitate data-harmonized platforms		x	
2.2.6 Integration of GBV and SRHR into the Community Information data collection system (CIS)		x	
2.2.7 Improved data on SRH/FP/ASRH/GBV indicators to inform resource allocations during budget conferences, district budget review meetings and in district council budget discussions.		x	
2.2.8 To enhance accountability and oversight in the planning and budgeting processes	x		

4.5 Coherence

Summary of Findings

- Mechanisms existed at all levels to ensure high internal coherence, and cross-pollination and synergies between programmes implemented through UNFPA.
- The leadership and coordination by national and district government agencies ensured external coherence with the government itself and with other development actors. Also, UNFPA assisted UBOS in coordinating development actors supporting census and other activities.
- Although still a work in progress, other platforms exist to coordinate the activities of development actors at national and devolved levels, especially those focused on thematic areas. UNFPA has been particularly active in promoting and coordinating these platforms.

EQ11 How effectively did the Programme coordinate and achieve synergies with other UNFPA programmes? How well does the UNFPA collaborate with other UN agencies, development partners, NGOs, and partners, and what are opportunities for increasing this coordination? (Coherence Q11)

UNFPA had adequate internal mechanisms that ensured internal coherence between ANSWER and other UNFPA programmes. Strong coordination with government agencies at national and district levels and various inter-development partner platforms ensured external coherence with programmes implemented by other actors.

UNFPA possesses strong internal and external coordination structures and mechanisms to ensure a high level of coherence and synergies between programmes funded and/or implemented through UNFPA. There was a deliberate effort to improve coordination between UNFPA programmes, including joint monitoring visits and joint donor meetings (programmes and donors), thereby maximizing learning and synergies. For example, the ANSWER and the WAY programmes (KIIs with donors, UNFPA) shared monitoring visits.

At the national level, the MoH coordinates all interventions in the health sector. In certain areas, such as RH commodities, the MoH coordinates all the development partners who plan together and contribute to a common pool. For example, digitising commodities is an MoH initiative to which the ANSWER Programme contributes. MoH requested UNFPA to focus on HCIIIs, while HCIVs, hospitals, and regional referral hospitals are addressed by USAID initiatives. The CQI initiative focused on MCH, another national initiative, with different partners contributing and being allocated to intervene in different parts of the country. Sexuality education under the PIASCY curriculum, is another national initiative that the ANSWER Programme energized in the supported districts. UNFPA also plays a coordinating and resource mobilization role for partners supporting UBOS for census activities.

UNFPA works very closely and collaborates with relevant national government ministries and agencies. It participates in the relevant technical working groups and has an officer permanently stationed in the MoH to coordinate activities closely. At the district level, UNFPA field officers work closely with district authorities (DLCs, DHOs, DEOs, CDOs, etc.) to coordinate and monitor activities/interventions in the districts. They ensure harmonious relationships between IPs and the district authorities, strengthen the guidance and monitoring role of the latter, and facilitate coherence and synergies with other related initiatives implemented in the districts. District heads coordinate with UNFPA on ANSWER and other UNFPA programme interventions in the districts. For example, DHOs coordinate all health interventions in the district. In refugee settlements where UNFPA also contributed through the ANSWER Programme, humanitarian response partners hold monthly coordination forums to discuss and share what each partner is doing and bringing to the table. This minimizes duplication and helps develop synergies. UNFPA has also leveraged the UN Area Coordination Team (UNAC) to align its programming to that of other UN agencies in the districts and regions of operation.

In the last two years, UNFPA has organized semi-annual meetings with all development partners focusing on SRHR (including USAID, SWEDEN, RNE, Norway, EU, UK, and Belgium) to share experiences and plans. These meetings focus on high-level policy and advocacy issues of mutual interest and updates on UNFPA efforts to facilitate harmonization and coordination of the different SRHR interventions funded by multiple donors. (KIIs with donors, UNFPA).

5 Conclusions

This section provides conclusions derived from the findings and is categorised into the strategic level (those related to overall relevance, efficiency, coherence, and sustainability) and programme-level conclusions.

5.1. Strategic Level

Conclusion 1: The ANSWER programme is well-aligned strategically to international frameworks and national priorities, addressed the SRHR needs of the targeted populations, especially adolescents and young people, and responded appropriately to the changing context and demands. The needs of people living with disabilities were not fully addressed in the programme. There was also limited engagement with beneficiary groups during the design and inception phase to obtain their input.

Evaluation criteria: Relevance
Associated recommendation(s): R

The ANSWER programme remains relevant in the Acholi and the Western Nile sub-regions. The Programme is well aligned with international frameworks, national policies, and priorities. Specifically, it is aligned with relevant country and Royal Netherlands Embassy policies and plans.

It is also relevant to the SRHR needs of the targeted populations, especially the needs of adolescents and young people in Uganda's Acholi and West Nile sub-regions. However, there was limited engagement of the target beneficiaries in the programme's design phase. Due to the sensitivity of programming with vulnerable populations, more end-user engagement at the design stage is desirable to ensure the activities are relevant, engaging, and impactful. Although well-articulated in the programme's design, the inclusion of the needs of the PWDs and the implementation were weak, attempted late, or not addressed at all.

Regarding responsiveness, the programme responded appropriately to the demands of the COVID-19 pandemic, by ensuring the continuation of essential SRHR services during the pandemic. This included critical supplies and skills and awareness of the safe provision of and access to lifesaving SRHR services. It also facilitated the provision of ambulance services for more efficient and safer referrals for pregnant mothers. The programme also responded to the identified gaps in RH equipment that were necessary to implement improvements in SRHR services fully.

Conclusion 2: Although the ANSWER programme faced significant challenges in its implementation, it achieved many of the expected results, especially in the areas of maternal health, family planning and GBV services, youth-friendly services, and positive knowledge and attitudes of young people and couples, although some outputs were not fully achieved in relation to post-abortion care and HIV-testing and changing social norms.

Evaluation Criteria: Effectiveness, Efficiency

The COVID-19 pandemic significantly impacted the implementation of the programme. It reduced the effective implementation period to about 2 years, adversely impacting the efficient use of resources. Despite this, the Programme made progress in maternal health, family planning and GBV services, youth-friendly services, and positive knowledge and attitudes of young people and couples. Overall, the ANSWER programme made significant achievements in strengthening SRHR care. Yet, the achievements related to addressing social norms and knowledge, attitudes and practices, and creating a supportive policy environment were more mixed. A key finding is that there is strong evidence that the ANSWER programme contributed to achieving key programme outcomes: (1) reducing maternal deaths in West Nile and Acholi sub-region by strengthening the capacity of the health system to provide quality maternal health services through training. Continuous quality improvement, MPDSR, etc.; (2) increased

family planning uptake through outreach services, work around social norms and sexuality education; and (3) strengthened health provider capacities to deliver youth-friendly services. These outcomes were achieved by the ANSWER programme strengthening the supply and service provision of maternal health, family planning and GBV services, and partly contributed to by the efforts to intentionally remove social and personal barriers and improve knowledge and attitudes of young people to access services and enable demand for SRHR services and improving the policy context and public discourse around the value of SRHR and investing in this as part of wider societal progress in SRHR services in Western Nile and Acholi at this stage, but not in changing allocation of resources.

Conclusion 3: The ANSWER theory of change underlying the results chain logic was sound and still relevant. The programme's design simultaneously addresses supply and demand side factors. It focuses on enabling policy and social environment to address poor SRHR outcomes in Acholi and Western Nile Region, which is effective. However, there were different levels of investment in the different causal pathways, with more significant investments in the supply side than the demand side. While there were issues with the integration of interventions at the beginning of the programme, with the 2022 review and programmatic and operational adaptations, internal coherence and integration were strengthened.

Evaluation Criteria: Efficiency

The programme's Theory of Change (ToC) continues to be highly relevant to the issues faced in Acholi and Western Nile Region. Simultaneously addressing supply and demand side factors whilst supporting the development of an enabling policy environment and addressing negative gender and social norms is an effective design and strategy. However, there were different levels of investment in the different causal pathways, and they were not necessarily initially implemented in the integrated manner intended.

The ToC was envisaged as an integrated package of interdependent interventions addressing demand, supply and enabling environment with appropriate resources and implemented to obtain the desired holistic outcomes. The level of impact of each pathway of the TOC depended on the integration and intensity of various activities in one locale; however, the activities were often spread over a wide geographical area (too many districts and sub-counties) with limited resources to reach saturation. There was also a disproportionate investment in supply (e.g., strengthening the health facility) compared to the demand side (e.g., the community structures), as presupposed by the TOC.

Conclusion 4: Efforts were made to address cross-cutting issues of gender equality and disability inclusion in select activities. However, these were not addressed systematically and consistently mainstreamed across all the programme activities.

Evaluation Criteria: Relevance, Effectiveness, Efficiency

There were attempts to tackle gender equality and disability inclusion within the programme, but these efforts lacked consistent and systematic integration across all activities. At the core, the Programme targeted young people through service delivery and sexuality education. It endeavoured to raise awareness about gender inequality and (GBV) at multiple levels, spanning community, district, and national tiers. Efforts to integrate PWDs into the education system were belated to produce visible results by the end of the Programme. Similarly, while training was undertaken for greater inclusion of PWDs, this only occurred in the programme's second half.

Yet these efforts were limited to certain activities and not across the programme. The involvement of these marginalised groups in designing interventions that directly impacted them was limited, consequently weakening the design of specific interventions that could cater to their needs. Health facilities inadequately addressed the inclusion of youth and people with disabilities (PWDs). In addition, the workaround demographic dividend (DD) did not include a strong gender transformative lens or a focus on equity. There is notably little work on promoting and protecting human rights.

Conclusion 5: UNFPA and the IPs provided timely and quality financial and technical support to partners and stakeholders and used an appropriate mix of implementation modalities to implement the programme. The programme structure, coordination and collaboration mechanisms were appropriate for efficient implementation and coherence. However, the human resources capacity at the field level was spread too thin for optimal impact. While the changes to the deployment of IPs in 2022 improved coordination and increased efficiency in implementation, these changes midstream adversely impacted efficiency in the implementation of the Programme.

Evaluation Criteria: Efficiency, Coherence

UNFPA provided timely and quality financial and technical support to its partners. The IPs were also acknowledged for their commitment and timely and quality support in the field. The implementation modalities were generally appropriate, although challenges were experienced in moving funds and implementation of activities between the national and district authorities. The programme structure within UNFPA, along with IPs and technical experts, was appropriate for efficient implementation. Good coordination, collaboration mechanisms, and relationships with the national and district governments and community structures contributed to the efficient execution of interventions.

Government leadership adopted by the Programme (and other actors) has created an effective mechanism to avoid duplication, thereby ensuring coherence. There are also ongoing mechanisms and efforts to coordinate initiatives and enhance synergies between development partners, which is still a work in progress. However, the field-level human resources (UNFPA and IP field staff) were spread too thin (in too many districts and sub-counties) for optimal impact. While timely and necessary to improve coordination, the midstream changes in the deployment of IPs also caused losses in momentum and delays in the implementation of some activities and impacted efficiency in the implementation of the programme. It provides useful lessons for future IP assignments at the onset of new programmes of a similar nature.

It appears that the Programme inception period was too short to allow for intensive consultations with IPs and subnational authorities, especially with IPs and subnational authorities necessary and commensurate with the level of investment in this Programme.

Conclusion 6: UNFPA established effective Programme coordination mechanisms coupled with a well-defined and elaborate monitoring and evaluation framework that allowed the capturing of appropriately disaggregated data (including for adolescents and young people, gender, PWDs and refugees.) and reporting of Programme activities and outcomes. However, challenges remain in the integrity and reliability of the data of national systems and district systems.

Evaluation Criteria: Efficiency

The Programme has effective coordination mechanisms with bi-weekly, monthly, quarterly and annual meetings. The monitoring and evaluation framework is comprehensive and appropriate for capturing data related to Programme interventions, including disaggregated data. Data capturing and reporting instruments are in place from the community to the national level.

However, there were some challenges in the availability and reporting of data in some areas by national and district health teams. For example, at the community level, data is captured by community structures, e.g. VHTs, who are voluntary with weak oversight and supervision, raising questions about the integrity of the data. At the same time, there are data management capacity issues with the institutions on the ground (e.g. district authorities, health facilities and the police). A harmonised approach and framework have not been established nationally, creating confusion in the field.

Conclusion 7: Overall, sustainability was well-designed and implemented. These include supporting government initiatives, aligning with its policies and frameworks, working with and through national and district authorities, building institutional capacity and building and using local technical resources. However, sustainability challenges remain, including inadequate government resources and the limited time of implementation of interventions due to COVID-19, and some programme adaptations were introduced in the second half of the programme.

Evaluation Criteria: Sustainability

Overall, sustainability was well-designed and implemented for sustainability. The programme's interventions support government efforts to implement policies and seek to address the same issues the government aims to address. The Programme worked with and through national and district agencies, emphasising their leadership and coordination. This promoted ownership and contributed to sustainability. It also supported building institutional capacities at national, district and community levels while utilizing local technical resources. UNFPA made extensive efforts to support developing and reviewing policies, plans, and guidelines.

However, sustainability challenges exist, including inadequate government resources to sustain interventions at the same level and weak administrative and coordination structures within government at national and district levels. The limited implementation period of some interventions, e.g., inter-generational dialogues, limits the desired results and sustainability. Some practices, such as facilitating community activities, may undermine their sustainability. The community structures such as SASA activists and MAGs (though they have demonstrated effectiveness) that are not already part of the organic community structures are unlikely to be sustained without external investment as opposed to the activities with the cultural and religious leaders that were already well-established in the community prior to the Programme.

5.2. Programmatic level

Conclusion 8: The ANSWER Programme put significant effort and resources into strengthening health systems at health facility, district and national levels with demonstrable results. The Programme achieved many of its planned targets despite the significant challenges of COVID-19. However, inherent health system challenges and upstream issues beyond the programme's control affected the interventions' effectiveness in some respects.

Evaluation Criteria: Effectiveness

The investments in strengthening the health system have resulted in more people being reached with SRHR services, including adolescents and young people and improved health outcomes such as reducing facility maternal mortality rate in the supported health facilities. The programme has enhanced the capacity of health facilities to provide quality SRHR services, including youth-friendly services, as well as community-based services such as VHTs and peer educators to extend SRHR services to the community level. Health system challenges (an inadequate number of health workers and equipment at health facilities) and upstream issues (policy issues, IT systems, commodity supply chains) affected the effectiveness of some of the interventions (e.g., availability of RH commodities at facility level, implementation of youth-friendly services).

Conclusion 9: UNFPA has put significant effort into the implementation of sexuality education for the youth in school, which has contributed to enhanced knowledge and positive attitudes towards SRHR. However, contextual social and political challenges have slowed the progress of this initiative in the school system and prevented it from gaining much traction.

Evaluation Criteria: Effectiveness

The additional modules included as part of the PIASCY curriculum, namely menstrual hygiene management, have been highly successful and valued. Diverse stakeholders have pin-pointed it as a gender transformative approach and it has elicited buy-in from boys and the community, including cultural and religious leaders, teachers, and parents. However, the modality of delivery of the PIASCY curriculum limited the reach of the ANSWER programme within school settings. Few teachers were trained per school, and each had a limited number of students attending the clubs, which curtailed its potential reach. Moreover, teachers were overloaded trying to compensate for 18 months of absence of students due to COVID-19 lockdowns. The emphasis on abstinence-only sexuality education is at odds with UNFPA's normative standards of comprehensive sexuality education. However, this was beyond the control of UNFPA and was the only option allowed to increase awareness of SE and SRHR among learners, given the political, religious, and cultural context at the time.

Conclusion 10: UNFPA supported interventions to engage out-of-school youth, and there have been achievements with improvements in SRHR knowledge among out-of-school youth.

Evaluation Criteria: Effectiveness
Associated recommendation: 11

The ANSWER programme enhanced knowledge and skills on SRHR/GBV among out-of-school youth through community interventions and VSLA activities. To reach out-of-school youth groups, the ANSWER programme set up Village Savings and Loans Associations (VSLAs). These have successfully raised knowledge and awareness about GBV, unintended pregnancies, and contraception. All the participating stakeholders positively valued these activities. Moreover, there were attempts to engage youth from marginalized groups after conducting a vulnerability assessment and developing activities to exclusively support their needs. These activities may continue in terms of the income-generating groups registering with the local government for funds; however, this will not include the SRHR content that was included by the ANSWER programme.

Conclusion 11: On gender and social norms change, the ANSWER programme successfully enhanced the skills and supported community structures and resource persons to shift social and gender norms, but issues with fidelity, intensity and reach around these activities suggest they were too diffused over a large geographic area to achieve desired change and sustained impact.

Evaluation Criteria: Effectiveness
Associated recommendation: 12

The ANSWER programme identified the appropriate community structures (e.g. SASA, IGDs, MAGs, model parents, cultural and religious leaders) and enhanced their skills to challenge negative gender and social norms. However, there were a few challenges to the success of the interventions. First, some of the models may not have been implemented as intended; for instance, the implementation of the SASA approach was interrupted by the COVID-19 pandemic and the changes in IPs in 2022 and did not consistently follow the methodology as stipulated, while that of intergenerational dialogues was implemented late. Secondly, the number of trained structures and the incentives for these structures were relatively low to achieve the desired social norm change. For example, no clear and adequately resourced diffusion strategies, mentoring, or monitoring were used after the participants had been trained. It is also unclear if those trained were given the support and skills for when they experienced push-back. When you introduce new norms, it is inevitable.

Conclusion 12: The ANSWER programme increased the resources and created useful technical guidance, mechanisms, and tools (e.g., planning process, updating staff knowledge) to strengthen the capacity around the demographic dividend at the national and district level. However, the programme sets unrealistic expectations about what district-level leadership can change, e.g., policy priorities and budget allocations.

Evaluation Criteria: Effectiveness, Coherence

Building on an established collaboration with NPC and NPA, UNFPA successfully supported building political priority for the demographic dividend roadmap at the national level. The training and technical resources to support district-level interpretation, use of data and informed planning were highly valued. However, capacity building at the district level did not translate into budget allocations as district budgets are already earmarked and limited funds are controlled locally.

6 Recommendations

The following recommendations are focused on what needs to be done to address the conclusions in Chapter 5. They are categorised into strategic levels (those related to overall relevance, coherence, and sustainability), followed by programme-level recommendations.

6.1 Strategic Level

Recommendation 1: UNFPA should continue to harness its strong relationship and alignment with the existing structures at the national, district and community levels. However, it must be more intentional in its engagement with its target beneficiaries throughout the project cycle to ensure their needs and inputs shape the design, implementation, and monitoring of the Programme.

The programme has aligned with the country's policies and frameworks and supported the government in implementing initiatives to achieve its objectives. It also consults and collaborates extensively at the national and district level. However, there was insufficient engagement of the target populations in designing the implementation and assessing the programme's performance. We recommend systematic engagement with target beneficiary groups, particularly vulnerable groups, from the inception of programmes to ensure interventions respond to their varying and unique needs and preferences.

Evaluation Criteria: Relevance
Based on the conclusion: 1

Recommendation 2: The Theory of Change still holds and remains relevant. Interdependent components of the Programme should be appropriately resourced and implemented in such a way as to ensure their respective contributions work together to deliver holistic and optimal results.

The ANSWER programme Theory of Change still holds and remains relevant. Many of the interventions identified were suitable for operationalizing the Theory of Change. It is necessary to ensure that all stakeholders involved in the implementation are fully aware of how their components contribute to the overall result. The level of resources allocated and the intensity of implementing the different components should ensure that each component contributes appropriately to the whole. Specifically, the investment in the interventions under each element of the Theory of Change should be proportionate; the investment work in generating demand should be equivalent to efforts to address service delivery. The level of impact depends on the strategic integration and intensity of activities in one location. The activities should be collaboratively planned with IPs and district leadership to foster this synergy and reach the necessary saturation.

Evaluation Criteria: Efficiency, Effectiveness
Based on the conclusion: 3

Recommendation 3: The cross-cutting issues at the heart of the ANSWER programme should be consistently integrated across the programme.

Some efforts were made to address gender equality and disability inclusion across the programme, particularly around young people, and to address harmful gender norms. These efforts need to be mainstreamed across ALL activities and IPs. This includes how the activities are undertaken, from gender-sensitive and inclusive design to monitoring. It also includes consistent messaging across all activities. This work requires highly specialized skills and technical capacity from the start to work with UNFPA and the implementing partner on values clarification and revising methodologies to ensure they are gender transformative and inclusive of young people, PWD, and refugee settings. This work should be frontloaded and regularly monitored and adapted during the programme's inception.

Moreover, many of those engaged in this work are putting themselves at risk of stigma and abuse. Sexual and reproductive health is a sensitive issue the world over, and working to change knowledge and attitudes around issues related to sex, sexuality, and reproduction can trigger pushback and hostilities for those working on these issues. Appropriate safeguards should be put in place, e.g. hotline, guidance, training, etc., for those supported by the Programme. In addition, human rights-based approaches need to be explicitly used.

Evaluation Criteria: Relevance, Effectiveness
Associated with Conclusion 4

Recommendation 4: In future large-scale, multi-component programming, adequate time, resources, and flexibility for the inception phase to allow for more detailed consultations, co-creation and planning, especially with beneficiaries, implementers and stakeholders in the districts. It is also recommended that programmes plan and allocate resources to allow the full implementation of the comprehensive package of related and interdependent interventions over a smaller geographical scope for the desired impact that is in line with the theory of change.

While factors beyond the control of the programme's management affected the programme's implementation, some lessons can be learned. UNFPA should draw lessons for more effective and efficient deployment of IPs from the inception of programme/project implementation. There is also a need to focus on and balance resources within a smaller geographical scope to ensure all the interdependent interventions in the package are fully implemented to achieve the desired impact as per the theory of change.

On the implementation modalities, there is a need to review the role of national agencies in the channelling of funds and implementation of activities at the district level. UNFPA should continue building on and advancing good collaboration and coordination with national and district agencies, while supporting the building of their capacities to play their leadership and coordinating role effectively. This will ensure greater efficiency, coherence and effectiveness.

Evaluation Criteria: Efficiency, Effectiveness, Coherence
Based on the conclusion: 5

Recommendation 5. UNFPA and other partners should put adequate resources and effort into improving data capture, analysis and reporting.

UNFPA and other partners should focus on building the capacity and systems at the district and lower levels to capture comprehensive, accurate and timely data. This includes building the capacity to capture data in the communities, overseeing and supervising to ensure integrity, and capturing and analysing that data by the agencies on the ground, e.g., health facilities, police, prosecution, etc. UNFPA should, at the same time, put effort into upstream advocacy and provide technical and financial support to harmonise databases and systems at the national level and their linkages to districts and lower levels.

Evaluation Criteria: Efficiency
Based on the conclusion: 6

Recommendation 6: UNFPA should continue and learn from its already effective approaches to sustainability. At the same time, it should continually assess and address the challenges to sustainability.

UNFPA should continually build on its effective approaches, including ensuring government agencies' leadership and coordination while continuously building institutional capacities and using local technical resources. There is also a need to address challenges, including reviewing and discouraging practices that run counter to sustainability as far as practicable. Programme design and implementation

should focus more on the depth and fidelity of the interdependent package of interventions, ensuring they fully mature and achieve optimal impact.

Evaluation Criteria: Sustainability
Based on the conclusion: 7

6.2 Programmatic level

Recommendation 7: On strengthening health systems, UNFPA and partners attend to upstream issues by supporting advocacy activities and systems-strengthening interventions to address identified challenges and ensure optimal results from implementing activities at the district level.

UNFPA, in coordination with other partners implementing health systems strengthening interventions, needs to support efforts to address upstream challenges adversely affecting the success of interventions in the districts. These include challenges from implemented IT systems, commodity supply chains, and health human resources capacity and deployment. This is done through advocacy activities and supporting interventions addressing identified upstream challenges.

Evaluation Criteria: Effectiveness, Efficiency
Based on the conclusion: 8

Recommendation 8: The ANSWER Programme focused primarily on improving access to quality SRHR services for youth and adolescents within health facilities and in communities. However, access to these services within health facilities remains inadequate. UNFPA should work with the MoH to strengthen the implementation of youth-friendly services in health facilities further.

UNFPA should continue working with the MoH and other partners, implementing interventions focusing on access to health services for young people to support the implementation of the revised MoH guidelines and quality standards for youth-friendly services in health facilities. This ensures a more sustainable setup for access to quality SRHR services for adolescents and youth at the facility level. This should include the approach, capacity building and deployment of health personnel, and the necessary facilities and equipment,

Evaluation Criteria: Effectiveness
Based on the conclusion: 8

Recommendation 9: There is a need to re-envision the interventions to reach more youth in school with age-appropriate sexuality education, including menstrual hygiene management, but supplement what they learn with other community approaches.

There is a need for more resources to identify more suitable interventions and resources to reach more adolescents and youth with age-appropriate sexuality education, including menstrual hygiene management, that adheres to UNFPA's standards of comprehensive sexuality education. These could include reaching out to in-school youth through activities outside school hours, such as peer education, model parents, and health talks.

Evaluation Criteria: Effectiveness
Based on the conclusion: 9

Recommendation 10: While there is a need to reach more out-of-school youth with SRHR information and services and behaviour change interventions, there is also a need for more emphasis on their livelihood empowerment.

While the model used (reaching youth in YSLA groups through peer educators) is effective, there is a need to scale up to reach more young people. It is, however, also extremely necessary to scale up interventions that address their livelihoods, such as unemployment and lack of skills and opportunity, which are key factors in poor social and health outcomes. The curriculum should also be brought in line with gender transformative principles.

Evaluation Criteria: Effectiveness
Based on the conclusion: 10

Recommendation 11: On gender and social norms change interventions, there is a need for more effort and resources to implement the selected approaches fully and to scale up the interventions with more community and financial resources for organised diffusion to achieve the desired impact.

UNFPA and other actors should scale the interventions to achieve gender and social norm changes necessary for improved social and health outcomes, especially for youth and women. More resources and effort should be put into developing a fully-fledged SBC programme, including identifying and fully implementing the proven approaches, e.g., inter-generational dialogues. Efforts and resources should be concentrated within a manageable geographic scope to allow for sufficient organised diffusion activities to achieve the necessary threshold to achieve the desired change. The resources allocated should be commensurate with the impact of these interventions envisaged in the theory of change. In other words, there is a need to increase resources and focus on fewer districts and sub-counties.

Evaluation Criteria: Effectiveness, Efficiency
Based on the conclusion: 11

Recommendation 12: UNFPA should build on its successful work to raise awareness and capacity around the demographic dividend at the national and focus on further strengthening the actors at the district level to move this agenda forward.

UNFPA should continue to invest in supporting national partners to provide technical capacity and political support on the demographic dividend nationally and to support the work to localise the demographic dividend (DD) agenda at the district level. A simpler, more consistent curriculum and IEC materials need to be developed to fully articulate the roles of different actors at the district level to move this agenda forward.

Evaluation criteria: Effectiveness
Based on the conclusion: 12

Annexes

Annex 1: Persons interviewed

Role	Organization or district
Director, Family Health	National Population Council (NPC)
Ag. Manager, Population and Sector Planning Dept	National Planning Authority (NPA)
Director, Population and Social Statistics	Uganda Bureau of Statistics (UBOS)
Ass. Commissioner Health Services. Supply Chain and Logistics.	Ministry of Health (MoH)
Principal Officer- RH	Ministry of Health (MoH)
Senior Prog. Officer, ADH	Ministry of Health (MoH)
Technical Advisor for school health	Ministry of Education and Sports (MoES)
Programme Specialist – Coordination and Delivery	UNFPA
Programme Specialist – RH	UNFPA
Programme Specialist – Coordination and Delivery	UNFPA
Programme Analyst- ASRH/Gender	UNFPA
Prog Specialist- Population Dynamics	UNFPA
Prog Analyst- family planning/RHSC	UNFPA
Prog. Specialist- ASRH	UNFPA
Field Officer / Gender Specialist	UNFPA
Programme Manager- ANSWER Programme	Save the Children
Project Officer Lamwo	Save the Children
Prog Officer, ASRHR,	Save the Children
Programme Officer. In charge of Koboko, Maracha, Terego, Arua District, Arua City.	MSU
Project officer Yumbe	Plan Int'l
Project Officer, Adjumani District	Plan Int'l
Project Coordinator PI Real (Resilient Empowered Adolescent Led / livelihood) Project / AP, Adjumani District	Plan Int'l
Programme Specialist- MCH	Jphpeigo
M&E advisor for JPIEGO	Jphpeigo
President	Uganda Private Midwives Association
Training Coordinator	Uganda Private Midwives Association
Executive Director.	Reproductive Health Uganda
Richard Simon Mugwenyi. Advocacy and Communications Manager	Reproductive Health Uganda
Ass. Public Health Officer, family planning for SRH, HIV services	UNHCR
Assistant Field Officer.	UNHCR
Field Assistant. Field Unit. Palabek	UNHCR
Assistant Community Based Protection Officer. Palorinya	UNHCR
MCH Specialist	UNICEF
Manage the SRHR and Gender.	Royal Danish Embassy
In charge of Cfamily planning Unit, Lamwo Police Station	Lamwo District
Gender Focal Person	Lamwo District
CAO	Lamwo District

DEO	Lamwo District
ADHO / MCH	Lamwo District
Senior Clinical Officer. Adolescent family planning. Palabek Gem Health Center	Lamwo District
District Planner	Lamwo District
DHO	Lamwo District
DCDO	Lamwo District
Chairperson. District Youth Council.	Lamwo District
Catechist. Paloga Catholic Church.	Lamwo District
Muslim Sheik	Lamwo District
Pastor. Pentecostal Church of Uganda (PCU)	Lamwo District
SASA! ToT	Lamwo District
District Councilor, Female. Member DEC	Lamwo District
Administrator. Ker-Kwaro Acholi (Cultural Insitution) – oversees East Acholi (Lamwo, Kitgum, Pader, Agago districts).	Lamwo District
Ag Refugee Desk Officer (RDO). OPM. Palabek Refugee Settlement	Lamwo District
Settlement Commander. OPM. Palabek Refugee Settlement	Lamwo District
Ass. Settlement Commandant. OPM. Palabek Refugee Settlement	Lamwo District
Community Liaison Officer. Yumbe Police Station	Yumbe District
Vice-Chair, DLC	Yumbe District
Community Liaison Officer. Yumbe Police Station	Yumbe District
DEO.	Yumbe District
EO	Yumbe District
District Health Educator. –VHTs, voucher, CQI.	Yumbe District
ADHO. In charge Mocha HC3. CQI mentor.	Yumbe District
DHO.	Yumbe District
RWC2 Chairperson. Yangani Cluster (18 villages)	Yumbe District
RWC Youth Secretary. Yangani Cluster.	Yumbe District
RWC Chairperson Zone 5 (24 villages)	Yumbe District
District Chief Kadhi. Muslim HQs Yumbe	Yumbe District
Muslim Teacher.	Yumbe District
Yumbe District Youth Chairperson (sits in NYC).	Yumbe District
Female youth member of DLG.	Yumbe District
Rep PWDs in the DLC	Yumbe District
Chairman. PWDs Union in the District. Umbrella of PWD organisations.	Yumbe District
Chairman. District Council for PWDs	Yumbe District
Cultural leaders. Aringa Kingdom.	Yumbe District
Arch Deacon. Church of Uganda, Yumbe	Yumbe District
ADHO. Yumbe	Yumbe District
Ag District Planner	Yumbe District
SCDO / Gender Officer	Yumbe District

Secretary – Health and Education / Youth Councilor. Yumbe DLG..	Yumbe District
OIC Child and Family Protection Unit, Adjumani Central Police Station.	Adjumani District
Senior State Attorney. ODPP. Adjumani District	Adjumani District
Secretary – Paramount Chief. Coordinates cultural activities. Gender family planning person. Madi Cultural Institution (3 districts of Adhumani, Moyo and Obongi.)	Adjumani District
A nurse / pharmacist. Sisters of the Sacred Heart of Jesus	Adjumani District
Medical Superintendent. Adjumani Hospital	Adjumani District
District Medicine Management Supervisor (MMS).	Adjumani District
ADHO MCH	Adjumani District
Female Councilor. PWD Rep. DLC.	Adjumani District
Male Councilor. PWD Rep. DLG	Adjumani District
Teacher. Implementing PIASCY in school. Trained to handle children with intellectual disabilities	Adjumani District
Youth Councilor, DLG	Adjumani District
Gender Officer	Adjumani District
Probation Officer.	Adjumani District
DCDO	Adjumani District
Nursing Officer. District family planning for adolescent health and palliative care. Adjumani Hospital	Adjumani District
Principal Assistant Nursing Officer / Head of Nursing. Focal point for midwifery.	Adjumani District
RDC. Head of security in the district	Adjumani District
Principal ACAO	Adjumani District
Det Corporal Mutahi Constant.	Obongi District
Nyani Okudra.	Obongi District
Akello Doris.	Obongi District
Santos Drangwiai	Obongi District
Lemeriga George,	Obongi District
Abdul Rahman	Obongi District
	Obongi District
Sabir Rashid Kemis	Obongi District
Youth Councilor, Female (DLC)	Obongi District
DCDO	Obongi District
Secretary for Health and Community Service / Member of the DLC / Member of DEC	Obongi District
Gender family planning	Obongi District
Child and Family Protection	Obongi District
Gender	Obongi District
RWC2, Base Camp Zone Refugees Welfare Committee / Council, Palorinya Base Camp Zone	Obongi District
Women Rep. RWC3	Obongi District
Chairman RWC3, overall	Obongi District

Cultural leader. Paramount Chief. Spokesperson for Aliba, Gimara, Reli, Madi Palujo tribes	Obongi District
PWD chairperson, Gimara Sub County	Obongi District
Female Councilor, rep PWDs, Itula SC. SASA! Activist	Obongi District
District Chairperson, PWDs	Obongi District
CDO. Obongi Town Council	Obongi District
Magistrate Grade 1.	Obongi District
Chief Magistrates Court in Moyo District.	Obongi District
Health Inspector	Obongi District
DEO	Obongi District
DHO	Obongi District
District Communications Officer	Obongi District
Biostat.	Obongi District
Church of Uganda	Obongi District
Church of Uganda	Obongi District
Catechist. Catholic Church. Palorinya Parish	Obongi District
Imam. Aliba Sub County	Obongi District
Assistant Community Services Officer. OPM. Palorinya.	Obongi District
Community Services Officer, OPM. Palorinya.	Maracha District
ASP / Ag. DPC. Maracha Police Station	Maracha District
Det / ASP in charge of CID. Maracha Police Station	Maracha District
Inspector / Dep CID. Maracha Police Station	Maracha District
AIP / In charge Cfamily planningU. Maracha Police Station	Maracha District
DEO	Maracha District
LC5 chairman	Maracha District
Senior Health Educator	Maracha District
DHO	Maracha District
ADHO MCH	Maracha District
Secretary for Education, Health and Social Services	Maracha District
Priest, All Saints Parish, Oluvu. Arua Diocese	Maracha District
Pastor. Church of Uganda	Maracha District
Imam / Deputy Kadhi.	Maracha District
Maracha Town Council	Maracha District
District Councilor, DLC, PWD Rep, Male.	Maracha District
Chairperson. District Union of PWDs	Maracha District
District Youth Councilor. Male	Maracha District
District Youth Councilor. Female. Also youth activist.	Maracha District
Youth Leader, activist. Peer Educator	Maracha District
Chairman of Maracha Elders Association	Maracha District
District Planner	Maracha District
DCDO	Maracha District
Probation Officer	Maracha District

Health worker	Amuru District
Health worker Atiak HC V	Amuru District
In-charge kaladima HCIIi	Amuru District
In-charge - Palabek Gem Health Facility_	Lamwo District
health worker Alere HCII	Adjumani District
Health worker HC IV	Yumbe District
Healht worker ALIBA HC III_	Obongi District
Health Worker ITULA HC III	Obongi District
Health Worker_RHINO CAMP HC IV_	Madi Okollo District
In-charge Palabek Kal health facility	Lamwo District
KII MUNGULA HEALTH CENTER 1v	????
Health worker	Maracha District
Health facility staff	Zombo District
Health facility staff	Zombo District
Health facility staff	Madi Okollo District
DISABILITY ADJUMANI TOWN COUNCIL	Adjumani District
DISABILITY CIFORO_ADJUMANI	Adjumani District
Traditional leader LAMOGI CHIEF	Amuru District
Local chairperson LC5	Amuru District
Local chairperson LC1	Amuru District
Disabilty - person living with disability	Amuru District
Religious leader, Hajji Seki Yusuf- Yepi North village, Alikua SC	????
cultural leader Pagak Amuru	Amuru District
Cultural Leader, Atyak SC.	????
Cultural Leader	Zombo District
Local Coucnil LC1, Kololo east village, Tara subcounty	????
Local Council Leader 1,	Lamwo District
Local council LC1 Acoro village, Oyeyo Parish, Nyapea SC.	????
Disability - PWD, Barunze village, Pasai parish, Alangi SC.	????
Religious leader	Maracha District
Senior Medical Officer HC IV	Maracha District
In- charge HC, Palabek Gem	????
Mr. John Pasquale, Refugee Welfare Council,	????
Teacher ARIWA SS	Yumbe District
Matron IN AMEI PS_PAIDHA-	Zombo District
Teacher in Paluda SS	Lamwo District
ADHO	Zombo District
DCDO Continuation_ District Level	Zombo District

DCDO ZOMBO_ District Level	Zombo District
DEO Office Zombo	Zombo District
District Peer Educator Amuru	Amuru District
ADHO-Maternal Health Amuru	Amuru District
CAO Amuru	Amuru District
DCDO Amuru	Amuru District
DEO Amuru	Amuru District
PLANNER AMURU	Amuru District
Police Zombo	Zombo District
RDC AMURU	Amuru District
Cultural leader District level_Zombo	Zombo District
CHILD PROTECTION MADI OKOLLO	Madi Okollo District
DCDO MADI OKOLLO DLG	Madi Okollo District
DEO OFFICE MADI OKOLLO	Madi Okollo District
DEO OFFICE - SPECIAL NEEDS MADI OKOLLO	Madi Okollo District
DEO_ADJUMANI	Adjumani District
District inspector of schools_Lamwo	Lamwo District
Gender focal person Adjumani	Adjumani District
OC STATION MADI OKOLLO	Madi Okollo District
DHO MADI OKOLLO DLG	Madi Okollo District
Police in Amuru	Amuru District
Disability SPECIAL OLYMPICS_MADI OKOLLO	Madi Okollo District
ADHO_ZOMBO	Zombo District
District Health Secretary	Lamwo District

Annex 2: List of ANSWER interventions

Objective One
1.1.1. Improving the availability of family planning method mix at service delivery points and scaling-up last mile access to new contraceptive technologies
1.1.1.1 Procure and distribute family planning commodities
1.1.1.2 Conduct District TOT training on method mix and new contraceptive technologies
1.1.1.3a Support Uganda Private Midwives and District TOTs to conduct mentorship at Health facilities on range of contraception
1.1.1.3b Support Uganda Private Midwives and District TOTs to conduct mentorship at Health facilities on range of contraception
1.1.1.4 Identification and orientation of VHTs on family planning methods incl. Sayana Press, and scaleup of use in the communities.
1.1.1.5 Monitoring of service delivery points (SDP) for availability, accessibility and acceptable contraceptive stock levels, by supporting DLG support supervision and redistribution
1.1.2. Support to functionalise logistics management information systems and a web-based real-time monitoring system
1.1.2.1 Conduct Needs Assessment for eLMIS suitability in the 12 Districts
1.1.2.2 Procure eLMIS equipment based on needs assessment
1.1.3.1 Conduct mentoring and coaching of health facility service providers and District Health Management teams on forecasting, quantification, procurement, storage and distribution to the last mile once a year
1.1.4. Delivery of the three-phase continuous quality improvement (CQI) approach for SRHR services, including for vulnerable populations
1.1.4.1 Strengthen National QI coordination committee by supporting National QI Planning meetings
1.1.4.10 Support QI National Team to conduct follow up and continuous mentoring to District Trainers
1.1.4.11 Increasing health facility physical accessibility for PWDs
1.1.4.12 Developing/reviewing disability-sensitive protocols and guidelines and human rights based service delivery
1.1.4.13 Provide support to translation services for refugees and PWDs
1.1.4.14 Developing and printing IEC Materials for PWDs, adolescents and refugees
1.1.4.16 Orientation of VHTs to identify PWDs, share GBV/SRH information and where appropriate provide them with services.
1.1.4.17 Training of peer educators
1.1.4.18 Peer educators - support at health centres and for health outreaches
1.1.4.19 Capacity for health facilities to engage in data capture and analysis
1.1.4.2 Develop/Review, Print and disseminate QI materials
1.1.4.20 Support Health facility meetings
1.1.4.21 Support Districts to conduct inter facility collaborative learning meetings
1.1.4.22 Conduct interdistrict collaborative learning visits
1.1.4.3 Hold District inception meetings on CQI
1.1.4.4 Functionalize the district CQI coordination committees
1.1.4.5 Functionalization of the HCW training database
1.1.4.6 Train District Trainers on QI for family planning, maternal health, PAC, HIV testing and GBV
1.1.4.7 Train District Trainers on youth friendly services, disability friendly services and provision of services for refugees,
1.1.4.8 Build capacity in health facilities through the district health office in data capture, analysis and disaggregation

1.1.4.9 Support District Trainers to conduct QI mentoring, including for youth, disability and refugee friendly services at health facility level
1.1.5. Pre-service training for anaesthetists' assistants as a critical cadre for comprehensive SRH service delivery
1.1.5.1 Support training of Anaesthetist assistants
1.1.6. Support development/review and printing of GBV referral pathways
1.1.6.1. Support GBV referral mechanisms
1.1.7. Improved availability and quality and accessibility of integrated SRH services including contraception for young people, PWDs and refugees
1.1.7.1 Support district local government to carry out quarterly SRHR outreaches in target districts
1.1.7.2 Mobilization of young people, refugees for outreach services - community activations
1.1.7.3 implement a voucher system for teenagers to access family planning and safe delivery services
1.1.7.4 Pregnancy mapping in target areas
1.4.1. Strengthen cultural, religious and community leaders' engagement
1.4.1.1 Strengthen cultural and religious leaders' engagement in SRHR
1.4.2.1 Establishment of Male model groups (MAGs)
1.4.2.2 Training of MAGs
1.4.2.3 Continuous support to MAGs
1.4.3.1 Implement SASA!
1.5.1 Development of School Operational Health Policy Guidelines
1.5.1.1 Development of the School Health policy operational guidelines
1.5.2 Support teachers to provide SE (PIASCY) at community level and/or in schools
1.5.2.1 Orientation of teachers and school administrator of the sexuality education framework and the School Health Policy
1.5.2.2 Support to schools implementing the Sexuality education framework and the School health policy
1.5.2.3 Learning circles for trained teachers
1.5.2.4 Mentoring and support supervision by the district education office
1.5.2.5 Orientation of the Sexuality education framework to 400 religious, cultural and political leader2
1.5.2.6 Regional summits on SE
1.5.2.7 Health education outreaches by peers
1.5.2.8 Support menstrual health management in young people's clubs, AFRI Pads
1.5.3 Support peer educator to deliver comprehensive SRHR information and livelihood skills
1.5.3.1. Establishment of VSLA clubs
1.5.3.2 .VSLA club training skills and information activities
1.5.3.3 VSLA clubs Community level engagement activities
1.5.3.4 VSLA clubs Communication materials
1.5.4.1 Support school health clubs with MHM IEC materials and teaching aids and linkage to health services
1.5.4.2 Training in the use of AFRI pads
Objective Two
2.1.1. Enhance advocacy for resource allocation to demographic dividend (DD)strategic areas

2.1.1.1: Assessment of sectors on demographic dividend (DD)compliance
2.1.1.2: Conduct a gap analysis on demographic dividend (DD)investments using RAPID
2.1.1.3 a. Budget advocacy engagements - meetings/dialogues
2.1.1.3 b: Budget advocacy engagements - meetings/dialogues
2.1.1.4: Production of advocacy materials
2.1.2. Strengthened capacity to provide leadership, advocacy and coordination of population and development in the Country.
2.1.2.1: Technical capacity in Innovations
2.1.2.2: Technical support - Consultant
2.1.3.1: Evidence generation through in-depth analysis, research
2.1.3.2: Conduct high leaders engagements to promote investments in young people
2.1.3.3: Facilitate dialogues that can result into successful participatory youth programmes and actions
2.1.4. Strengthen the research capacity of the Parliamentary Research Department to provide required evidence for decision-making especially on SRH, GBV and population dynamics.
2.1.4.1: Research, Data analysis and presentation
2.1.4.2: Parliamentary Outreach programmes on SRH, family planning, demographic dividend (DD)(Issue based)
2.1.4.3: Production of briefs, fact sheets and disseminate information to influence policy positions.
2.1.5. Support the newly-established structures at MOH specifically dedicated to adolescent health
2.1.5.1 Support to the newly established structures on ADH at the ministry, with support for meetings, advocacy briefs
2.1.5.2 Development of an ADH operational implementation strategy and plan, followed by development of a Costed Implementation Plan (CIP) for Adolescent Health services
2.1.6. Improve coordination and scale up advocacy for leadership and accountability for the national family planning programme
2.1.6.1 Support the Uganda Family Planning Consortium to hold Advocacy nurturing workshops for identified CSOs and follow up engagements with various platforms to influence allocation, implementation and accountability for family planning.
2.1.6.2 Support family planning2020 Donor Focal points for strengthened coordination
2.1.6.3 Document good practices on advocacy
2.1.6.4 Support national Platforms to conduct coordination and advocacy meetings
2.2.1 Multi-sectoral coordination of the SRH/GBV/HIV/demographic dividend (DD)at the district level
2.2.1.1 Establish functional participatory platforms that advocate for increased investment in adolescents and youth within development and health policies and programmes at district level.
2.2.3.1 Support the functionality of the District Medicines and Therapeutic Committees
2.2.4. Yes, I Can Dare Challenge
2.2.4.1 Conduct inception meetings
2.2.4.2 Contribution to TCI
2.2.5. Facilitate data harmonised platforms
2.2.5.1 Facilitate data harmonized platforms
2.2.6.1 Integration of GBV and SRHR into the Community Information data collection System (CIS)
2.2.6.1 Integration of GBV and SRHR into the Community Information data collection system (CIS)
2.2.7. Improved data on SRH/family planning/ASRH/GBV indicators to inform resource allocation during budget conferences, district budget review meetings and district council budget discussions.
2.2.7.1 Improved data on SRH/family planning/ASRH/GBV indicators to inform resource allocations during budget conferences, district budget review meetings and in district council budget discussions.
2.2.8. Enhance accountability and oversight in the planning and budgeting processes
3.4.1 Capacity building of field-based staff

Annex 3: List of indicators for secondary data analysis

1. Number of beneficiaries served with SRHR services in target health facilities in the past 12 months (ANC, family planning, HIV/STI, deliveries, PNC, GBV)
2. Trends in percentage of 10-19 years women receiving ANC1 with respect to all pregnant women receiving ANC1 in 2019-2023
3. Number of service providers in target districts trained in youth-responsive services, rape management and psychosocial support in the past 12 months.
4. Percentage of 10–24-year-olds among new users of modern contraception methods in target districts in the past 12 months
5. Number of women who have reported sexual, physical and/or psychosocial violence in the target districts in the past 12 months.
6. Number of GBV cases managed or resolved as a percentage of cases reported in target districts in the past 12 months
7. Number of women aged 15 - 19 who have given birth (x1000) in West Nile and Acholi sub-regions
8. Number of deliveries in ANSWER programme supported health facilities
9. Total number of SGBV survivors reporting to the facility within 72 hours of incidence (disaggregated on PWDs, refugees, sex, age)
10. Number of clients provided with post abortion care (PAC) services at the supported health facilities.
11. Number of people tested for HIV through supported health facilities
12. Number of women already using a contraceptive method revisiting health centers for modern contraceptives.
13. Number of maternal deaths in ANSWER supported health facilities/institutions (x 100,000)
14. Number of young people (10-24 years) provided with maternal health services through differentiated points of delivery (outreaches, vouchers and health facility)
15. Number of young people (10-24 years) provided with family planning services through differentiated points of delivery (outreaches, vouchers and health facility)
16. Number of people referred to health facilities through ANSWER supported structures (VHTs, peer educators, youth clubs among others)
1. Percent of health facilities experiencing no stock-outs of at least three modern family planning methods over a period of three consecutive months.
2. Percentage of clients at the supported health facilities who are satisfied or very satisfied with family planning/MH/HIV/GBV services (disaggregated by gender, age, disability, refugee and service)
17. Number of adolescents, youth and adults reached through various community platforms including MAGS, SASA Activities, VHTs, religious leaders and cultural leaders.
3. Number and type of community actions taken to contribute to reduction of SGBV, teenage pregnancy and child marriage.
18. Number of SGBV survivors (rape and defilement) reporting timely (within 72hrs) for post SGBV health services.
19. Number of people engaging as community resource persons on GBV, teenage pregnancy, child marriage, family planning
20. Number of schools providing sexuality education (SE) programme
21. Number of young people (10-24 years) in school (students and pupils) who undertake/ attend at least 80 percent of the designed sexuality education (SE) package (PIASCY)
22. Number of young people (10-24 years) reached with age-appropriate information on SRHR and GBV through various strategies (outreaches, health education sessions, peer educators, SE sessions (attended less than 80 percent of SE sessions) etc.)
23. Number of out of school young people (10-24 years) enrolled in young empowerment clubs who undertake/attend at least 80 percent of the designed SE package

Annex 4: Outcome and output indicators for health systems strengthening (Output 1.1)

Project Goal Indicators

Goal: Contribute to the achievement of universal access to SRHR of women, girls, boys and men including disadvantaged and vulnerable populations in Uganda (Targets for indicators are based on National targets, Gou-UNFPA CP8 while some are project specific)

Indicators	Baseline (Source)	4-Year Target (new)	2023 (UDHS 2022)
Maternal Mortality ratio (SDG indicators 3.1.1; NDP II/NDPIII and Vision 2040 Indicator3.4, (UNFPA Strategic Plan Impact indicator)	336 per 100,000 live births (National, UDHS 2016)	219 per 100,000 live births (National Target for 2020, (MoH) RMNCAH Sharpened Plan 2017	189/100,000 live births (National)
Percentage of live births in the five years preceding the survey delivered at a health facility in West Nile and Acholi sub-regions (CP8 outcome indicator; UDHS)	West Nile: 78.2 percent Acholi: 84.1 percent UDHS, 2016	West Nile: 85 percent Acholi: 85 percent (Programme specific target)	West Nile: 86.3 percent Acholi: 89.5 percent
Modern Contraceptive Prevalence Rate (mCPR) in West Nile and Acholi sub-regions (CP8 outcome indicator; MASC SRHR outcome indicator)	West Nile: 19.0 percent Acholi: 36.3 percent UDHS, 2016	West Nile: 23 percent Acholi: 40 percent (Programme specific target aligned to GoU-UNFPA CPD9)	West Nile: 25.2 percent Acholi: 29.8 percent
Adolescent birth rate (SDG indicators 3.7.2; UDHS, UNFPA Strategic Plan Impact indicator)	West Nile: 145/1000 Acholi: 145/1000 (UDHS - 2016)	Target: 135/1000 (Programme specific target)	West Nile 18.2 percent Acholi 21.7 percent.
GBV Incidence Rate (SDG indicators 5.2.1); (UNFPA Strategic Plan outcome indicator)	West Nile: 43.4 percent Acholi: 38.6 percent (UDHS, 2016)	West Nile: 42 percent Acholi: 37 percent (Programme specific target)	West Nile: 40.1 percent Acholi: 37.7 percent

Outcome 1 and output indicators for health systems strengthening (Output 1.1)

Outcome indicators related to supply	Region	Baseline	Target (4 Yr)	Achieved (From the start of the programme to June 2023)
1.1 Institutional Maternal Mortality Ratio at the ANSWER-supported health facilities	West Nile	104	72	86
	Acholi	45	31	47
	Overall	**94**	**65**	**79**
1.2 Number of new users of modern contraceptives (disaggregated by age (10-19,20-24 and 25+), type of method, district and specific groups	West Nile	48,966	264,747	299,992
	Acholi	14,942	78,329	85,710
	Overall	**63,908**	**343,076**	**385,702**

Outcome indicators related to supply	Region	Baseline	Target (4 Yr)	Achieved (From the start of the programme to June 2023)
refugees, PWDs) at the ANSWER-supported facilities				
1.3 Number of women and girls provided with maternal health services (disaggregated by age, location, PWDs, refugees) at the ANSWER-supported facilities	West Nile	93,793	479,200	313,400
	Acholi	19,958	98,639	62,085
	Overall	**113,751**	**577,839**	**375,485**
1.4 Number of GBV survivors provided with post-GBV health services (disaggregated by age, sex, location, and specific groups (refugees, PWDs)) at the ANSWER-supported facilities	West Nile	2,354	18,212	14,916
	Acholi	636	4,053	3,324
	Overall	**2,990**	**22,265**	**18,240**
1.5 Number of women and girls provided with post-abortion care (disaggregated by age, location, PWDs, refugees) at the ANSWER-supported health facilities	West Nile	4,312	19,994	12,520
	Acholi	1,427	5,880	1,560
	Overall	**5,739**	**25,874**	**14,080**
1.6 Number of people provided with HIV Testing services from the supported health facilities (disaggregated by sex, age, location, and specific groups (PWDs, refugees)) at the ANSWER-supported facilities	West Nile	170,205	719,485	525,630
	Acholi	52,967	211,742	146,690
	Overall	**223,172**	**931,227**	**672,320**

Deep Green is for results whose targets were achieved 100% or above.
Light green for results that are between 70% to 100% achieved
Yellow for results that are between 40% to 70% achieved
Orange is used for results between 1% and 40% achieved.
Red for results/indicators that worsened below baseline values or did not improve at all.

Output 1.1: 210 public HFs in West Nile and Acholi sub regions offer quality equitable SRHR services (family planning/Maternal health/Post abortion Care and Post GBV health and HIV) that are responsive to the needs of women, girls, boys and men, PWDs and refugees by 2023.

Indicators		Baseline (Source)	4-Year Target (new)	Achieved June 2023
1.1.1 Percent of target health facilities with capacity to provide quality GBV/HIV/family planning/MH	**FP: Overall**	68.8	78.8	87.2
	West Nile	63.9	73.4	84.0
	Acholi	85.7	96.7	92.0
	MH: Overall	42.6	61.6	66.7
	West Nile	44.6	65.6	70.0
	Acholi	35.7	53.7	60.0
	PAC: Overall	59.4	69.4	86.0
	West Nile	56.8	63.8	84.1
	Acholi	73.3	86.3	89.4
	SGBV: Overall	49.6	64.6	82.8
	West Nile	50.5	65.5	84.0
	Acholi	46.4	64.4	80.0
	HIV/STD: Overall	81.3	89.3	83.2
	West Nile	84.2	90.2	84.0
	Acholi	71.4	82.4	80.0
1.1.2 % of health facilities experiencing no stock-outs of at least three modern family planning methods over a period of three consecutive months.	West Nile	65.8	75.8	62.0
	Acholi	81.5	89.0	76.0
	Overall			
1.1.3 No. of young people provided with maternal health services through differentiated points of delivery		0	107,273	180,858
1.1.4 No. of young people provided with FP services through differentiated points of delivery		0	165,493	253,051
1.1.5 Number of revisits for modern contraceptives	West Nile	31,949	210,302	156,212
	Acholi	8,715	61,656	50,633
	Overall	40,665	271,958	206,845
1.1.6. Percentage of clients at the supported health facilities who are satisfied or very satisfied with family planning/MH/HIV/GBV services (disaggregated by gender, age, disability, refugee and service)	**FP: Overall**	73.1	83.1	70.3
	West Nile	76.4	86.4	73.3
	Acholi	66.0	77.0	66.2
	MH: Overall	68.7	77.7	76.5
	West Nile	73.5	80.5	78.2
	Acholi	53.2	65.2	64.4
	PAC: Overall	66.7	74.7	70.0
	West Nile	68.4	76.4	69.3
	Acholi	60.0	68.1	73.3
	SGBV: Overall	77.3	85.3	74.1
	West Nile	77.8	85.8	76.0
	Acholi	75.0	83.1	50.0
	HIV/STD: Overall	69.4	77.4	71.8
	West Nile	68.4	78.4	70.7
	Acholi	72.7	79.2	78.6
1.1.7 No. of people referred to access quality SRHR services (FP, MH, PAC, HIVand Post GBV from the community)	West Nile	0	87,302	68,340
	Acholi			30,816
	Overall			99,156

Annex 5: Indicators for Outcome 2: Strengthened multi-disciplinary leadership for improved implementation of and accountability towards the demographic dividend road map by 2023.

	Year 1 (Oct 2019 - Dec 2020)		Year 2 (Jan 2021 - Dec 2021)		Year 3 (Jan 2022 - Dec 2022)		
Indicators	**Target**	**Achievement**	**Target**	**Achievement**	**Target**	**Achievement**	**Comment**
2.1 Percentage increase of Public Expenditure on FP at national level	Not Applicable	Not Applicable	10.0%	Not Applicable	10.0%	24.0%	Target Achieved in Year 3. Attributed to advocacy for increased resource allocation for FP. (RESOURCE FLOWS SURVEY ON FP IN UGANDA, 2021, UBOS).
2.3 Percentage increase of Public Expenditure on GBV (disaggregated at national level)	Not Applicable	Not Applicable	1.0%	0.72% (FY 19/20)	1.0%	109.30%	There was significant increase in expenditure for GBV activities from 43.4 billion UGX in FY2021 to 90.9 billion in FY 2022. Used FY 2021 Vs 2020 figures as 2018 data was not available.
2.4 Percentage increase of Public Expenditure maternal health (disaggregated at national level)	Not Applicable	Not Applicable	10.0%	22.4% (FY 19/20)	10.0%	0.8% (FY2021-2022)	The expenditure on maternal health increased by 0.8% between 2020/2021 and 2021/2022. Used FY 2021/2022 vs FY 2020/2021 due to lack of data for 2018.
Output 2.1: Enhanced implementation of and accountability towards the DD priorities at national level.							
2.1.1 Percentage of sector (health, education, gender) budget released to districts (disaggregation by sector)	Not Applicable	Not Applicable	Overall= 41.9% Gender=5.5% Education=58.6% Health=24%	Overall= 40.0% Gender=5.1% Education=53.6% Health=23.4% (FY 2019/2020)	Overall= 42.5% Gender=6.5% Education=59% Health=25%	Not Applicable	Tracking this indicator stopped following change to programme based budgeting.
2.1.2 Budget execution on DD priorities within the sectorial plans/BFPs (disaggregation by sector)	Not Applicable	Not Applicable	Overall=76% Gender=98.1% Education=84% Health=61%	Overall=70.2% Gender=112.5% Education=79.5% Health=45.1% (FY 2019/20)	Overall=78% Gender=98.3% Education=86% Health=65%	Not Applicable	Tracking this indicator stopped following change to programme based budgeting.
2.1.3 No. of targeted sectors (Health, education, gender, Lands and urban development, Water, Agriculture) with annual plans and budgets which are compliant with DD indicator	0	3 Sectors (Health, Gender and Water meet the 80% score)	1	Not Applicable	Not Applicable	Not Applicable	Not Applicable

	Year 1 (Oct 2019 - Dec 2020)		Year 2 (Jan 2021 - Dec 2021)		Year 3 (Jan 2022 - Dec 2022)		
Indicators	**Target**	**Achievement**	**Target**	**Achievement**	**Target**	**Achievement**	**Comment**
requirements at a minimum of 80%, by 2023.							
2.1.3b Number of targeted programs with annual plans and budgets which are compliant with the demographic dividend indicator requirements at a minimum of 80%, by 2023	Indicator introduced in September 2022 to replace the above indicator	Not Applicable	Not Applicable	2 (programs were compliant i.e. Private Sector Development (84.1%) and Tourism Development (80%)	3	6 (Tourism Development 87.5%, Private Sector Development 96.1%, Sustainable Urbanisation and Housing 87.2%, Human Capital Development 93.6%, Community Mobilization and Mindset Change 86.6%, Governance and Security 81.9%)	Target exceeded. 6 programmes were compliant per the DD compliance assessment report 2021/2022. (DD COMPLIANCE REPORT 2021/2022). 6
2.1.4 No. of motions on relevant SRH, DD, FP, GBV issues presented on floor of parliament and commitment passed and implemented.	1	0	1	1	1	2	Two motions, on teenage pregnancy and on GBV were presented on the floor of parliament. Parliament Reports.
Output 2.2: Enhanced implementation of and accountability towards the DD priorities at the targeted districts in West Nile and Acholi Sub regions by 2023							
2.2.1 %age of district approved budget (education, health & gender) allocated on DD priorities (disaggregation by district)	Not Applicable	Not Applicable	Overall=65.5% Acholi=69% West Nile=66%	Overall=66.7% Acholi=67.3% West Nile=66.5% (FY 2019/20)	Overall=67% Acholi=70% West Nile=67.3%	Overall= 108.3% Acholi= 120.9 % West Nile=105.6% (FY 2021/22)	Target Exceeded.
2.2.2 Budget execution on DD priorities within the district plans/BFPs (disaggregation by district and department)	Not Applicable	Not Applicable	Overall=91% Acholi=84% West Nile=92%	Overall=89.7% Acholi=76.8% West Nile=92.8% (FY 2019/20)	Overall=89% Acholi=88% West Nile=93%	Overall= 82.4% Acholi=81.6% West Nile=82.6% (FY 2021/2022)	Target Achieved.
2.2.3 Average DD Compliance Score for ANSWER Targeted Districts	Not Applicable	Not Applicable	Overall=60% Acholi=40% West Nile=67%	Overall=64.6% Acholi=65.9% West Nile=64.2%	Overall=65% Acholi=55% West Nile=70%	Overall=69.3% Acholi=73.1% West Nile=68.1%	Target Exceeded. This is attributed to improved investments in these districts under the Country programme.
2.2.4 Number of ordinances/by laws related to Adolescent SRHR, Maternal health, DD, FP, and GBV issues presented to the district council, passed and implemented.	2	3 (all in West Nile)	9	3	9	4	4 Ordinances on education were approved and are under implementation in Koboko, Maracha, Adjumani and Pakwach.

Annex 6: Indicators for outputs related to social norms (Output 1.4)

Table 3.54: Percentage distribution of out-of-school young people with positive scores on the GEM scale

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi – control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	57.2	54.2	56.5	61.2	63.1	57.0	61.8	55.0	9.0	11.5
Sex										
M	52.0	51.4	51.8	61.6	62.4	58.1	61.5	54.0	14.3	17.3
F	62.6	56.4	60.9	60.7	63.5	56.6	61.9	55.4	5.5	6.3
Age group										
10-14	56.3	56.0	56.2	64.5	60.5	55.0	59.5	51.8	11.7	16.0
15-19	56.8	52.9	55.8	60.0	60.1	53.2	58.8	54.0	6.3	9.0
20-24	58.0	54.5	57.2	60.6	65.1	58.6	63.5	56.0	8.7	10.9
Disability status										
No	57.3	54.5	56.7	61.5	63.3	56.5	61.7	55.1	8.4	11.4
Yes	56.6	53.2	55.4	59.1	62.4	60.7	62.1	54.9	11.7	10.9
Ever had sex										
No	56.3	54.4	55.9	60.3	58.6	58.3	58.6	54.3	9.9	8.7
Yes	57.8	54.0	56.9	62.0	64.7	56.8	62.7	55.4	9.4	12.4

Table 3.55: Percentage distribution of young people with Attitudes toward equal roles of men and women

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi – control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	12.4	3.6	10.3	7.6	16.6	7.0	14.4	6.2	4.8	5.5
Sex										
M	6.3	0.5	5.0	6.8	16.2	8.4	14.6	4.9	9.8	11.5
F	18.6	6.0	15.3	8.3	16.8	6.4	14.4	6.7	2.0	0.7
Age group										
10-14	8.1	7.1	7.9	11.3	6.4	0.0	5.3	0.0	4.2	8.7
15-19	12.2	2.5	9.8	6.7	11.2	2.6	9.6	7.0	-0.2	-0.5
20-24	14.6	2.9	11.8	6.7	20.3	8.9	17.4	5.9	6.8	6.4
Disability status										
No	12.7	3.5	10.7	7.8	17.1	6.7	14.8	6.0	5.0	5.9
Yes	9.9	3.9	7.9	6.2	13.3	8.8	12.4	6.9	4.2	3.8
Ever had sex										
No	9.5	4.0	8.2	7.2	10.5	10.7	10.5	7.8	6.1	1.7
Yes	14.6	3.3	11.9	7.9	18.7	6.2	15.7	5.4	5.4	6.3

Table 3.53: Percentage distribution of young people thinking that Girls as smart as boys

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi – control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	76.3	70.5	74.9	71.6	88.7	80.5	86.9	82.6	-1.0	1.0
Sex										
M	77.6	62.2	74.3	74.3	86.6	79.0	85.0	80.2	10.9	4.8
F	74.8	77.0	75.4	69.1	89.7	81.1	87.7	83.5	-10.3	-2.1
Age group										
10-14	70.4	75.6	71.6	73.2	95.7	70.0	91.2	73.9	-6.3	18.9
15-19	75.8	70.0	74.4	66.9	87.2	80.0	85.9	84.7	-7.8	-6.3
20-24	79.5	68.4	76.9	74.9	89.4	80.9	87.2	81.5	5.9	3.7
Disability status										
No	77.0	72.2	75.9	73.1	89.5	79.0	87.1	83.3	-3.4	1.0
Yes	71.6	64.4	69.2	63.3	83.6	90.5	85.1	78.3	11.1	0.9
Ever had sex										
No	73.6	74.2	73.7	70.6	85.3	75.8	83.7	84.7	-12.5	-4.1
Yes	78.3	67.7	75.8	72.5	89.9	81.5	87.8	81.5	4.8	3.0

Table 3.56: Percentage distribution of young people thinking that A woman sometimes deserves to be beaten

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi – control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	15.9	20.0	16.9	12.0	10.6	18.4	12.4	23.0	-12.6	-15.5
Sex										
M	18.1	25.8	19.8	12.8	11.8	10.3	11.5	30.5	-33.2	-26.0
F	13.6	15.4	14.1	11.2	10.0	21.6	12.8	20.1	-2.7	-10.2
Age group										
10-14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15-19	16.2	21.0	17.4	12.1	13.0	12.3	12.9	25.8	-22.4	-18.2
20-24	15.6	19.0	16.4	11.9	9.1	20.8	12.1	20.8	-7.1	-13.2
Disability status										
No	15.5	19.4	16.4	10.7	9.9	18.6	11.9	20.7	-10.8	-14.5
Yes	18.4	21.9	19.6	19.8	14.8	16.8	15.2	35.4	-20.7	-20.0
Ever had sex										
No	18.5	19.7	18.8	13.2	16.7	16.6	16.7	27.0	-16.9	-15.9
Yes	14.8	20.1	16.0	11.2	8.6	18.8	11.1	21.1	-11.2	-14.8

Table 3.57: Percentage distribution of young people thinking that Final decision is by the husband and should be obeyed

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	80.9	91.7	83.5	73.3	73.6	78.9	74.8	77.8	-17.3	-13.2
Sex										
M	90.6	97.3	92.0	75.1	77.1	76.3	76.9	80.5	-26.4	-20.5
F	70.8	87.5	75.2	71.7	72.0	79.9	73.9	76.7	-12.6	-6.3
Age group										
10-14	90.1	97.4	91.8	79.2	85.1	70.0	82.5	82.6	-30.8	-12.7
15-19	79.9	91.3	82.7	75.6	78.0	86.1	79.4	81.6	-11.2	-9.3
20-24	77.3	89.3	80.1	68.8	70.5	76.2	71.9	74.5	-18.8	-13.9
Disability status										
No	80.0	91.4	82.5	72.3	74.8	78.2	75.6	77.6	-18.5	-12.2
Yes	86.3	93.2	88.6	79.3	66.0	83.8	69.8	78.7	-8.8	-18.2
Ever had sex										
No	84.8	93.6	86.9	73.7	80.3	76.3	79.6	83.7	-27.3	-17.3
Yes	77.8	90.3	80.8	73.0	71.3	79.4	73.3	74.8	-12.7	-9.3

Table 3.54: Percentage distribution of in-school young people with positive scores on the GEM scale

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	59.6	55.1	58.5	62.6	64.1	54.6	62.4	54.4	7.7	12.1
Sex										
M	55.1	51.2	54.3	61.2	63.7	54.0	62.1	52.0	12.0	17.0
F	64.2	58.2	62.7	63.9	64.4	54.8	62.5	55.4	5.1	8.3
Age group										
10-14	60.1	55.5	59.1	63.9	61.8	59.9	61.5	52.5	15.8	13.8
15-19	58.8	53.7	57.6	60.8	64.7	53.1	62.4	55.5	4.7	10.1
20-24	59.8	56.1	58.8	63.0	66.2	51.8	64.9	56.7	2.0	12.4
Disability status										
No	59.7	55.1	58.7	62.7	64.6	54.6	62.7	54.6	7.6	12.1
Yes	58.8	54.9	57.8	61.7	60.6	54.7	59.6	53.3	8.2	10.2
Ever had sex										
No	59.3	55.0	58.3	62.3	63.0	52.7	61.3	54.5	5.5	10.8
Yes	61.1	55.3	59.7	65.4	66.5	57.5	64.5	53.5	14.1	16.7

Table 3.55: Percentage distribution of young people with Attitudes toward equal roles of men and women

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	12.6	4.2	10.7	8.1	18.0	4.1	15.4	6.8	1.2	6.0
Sex										
M	8.7	1.5	7.2	6.0	17.4	5.9	15.5	2.5	7.9	11.8
F	16.7	6.5	14.2	10.2	18.3	3.4	15.4	8.7	-1.6	2.7
Age group										
10-14	11.0	5.3	9.7	8.2	17.3	8.4	15.7	3.5	7.8	10.7
15-19	11.8	1.5	9.5	6.8	17.6	3.0	14.7	8.3	0.0	3.7
20-24	16.1	6.1	13.6	10.0	23.9	0.0	21.7	12.5	-8.6	5.6
Disability status										
No	12.4	4.4	10.6	8.3	18.3	3.7	15.6	7.3	0.3	6.0
Yes	13.9	3.3	11.2	6.8	16.0	7.6	14.6	4.3	6.8	5.9
Ever had sex										
No	11.7	4.2	10.0	8.0	18.7	3.6	16.2	5.8	1.6	8.4
Yes	17.4	4.4	14.1	9.5	16.4	4.9	13.9	11.5	-1.5	-2.2

Table 3.53: Percentage distribution of young people thinking that Girls as smart as boys

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi – control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	78.7	70.9	76.9	69.6	91.6	72.4	88.1	72.3	-1.2	8.5
Sex										
M	79.5	62.6	76.0	70.9	91.2	56.7	85.6	71.9	-6.9	8.6
F	77.9	77.7	77.8	68.4	91.8	79.1	89.4	72.4	-2.6	7.6
Age group										
10-14	76.7	72.1	75.7	67.0	88.6	70.5	85.3	68.4	-3.0	8.2
15-19	78.8	69.6	76.7	70.0	92.5	73.1	88.7	72.9	0.6	9.1
20-24	81.5	70.7	78.8	73.5	92.9	68.4	90.6	83.1	-11.9	2.2
Disability status										
No	79.3	72.1	77.7	69.8	92.7	71.9	88.8	73.5	-3.9	7.4
Yes	75.0	64.4	72.3	68.0	83.3	76.6	82.2	66.3	13.9	11.6
Ever had sex										
No	78.6	72.3	77.2	70.3	91.9	66.8	87.8	70.8	-6.0	10.1
Yes	79.0	64.4	75.3	62.8	91.0	80.7	88.7	79.6	-0.5	-3.4

Table 3.56: Percentage distribution of young people thinking that A woman sometimes deserves to be beaten

	Baseline				Endline				Effect size	
	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	13.4	18.2	14.5	13.0	12.0	18.4	13.2	23.9	-10.7	-12.2
Sex										
M	14.5	25.3	16.8	14.8	10.0	20.7	11.7	34.9	-24.7	-25.2
F	12.2	12.1	12.2	11.0	13.1	17.4	13.9	18.7	-2.4	-6.0
Age group										
10-14	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
15-19	11.5	18.1	13.0	14.0	11.9	19.3	13.3	22.3	-7.1	-8.0
20-24	15.9	18.2	16.5	11.5	13.0	0.0	11.8	29.4	-36.1	-22.6
Disability status										
No	13.6	17.9	14.5	13.1	10.9	19.7	12.5	21.4	-6.5	-10.3
Yes	12.6	19.7	14.6	12.3	20.0	8.9	17.9	40.4	-38.9	-24.8
Ever had sex										
No	13.5	15.5	14.0	13.3	11.6	15.8	12.4	19.3	-5.7	-7.6
Yes	13.3	25.0	16.2	11.4	12.8	23.0	14.7	36.1	-26.7	-26.2

Table 3.57: Percentage distribution of young people thinking that Final decision is by the husband and should be obeyed

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	81.4	93.6	84.2	73.2	70.5	76.1	71.5	77.8	-22.1	-17.3
Sex										
M	88.2	96.2	89.9	74.4	72.0	71.6	71.9	85.2	-35.4	-28.8
F	74.2	91.4	78.5	72.0	69.7	78.1	71.3	74.6	-15.9	-9.8
Age group										
10-14	88.6	96.8	90.4	75.9	66.5	47.4	63.0	80.7	-54.2	-32.2
15-19	78.5	94.6	82.1	71.0	71.8	85.3	74.4	76.5	-14.8	-13.2
20-24	74.4	88.4	77.9	72.0	70.6	73.7	70.9	72.8	-15.5	-7.8
Disability status										
No	81.4	93.2	84.0	72.9	69.7	75.4	70.8	75.9	-20.8	-16.2
Yes	81.0	95.9	84.8	75.5	76.5	82.5	77.5	87.1	-25.0	-18.9
Ever had sex										
No	82.6	94.2	85.2	73.1	69.7	84.9	72.2	79.8	-16.0	-19.7
Yes	74.8	91.1	78.9	73.9	72.2	62.9	70.1	67.8	-22.1	-2.7

Annex 7: Output indicators related to sexuality education (output 1.5)

Output 1.5 - in school sexuality education - indicators, targets, achievements

Indicators			Baseline	Target	Achieved June 2023
1.5.1 Number of schools providing sexuality education Programme		All	0	450	421
1.5.2 No. of young people in school (students and pupils) reached with comprehensive age-appropriate information on SRHR and GBV (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	**overall**	All	0	315,000	154,383
	West Nile				127,318
	Acholi				27,065
1.5.3 Percentage of young people in school (students and pupils) with comprehensive correct information on sexuality, HIV/STIs, pregnancy and contraception (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	**Sexuality**				
	10-14.	Acholi	11.1	21.1	83.0
		WN	5.3	10.6	40.0
	Pregnancy				
	10-14.	Acholi	2.2	12.2	6.3
		WN	5.7	11	15.8
	15-19.	Acholi	8.1	18.1	27.7
		WN	17.8	23.1	23.8
	20-24.	Acholi	19.6	29.6	36.3
		WN	25.3	30.6	33.3
	Contraception				
	10-14.	Acholi	3.2	13.2	4.0
		WN	3.8	9.1	3.2
	15-19.	Acholi	32	42	48.4
		WN	37	42.3	36.4
	20-24.	Acholi	55.1	65.1	57.9
		WN	51.3	56.6	57.9
	HIV/AIDS and STIs				
	10-14.	Acholi	6.8	16.8	6.8
		WN	24	29.3	34.9
	15-19.	Acholi	36.8	46.8	39.0
		WN	42.3	47.6	51.2
	20-24.	Acholi	55.2	65.2	65.3
		WN	52.3	57.6	65.8
	Composite all categories				
	10-14.	Acholi	1.6	4.1	4.2
		WN	2.8	4.1	10.7
	15-19.	Acholi	3.6	6.1	40.0
		WN	7.4	8.7	33.1
	20-24.	Acholi	11.5	14.0	31.6
		WN	12.5	13.8	53.8
1.5.4 No. of young people reached with age-appropriate information on SRHR and GBV through various strategies			0	542,612	292,555
1.5.5 % of sexually active in school (students and pupils) young people (15-24 years) who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner)		Acholi	53.0	60.9	38.6
		WN	56.9	61.0	75.5
1.5.7 No. of young people out of school reached with comprehensive, age-appropriate correct information on SRHR/GBV (i.e., good knowledge of prevention of pregnancy, contraceptives and their user and sources, and prevention of HIV and STIs)		All	0	22,320	18,505
1.5.6 Percentage of sexually active in school (students and pupils) young people (15-24 years) who use modern contraception		Acholi	29.4	37.3	47.1
		WN	35.1	39.2	63.6

Sexuality education for out-of-school young people - indicators, baselines, targets and achievements

Indicators			Baseline	Target	Achieved June 2023
1.5.8 Percentage of young people out of school with comprehensive correct knowledge on sexuality, HIV/STIs, pregnancy and contraception	**Sexuality**				
	10-14.	Acholi	5.1	15.1	77.7
		WN	4.7	10.0	81.1
	Pregnancy				
	10-14.	Acholi	4.5	14.5	31.6
		WN	5.7	11.0	45.1
	15-19.	Acholi	59.3	69.3	82.0
		WN	73.9	79.2	82.9
	20-24.	Acholi	71.5	81.5	83.7
		WN	84.2	89.5	91.5
	Contraception				
	10-14.	Acholi	1.5	11.5	1.0
		WN	5.3	10.6	1.0
	15-19.	Acholi	50.1	60.1	48.3
		WN	42.6	47.9	32.9
	20-24.	Acholi	62.3	72.3	70.1
		WN	55.6	60.9	58.2
	HIV/AIDS and STIs				
	10-14.	Acholi	12.4	22.4	21.4
		WN	10.4	15.7	24.3
	15-19.	Acholi	38.1	48.1	61.4
		WN	38.2	43.5	51.4
	20-24.	Acholi	47.9	57.9	51.6
		WN	46.7	52.0	71.5
	Composite all categories				
	10-14.	Acholi	1.3	3.8	1.2
		WN	2.6	3.9	2.1
	15-19.	Acholi	5.8	8.3	32.4
		WN	6.7	8.0	31.1
	20-24.	Acholi	15.2	17.7	47.7
		WN	15.4	16.7	42.6
1.5.9 Percentage of sexually active out of school young people (15-24 years) who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner)		Acholi	75.4	83.3	68.0
		WN	75.4	79.5	70.8
1.5.10 Percentage of sexually active out of school (students and pupils) young people (15-24 years) who use modern contraception		Acholi	32.4	40.3	48.5
		WN	32.4	36.5	37.2

Percentage distribution of out-of-school young people with attitudes toward equal roles of men and women

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi– control***	WN	***Acholi– treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	12.4	3.6	10.3	7.6	16.6	7.0	14.4	6.2	4.8	5.5
Sex										
M	6.3	0.5	5.0	6.8	16.2	8.4	14.6	4.9	9.8	11.5
F	18.6	6.0	15.3	8.3	16.8	6.4	14.4	6.7	2.0	0.7
Age group										
10-14	8.1	7.1	7.9	11.3	6.4	0.0	5.3	0.0	4.2	8.7
15-19	12.2	2.5	9.8	6.7	11.2	2.6	9.6	7.0	-0.2	-0.5
20-24	14.6	2.9	11.8	6.7	20.3	8.9	17.4	5.9	6.8	6.4
Disability status										
No	12.7	3.5	10.7	7.8	17.1	6.7	14.8	6.0	5.0	5.9
Yes	9.9	3.9	7.9	6.2	13.3	8.8	12.4	6.9	4.2	3.8
Ever had sex										
No	9.5	4.0	8.2	7.2	10.5	10.7	10.5	7.8	6.1	1.7
Yes	14.6	3.3	11.9	7.9	18.7	6.2	15.7	5.4	5.4	6.3

Percentage distribution of in-school young people with attitudes towards equal roles of men and women

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	12.6	4.2	10.7	8.1	18.0	4.1	15.4	6.8	1.2	6.0
Sex										
M	8.7	1.5	7.2	6.0	17.4	5.9	15.5	2.5	7.9	11.8
F	16.7	6.5	14.2	10.2	18.3	3.4	15.4	8.7	-1.6	2.7
Age group										
10-14	11.0	5.3	9.7	8.2	17.3	8.4	15.7	3.5	7.8	10.7
15-19	11.8	1.5	9.5	6.8	17.6	3.0	14.7	8.3	0.0	3.7
20-24	16.1	6.1	13.6	10.0	23.9	0.0	21.7	12.5	-8.6	5.6
Disability status										
No	12.4	4.4	10.6	8.3	18.3	3.7	15.6	7.3	0.3	6.0
Yes	13.9	3.3	11.2	6.8	16.0	7.6	14.6	4.3	6.8	5.9
Ever had sex										
No	11.7	4.2	10.0	8.0	18.7	3.6	16.2	5.8	1.6	8.4
Yes	17.4	4.4	14.1	9.5	16.4	4.9	13.9	11.5	-1.5	-2.2

Percentage distribution of out-of-school young people thinking that girls are as smart as boys

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi– control***	WN	***Acholi – treated***	***All treated***	***Acholi– control***	**Acholi**	**All**
All	76.3	70.5	74.9	71.6	88.7	80.5	86.9	82.6	-1.0	1.0
Sex										
M	77.6	62.2	74.3	74.3	86.6	79.0	85.0	80.2	10.9	4.8
F	74.8	77.0	75.4	69.1	89.7	81.1	87.7	83.5	-10.3	-2.1
Age group										
10-14	70.4	75.6	71.6	73.2	95.7	70.0	91.2	73.9	-6.3	18.9
15-19	75.8	70.0	74.4	66.9	87.2	80.0	85.9	84.7	-7.8	-6.3
20-24	79.5	68.4	76.9	74.9	89.4	80.9	87.2	81.5	5.9	3.7
Disability status										
No	77.0	72.2	75.9	73.1	89.5	79.0	87.1	83.3	-3.4	1.0
Yes	71.6	64.4	69.2	63.3	83.6	90.5	85.1	78.3	11.1	0.9
Ever had sex										
No	73.6	74.2	73.7	70.6	85.3	75.8	83.7	84.7	-12.5	-4.1
Yes	78.3	67.7	75.8	72.5	89.9	81.5	87.8	81.5	4.8	3.0

Percentage distribution of in-school young people thinking that girls are as smart and boys

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi– control***	WN	***Acholi – treated***	***All treated***	***Acholi-control***	**Acholi**	**All**
All	78.7	70.9	76.9	69.6	91.6	72.4	88.1	72.3	-1.2	8.5
Sex										
M	79.5	62.6	76.0	70.9	91.2	56.7	85.6	71.9	-6.9	8.6
F	77.9	77.7	77.8	68.4	91.8	79.1	89.4	72.4	-2.6	7.6
Age group										
10-14	76.7	72.1	75.7	67.0	88.6	70.5	85.3	68.4	-3.0	8.2
15-19	78.8	69.6	76.7	70.0	92.5	73.1	88.7	72.9	0.6	9.1
20-24	81.5	70.7	78.8	73.5	92.9	68.4	90.6	83.1	-11.9	2.2
Disability status										
No	79.3	72.1	77.7	69.8	92.7	71.9	88.8	73.5	-3.9	7.4
Yes	75.0	64.4	72.3	68.0	83.3	76.6	82.2	66.3	13.9	11.6
Ever had sex										
No	78.6	72.3	77.2	70.3	91.9	66.8	87.8	70.8	-6.0	10.1
Yes	79.0	64.4	75.3	62.8	91.0	80.7	88.7	79.6	-0.5	-3.4

Percentage of out-of-school young people thinking that final decision is by the husband and should be obeyed

	Baseline				Endline				difference	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	80.9	91.7	83.5	73.3	73.6	78.9	74.8	77.8	-17.3	-13.2
Sex										
M	90.6	97.3	92.0	75.1	77.1	76.3	76.9	80.5	-26.4	-20.5
F	70.8	87.5	75.2	71.7	72.0	79.9	73.9	76.7	-12.6	-6.3
Age group										
10-14	90.1	97.4	91.8	79.2	85.1	70.0	82.5	82.6	-30.8	-12.7
15-19	79.9	91.3	82.7	75.6	78.0	86.1	79.4	81.6	-11.2	-9.3
20-24	77.3	89.3	80.1	68.8	70.5	76.2	71.9	74.5	-18.8	-13.9
Disability status										
No	80.0	91.4	82.5	72.3	74.8	78.2	75.6	77.6	-18.5	-12.2
Yes	86.3	93.2	88.6	79.3	66.0	83.8	69.8	78.7	-8.8	-18.2
Ever had sex										
No	84.8	93.6	86.9	73.7	80.3	76.3	79.6	83.7	-27.3	-17.3
Yes	77.8	90.3	80.8	73.0	71.3	79.4	73.3	74.8	-12.7	-9.3

Percentage distribution of in-school young people thinking that final decisions is by the husband and should be obeyed

	Baseline				Endline				Effect size	
	WN	***Acholi – treated***	***All treated***	***Acholi - control***	WN	***Acholi – treated***	***All treated***	***Acholi - control***	**Acholi**	**All**
All	81.4	93.6	84.2	73.2	70.5	76.1	71.5	77.8	-22.1	-17.3
Sex										
M	88.2	96.2	89.9	74.4	72.0	71.6	71.9	85.2	-35.4	-28.8
F	74.2	91.4	78.5	72.0	69.7	78.1	71.3	74.6	-15.9	-9.8
Age group										
10-14	88.6	96.8	90.4	75.9	66.5	47.4	63.0	80.7	-54.2	-32.2
15-19	78.5	94.6	82.1	71.0	71.8	85.3	74.4	76.5	-14.8	-13.2
20-24	74.4	88.4	77.9	72.0	70.6	73.7	70.9	72.8	-15.5	-7.8
Disability status										
No	81.4	93.2	84.0	72.9	69.7	75.4	70.8	75.9	-20.8	-16.2
Yes	81.0	95.9	84.8	75.5	76.5	82.5	77.5	87.1	-25.0	-18.9
Ever had sex										
No	82.6	94.2	85.2	73.1	69.7	84.9	72.2	79.8	-16.0	-19.7
Yes	74.8	91.1	78.9	73.9	72.2	62.9	70.1	67.8	-22.1	-2.7

Annex 8: Bibliography/list of documents consulted at Inception phase

Uganda national strategies, policies and action plans

- National Poverty Reduction Strategy
- National Development Plan
- Relevant national strategies and policies for each thematic area of the ANSWER programme including the health, education, gender/community sectors and DD
- United Nations Development Assistance Framework (UNDAF) and/or United Nations Sustainable Development Cooperation Framework (UNSDCF)

ANSWER programme documents

- Original proposal
- Annual programme workplans 2020. 2021, and 2022
- Annual programme progress reports
- Baseline reports including KAP and HFA baseline tools
- Mid-term evaluation report
- Field mission reports (Embassy and UNFPA)

UNFPA Uganda CO programming documents

- Government of Uganda/UNFPA 9th Country Programme Document ([year-year])
- United Nations Common Country Analysis/Assessment (CCA)
- Mapping of UNFPA interventions including ANSWER (2021)
- Other evaluations and programme documents on UNFPA supported programmes implemented in the same districts as the ANSWER programme (e.g. WAY programme, Joint Programme GBV, and ADA)
- COVID contingency and adaptation plans relevant to the ANSWER programme

UNFPA global documents

- UNFPA Strategic Plan (2014-2017) (incl. annexes)
- https://www.UNFPA.org/resources/strategic-plan-2014-2017
- UNFPA Strategic Plan (2018-2021) (incl. annexes)
- https://www.UNFPA.org/strategic-plan-2018-2021
- UNFPA Strategic Plan (2022-2025) (incl. annexes)
- https://www.UNFPA.org/UNFPA-strategic-plan-2022-2025-dpfamily planninga20218
- UNFPA Evaluation Policy (2019)
- https://www.UNFPA.org/admin-resource/UNFPA-evaluation-policy-2019
- Evaluation Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA (2019)
- https://www.UNFPA.org/EvaluationHandbook

Annex 9: Evaluation Matrix

RELEVANCE

i. To what extent was the ANSWER programme a to address the SRHR needs the target population including (adolescents, people with disabilities and refugees), and relevant government agencies at national and district levels?

ii. To what extent was the ANSWER programme a with priorities set by the relevant national and district policies and strategies related to SRHR and GBV, the GOU-UNFPA 9th Country Programme and the Multi-Annual Country Strategy of the Netherlands Embassy.

iii. To what extent was the ANSWER programme a to respond to changes in the national and district context including COVID-19, the evolving SRHR landscape and the socio-political environment during the period of implementation

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The needs of the target pop. including vulnerable and marginalized groups (adolescents and youth, refugees, PWDs), and those of relevant government agencies at national and district level were considered in the design of the Programme. The Programme is aligned with GOU-UNFPA 9th CP, the Multi-Annual Country Strategy of the RNE, and the national and district priorities related to SRHR and GBV set in national and district policies and plans.	● Evidence of systematic identification of the needs of the country and the target population, especially those of the most vulnerable and marginalized groups prior to the programming of the components of the Programme. ● The Programme document and AWPs are consistent with GOU-UNFPA CP, and the national and district policies and plans related to SRHR and GBV, and the Multi-Annual Country Strategy of the Netherlands Embassy ● The selection of the target groups for Programme supported interventions in Programme document and the AWPs is consistent with the identified needs as well as national priorities (as reflected in the national and district policies and plans) in the CPD and the AWPs.	● ANSWER Programme document ● GOU-UNFPA 9th CP (2021-2025) ● Multi-Annual Country Strategy of the Netherlands Embassy ● AWPs ● Atlas list of projects ● National and district policies and plans related to SRHR and GBV ● Implementing partners ● Representatives of relevant national and local (district) government agencies ● UNFPA Uganda CO staff ● Beneficiaries (adolescents and youth, in and out of school youth, refugees, PWDs, people in hard-to-reach areas) ● NGOs working in the same mandate area as UNFPA but not partners of UNFPA	● Document review ● KI interviews ● Group discussions ● Focus Group Discussions
Assumption 2: The Programme adequately responded to changes in needs and priorities as reflected by changes in the national and district context including as a result of COVID-19, the evolving SRHR landscape and the social, political and economic environment during the period of implementation.	● Evidence of a response and whether the response was considered timely and of quality. ● Evidence of changes in programme design or interventions reflecting changes in needs of the population and national and target district priorities	● AWPs ● Atlas list of projects ● Annual Reports ● Reviews ● ANSWER programme document ● UNFPA CO staff ● NGOs / other UN agencies ● Implementing partners at national and in target districts	● Document review ● KI interviews

Assumption 3: UNFPA considered the recommendations and lessons learned from the Mid Term Review	● The Programme document reflects the implementation of the recommendations of the Mid Term Review	● ANSWER programme document ● AWPs ● Mid Term Review ● UNFPA CO staff	● Document review ● KI interviews
EFFECTIVENESS I. To what extent have the outputs of the Programme been achieved and likely to contribute to the achievement of Programme outcomes? How adequate is the theory of change underlying the results chain logic? II. To what extent has the Programme integrated the cross-cutting issues of gender equality, disability inclusion and human rights-based approaches? III. What were the unforeseen consequences of the Programme?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
Assumption 1: The Programme has a robust theory of change underlying the results chain logic.	● Extent to which inputs in the programme are likely to have contributed to outputs and the extent to which Programme outputs are likely to have contributed to outcome results (an assessment of underlying theory of change	● Programme document ● AWPs ● Programme reports ● UNFPA CO staff ● Implementing partners (including national and district government agencies) ● HMIS ● KAP study ● HFA study	● Document review ● KI interviews ●
Assumption 2: Programme interventions have contributed to enhanced access and utilization of SRHR services (family planning, Maternal Health, Post Abortion Care, HIV Testing and Post GBV) by women, girls, boys and men including refugees and PWDs in West Nile and Acholi sub regions	● Evidence of change in the number and proportion of the different beneficiary groups use against the programme indicators, including the additional indicators ● Evidence that deliberate integration of interventions was pursued by the Programme resulted in greater contribution to results	● HMIS ● KAP study ● HFA study ● Programme reports ● Relevant programme, project and institutional reports of stakeholders ● UNFPA CO staff ● Implementing partners ● Health system actors – service providers (including VHTs) and government leadership (e.g., district health authorities, secretary of health) ● Beneficiaries and non-beneficiaries	● Document review ● KI interviews with IPs at national and district levels ● Focus group discussions with beneficiaries (health personnel at district level, women, young people, PWDs, refugees) and non-beneficiaries ● Observations

Assumption 3: Programme interventions contributed strengthened public health services in the 15 districts which are now able to offer quality SRHR services (family planning/MH/PAC, HIV Testing and Post GBV) that are responsive to the needs of women, girls, boys, and men, PWDs and refugees; with strengthened SRH commodity security system in place at national, district and health facility levels.	● Evidence of the capacity to offer quality SRHR services (family planning/MH/PAC, HIV Testing and Post GBV) at public health facilities in the 15 districts has improved. ● Evidence that the quality of SRHR services offered in the public health facilities in the 15 districts have improved. ● Evidence of the existence of an operational, effective and efficient SRH commodity security system in place at the national, district and health facility levels.	● Programme document / AWPs ● Programme reports ● HFA baseline endline study (including Client Exit Interview) ● Implementing partners at national and district levels ● National and district health institutional reports ● Beneficiaries (women, young people, PWDs, refugees) ● Beneficiaries (health workers)	● Document review ● Observations ● KI Interviews ● FGDs with beneficiaries
Assumption 4: Adolescents and youth, PWDs and refugees have improved self-efficacy and agency to demand and access high quality services in the 15 districts	● Evidence of changes in knowledge, attitudes and demand for SRH, including self-efficacy and self- agency	● KAP study ● Beneficiaries (women, young people, PWDs, refugees)	● Document review ● Focus Group Discussions ● In-depth interviews with PWDs
Assumption 5: Local leaders and reference groups promote positive gender and social norms and support access and utilization of SRHR/GBV services in the 15 districts	● Evidence of capacity building and transformative approaches in changing gender and social norms ● Evidence of the fidelity and quality of the behavior change interventions	● Annual reports and AWP ● Implementing Partner reports ● Local cultural and religious leaders ● Community volunteers, teachers, parents, SASA, MAG ● Beneficiaries (women, adolescents and youth) ● Implementing partners at district level	● Document review ● KI interviews and in-depth interviews local cultural and religious leaders ● FGDs with community volunteers, beneficiaries
Assumption 6: Programme interventions contributed to strengthened multi-disciplinary leadership for improved implementation of and accountability towards demographic dividend road map at national and district levels.	● Evidence of multisectoral district actors formed policy coalitions that together implement and ensure accountability towards demographic dividend (DD)in target districts ● Evidence of national policy actors working together to have enhanced implementation of and accountability towards demographic dividend (DD)at national level	● AWPs, APRs ● UNFPA CO ● IPs at national and district levels ● Other relevant MDAs at national and district levels (e.g. NPA, NPC and UBOS) ● demographic dividend (DD)compliance data	● Document review ● KI interviews
Assumption 7: The cross-cutting issues of gender, disability inclusion and human rights-based approach is clearly apparent in the implementation of the programme	● Evidence of that the programming adhered to the guidance on integration of gender, disability inclusion and a human rights-based approach in the Programme plans, reports and evaluation ● Evidence of reach and benefit for those vulnerable and marginalized populations that are harder to reach	● AWPs and APRs ● UNFPA CO staff ● IP progress reports ● Beneficiaries ● KAP study	● Document review ● KI interviews ● Focus Group Discussions with beneficiaries and non-beneficiaries

Assumption 8: Any unforeseen consequences (negative and positive) of the ANSWER programme have been documented and, where necessary, amendments are implemented planned	● Evidence of unforeseen consequences and their documentation in Programme plans and reports.	● AWPs and APRs ● UNFPA CO staff ● Implementing partners ● Beneficiaries and non-beneficiaries, and community volunteers	● Document review ● KI interviews ● Focus Group Discussions with beneficiaries and non-beneficiaries, community volunteers
EFFICIENCY i. To what extent has UNFPA made good use of its human, financial, technical and administrative resources and appropriate combination of policies, procedures, tools, innovative approaches and implementation modalities to pursue the achievement of the outputs and outcomes of the programme? ii. To what extent did UNFPA resources have a leveraging effect (e.g. initial investments catalyze other resources)? iii. To what extent was the progress and results of the programme effectively and efficiently measured and reported?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
Assumption 1: Administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient execution of programme activities.	● Appropriateness of UNFPA administrative, procurement and financial procedures ● Evidence of the adequacy of UNFPA's procurement, administrative and financial capacity ● Appropriateness of IP selection criteria ● Evidence of successful capacity building of partners to manage their engagement in the programme	● AWPs ● ARs, COARs ● UNFPA CO staff ● IPs at national and district levels	● Document review ● KI interviews ●
Assumption 2: Implementing partners received UNFPA financial and technical support as planned and in a timely manner	● Evidence that financial resources were received to the level planned in the AWPs and in a timely manner. ● Quality technical assistance was available to the level planned. ● Evidence that technical assistance increased capacity among recipient stakeholders	● AWPs and APRs ● Reports ● Programme financial reports ● UNFPA CO ● IPs at national and district level	● Document review ● KI interviews ●
Assumption 3: UNFPA contributed to effective coordination between actors in the pursuit of the achievement of programme results	● Evidence of coordination between actors and activities that the improves the delivery of the programme ●	● AWPs, APRs ● UNFPA CO ● UN agencies and other donors ● IPs at national and district level	● Document review ● KI interviews
Assumption 4: The resources provided by programme have a leveraging effect	● Evidence of additional resources from the government at national and district levels supporting the achievement of Programme results in the targeted areas during implementation Evidence of additional resources from other NGOs and other actors supporting the achievement of Programme results in the targeted areas during implementation	● UNFPA CO ● IPs at national and district levels ● National and district government ● Annual Reports	● KIs ● Document review

Assumption 5: Programme progress and results were effectively and efficiently measured and reported	• Evidence of an effective and efficient M&E system in place • Evidence of M&E capacity and capacity building in UNFPA and in IPs at national and district level	• M&E framework and plan • M&E reports, CO and IPs • UNFPA CO • IPs at national and district levels	• Document review • KI interviews
SUSTAINABILITY To what extent have UNFPA-supported interventions promoted national ownership and contributed to capacity development in its implementing partners and communities (in terms of policies, increased capacity and budgetary allocation)?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for the data collection**
Assumption 1: UNFPA has contributed to sustainable capacity development in the IPs at national and district levels, and among primary beneficiaries and community volunteers and structures	• Evidence of capacity development initiatives supported by CO and of the likelihood of sustainable results • Evidence of resources and capacity to continue the benefits •	• AWPs and APRs • CO staff • IPs at national and district levels • IP reports	• Document review • KI Interviews •
Assumption 2: The Programme has contributed to increased national and district ownership, and to relevant national policies, strategies, plans and budgets	• Evidence of policy (policies, strategies, regulations, guidelines, etc) development and implementation related to SRHR and GBV as a result of UNFPA supported interventions • Evidence of increased resource and budgetary provisions related to SRHR and GBV as a result of UNFPA supported interventions	• AWPs and APRs • National, sectoral and county policies, plans, budgets and reports • IPs at national and district levels	• Document review • KI interviews
COHERENCE How effectively does UNFAP coordinate with other UNFPA programme, particularly in areas of potential overlap? How well does the UNFPA collaborate with development partners, NGOs and partners and what are opportunities for increasing this coordination?			
Assumption 1: The Programme effectively leveraged on and collaborated with other UNFPA programmes in the achievement of the Programme results	• Evidence of the contribution of other UNFPA programmes during Programme implementation	• M&E reports • AWPs • APRs • UNFPA CO	• Document review • KI interviews
Assumption 2: The Programme effectively developed and leveraged on strategic partnerships with other UN agencies, donors, NGOs and other actors in the achievement of planned results	• Evidence of enhanced partnerships and good working relationship between UNFPA and donors • Evidence of collaboration between UNFPA and partners including other UN agencies, NGOs and other actors at district and national level •	• M&E reports • AWPs • APRs • Other donors • Other UN agencies working in the same area • NGOs and other actors	• Document review • KI interviews

Annex 10: Results Framework

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
Goal: Contribute to the achievement of universal access to SRHR of women, girls, boys and men including disadvantaged and vulnerable populations in Uganda (Targets for indicators are based on National targets, Gou-UNFPA CP8 while some are project specific)					
Maternal Mortality ratio (SDG indicators 3.1.1; NDP II/NDPIII and Vision 2040 Indicator3.4, (UNFPA Strategic Plan Impact indicator)	Number of maternal deaths per 100,000 live births Numerator: Number of maternal deaths in the 7-year period preceding the survey (x100,000) Denominator: Number of live births in the 7-year period preceding the survey	336 per 100,000 live births (National, UDHS 2016)	219 per 100,000 live births (National Target for 2020, (MoH) RMNCAH Sharpened Plan 2017	UDHS	UBOS (UDHS) UNFPA (CIS)
Percentage of live births in the five years preceding the survey delivered at a health facility in West Nile and Acholi sub-regions (CP8 outcome indicator; UDHS)	Numerator: Deliveries that occur in a health facility in West Nile and Acholi sub-regions Denominator: All live births in the 5 years before the survey in West Nile and Acholi sub-regions	West Nile: 78.2 percent Acholi: 84.1 percent UDHS, 2016	West Nile: 85 percent Acholi: 85 percent (Programme specific target)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)
Modern Contraceptive Prevalence Rate (mCPR) in West Nile and Acholi sub-regions (CP8 outcome indicator; MASC SRHR outcome indicator)	Percentage distribution of currently married women and sexually active unmarried aged 15 - 49 in West Nile and Acholi sub-regions using modern of contraceptive methods	West Nile: 19.0 percent Acholi: 36.3 percent UDHS, 2016	West Nile: 23 percent Acholi: 40 percent (Programme specific target aligned to GoU-UNFPA CPD9)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)
Adolescent birth rate (SDG indicators 3.7.2; UDHS, UNFPA Strategic Plan Impact indicator)	Numerator: Number of women aged 15 - 19 who have given birth (x1000) in West Nile and Acholi sub-regions Denominator: Number of women aged 15 - 19 sampled in West Nile and Acholi sub-regions	West Nile: 145/1000 Acholi: 145/1000 (UDHS - 2016)	Target: 135/1000 (Programme specific target)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18 in West Nile and Acholi sub-regions SDG indicators 5.3.1	Numerator: Number of women aged 20–24 years who were married or in a union before age 15 and before age 18 in West Nile and Acholi sub-regions Denominator: Number of women aged 20–24 years in West Nile and Acholi sub-regions	By 15: West Nile=10 percent, Acholi=10.8 percent By 18: West Nile=46.1 percent, Acholi=38.3 percent (UDHS 2016)	By 15: West Nile=8.5 percent, Acholi=9.3 percent By 18: West Nile=44.8 percent, Acholi=37.3 percent (Programme specific target)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)
GBV Incidence Rate (SDG indicators 5.2.1); (UNFPA Strategic Plan outcome indicator)	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 form of violence and by age in West Nile and Acholi sub-regions	West Nile: 43.4 percent Acholi: 38.6 percent (UDHS, 2016)	West Nile: 42 percent Acholi: 37 percent (Programme specific target)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)
Percentage of women and men aged 15-49 years who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner) in West Nile and Acholi sub-regions (CP8 outcome indicator; UDHS, MASC SRHR outcome indicator)	Numerator: Number who reported using condoms at last sexual intercourse with a non-marital, non-cohabiting partner in West Nile and Acholi sub-regions Denominator: Number of women and men aged 15-49 years who had intercourse in the past 12 months with on-marital, non-cohabiting partner in West Nile and Acholi sub-regions	West Nile Men: 63.1 percent Women: 35.9 percent Acholi Men: 81 percent Women: 63 percent (UDHS, 2016)	West Nile Men: 70 percent, Women: 40 percent Acholi Men: 90 percent, Women: 70 percent (Programme specific target)	UDHS Community Information System (CIS)	UBOS (UDHS) UNFPA (CIS)
Outcome 1: Enhanced access to and utilization of quality SRHR services (family planning, Maternal health, Post abortion Care, HIV Testing and Post GBV) by 1,057,177 women, girls, boys and men including refugees and PWDS in West Nile and Acholi sub regions, by 2023.					
1.1 Institutional Maternal Mortality Ratio at the ANSWER supported health facilities	Numerator: Number of maternal deaths in ANSWER supported health facilities/institutions (x 100,000)	West Nile: 104 Acholi: 45 Overall: 94	West Nile: 72 Acholi: 31 Overall: 65	HMIS	UNFPA, MOH

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
	Denominator: Number of deliveries in ANSWER supported health facilities/institutions.	(HMIS 2018)			
1.2 Number of new users of modern contraceptives (disaggregated by age (10-19,20-24 and 25+), type of method, district and specific groups refugees, PWDs) at the ANSWER supported facilities	Number of new users of modern contraceptives (Modern Contraceptive Method excludes lactational amenorrhea, calendar methods, withdrawal, and the 2-days methods)	West Nile: 48,966 Acholi: 14,942 Total: 63,908 HMIS (2018)	Overall: 343076 West Nile: 264747 Acholi: 78329	HMIS	UNFPA, MOH
1.3 Number of women and girls provided with maternal health services (disaggregated by age, location, PWDs, refugees) at the ANSWER supported facilities	Number of women and girls attending 1st ANC at supported health facilities.	West Nile: 93,793 Acholi: 19,958 Total: 113,751 HMIS (2018)	Cumulative MH services Overall: 577839 West Nile: 479200 Acholi: 98639	HMIS	UNFPA, MOH
1.4 Number of GBV survivors provided with post GBV health services (disaggregated by age, sex, location, and specific groups (refugees, PWDs)) at the ANSWER supported facilities	Total number of clients provided with different types of post GBV services at the supported health centers. Services includes: PEP, Treatment of injuries, treatment for STIs, anxiety, and abortions due to GBV)	West Nile: 2,354 Acholi: 636 Total: 2,990 HMIS (2018)	Cumulative GBV services Overall: 22265 West Nile: 18212 Acholi: 4053	HMIS, NGBV Database, GBVMIS and Activity Reports	UNFPA, MOH, MOGLSD
1.5 Number of women and girls provided with post abortion care (disaggregated by age, location, PWDs, refugees) at the ANSWER supported health facilities	Number of clients provided with post abortion care (PAC) services at the supported health facilities.	West Nile: 4,312 Acholi: 1,427 Total: 5,739 HMIS (2018)	Overall: 25874 West Nile: 19994 Acholi: 5880	HMIS	UNFPA, MOH
1.6 Number of people provided with HIV Testing services from the supported health facilities (disaggregated by sex, age, location, and specific groups (PWDs, refugees)) at the ANSWER supported facilities	Number of people tested for HIV through supported health facilities To avoid double counting, women who receive HIV testing services at ANC clinics are not included in targeting.	Overall: 223172 West Nile: 170205 Acholi: 52967 (HMIS 2018)	Cumulative HIV services Overall: 931227 West Nile: 719485 Acholi: 211742	HMIS	UNFPA, MOH

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
Output 1.1: 210 public health facilities in West Nile and Acholi sub regions offer quality equitable SRHR services (family planning/Maternal health/Post abortion Care and Post GBV health and HIV) that are responsive to the needs of women, girls, boys and men, PWDs and refugees by 2023.					
1.1.1 Percent of target health facilities with capacity to provide quality GBV/HIV/family planning/MH	Numerator: Number of health facilities with capacity to provide quality family planning/MH/HIV/GBV services as per MoH guidelines (see Capacity definition sheet) Denominator: Total number of supported health facilities in target districts	family planning: 68.8 percent, (West Nile=63.9 percent, Acholi=85.7 percent)	family planning: 78.8 percent, (West Nile=73.4 percent, Acholi=96.7 percent)	Baseline and Project evaluation survey	UNFPA
		MH: 42.6 percent, (West Nile=44.6 percent, Acholi=35.7 percent)	MH: 61.6 percent, (West Nile=65.6 percent, Acholi=53.7 percent)		
		PAC: 59.4 percent, (West Nile=56.8 percent, Acholi=73.3 percent)	PAC: 69.4 percent, (West Nile=63.8 percent, Acholi=86.3 percent)		
		GBV: 49.6 percent, (West Nile=50.5 percent, Acholi=46.4 percent)	GBV: 64.6 percent, (West Nile=65.5 percent, Acholi=64.4 percent)		
		HIV: 81.3 percent, (West Nile=84.2 percent, Acholi=71.4 percent)	HIV: 89.3 percent, (West Nile=90.2 percent, Acholi=82.4 percent)		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
1.1.2 Percent of health facilities experiencing no stock-outs of at least three modern family planning methods over a period of three consecutive months.	Numerator: Number of HC II - Hospitals in target districts experiencing no stock-outs of at least three modern family planning methods over three consecutive months (X100) Denominator: Number of HC II, HC III, HC IV, and Hospitals surveyed in target districts	West Nile=65.8 percent, Acholi=81.5 percent SDP survey (2019)	West Nile: 75.8 percent Acholi: 89.0 percent	Service Delivery Point Survey and Quarterly Stock Monitoring Reports	UNFPA, Responsible IP
1.1.3 Number of young people provided with maternal health services through differentiated points of delivery (Disaggregated by district and specific groups (refugees and PWDs)	Number of young people (10-24 years) provided with maternal health services through differentiated points of delivery (outreaches, vouchers and health facility)	0	107,273	Project activity reports	UNFPA, Responsible IP
1.1.4 Number of young people provided with family planning services through differentiated points of delivery (Disaggregated by district and specific groups (refugees and PWDs)	Number of young people (10-24 years) provided with family planning services through differentiated points of delivery (outreaches, vouchers and health facility)	0	165,493	Project activity reports	UNFPA, Responsible IP
1.1.5 Number of revisits for modern contraceptives (disaggregated by age (10-19,20-24 and 25+), type of method, district and specific groups refugees, PWDs)	Number of women already using a contraceptive method revisiting health centers for modern contraceptives.	West Nile: 31,949 Acholi: 8,715 Total: 40,665 HMIS (2018)	Overall: 271958 West Nile: 210302 Acholi: 61656	HMIS	UNFPA, MOH
1.1.6. Percentage of clients at the supported health facilities who are satisfied or very satisfied with family planning/MH/HIV/GBV services (disaggregated by gender, age, disability, refugee and service)	Numerator: Number of clients at the supported health facilities who are satisfied with family planning/MH/HIV/GBV services based on an exit interview tool (see comments on satisfaction definition) Denominator: Number of clients who received family planning/MH/HIV/GBV services interviewed	family planning: 73.1 percent, (West Nile=76.4 percent, Acholi=66 percent)	family planning: 83.1 percent, (West Nile=86.4 percent, Acholi=77 percent)	Client Exit Surveys	UNFPA, Responsible IP
		MH: 68.7 percent, (West Nile=73.5 percent, Acholi=53.2 percent)	MH: 77.7 percent, (West Nile=80.5 percent, Acholi=65.2 percent)		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
		PAC: 66.7 percent, (West Nile=68.4 percent, Acholi=60 percent)	PAC: 74.7 percent, (West Nile=76.4 percent, Acholi=68.1 percent)		
		GBV: 77.3 percent, (West Nile=77.8 percent, Acholi=75 percent)	GBV: 85.3 percent, (West Nile=85.8 percent, Acholi=83.1 percent)		
		HIV: 69.4 percent, (West Nile=68.4 percent, Acholi=72.7 percent)	HIV: 77.4 percent, (West Nile=78.4 percent, Acholi=79.2 percent)		
1.1.7 Number of people referred to access quality SRHR services (family planning, Maternal health, Post abortion Care, HIV Testing and Post GBV from the community)	Number of people referred to health facilities through ANSWER supported structures (VHTs, peer educators, youth clubs among others)	0	87,302	IP monitoring reports	UNFPA, Responsible IP
Output 1.4: 866,415 community members (host and refugees) empowered 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 by 2023.					
1.4.1 Number of community members reached (per year) through different strategies with standard package of information on SRHR/GBV (disaggregated by age, sex, district and specific groups (refugees, PWDs))	Number of adolescents, youth and adults reached through various community platforms including MAGS, SASA Activities, VHTs, religious leaders and cultural leaders.	0	866,415	Project activity reports	UNFPA, Responsible IP

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
1.4.2 # and type of community actions taken to contribute to reduction of SGBV, teenage pregnancy and child marriage.	For the purpose or measurement, a community will consist of a sub-county in which the project is implemented, and the cooperate institutions targeted. This is a indicator which will be measured by counting and describing the type of actions taken to enhance use of SRHR services and to prevent GBV	0	48	Activity reports and most significant change stories	UNFPA
1.4.3 Percentage of SGBV survivors (rape and defilement) reporting timely (within 72hrs) for post SGBV services at health facilities. (Disaggregated by age, sex, district and specific groups (refugees, PWDs))	Numerator: Number of SGBV survivors (rape and defilement) reporting timely (within 72hrs) for post SGBV health services. Denominator: Total number of SGBV survivors reporting for post SGBV health services.	Overall=63.7 percent West Nile=63.8 percent Acholi=63 percent	Overall=70.3 percent West Nile=70.8 percent Acholi=70 percent	GBV registers at Health Facilities	UNFPA, MOH
1.4.4 Number of people engaging as community resource persons including activists on GBV, teenage pregnancy, child marriage, family planning (Disaggregated by age, sex, district and specific groups (refugees and PWDs)).	Number of people engaging as community resource persons on GBV, teenage pregnancy, child marriage, family planning	0	1,964	Activity Reports	UNFPA, Responsible IP
Output 1.5 Girls and boys (10- 14, 15-19 yrs.) and older youth (20-24 yrs.), in West Nile and Acholi regions including refugees are provided with age appropriate, correct and comprehensive SRHR information to create demand for SRHR services including contraceptives by 2023					
1.5.1 Number of schools providing sexuality education Programme	Number of schools providing sexuality education Programme	0	450	School activity reports and SE session registers	UNFPA, Responsible IP
1.5.2 Number of young people in school (students and pupils) reached with comprehensive age appropriate information on SRHR and GBV (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	Number of young people (10-24 years) in school (students and pupils) who undertake/attend at least 80 percent of the designed SE package (PIASCY)	0	315,000	School activity reports and SE session registers	UNFPA, Responsible IP

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
1.5.3 Percentage of young people in school (students and pupils) with comprehensive correct information on sexuality, HIV/STIs, pregnancy and contraception (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	Numerator: Total number of young people (10-24 years) in school with correct comprehensive information on sexuality, HIV, pregnancy and contraception Denominator: Total number of young people (10-24 years) in school surveyed.	**Sexuality**	**Sexuality**	Baseline and Endline Surveys	UNFPA
		10-14 (Acholi=11.1 percent, West Nile=5.3 percent)	10-14 (Acholi=21.1 percent, West Nile=10.6 percent)		
		Pregnancy	**Pregnancy**		
		10-14 (Acholi=2.2 percent, West Nile=5.7 percent)	10-14 (Acholi=12.2 percent, West Nile=11 percent)		
		15-19 (Acholi=8.1 percent, West Nile=17.8 percent)	15-19 (Acholi=18.1 percent, West Nile=23.1 percent)		
		20-24 (Acholi=19.6 percent, West Nile=25.3 percent)	20-24 (Acholi=29.6 percent, West Nile=30.6 percent)		
		Contraception	**Contraception**		
		10-14 (Acholi=3.2 percent, West Nile=3.8 percent)	10-14 (Acholi=13.2 percent, West Nile=9.1 percent)		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
		15-19 (Acholi=32 percent, West Nile=37 percent)	15-19 (Acholi=42 percent, West Nile=42.3 percent)		
		20-24 (Acholi=55.1 percent, West Nile=51.3 percent)	20-24 (Acholi=65.1 percent, West Nile=56.6 percent)		
		HIV/AIDS and STIs	**HIV/AIDS and STIs**		
		10-14 (Acholi=6.8 percent, West Nile=24 percent)	10-14 (Acholi=16.8 percent, West Nile=29.3 percent)		
		15-19 (Acholi=36.8 percent, West Nile=42.3 percent)	15-19 (Acholi=46.8 percent, West Nile=47.6 percent)		
		20-24 (Acholi=55.2 percent, West Nile=52.3 percent)	20-24 (Acholi=65.2 percent, West Nile=57.6 percent)		
		Composite (all categories)	**Composite (all categories)**		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
		10-14 (Acholi=1.6 percent, West Nile=2.8 percent)	10-14 (Acholi=4.1 percent, West Nile=4.1 percent)		
		15-19 (Acholi=3.6 percent, West Nile=7.4 percent)	15-19 (Acholi=6.1 percent, West Nile=8.7 percent)		
		20-24 (Acholi=11.5 percent, West Nile=12.5 percent)	20-24 (Acholi=14 percent, West Nile=13.8 percent)		
1.5.4 Number of young people reached with age appropriate information on SRHR and GBV through various strategies (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	Number of young people (10-24 years) reached with age appropriate information on SRHR and GBV through various strategies (outreaches, health education sessions, peer educators, **SE sessions (attended less than 80 percent of SE sessions)** etc.)	0	542,612	IP monitoring reports	UNFPA, Responsible IP
1.5.5 Percentage of sexually active in school (students and pupils) young people (15-24 years) who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner) (disaggregated by sex, age group 15-19,20-24 and refugee and PWDs)	Numerator: Number of young people in school (15-24 years) who reported using condoms at last sexual intercourse with a non-marital, non-cohabiting partner Denominator: Total number of young people (15-24 years) in school clubs who had intercourse in the past 12 months with non-marital, non-cohabiting partner	Acholi=53 percent, West Nile=56.9 percent	Acholi=60.9 percent, West Nile=61 percent	Baseline and Endline Surveys	UNFPA
1.5.6 Percentage of sexually active in school (students and pupils) young people (15-24 years) who use modern contraception (disaggregated by sex, age group 15-19,20-24 and refugee and PWDs)	Numerator: Number of young people in school (15-24 years) who currently use modern contraception. Denominator: Total number of young people in school reached with comprehensive information on sexuality, HIV, pregnancy and contraception.	Acholi=29.4 percent, West Nile=35.1 percent	Acholi=37.3 percent, West Nile=39.2 percent	Baseline and Endline Surveys	UNFPA

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
1.5.7 Number of young people out of school reached with comprehensive, age appropriate correct information on SRHR/GBV (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	Number of out of school young people (10-24 years) enrolled in young empowerment clubs who undertake/attend at least 80 percent of the designed SE package	0	22,320	Clubs Registers and Activity Reports	UNFPA, Responsible IP
1.5.8 Percentage of young people out of school with comprehensive correct knowledge on sexuality, HIV/STIs, pregnancy and contraception (disaggregated by sex, age group 10-14,15-19,20-24 and refugee and PWDs)	Numerator: Total number of young people (10-24 years) out of school with correct comprehensive knowledge on sexuality, HIV/STIs, pregnancy and contraception Denominator: Total number of young people (10-24 years) in school surveyed.	**Sexuality**	**Sexuality**	Baseline and Endline Surveys	UNFPA
		10-14 (Acholi=5.1 percent, West Nile=4.7 percent)	10-14 (Acholi=15.1 percent, West Nile=10 percent)		
		Pregnancy	**Pregnancy**		
		10-14 (Acholi=4.5 percent, West Nile=5.7 percent)	10-14 (Acholi=14.5 percent, West Nile=11 percent)		
		15-19 (Acholi=59.3 percent, West Nile=73.9 percent)	15-19 (Acholi=69.3 percent, West Nile=79.2 percent)		
		20-24 (Acholi=71.5 percent, West Nile=84.2 percent)	20-24 (Acholi=81.5 percent, West Nile=89.5 percent)		
		Contraception	**Contraception**		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
		10-14 (Acholi=1.5 percent, West Nile=5.3 percent)	10-14 (Acholi=11.5 percent, West Nile=10.6 percent)		
		15-19 (Acholi=50.1 percent, West Nile=42.6 percent)	15-19 (Acholi=60.1 percent, West Nile=47.9 percent)		
		20-24 (Acholi=62.3 percent, West Nile=55.6 percent)	20-24 (Acholi=72.3 percent, West Nile=60.9 percent)		
		HIV/AIDS and STIs	**HIV/AIDS and STIs**		
		10-14 (Acholi=12.4 percent West Nile=10.4 percent)	10-14 (Acholi=22.4 percent West Nile=15.7 percent)		
		15-19 (Acholi=38.1 percent West Nile=38.2 percent)	15-19 (Acholi=48.1 percent West Nile=43.5 percent)		
		20-24 (Acholi=47.9 percent West Nile=46.7 percent)	20-24 (Acholi=57.9 percent West Nile=52 percent)		

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
		Composite (all categories)	**Composite (all categories)**		
		10-14 (Acholi=1.3 percent, West Nile=2.6 percent)	10-14 (Acholi=3.8 percent, West Nile=3.9 percent)		
		15-19 (Acholi=5.8 percent, West Nile =6.7 percent)	15-19 (Acholi=8.3 percent, West NIle =8 percent)		
		20-24 (Acholi=15.2 percent West Nile =15.4 percent)	20-24 (Acholi=17.7 percent West Nile =16.7 percent)		
1.5.9 Percentage of sexually active out of school young people (15-24 years) who used a condom at last high-risk sex (sex with a non-marital, non-cohabiting partner) (disaggregated by sex, age group 15-19,20-24 and refugee and PWDs)	Numerator: Number of young people out of school (15-24 years) who reported using condoms at last sexual intercourse with a non-marital, non-cohabiting partner Denominator: Total number of young people (15-24 years) out of school clubs who had intercourse in the past 12 months with non-marital, non-cohabiting partner	Acholi=75.4 percent, West Nile =75.4 percent	Acholi=83.3 percent, West Nile =79.5 percent	Baseline Survey and clubs Pre-Post Survey	UNFPA, Responsible IP
1.5.10 Percentage of sexually active out of school young people (15-24 years) who use modern contraception (disaggregated by sex, age group 15-19,20-24 and refugee and PWDs)	Numerator: Number of young people out of school (15-24 years) who currently use modern contraception. Denominator: Total number of young people out of school reached with comprehensive information on sexuality, HIV, pregnancy and contraception through clubs.	Acholi=32.4 percent, West Nile =32.4 percent	Acholi=40.3 percent, West Nile =36.5 percent	Baseline Survey and clubs Pre-Post Survey	UNFPA, Responsible IP

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
Outcome 2: Strengthened multi-disciplinary leadership for improved implementation of and accountability towards the demographic dividend road map by 2023.					
2.1 Percentage increase of Public Expenditure on family planning at national level	Numerator: Amount of the funds actually spent on family planning activities at national level in 2023 less Amount of the funds actually spent on family planning activities at national level in 2018 Denominator: Amount of the funds actually spent on family planning activities at national level in 2018	0.0 percent	25.0 percent	Government expenditure reports at national level. Resource Flows On Family Planning Survey In Uganda by UBOS.	UNFPA, Mofamily planningED, NPC
2.3 Percentage increase of Public Expenditure on GBV (disaggregated at national level)	Numerator: Amount of the funds actually spent on GBV activities at national level in 2023 less Amount of the funds actually spent on GBV activities at national level in 2018 Denominator: Amount of the funds actually spent on GBV activities at national level in 2018	0.0 percent	5.0 percent	Government expenditure reports at national level	UNFPA, Mofamily planningED, NPC
2.4 Percentage increase of Public Expenditure maternal health (disaggregated at national level)	Numerator: Amount of the funds actually spent on Maternal Health activities (ANC, delivery and postnatal) at national level in 2023 less Amount of the funds actually spent on Maternal Health activities at national level in 2018 Denominator: Amount of the funds actually spent on Maternal Health activities at national level in 2018	0.0 percent	25.0 percent	Government expenditure reports at both national level.	UNFPA, Mofamily planningED, NPC
Output 2.1: Enhanced implementation of and accountability towards the demographic dividend (DD)priorities at national level.					

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
2.1.1 Percentage of sector (health, education, gender) budget released to districts(disaggregation by sector)	Numerator: Actual amount released by sectors to districts Denominator: Total amount in budgets release for each sector	Overall= 40.9 percent Gender=4.1 percent Education=57.8 percent Health=23.1 percent Baseline 2018/19	Overall= 43 percent Gender=7 percent Education=60 percent Health=26 percent	Baseline survey, Activity reports	UNFPA, Responsible IP
2.1.2 Budget execution on demographic dividend (DD)priorities within the sectorial plans/Bfamily plannings (disaggregation by sector)	Numerator: Amount of the funds for demographic dividend (DD)priorities actually spent on demographic dividend (DD)activities by the targeted sectors (health, education, gender) in a year Denominator: Amount of the funds planned/budgeted for demographic dividend (DD)priorities by the targeted sectors (health, education, gender) in the same period	Baseline 2018/19 Overall= 72.1 percent Gender=97.7 percent Education=79.5 percent Health=48.6 percent	Overall=80 percent Gender=98.5 percent Education=88 percent Health=70 percent	Baseline survey, Activity reports	UNFPA, Responsible IP
2.1.3 Number of targeted sectors (Health, education, gender, Lands and urban development, Water, Agriculture) with annual plans and budgets which are compliant with demographic dividend indicator requirements at a minimum of 80 percent, by 2023.	Plans and budgets are assessed separately for compliance to demographic dividend (DD)indicators, and scores provided. A plan or budget is considered compliant if it obtains at least 50 percent point score on a composite index. We target each sector to have at least 80 percent point score.	0 (None of the sectors meet the 80 percent minimum score) (2018/19)	Not Applicable	Baseline survey, demographic dividend (DD)Assessment Reports	UNFPA, Responsible IP
2.1.3b Number of targeted programs with annual plans and budgets which are compliant with the demographic dividend indicator requirements at a minimum of 80 percent, by 2023	Plans and budgets are assessed separately for compliance to demographic dividend (DD)indicators, and scores provided. A plan or budget is considered compliant if it obtains at least 50 percent point score on a composite index. We target each programmeto have at least 80 percent point score.	2 (Tourism Development and Private Sector Development meet the 80 percent minimum score) (2021)	5	Baseline survey, demographic dividend (DD)Assessment Reports	UNFPA, Responsible IP

Indicators	Indicator Definition	Baseline (Source)	4-Year Target (new)	Data Source	Responsibility
2.1.4 Number of motions on relevant SRH, DD, family planning, GBV issues presented on floor of parliament and commitment passed and implemented.	Number of motions on relevant SRH, DD, family planning, GBV issues presented on floor of parliament and commitment passed and implemented through this programme	0	5	Baseline survey, Activity reports	UNFPA, Responsible IP
Output 2.2: Enhanced implementation of and accountability towards the demographic dividend (DD)priorities at the targeted districts in West Nile and Acholi Sub regions by 2023					
2.2.1 Percentage of district approved budget (education, health & gender) allocated on demographic dividend (DD)priorities (disaggregation by district)	Numerator: Total amount (in UGX) of district budget allocated to demographic dividend (DD)priorities. Denominator: Total approved district budget (in UGX)	Overall=63.9 percent Acholi=66.8 percent West Nile=63.3 percent (FY 2018/19)	Overall=69 percent Acholi=71.8 percent West Nile=68.8 percent	Baseline Survey, Government Budgets at district level.	UNFPA, Responsible IP
2.2.2 Budget execution on demographic dividend (DD)priorities within the district plans/Bfamily plannings (disaggregation by district and department)	Numerator: Amount of the funds for demographic dividend (DD)priorities actually spent on demographic dividend (DD)activities by the targeted districts in a year Denominator: Amount of the funds planned/budgeted for demographic dividend (DD)priorities by the targeted districts in the same period	Overall=87 percent Acholi=78.1 percent West Nile=88.9 percent (FY 2018/19)	Overall=95 percent Acholi=95 percent West Nile=95 percent	Baseline survey, Activity reports	UNFPA, Responsible IP
2.2.3 Average demographic dividend (DD)Compliance Score for ANSWER Targeted Districts	Numerator: Total demographic dividend (DD)compliance score for ANSWER supported districts. Denominator: Total number of ANSWER supported districts	Overall=50.2 % Acholi=24.0% West Nile=59.0 percent (FY 2018/19)	Overall=70 percent Acholi=60 percent West Nile=75 percent	Baseline Survey, Government Budgets at district level.	UNFPA, Responsible IP
2.2.4 Number of ordinances/by laws related to Adolescent SRHR, Maternal health, DD, family planning, and GBV issues presented to the district council, passed and implemented.	Number of ordinances/by laws related to Adolescent SRHR, Maternal health, DD, family planning, and GBV issues presented to the district council, passed and implemented.	0	24	Baseline survey, Activity reports	UNFPA, Responsible IP

Annex 10: Members of the Evaluation Reference Group

	Organization	Name	Position
	National Population Council (NPC)	Samuel Omwa	Director M&E
		Betty Kyandodo	Director Family Department
	National Planning Authority (NPA)	Judith Mutabazi	Acting Manager Population and Social Planning
	Uganda Bureau of Statistics (UBOS)	Helen Nviiri	Director, Population and Social Statistics
	MOH	Dr Richard Mugahi (Chair)	Ag. Commissioner; Maternal and Child Health
		Robert Mutumba	Principal Officer - Reproductive and Infant Health
	MGLSD	Annet Kabarungi	Principal Officer - Women in Development Officer
	MOE	Muhammed Kasule	Principal Officer
	Plan International	Patrick Okello	Programme Manager- ANSWER Programme
	Save the Children	Pauline Kabangenyi	Programme Manager- ANSWER Programme
		Benjamin Bwambale	M&E Officer
	Special Olympics (PWD)	Ms. Genevieve Bamwidhukire	SO Uganda Acting National Director
	Marie Stopes	William Nnyombi	Director Programs
		Mukwaya Aloysius	M&E officer
	District Local Government	Planner	James Bagada, Agago District
		District Education Officer	Lanyero Joyce, Amuru District
		District Health Officer	Dr. Paul Onzubo, Maracha District
		District Community Development Officer	Richard Obia, Terego District
	Field officers, UNFPA	Wilberforce Mugwanya	Programme Coordinator
		Cinderella Anena	Programme Analyst
		Erongot Judi Emorut	Programme Analyst Delivery of Rights AYSRH
		Alex Chono	Programme Coordinator
	UNFPA Kampala	Odaga John	Programme Specialist M&E / Evaluation Manager
		Camilla Buch von Schroeder	Programme Specialist / ANSWER programme manager
		Christine Kajungu	Programme Specialist Maternal Health
		Anne Sizomu	Programme Specialist - Adolescents/Youth
		Timothy Kasule	Programme Analyst – Reproductive Health Commodity Security
		Harriet Ndagire	Programme Analyst - GBV/FGM/ECM
		Allan Agaba	Programme QA
	Embassy of Netherlands	Ruth van den Zorge	First Secretary- SRH and GBV
		Judith Adokorach	Policy Advisor - SRH and GBV
		Caspar	Ministry of Foreign Affairs - M&E specialist

Annex 11: Sustainable Development Goals Status

SUSTAINABLE DEVELOPMENT GOALS STATUS		
GOAL	Indicator and Source	Status
SDG1	Poverty headcount ratio at $1.90 a day (percent of population) (2011) PPP[95]	19.2 percent (2012-2013)
SDG2	Prevalence of stunting (low height-for-age) in children under 5 years of age (percent)	29 percent (2016)
	Prevalence of wasting in children under 5 years of age (percent)[96]	4.7 percent (2014/2016)
	Prevalence of obesity. BMI ≥ 30 (percent adult population)[97]	4.2 (women); 0.6 (men) (2011)
SDG3	Maternal mortality ratio per 100 000 live births[98]	336 (2016)
	Neonatal mortality rate (per 1 000 live births)[99]	43 (2016)
	Mortality rate. under-5 (per 1 000 live births)[100]	64 (2016)
	Incidence of tuberculosis (per 100 000 people)[101]	202 (2015)
	HIV prevalence (per 1 000)[102]	7.6 (2011)
	Healthy Life Expectancy at birth (years)[103]*	63.6 years (2014)
	Adolescent fertility rate (births per 1 000 women ages 15- 19)[104]	132 (2016)
	Proportion of births attended by skilled health personnel (percent)[105]	74.2 percent (2016)
SDG4	Net primary enrolment rate (percent)[106]	97 percent (2014)
	Expected years of schooling (years)[107]	11.1 (2012)
	Literacy rate of 15–24-year-olds. both sexes (percent)[108]*	72.2 percent (2014)
	Primary completion rate[109]	61 percent (2015)
SDG5	Estimated demand for contraception that is unmet (percent women married or in union. ages 15-49)[110]	28 percent (2016)
	Proportion of seats held by women in national parliaments (percent)[111]	35 percent (2016)
SDG6	Improved water source (percent of population with access)	73 percent (2012-2013)
	Access to improved sanitation facilities (percent population) [112]*	91.2 percent (2012-2013)
	Imported groundwater depletion (m3/year/capita)[31]	29 billion (2013)
SDG7	Access to electricity (percent population)[113]*	872 836 customers (2015)
	Access to non-solid fuels (percent population)[114]*	4.2 percent (012-2013)

[95] UNHS 2012/13, UBOS
[96] UDHS 2016, UBOS
[97] Ibid.
[98] Ibid.
[99] Ibid.
[100] Ibid.
[101] https://data.worldbank.org/indicator/IP.JRN.ARTC.SC
[102] Sero Survey 2014
[103] UPHC 2014, UBOS
[104] UDHS. 2016, UBOS
[105] Ibid.
[106] MoEs
[107] Human Development Report (2013). UNHS 2012/13, UBOS
[108] UNHS 2012/13. UDHS 2016. NPHC 2014, UBOS
[109] MoES. Education Statistical Abstract. UNHS. 2012/13, UBOS
[110] UDHS 2016, UBOS
[111] The Uganda Parliament, 2016
[112] National Water Resource Assessment
[113] UNHS 2012/13, UBOS
[114] Ibid.

SDG8	Proportion of the population using the internet (percent)[115]*	39.7 percent (2015)
	Mobile broadband subscriptions (per 100 inhabitants)[116]	10.267 (2014)
	Logistics performance index: Quality of trade and transport related infrastructure (1=low to 5=high)[117]	2.74 (2016)
	Number of scientific and technical journal articles (per capita)[118]	474 (2013)
SDG10	Gini index (0-100)[119]	0.395 (2012-2013)
SDG11	Improved water source piped (percent urban population with access)[120]	87.3 percent (2012-2013)
	Urban population (percent of total)[121]	21.4 percent (2017)
	Population living in slums (percent of urban population)[122]	*54 (2014)
SDG12	Municipal Solid Waste (kg/year/capita)[123]	0.56 (2014)
	Production-based SO2 emissions (kg/capita)[124]	0.2 (2014)
SDG13	Energy-related CO2 emissions per capita (tCO2/capita) [125]	0.033 (2014)
SDG14	Total Fisheries Production (Metric Tons)[126]	454 860 tonnes (2015)
SDG15	Terrestrial protected areas (percent of total land area)[127]	16 percent (2014)
	Annual change in forest area (percent)[128]	-2.2 percent (2015)
SDG16	Prison population (per 100,000 people)[129]	115 per 100,000 people (2014-2015)
	Proportion of the population who feel safe walking alone at night in the city or area where they live (percent)[130]	60 percent (2010-2015)
	Slavery score (0-100)[131]	50 (2016)
	Transfers of major conventional weapons (exports) (constant 1990 US$ million per 100 000 people)[132]	per 100 000 people (2014)
	Bribery incidence (percent of firms experiencing at least one bribe payment request)	22 percent
SDG17	Tax revenue (percent GDP)[133]	14.0 percent (Q1 FY 2016/2017)

115 Ibid.

116 https://data.worldbank.org/indicator/IT.NET.BBND.P2

117 https://data.worldbank.org/indicator/IP.JRN.ARTC.SC

118 https://data.worldbank.org/indicator/IP.JRN.ARTC.SC

119 UNHS 2012/13, UBOS

120 Ibid.

121 NPHC 2014, UBOS

122 https://data.worldbank.org/indicator/EN.POP.SLUM.UR.ZS

123 National Environment Management Authority (NEMA) and UBOS

124 2nd National Communication on Green House Gas(GHG) Emission 2014

125 Ibid.

126 MAAIF

127 State of Environment Report, NEMA

128 National Forest Authority (NFA)

129 ICPR (2016)

130 UNICEF (2016)

131 Walk Free Foundation (2016

132 Stockholm International Peace Research Institute (2017)

133 State of the economy, BOU

Key facts table

LAND	
Geographical location	East Africa, West of Kenya, East of the DRC, North of Tanzania, South of Southern Sudan
Land area	241,507 square kilometres
	Open water bodies cover 36 864 01 square kilometres
Terrain	Mostly Plateau with rim of mountains
PEOPLE	
Population[134]	Total Population 40 299 300; Male=49 percent; Female=51 percent (UBOS, 2012); Urban Population: 6624 050 (21.4 percent); Rural Population: 31 675 250 (78.6 percent)
	Population growth rate 3.0 (2014/15)
Government	Republic per 1995 Constitution, amended in 2005
	1962: Independence from British colonial rule;
	1971 – 1979: Military takeover/government characterised by dictatorship and economic decline;
	1980 – return of democratically elected government
	1981 – 1986: Civil war
	1986: National Resistance Movement Unitary Government
	1986-2006: Civil war in Northern Uganda
	2001 – to-date: Current National Resistance Government under multiparty dispensation.
ECONOMY	
GDP Per Capita (US$), Current Prices[135]	724 (2017/18)
GDP Growth Rate (percent)[136]	6.1 percent (2017/18)
Proportion of Population below the National Poverty Line (percent)[137]	21.4 percent (2016/2017)
Income distribution (GINI Coefficient)[138]	0.42 (2016/2017)
US$ Labour Productivity Per Worker – Total[139]	2.786 (2014/15)

[134] National mid-year population projections 2015-2050 (UBOS, 2018) and UNHS 2012/13, UBOS

[135] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)

[136] Ibid.

[137] Ibid.

[138] Ibid.

[139] Ibid.

Working-Age Population Employed	47.5 (2016/17)
SOCIAL AND HEALTH INDICATORS	
Human Development Index Rank[140]	0.516
Unemployment rate (overall)[141]	9.2
Per capita public health expenditure, Uganda shillings[142]	49 637 (2016/17)
Literacy Rate (10 Yrs.+) – Total[143]	73.5 (2017/2018)
Total fertility rate[144]	5.4 (2015/16)
Infant mortality rate per 1000 live births[145]	43 (2015/16)
Human Development Index Rank[146]	0.516

[140] Uganda UNDP Human Development Report, 2018

[141] UNHS 2012/13 & UNHS 2016/17, UBOS

[142] Annual Statistical Abstract Statistical Abstract (UBOS, 2018)

[143] Ibid.

[144] UDHS 2016, UBOS

[145] Ibid.

[146] Uganda UNDP Human Development Report, 2018