EVALUATION OF THE JOINT PROGRAMME ON GENDER-BASED VIOLENCE AT NATIONAL AND IN THE TARGET DISTRICTS IN UGANDA

REPORT

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LIST OF ACRONYMS AND ABBREVIATIONS

CCFU	Cross Cultural Foundation of Uganda
CDFU	Communication For Development Foundation Uganda
CDOs	Community Development Officers
CEDOVIP	Center for Domestic Violence Prevention
CSBAG	Civil Society Budget Advocacy Group
CSOs	Civil Society Organizations
EPRC	Economic Policy Research Centre
FIDA	Uganda Association of Women Lawyers
GBV	Gender Based Violence
GE	Gender Equality
GoU	Government of Uganda
HR	Human Rights
IPs	Implementing Partners
JCU	Justice Centre Uganda
KCCA	Kampala Capital City Authority
MGLSD	Ministry of Gender Labour and Social Development
MoV	Means of Verification
NGOs	Non-Government Organisations
ODPP	Office of the Director of Public Prosecutions
RLP	Refugee Law Project
SRHR	Sexual and Reproductive Health and Rights
TPO	Transcultural Psychosocial Organization
UBOS	Uganda Bureau of Statistics
UGANET	Uganda Network on Law Ethics and HIV/AIDS
ULS	Uganda Law Society
UPF	Uganda Police Force
UN	United Nations
UNCST	Uganda National Council for Science and Technology
UNFPA	United Nations Population Fund
UNJPGBV	United Nations Joint Programme on Gender Based Violence Prevention
UN-WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UWEP	Uganda Women Entrepreneurship Programme
UWOPA	Uganda Parliamentary Women's Association

EXECUTIVE SUMMARY

BACKGROUND

The JPGBV is a 5-year (2018-2024) programme funded by the Swedish Government. The programme is a partnership of the United Nations Population Fund (UNFPA), United Nations Entity for Gender Equality and the Empowerment of Women (UN-WOMEN), and Ministry of Gender Labour and Social Development (MGLSD) and is implemented through government line ministries, local governments, national and international NGO partners and Civil Society Organizations (CSOs). The programme has several interventions targeting legal and policy reform at national and sub-national level with implementation focus in 14 target districts of Napak, Nakapiripirit, Kaabong, Abim, Amuria, Kotido, Pader, Kiryandongo, Kaberamaido, Yumbe, Moroto, Gulu, Bundibugyo and Kampala. The goal of the JPGBV is to contribute to the elimination of GBV and improvement of SRHR of women, men, girls, and boys including disadvantaged hard to reach and vulnerable populations in Uganda. It aims to achieve four major outcomes: (i) an enabling policy, legislative and accountability environment for elimination of GBV and improvement of SRHR is translated into action; (ii) reduced social tolerance for GBV and improved sexual reproductive health and rights (SRH&R); (iii) increased utilization of quality integrated GBV and SRH&R services in the target districts and (iv) strengthened coordination, partnerships, learning & innovation for integrated SRHR and GBV multi-sectoral response and prevention

OBJECTIVES

The end of term evaluation (ETE) serves three main purposes; (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the achievements in addressing GBV and HPs. The specific objectives of the evaluation were two-fold:

1. To provide an independent assessment of the relevance and performance of the JPGBV and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results; and
2. To broaden the evidence-base to inform the design of similar programmes in Uganda. Additionally, the evaluation draws key lessons and conclusions and provide a set of clear and forward-looking options leading to strategic actionable recommendations to key stakeholders in gender and human rights space.

More specifically, the ETE assessed the relevance, coherence, efficiency, effectiveness, sustainability of the programme, and challenges encountered during implementation and documented good practices and lessons learned during the 5 year and half-life of the project.

METHODS

The ETE was conducted at the national, district and community level. A cross-sectional mixed-methods design involving qualitative and quantitative methods of data collection was adopted. The methods used followed the Organisation of Economic Cooperation and Development's (OECD) evaluation criteria for assessing relevance, effectiveness, efficiency, sustainability and impact of programmes. Qualitative data approaches included **20** Key informant interviews (KIIs) at national level and **45** KIIs at district level; **10** In-depth interviews (IDIs) and **31** focus group discussions (FGDs) at community level. The quantitative data collection approaches used included document review and household survey. A desk review of the

programme documents including the JPGBV strategy document, baseline report, results framework and annual progress reports was undertaken. The household survey was conducted among a random sample of **1,640** individuals. These included **978** women of reproductive age (15-49 years), 335 adolescents and **327** men living in couple relationships. Thematic content analysis was used for the qualitative data. Descriptive statistical analysis was performed for quantitative data. The key baseline and mid-term indicator values were compared.

FINDINGS: The key results are summarized and organized according to each of the specific objectives of the ETE.

Objective 1: Relevance of the JPGBV

Evaluation of the relevance of the JPGBV programme focused on determining whether: (i) the programme fits within the policies and priorities of Uganda and the participating UN organizations; (ii) the programme responds to the needs of the most vulnerable populations, and the changing context and (iii) the extent to which the planned interventions adequately reflect the outputs and outcomes stated in the project design and logframe.

At the national level, the JPGBV program aligns with Uganda's national policies and priorities, as well as those of the participating UN organizations. The program was integrated within the second National Development Plan (NDP II) (2015/16-2019/20), its successor NDP III (2020/21-2024/25), and Vision 2040. Operating within existing national frameworks, the program aligns with the National Plan of Action for Sexual and Gender-Based Violence and Violence Against Children (2019/2030), which prioritizes addressing GBV and violence against children at all levels. It also adheres to the National Policy on SRHR (2006), which emphasizes ensuring access to SRHR information. Additionally, the programme is in tandem with the National Policy on the Elimination of GBV and its National Action Plan (2016), the National Health Policy II (2010/11 - 2019/20), the National Gender Policy 2016-2020; the National Male Involvement Strategy for Prevention and Response to GBV in Uganda 2017; the Social Development Sector Plan (SDSP 2016-2020), the Reproductive Maternal Neonatal Child Health (RMNCH) Sharpened Plan (2016-2020), and the JLOS Fourth Strategic Development Plan. Further, the programme aligns with the Ministry of Education's strategies under the Education and Sports Sector Strategic Plan (ESSP) 2017/2018-2019/2020, which focuses on equitable and quality primary and secondary education for all girls and boys. At the global level, The JPGBV programme contributes to the Sustainable Development Goals (SDGs) that the Government of Uganda and other partners are committed to achieving. Specifically, the programme aligns with the following goals: SDG 1 on ending poverty, SDG 3 on good health and well-being, SDG 4 on the provision of quality education, SDG 5 on gender equality, SDG 10 on reduced inequalities, and SDG 16 on promoting peace, justice, and strong institutions. At the UN level, the JPGBV is aligned to the United Nations Sustainable Development Cooperation Framework for Uganda (UNSDCF) 2021-2025. The outcomes of the JPGBV directly contribute to the UNSDCF Strategic Priorities 1 and 3. Strategic Priority 1 focuses on transformative and inclusive governance, while Strategic Priority 3 emphasizes human well-being and resilience.

The JPGBV made deliberate efforts to involve women and other disadvantaged groups in its activities, ensuring a comprehensive and inclusive approach. By building networks and partnerships with organizations focusing on women and youth, the program effectively reached vulnerable populations.

Women and girls were specifically targeted through awareness campaigns, training sessions, and access to SRHR clinics, including family planning, maternal healthcare, STI testing and treatment, and counseling services. Additionally, targeted outreach and education sessions empowered women and girls with vocational training, enabling them to gain economic independence. Children and adolescents also benefited from school-based and community-based education programs, counseling, HIV testing, educational scholarships, and vocational training, with a particular focus on orphans and vulnerable children. The establishment of community-based child protection committees, including community child activists, helped to monitor and address violence against children. Youth were actively included in sensitization activities aimed at preventing early marriages, teenage pregnancies, and STDs.

Through interviews held with different stakeholders at the national, district, and community levels, the evaluation established that the planned and implemented interventions reflect the outputs and outcomes stated in the project design.

Objective 2. Effectiveness of the JPGBV

Progress towards achievement of the programme goal

- A review of the outcome indicators shows that the programme made significant progress toward its goal of contributing to the elimination of GBV and improvement of the SRHR of women, girls, boys and men in Uganda. The proportion of women who experienced any form of violence reduced by 10.3% from 61.2% at the baseline to 50.1% at the endline. Similarly, the access to SRH services increased, with proportion of women with unmet contraceptive needs reducing from 39.5% at the baseline to 20.3% at the endline. This was overachieved as compared to the set target of 37.0%. The pregnancy rate among 10-14-year-old girls remained the same at 3.2%.

- Incidences of GBV have reduced significantly: The incidence of physical violence among women and girls in the past 12 months reduced by 5.4% from 35.8% at the baseline to 30.4% at the endline. This is lower than the percentage of 34.1% reported in the Uganda Demographic and Health Survey (UDHS) results of 2022 for the UNJPGBV supported regions. Similarly, the incidence of emotional violence among both women and men (15-64 years) and boys and girls (10-14 years) reduced from 60.1% and 60.2% to 40.8% and 41.2%, respectively. However, the incidences of sexual violence among women and girls in the past 12 months remained almost the same between the baseline and endline (14.2% vs. 13.8%).

Progress towards achieving the programme outcomes.

Outcome 1: An enabling policy, legislative and accountability environment for elimination of GBV and improvement of SRHR is translated into action.

- There is strong evidence that the programme has improved the legal and policy environment for GBV and SRHR in Uganda. The UNJPGBV has contributed to the development, reviews and enactment of relevant policies and laws through advocacy, strategic partnerships and collaborations, technical and financial support to the relevant institutions that fast tracked the enactment of the laws. The programme supported the 13 districts to develop ordinances and by laws on alcohol abuse, GBV prevention and promotion of SRHR.

- The programme supported the review and compiling of the maternal perinatal death surveillance and response (MPDSR) reports and also contributed resources towards the Uganda RMNCAH-Sharpened-

Plan-II 2022/23 – 2026/27, including the printing of the plan. In addition, the programme supported the review of the MHC, Maternal Child Health passport.

- The programme contributed to improved implementation of GBV and SRHR laws, policies and standards by government institutions and civil society organizations (CSOs) at both the national and sub-national levels (Output 1.1) through financial support to enactment and implementation activities, training and mentorship of duty-bearers (midwives, CDOs), financing of CSOs as IPs of the UNJPGBV activities, dissemination and orientation of duty-bearers on policies and strategies, technical support supervisions, support the development of implementation guidelines, and advocacy.

Outcome 2: Reduced social tolerance for GBV and improved sexual reproductive health and rights

- **Women empowerment improved**: The percentage of women who received cash earnings from employment and agricultural production increased to 68% from 56.2% at MTR. This illustrates that the programme contributed to increasing the number of women in employment and the agriculture sector. Overall, women empowerment in terms of having control over their own earnings and participation in decision making significantly improved. The percentage of women with control over their own earnings increased to 79.1% from 36.8% at baseline, surpassing the programme endline target of 50.0%. Similarly, women participation in household decision making increased to 69.4% from 31.6% at baseline, surpassing the programme endline target of 50.0%. At least 26,045 girls were enrolled in the programme supported ELA over the five years of the programme implementation, surpassing the set target of 15,000. However, percentage of women with ownership of assets was 68.4%, below the programme set target of 85.0%.

- **Social tolerance to GBV reduced:** The evaluation showed that the percentage of women and men who agree that a husband is justified to beat his wife was lower than that reported at MTR (30.1% vs. 36.0%) but were still higher than the programme endline target of 10%. There was moderate evidence that the programme shifted norms around gender and GBV.

- **Access to GBV services improved:** The percentage of the population seeking help and accessing GBV and SRHR services increased between the baseline and endline and surpassed the programme targets: Access to medical services increased from 76.0% to 88.0%; access to legal services increased from 2.5% to 23.1% and access to psychosocial support services increased from 4.1% to 45.3%. The targets for community-led initiatives and actions implemented to prevent GBV and promote SRHR and those for adolescent girls and women reached with life skills programmes that build their health, social and economic assets were reached.

Outcome 3: Increased utilization of quality integrated GBV and SRHR services

- The is strong evidence of increased uptake of family planning and access to healthcare and legal services through demand creation, engagement of men, training and mentoring of health and social welfare workers to provide friendly services including safe spaces for GBV survivors, integrated SRHR-GBV services. There were clear indications that uptake of health care services increased. In 2023, there is an increased number of family planning users to 719,725 from 416,882 in 2022. The number of fourth antenatal care visits increased to 146, 239 from 137,872 in 2022, there was slight improvement in postnatal care attendance to 376,857 from 333,570 in 2022 and 195,008 institutional deliveries. However, the programme did not achieve the targeted contraceptive prevalence rate (CPR) of 55.8%.

At the endline, the CPR was 40.4%, a significant improvement from 36.7% at the baseline. Only the target CPR for single girls/young women was achieved.

- Among the sexual GBV survivors who accessed healthcare, 100.0% did so within 72 hours; an increase from 90.6% at baseline. The percentage of GBV survivors who seek legal help within 24 hours significantly increased from 2.5% at baseline to 19.4% at the endline, surpassing the set target of 10.0%.

Outcome 4: Strengthened coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention.

- The outputs for strengthening coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention have been achieved. There was evidence of strengthened coordination, partnerships, and adaptive learning as noted by the stakeholders consulted. Several coordination platforms and partnerships were in place, quarterly coordination and review meetings were reported in all districts visited. The programme provided both technical and financial support to ensure functionality of the pertinent national and sub-national coordination mechanisms. The medical-legal task force, the National GBV Reference Group, and GBV in humanitarian settings working group and district GBV/SRH multisectoral coordination platforms are in place and functional. The programme has also supported the meetings of technical working groups or committees such as HIV technical working group and menstrual health management steering committee in 2023.

Objective 3: Coherence of the JPGBV

- The JPGBV advanced an integrated approach to SRHR at both the national and district levels through capacity building, facilitation of joint and multi-sectoral coordination, review and planning meetings, and platforms, facilitation of review and dissemination of policies, plans and guidelines. At the district level, the program led to improved capacity and attitudes of district teams, joint planning and coordination of an integrated approach to SRHR, facilitation of joint and multi-sectoral community meetings and dialogues. At the national level, SRHR and GBV have been integrated through the strategies and guidelines that are being used to promote provision of integrated GBV and SRH services to offer a holistic package of services to meet the rights of beneficiaries.

- The UNJPGBV has attempted to leverage and work in tandem with other related programmes such as the ANSWER programme, EU Spotlight the Access to Justice programme and the UN Spotlight Initiative to rationalize the support in the target districts to ensure synergy with other stakeholders and avoid duplication. There is evidence for complementarity of related programmes focusing on GBV and SRHR.

Objective 4: Efficiency of the JPGBV

- The programme had a robust system in place for ensuring checks and balances and promote accountability in a timely manner. Submitted quarterly reports provided a quick mechanism for review and accountability during the implementation of the programme. The funds allocated to the implementation of the programme were well utilized for the intended programme activities, although the evaluation noted limited budget to support activities effectively in a relatively wide geographical areas with the adequate intensity required.

- There was an effective performance monitoring system in place. Routine monitoring, and supervision visits were conducted. Performance review meetings were held at national and subnational levels. These meetings provided a platform for accountability. However, there was a gap in putting in place innovative collaborative learning and adaptation strategies to foster complex aware M&E as well as systematic documentation of pathways of change contributing to the various outcomes. The current M&E design was also perceived not to offer robust evidence for an impact evaluation.

Objective 5. Sustainability of the JPGBV

The key sustainability strategies adopted by the JPGBV programme included working within the existing national frameworks, structures and systems, partnerships and collaborations and capacity building at the national, subnational and community levels.

- The programme operated within the existing policies, frameworks and systems to contribute to elimination of GBV and improvement of the SRHR of women, girls, boys and men including disadvantaged and vulnerable population in the target districts. The programme functioned within the existing national strategic frameworks, policies, systems and structures at national, district and community levels. The programme heavily leveraged on the existing legal, medical and psychosocial support systems to deliver its mandate. This is particularly important for securing sustainability of the programme outcomes while promoting ownership at the various levels.

- Establishing meaningful collaborations with partners of complementary strengths at various levels holds sustainability potential for some of the key program outcomes. The programme established meaningful partnerships at national, sub-national and community levels. At the national level, the key partners included MGLSD, MoH, MOES, UBOS, NPA, NPC, MoJCA, UPF, ODPP, JLOS, ULRC, Parliament of Uganda, CSOs, Academia, FBOs, Media, Private sector and Cultural Institutions. At the subnational level, the programme collaborated the programme collaborated with the DLGs, CSOs, NGOs, Religious and Cultural Institutions and IPs, among others. At the community level, the programme engaged with the leadership structures including the political, culture and religious leaders, community health workers, community development officers, peer educators, and the police, among others. It is envisioned that these structures will continue to address GBV and promote SRHR beyond the programme span

- The legacy of the JPGBV programme was its ability to build capacity of institutions and individuals at various levels. The strengthened institutional and human resource capacity at the various levels is capable of supporting long term sustainability of the programme outcomes. For example, the trained health workers will continue to provide integrated SRHR, HIV and GBV services in the health facilities.

- The programme adopted a system strengthening approach and functioned to enhance the structural and technical capacity of organizations and institutions to plan, coordinate, implement, monitor and evaluate response to GBV and promotion of SRHR at all levels. The programme functioned to develop human resources and infrastructure capacity for institutions and structures at the various levels of planning and implementation. District-led programming was considered a viable sustainability strategy to enable grassroot strengthening of GBV and SRHR service delivery.

RECOMMENDATIONS

- Engaging top management of the MGLSD and the Attorney General to expedite the review and passing of the ordinances that were developed by the target districts is very critical. It is also important to explore and understand institutional social norms change that was developed but has seldom been implemented at the district and community level. [Priority; High; Actors: MGLSD, Attorney General, Civil Society (Women's Rights Advocates), UN Women, UNFPA]

- Strengthening the information management system through building capacity of staff to be able to collect, use and analyze GBV data to inform programming and policy, especially at the district level, is critical. Further, there is need to engage the Police, Director of Public Prosecutions (DPP) and the Judiciary to develop a data tool that can be used to collect administrative data on GBV. This will improve documentation of GBV cases, referrals, and use of quality data. There is also need to harmonize the tools to be able to capture the GBV Data in the National GBV data base to harmonize reporting and avoid duplication. [Priority: High; Actors: Local Governments, UNFPA, UN Women, Police, DPP, Judiciary]

- Despite the major inroads made in strengthening the capacity of JLOS institutions especially the police through trainings and logistical support and supplies, the evaluation team noted that there is still need specially to increase support in terms of procurement of supplies and scaling up trainings and capacity strengthening to facilitate delivery of HIV prevention and response services under its mandate.

- Efforts to increase coverage of interventions in the target districts are required. There is also need to consider expanding the interventions to do total coverage of the current programme districts. It is also important to explore and understand institutional social norms change. [Priority: Medium; Actors: UNFPA, UN Women]

- Efforts to increase effectiveness, reach and scale of social norm change interventions to address the harmful social norms that drive tolerance of GBV and harmful practices and constrain uptake of SRHR services are required. There is need to review and consider other social norm change strategies that have demonstrated effectiveness in Uganda such as the "Responsible, Engaged and Loving (REAL) Fathers Initiative[1]" was tested in Northern Uganda as a mentoring program focused on reaching young, first-time fathers before their expectations related to parenting and relationships are well established[2]. The programme should also draw lessons from the DREAMS model also tested in several regions of Uganda to add to the strategies used to engage in social norm change. Similarly, there is need to explore mechanisms to facilitate effective organized diffusion of information and learning from the various change agents to the various audiences at the household and community level. To do this, the programme should consider undertaking qualitative and quantitative social network analysis to deepen understanding of the social networks that can be used to facilitate diffusion of information, learning and social norm change. It is also important to explore and understand institutional social norms change in key institutions including the JLOS institutions and health provider norms and design social norm change strategies to facilitate provider norm change. These will

[1] https://www.usaid.gov/global-health/health-areas/family-planning/fathers-can-prevent-violence-too-lessons-real-fathers

[2] This approach has demonstrated evidence to improve prevention of intimate partner violence among couples; Improve fathers' use of positive parenting, their confidence in using nonviolent discipline and couple communication; Foster acceptance of non-traditional gender roles in parenting by fathers and the wider community; and Increase acceptability and use of voluntary modern family planning methods by REAL Fathers couples (also see: https://iidcug.org/proj/scaling-up-real-fathers-approach-in-uganda/)

contribute to delivery of adolescent and youth friendly as well as survivor centered services. [Priority: High; Actors; MGLSD, UNFPA, UN Women, Local Government]

- Based on the lessons learned on implementing GBV shelters, there is need to review the current model and guidelines for the GBV shelters to adapt them to suit the local context, to be cost-effective and sustainable. Given the limited coverage of GBV shelters in different regions, there is need to co-create sustainable community protections structures beyond the GBV shelters to supplement the existing GBV shelters in providing counseling, and psychosocial support. Developing and testing a community-based model that can enhance pathways for safety and referral of GBV survivors is required [Priority: High; Actors: MGLSD, Local Government, UNFPA, UN Women]

- Given that the programme targets populations that are vulnerable to psychosocial challenges, there is need to build on the current successes and lessons to scale up integration of mental health and psychosocial support in all programmatic GBV and SRHR interventions. Provision of psychosocial support should target both beneficiaries and staff since both categories of people are likely to experience the same challenges. For better results, there is also a need to work effectively with community-based structures such as VHTs, Community Activists, ELA Clubs to offer more psychosocial support in GBV programming. [Priority: High; Actors: UNFPA, UN Women, MGLSD, Ministry of Health, CSOs, Local Government]

- For future programmes, there is a need to review the staffing levels of the IPs to ensure the staff numbers and competences match the scope of work. Similarly, there is a need to assess and build capacity of the IPs in financial management and accountability procedures. For future programmes, there is a need to review the staffing levels of the IPs to ensure the staff and competences match the scope of work. It is also important for IPs to work with community structures or build their capacity and incentivize them to carry this kind of work forward beyond the project timelines. [Priority: High; Actors: UNFPA, UN Women, CSOs, Local Government]

- In order to strengthen the current MEAL systems, there is need to invest in collaborative learning and adaptations, complexity aware monitoring strategies and systematic documentation of the pathways that are contributing to changes in outcomes at every stage of programme implementation, including outcome harvesting approaches [Priority: High; Actors: UNFPA, UN Women, CSOs]

- Given the stagnation of teenage pregnancy or child marriage with no significant decline, it is important to increase focus on structural factors that combine with harmful social norms to drive teenage pregnancy. Given the nexus between school dropout and teenage pregnancy, there is need for any follow up programme to the UNJGBV to intensify interventions in schools that integrate SRHR and GBV prevention in schools. Lessons can be drawn from some of the interventions/strategies implemented in schools under the ANSWER Programme, a sister programme to the UNJGBV implemented by UNFPA.

- There is need to review the approaches and strategies used to engage with cultural and religious leaders to make them more effective. We recommend the approach of starting with identifying positive cultural resources and values that support GBV prevention and SRHR and then building on these to strengthen capacities to foster change of harmful social norms. This positive framing that starts with recognition of positive cultural resources that support GBV prevention and response as

well as SRHR that can build on existing cultural resources as entry points strengthen relationships with cultural leaders and help to create platforms for dialogue on change of harmful social norms. They also can initiate a process of reducing backlash arising from social sanctions associated with violation of social norms. This is in line with the cultural approach to development and mindset change promoted by UNESCO3 as well as the Parish Development Model in Uganda. This approach was also pioneered in Uganda under the cultural approach to HIV prevention and care4 in which culture was considered as a pillar for development and cultural resources were identified and consolidated but this was also used as a platform to initiate an sustain dialogue on harmful social norms. This provided a platform to promote positive cultural resources and values but also deepen a reflection on harmful social and gender norms.

- There is need to strengthen integration of livelihoods and economic empowerment with SRH and GBV prevention and response activities including ELA clubs, legal aid for GBV survivors among others.

- Existing evidence suggests that models such as the SASA! model is good and impactful, but it could be resource intensive during implementation. Based on this background, there is need to conduct implementation science to test the effectiveness of the different packages of GBV prevention from which to choose a low-resource intensive model or package that can be rolled out for GBV prevention.

[3] https://unesdoc.unesco.org/ark:/48223/pf0000224438_eng
[4] https://unesdoc.unesco.org/ark:/48223/pf0000125589

1.0 INTRODUCTION AND BACKGROUND

1.1 Background to the JPGBV Programme

Uganda has ratified a number of international and regional human rights instruments[5], which make explicit provisions for the principles of equality and non-discrimination, to protect the rights of women and children, and sexual reproductive health and rights (SRHR). Further, in addition to the Uganda's Constitution that guarantees equality between women and men before the law, Uganda has developed and/or enacted several acts and policies aimed at creating enabling policy and legal environment for protection, respect and fulfillment of gender equality and human rights[6]. Further, several strategic plans and frameworks have been developed[7].

Despite the progressive legal and policy environment on gender-based violence (GBV), significant gaps remain in: implementation, oversight and accountability mechanisms, planning and financing and inconsistencies within and between national laws and policies. Social accountability mechanisms such as Barazas and the Uganda Local Government Councils Score-Card Initiative (LGCSCI)[8] for holding national and sub national governments accountable for legal and policy reform and delivery of public services are compromised by lack of information, weak civic competency, corruption, weak structures and feedback mechanisms[9]. The deeply ingrained patriarchal system in the country upholds values, beliefs and practices that reinforce the privilege of men and their role in society at the expense of rights, safety, security and wellbeing of women and girls. Unequal gender and power relations and lack of respect for human rights underpin the widespread tolerance for GBV, harmful practices and denial of SRHR. Additionally, a high fertility rate of 5.4, big family sizes, a large youth population and high child dependency strain the social and economic resources of the family, which consequently aggravate the GBV situation leading to inhibition to use of contraception, early, child and forced marriages, 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 are well documented.

The structural and systemic issues within institutions attributed to low prioritization of resourcing for gender equality, GBV and SRHR, gaps in medico-legal forensic evidence collection, storage and documentation, reluctance of health workers to testify in courts, inadequate witness protection and survivor support services lead to low conviction rates in GBV cases and impinge on survivors' access to justice. Of equal concern is the health system, which is poorly equipped to the limited number and quality of medical and social workers, and a chronic shortage of commodities and supplies. Together with the

[5] Examples: ICERD, 1965; ICESCR, 1966; ICCPR, 1966; CEDAW, 1979; CAT, 1984; CRC,1989; CRPD, 2006; African Charter on the Rights and Welfare of Children 1990 and the Protocol to African Charter on Human and Peoples Rights on the Rights of Women (Maputo Protocol),2003.

[6] Examples: DVA, 2010 and its regulations (2011); Prohibition of Female Genital Mutilation Act 2010 and its Regulations (2011); Prevention of Trafficking in Persons Act 2009; National Gender Policy, Amendment of the Penal Code Act Cap 120; National Policy on the Elimination of GBV, 2016 and its Action Plan; the National Strategy for Male Engagement, the Children's Act 2016, and the National Health Policy 2017.

[7] Examples: the Settlement Transformation Agenda (STA) and the Comprehensive Refugee Response Framework (CRRF), the sharpened plan on reproductive, maternal, neonatal, child and adolescent health (RMNCAH), the Social Development Sector Plan (SDSP 2016-2020) and the JLOS Fourth Strategic Development Plan.

[8] http://www.acode-u.org/Files/Publications/infosheet_11.pdf

[9] Initiative for Social and Economic Rights, An Audit of Social Accountability Mechanisms in Local Government Processes in Uganda, 2017.

unconducive environment for management of GBV survivors within facilities and communities, these challenges have resulted in a sub-standard quality of care for GBV survivors.

The various entry points in the service delivery continuum have not been fully exploited to provide GBV and SRHR services to populations that experience multiple and intersecting forms of vulnerability because of the limited integration in GBV and SRHR services. These include adolescents and young people, refugee women, girls, men and boys, the elderly, people living with HIV and AIDS, women and men who engage in sex work, rural uneducated poor women and girls and persons living with disabilities (especially women and girls). The situation is made worse by the weak civic understanding and lack of strong social movements against GBV, both of which contribute to inadequate accountability mechanisms to hold duty bearers and government accountable for the provision of services that meet human rights standards of: availability, accessibility, acceptability quality, and commitment to end GBV and harmful practices

1.3 Overview of the JPGBV Programme

In December 2018, the United Nations and the Government of Uganda (GoU) with funding from the Swedish Government approved a 5-year (2018-2023) Joint Program on Gender Based Violence UNJPGBV) and the project got no cost extension for 6 months- January 2024 to December 2024. The JPGBV is implemented jointly through UN Agencies: UNFPA and UN-WOMEN; Government ministries: The Ministry of Gender Labour and Social Development; Ministry of Justice and Constitutional Affairs, the Parliament of Uganda, Ministry of Education and Sports; Ministry of Health; National Planning Authority, Kampala Capital City Authority, Uganda Bureau of Statistics, academic institutions, District Local Governments and Civil Society Organizations (CSOs).

The JPGBV is a national programme with several interventions targeting legal and policy reform at National and sub-national level with implementation focus in 14 selected districts: Napak, Nakapiripirit, Kaabong, Abim, Amuria, Kotido, Pader, Kiryandongo, Kaberamaido, Yumbe, Moroto, Gulu, Bundibugyo and Kampala. The Goal of the JPGBV is to contribute to the elimination of GBV and improvement of Sexual and Reproductive Health and Rights (SRHR) of women, men, girls and boys including disadvantaged hard to reach (furthest behind) and vulnerable populations in Uganda. The programme aims to achieve four major outcomes (Figure 1):

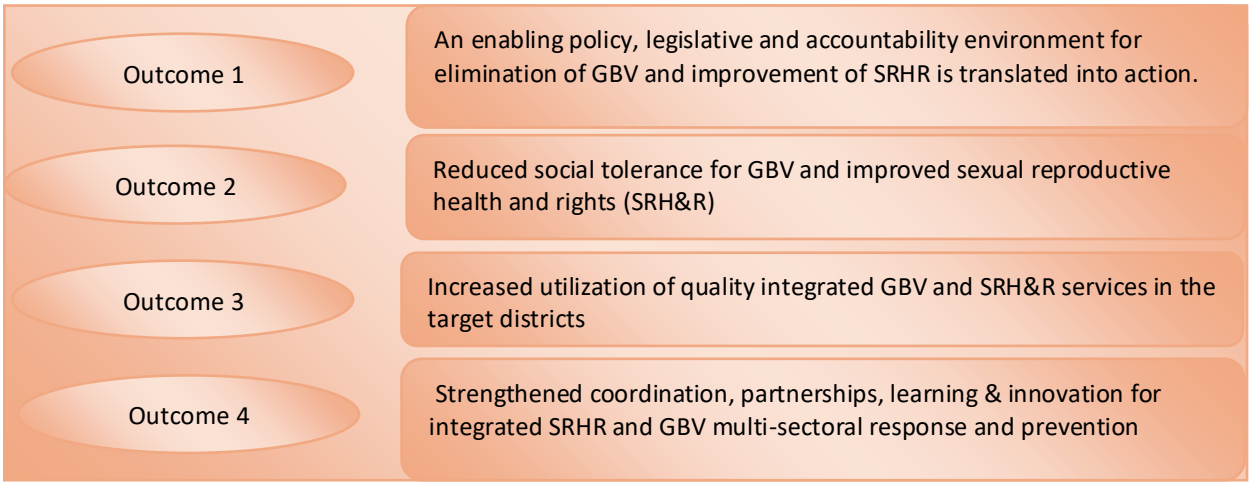


Figure 1. UNJPGBV outcomes

2.0 OBJECTIVES OF THE END-TERM EVALUATION

2.1 Purpose of the End-Term Evaluation (ETE)

The ETE serves the following three main purposes; (i) demonstrate accountability to stakeholders on performance in achieving development results and on invested resources; (ii) support evidence-based decision-making; and (iii) contribute key lessons learned to the existing knowledge based on how to accelerate the achievements in addressing GBV and HPs.

The objectives of the evaluation are two-fold:

1. To provide an independent assessment of the relevance and performance of the JPGBV and offer an analysis of various facilitating and constraining factors influencing programme delivery and the achievement of intended results; and
2. To broaden the evidence-base to inform the design of similar programmes in Uganda. Additionally, the evaluation draws key lessons and conclusions and provide a set of clear and forward-looking options leading to strategic actionable recommendations to key stakeholders in gender and human rights space.

Specifically, the end of term evaluation assessed the relevance, coherence, efficiency, effectiveness, sustainability of the programme, and challenges encountered during implementation and documented good practices and lessons learned during the 5 year and half-life of the project. Table 1 below shows a summary of the evaluation objectives and questions.

Table 1. Evaluation objectives and questions

Objectives	Evaluation questions
Relevance: The extent to which the programme design was relevant for its different stakeholder groups (including primary beneficiaries) and to national policies of the GOU, and Country Programme. How effectively the programme adapted its strategies and interventions to contextual changes to achieve results.	
	1. To what extent the UNJPGBV is aligned to national priorities (including Vision 2040, NDP II), sectoral priorities; coherence with needs of target groups, SDGs, and UNFPA & UNWomen Strategic plans (2018 – 2021, 2022-202) 2. To what extent do planned interventions adequately reflect the outputs and outcomes stated in the project design, the UNFPA and UN Women CPD8 and CPD9? 3. To what extent has UNFPA and UN Women been able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies and COVID-19? What was the quality of such a response, 4. To what extent has the programme integrated gender and human rights-based approaches? 5. To what extent was the intervention gender responsive in its design and implementation? Was it: gender negative, gender blind, gender-targeted gender-responsive, or gender transformative? 6. To what extent does the programme respond to the needs to the vulnerable populations including women, youth, people living with disabilities hard-to-reach populations?
Coherence: The internal and external coherence of the UNJPGBV programme, including the coherence between specific programme components, coherence between UNJPGBV and other UNFPA/UN Women programmes, and coherence with other partners' SRHR and GBV interventions in the UNJPGBV target districts	
	1. How well has the programme advanced an integrated approach to SRHR at national and sub national level and in the participating UN organizations?

Objectives	Evaluation questions
	2. How well does this programme collaborate, coordinate and leverage efforts with agencies, stakeholders and partners not involved in the programme, within the UN reform process? 3. To what extent is joint programming taking place among the participating UN organizations to achieve the expected results of the intervention?
Effectiveness: The extent to which the UNJPGBV programme outputs have been achieved, including both intended and unintended effects, and the extent to which these outputs have contributed to the achievement of the programme outcomes.	
	1. To what extent did the UNJPGBV programme achieve its expected results? 2. What internal and external factors facilitated or hindered the achievement of UNJPGBV programme results? 3. To what extent did the interventions supported by UNJPGBV contribute to the achievement of planned results (outputs and outcomes). Were the planned geographic areas and target groups successfully reached? 4. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA, UNWomen and partners and be applied in future programme and policy development? 5. How has the functionality of the governance structure, including the donor role, affect the effectiveness of the programme? 6. What lessons have been learned from these partnerships to date and the possibilities t replicate them?
Efficiency: The extent to which the programme outputs and outcomes have been achieved in the most economic and timely way, including an assessment of how funds, expertise, personnel, and implementation modalities contributed to, or hindered the achievement of results.	
	1. How and to what extent has the UNJPGBV facilitated the use of its funding, personnel, administrative arrangements, time and other inputs to optimize achievement of results described in the programme document? 2. To what extent did the intervention mechanisms (ELA, MAGs, CQI, partnership strategy, execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs. 3. What adaptations were made to ensure to enhance achievement of results, including those specifically related to advancing integration, and gender equality and human rights dimensions? 4. What impact does the current governance structure and administrative set up for the programme (with UNFPA as the Administrative and Convening Agent) have on joint ownership among all the participating UN organisations?
Sustainability: The continuation of benefits from the UNJPGBV programme after its termination, linked to their continued resilience to risks.	
	1. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions if any? 2. To what extent have the partnerships built by UNJPGBV programme promoted national ownership of supported interventions, programmes and policies? 3. What are the lessons learned from the programme? How can the lessons have learned from used for strategic positioning for future programming in humanitarian and development nexus? 4. To what extent has the programme contributed to Community monitoring, accountability and community ownership?
Impact: The extent to which the UNJPGBV programme has generated or is expected to generate significant positive or negative, intended or unintended, impact for its beneficiaries	

Objectives	Evaluation questions
	To what extent have the project interventions generated, or is expected to generate significant positive or intended, higher-level (capture the significance, the scope, and the transformative nature of the effects) effects?
Coordination: The extent to which the UNJGBV programme contributed to the functioning and consolidation of UNCT coordination mechanisms	
	To what extent has the UNJPGBV programme contributed to the functioning and consolidation of UNCT coordination mechanisms?
Gender and Human Rights: The extent to which the UNJPGBV programme activities were designed, implemented and monitored to promote the meaningful participation of both rights holders and duty bearers and to minimize negative effects of social exclusion	
	1. To what extent is the programme changing the dynamics of power in relationships between different groups? 2. What are some of the human rights and development effectiveness principles the project achieved during implementation?

3.0 METHODOLOGY

3.1 Setting

The end term evaluation was conducted at the national, district and community level. At district and community level, all the 14 focus districts of Napak, Nakapiripirit, Kaabong, Abim, Amuria, Kotido, Pader, Kiryandongo, Kaberamaido, Yumbe, Moroto, Gulu, Bundibugyo and Kampala were involved in the evaluation (Figure 2).

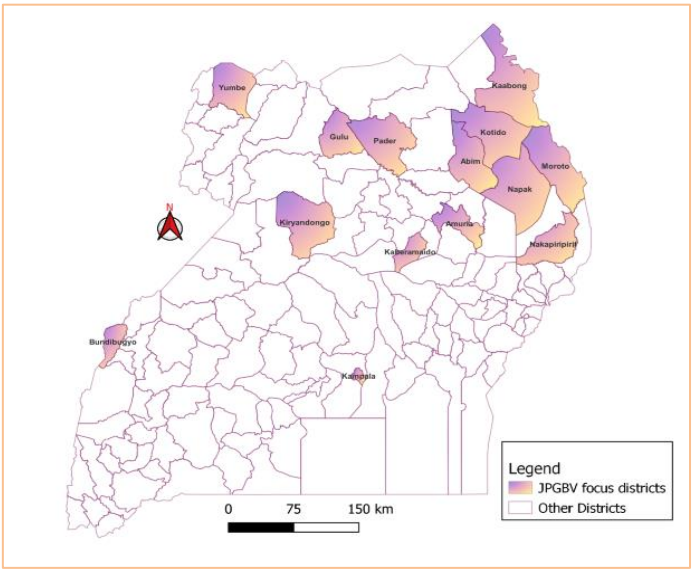


Figure 2. Map of Uganda showing the JPGBV focus districts.

3.2 Design

The end term evaluation adopted a cross-sectional mixed-methods design, in which both qualitative and quantitative methods of data collection were used. The methods followed the Organisation of Economic Cooperation and Development's (OECD)/Development Assistance Committee (DAC) evaluation guidelines that emphasize assessment of the programmes' dimensions of relevance, coherence, effectiveness, efficiency, impact and sustainability[10] (Figure 3). To be able to make meaningful comparison between the baseline and the mid-term and end term results, the methods used at baseline and MTR were adopted for the ETE and these are described in the subsequent sections of the report.

a) Qualitative data collection approaches: Qualitative data was collected through Key Informant Interviews (KIIs), In-depth Interviews (IDIs) and Focus Group Discussions (FGDs)

b) Quantitative data collection approaches: Quantitative data was collected through retrospective review of secondary data and household survey.

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

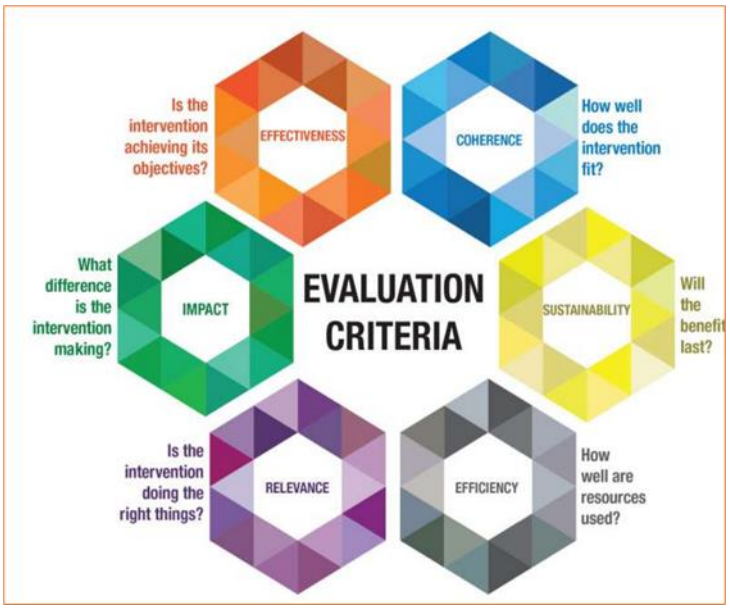


Figure 3. OECD DAC evaluation criteria for project evaluation

An evaluation matrix is included in the Annex.

3.3 Data collection methods

Qualitative and quantitative methods of data collection were employed during the end of term evaluation.

3.3.1 Qualitative data collection methods

Qualitative data approaches included Key informant interviews (KIIs), In-depth interviews (IDIs) and focus group discussions (FGDs)

a) Key Informant Interviews (KIIs)

KIIs were held with stakeholders at National and district levels to obtain their views on relevance, effectiveness, efficiency, sustainability, impact, gender and human rights, innovation, and lessons learned of the UNJPGBV. Based on the principle for saturation of qualitative data, a total of **20** KIIs at the national level and **45** KIIs at the district level were conducted. Different KII guides were prepared for respondents at national and district levels. At national level, most of the KIIs were conducted virtually via zoom while at district level, the KIIs were held physically. Each KII had a moderator and note taker. The moderator guided the interviews while the note taker audio-recorded and took additional notes of the discussions.

b) In-depth Interviews (IDIs)

IDIs were conducted at community level with purposively selected special groups including survivors of GBV, persons with disabilities (PWDs) and persons living with HIV (PLHIV). A total of **10** IDIs were held across the 8 districts using an IDI guide. Each IDI had a moderator and note taker who understood and speak the local language of the respective districts. The moderator guided the interviews while the note taker audio-recorded and took additional notes of the discussions.

c) Focus Group Discussions (FGDs):

Separate FGDs with young boys, girls, men and women were held at community level. Different FGD guides were used for the separate groups. A total of **31** FGDs were held across the 8 districts. Each FGD had a moderator and a note taker who understood and speak the local language of the respective districts. The moderator guided the discussions while the note taker audio-recorded and took additional notes of

the discussions. Throughout the qualitative interviews, data collection was an iterative process allowing for new questions to follow-up on emerging issues. Table 2 below provides a summary of the qualitative interviews held at the various levels.

Table 2. Distribution of KIIs, IDIs and FGDs

Level and category	Number
KIIS (National and district)	
National: UN Agencies, MOH, MGLSD, Police, IPs (CSOs)	20
District: State attorneys	1
Police (CFPU, O/C, CID, scene of crime officers)	6
Chief Administrative Officers	3
District Community Development Officer (DCDOs),	1
Labour Officer	1
Gender Focal Persons,	4
Sub-county CDOs (in the sampled sub-counties),	4
Para-social workers	4
NGOs working on GBV prevention/protection	2
Community based organizations/CSOs	2
Probation and social welfare officers	2
District Biostatisticians	1
Assistant DHO -Maternal and Child Health,	2
Health facility in-charges	1
Village Health Team	2
District Education officer	3
LCV Chairpersons/councilors	2
Camp Commandants,	2
Cultural leaders	2
Subtotal	**65**
IDIs (Community level)	
GBV survivors	5
PWDs	3
PLHAs	2
Subtotal	**10**
FGDs	
Young girls (10-14; 15-18 years)	6
Young boys (10-14; 15-18 years)	4
Men	5
Women	7
SASA Activists	6
Male Action Group members	3
Subtotal	**31**

3.3.1 Quantitative data collection methods

The quantitative data collection approaches used included document review and household survey.

a) Document review

This entailed desk review of the programme documents including the JPGBV strategy document, baseline report, results framework/matrix and annual progress reports

b) Household survey

Sample survey design: The household sample survey was based on a multi-stage cluster sample. In the first stage, 8 districts were randomly sampled. Similar to the baseline design, this was followed by a random sample of sub-counties (where the project was implemented) within each selected district at the second stage. At the third stage, a sample of villages/enumeration areas were selected from each selected sub-county based on probabilities proportional to size (PPS) of the population of villages (or households in the villages). In stage four, within each selected village, a systematic random sample of households was taken. Similar to the design used at the baseline and midterm review, a parallel sample survey of (a) women (15-49 years), (b) adolescent boys and girls (11-19 years) and (c) men living in couple relationships (15-64) were taken for interviews.

Sample size: Based on the sample size formula by Cochran (1977) and based on data at the baseline, the sample size to measure changes in indicators with 80% power and 95% certainty:

a) At least 6% reduction (on an absolute scale) in a proportion of women (15-49 years) who either: (i) experienced sexual GBV in the past 12 months, (ii) had an unmet need for FP, or (iii) 10% increase in the proportion of female GBV survivors in the past 12 months who accessed GBV care and support services and was satisfied with the quality of services offered, required a sample of **1,025** women (15-49 years); whereas
b) A total of 248 adolescents (11-19 years) needed to be interviewed to be able to measure a 10% reduction in the proportion of children that suffered emotional violence in the last 12 months. Of the 248 adolescents, 124 of these were in-school and 124 out-of-school young people.
c) Similarly, to assess if incidences of IPV had decreased over time by at least 50% (relative scale), a minimum sample of 216 partnered men was required.

The calculations allowed for a design effect of 1.6, and a non-response rate of 5%. The actual sample taken is shown in Table 3. The response rate for women 15-49 years, was 96% while the rates for coupled men and adolescents were at least 100% (Table 3).

Table 3. Actual sample size realized per district

District	Women (15-49 years)	Adolescents (11-19 years)	Men (living in couple relationship)	Total
Kotido	112	36	40	188
Moroto	122	40	50	212
Abim	108	48	27	183
Amuria	110	50	40	200
Gulu	120	36	40	196
Kiryandongo	128	44	40	212
Yumbe	164	47	50	261
Bundibugyo	114	34	40	188
Total	**978**	**335**	**327**	**1,640**

3.4 Data management and analysis

a) Qualitative data

This was in textual form, consisting of notes and stories generated from KIIs, IDIs and FGDs. These were transcribed, edited, typed out and analysed using the thematic analysis framework. This involved organizing data according to themes related to the evaluation objectives, thematic programmatic components and relevant evaluation questions. In addition, the team was open to emerging themes that were generated in the process of collecting and analyzing qualitative data. Some striking quotes and human stories from beneficiaries were cited verbatim in the findings to support the thematic analysis. Story lines from participants were analysed using narrative analysis.

b) Quantitative data

Household data was collected by trained field teams using structured data collection tools that were automated in an electronic form using the ODK collect[11]. The designed ODK tools were installed on android-based tablets and phones which enabled offline data collection and submission of data to the central aggregate server. Data collected on the tablets and phones was synchronized to the online ODK aggregate server. Access to the central server was assigned to authenticated users who were responsible for managing the data and perform data quality measures on the data submitted. Household survey data was downloaded from the server, cleaned and transported to STATA 15.0 for analyses. Stata survey suite commands were used in analysis to account for stratification and clustering. Univariate analysis was performed to generate descriptive statistics including frequencies and percentages for selected key indicators. Composite scores with their averages where relevant were used during analysis. The baseline and mid-term indicator values were compared.

3.5 Quality control

The following measures were undertaken to ensure quality assurance of the end-term evaluation .

- **Adherence to UNEG standards:** UNFPA and UN Women quality assurance systems draw on the UNEG norms and standards, the UNEG ethical guidelines for evaluation, the UNEG code of conduct for evaluation in the United Nations system, and on all relevant UNEG guidance documents[12]. The evaluation team ensured that the evaluation process was in line with the UNEG norms and standards which guarantees that the evaluation products conform to best practice and meet UN quality standards.
- **Inception meetings:** The consultants held inception meetings with UNFPA and UN Women to obtain consensus on the design, methods and implementation approach for the survey.
- **Tools design:** The data collection tools used at baseline were reviewed and updated as appropriate. As much as possible, the variables used at baseline were integrated into the mid-term survey tools to allow for meaningful comparison between the two time points. The tools were designed in ODK where quality checks and limits to data were integrated to prevent wrong and missing data entries. Access to the central server was restricted to authenticated users who were responsible for managing the data and performing data quality measures on the data submitted.
- **Hiring and training of data collectors and pre-testing of tools:** Experienced data collectors who are fluent in the local languages of the respective districts and have participated in similar surveys were hired and trained in data collection methods. A total of 39 data collectors (4 data collectors for Kampala and 5 data collectors for each of the other 7 districts were hired. The minimum educational qualification for the data collectors included a bachelor's degree in humanities, public health, statistics

11 https://opendatakit.org/use/collect/

12https://documents-dds-ny.un.org/doc/UNDOC/GEN/N20/245/50/PDF/N2024550.pdf?OpenElement, p. 10

(for the quantitative component), or other related discipline. The data collectors were trained in the use and application of data collection tools and conducting qualitative interviews including notetaking, maintaining a non-judgmental approach, listening skills, balancing discussions and picking up on emerging themes for further discussion.

- **Supervision of data collection:** The consultants closely supervised the data collectors during field data collection. The consultants ensured that data is checked for completeness and accuracy before submission to the server.
- **Data cleaning:** Once data was collected and uploaded to the server, preliminary data cleaning was conducted to check for any inconsistencies, whether the correct sample size had been reached and any missing data before finally exporting it to STATA for data analysis.

3.6 Ethical considerations

Permission to conduct the ETE was obtained from the respective institutions at national and district levels. The evaluation team committed to respecting the protection and confidentiality of data as recommended by UNEG[13] and the related code of conduct for evaluation in the UN system. The three ethical principles of research; respect for persons, beneficence and justice were strictly respected by the study team members. Written informed consent was obtained from all the study participants. Assent was obtained from participants who are below 18 years of age. Verbal informed consent was obtained from the participants in circumstances where written informed consent was challenging to obtain.

[13] http://www.uneval.org/document/detail/100

4.0 RESULTS

Evaluation Objective 1: Relevance of the UNJPGBV programme

Evaluation of the relevance of the JPGBV programme focused on determining whether: (i) the programme fits within the policies and priorities of Uganda and the participating UN organizations; (ii) the programme responds to the needs of the most vulnerable populations, including women, youth, and people living with disabilities and hard to reach populations, and the changing context and (iii) the extent to which the planned interventions adequately reflect the outputs and outcomes stated in the project design and logframe

(i) Extent to which the programme fits within the policies and priorities of Uganda and the participating UN organizations.

The JPGBV program aligns with Uganda's national policies and priorities, as well as those of the participating UN organizations. The program is integrated within the second National Development Plan (NDP II) (2015/16-2019/20), its successor NDP III (2020/21-2024/25), and Vision 2040. Both NDP II and NDP III commit to improving and coordinating policy and law implementation, developing strategies and programs to address GBV, and promoting universal health coverage, including expanded sexual and reproductive health services and information. Operating within existing national frameworks, the program aligns with the National Plan of Action for Sexual and Gender-Based Violence and Violence Against Children (2019/2030), which prioritizes addressing GBV and violence against children at all levels. It also adheres to the National Policy on SRHR (2006), which emphasizes ensuring access to SRHR information. Additionally, the programme is in tandem with the National Gender Policy 2016-2020, the National Male Involvement Strategy for Prevention and Response to GBV in Uganda 2017; National Policy on the Elimination of GBV and its National Action Plan (2016), the National Health Policy II (2010/11 - 2019/20), the Social Development Sector Plan (SDSP 2016-2020), the Reproductive Maternal Neonatal Child Health (RMNCH) Sharpened Plan (2016-2020), and the JLOS Fourth Strategic Development Plan. All these policies focus on addressing GBV, VAC, and SRHR challenges in communities. Further, the programme aligns with the Ministry of Education's strategies under the Education and Sports Sector Strategic Plan (ESSP) 2017/2018-2019/2020, which focus on equitable and quality primary and secondary education for all girls and boys. By addressing GBV and VAC, the programme creates safer learning environments, thereby fulfilling the goals of the ESSP. The quotations below from the interviews held at various levels highlight how the programme aligns the national policies, frameworks and priorities:

> "I think by design, the programme itself was aligned to the country NDP II, but also to the country's vision for 2040. Similarly, the JPGBV was aligned to the NDP III, making it more relevant because it was trying to address the needs that were already assessed, identified at country level and included in the National Development Program (Group interview with UNFPA staff)"

> "This programme aligns perfectly with the policies and priorities of both Uganda and the participating UN organizations. The National Plan of Action for Sexual and Gender-Based Violence and Violence Against Children (2016/17) directly addresses GBV and VAC, emphasizing a multisectoral approach which is exactly what the UNFPA programme employed. The National Policy on SRHR (2006) prioritizes ensuring access to SRHR information and services which the program addressed. Uganda's long-term development plan (Vision 2040) recognizes the importance of gender equality and women's empowerment, both of which are undermined by GBV and limited access to SRHR" (KII with district CDO).

> "Uganda's policies emphasize the importance of addressing GBV against children and improving SRHR. The programme's focus on these areas complements the country's Vision 2040 and the National Development Plan" (KII with district probation officer)""

> "Uganda's National development Plan (NDP III) prioritizes gender equality and women's empowerment. This project directly combats GBV and VAC, empowering girls to stay in school and pursue their education, contributing to NDP III's goals. Uganda Vision 2040 emphasizes a transformed society with improved quality of life. By addressing SRHR and reducing teenage pregnancy, our programme promotes responsible decision-making and a healthier future generation, aligning with Vision 2040's aspirations. Education Sector Strategic Plan prioritizes access to quality education for all. By addressing GBV and VAC, the programme creates a safer learning environment, especially for girls" (KII with DEO)"

The JPGBV programme contributes to the Sustainable Development Goals (SDGs) that the Government of Uganda and other partners are committed to achieving. Specifically, the programme aligns with the following goals: SDG 1 on ending poverty, SDG 3 on good health and well-being, SDG 4 on the provision of quality education, SDG 5 on gender equality, SDG 10 on reduced inequalities, and SDG 16 on promoting peace, justice, and strong institutions.

At the UN level, the JPGBV is aligned to the United Nations Sustainable Development Cooperation Framework for Uganda (UNSDCF) 2021-2025. The outcomes of the JPGBV directly contribute to the UNSDCF Strategic Priorities 1 and 3. Strategic Priority 1 focuses on transformative and inclusive governance and women's access to justice, while Strategic Priority 3 emphasizes human well-being and resilience. Specifically, the programme aligns with Outcome 3.1, which aims to achieve equitable social protection services, and outcome 3.2, which focuses on gender equality and human rights. Additionally, the four JPGBV outcomes are consistent with national priorities as described below:

- Outcome one of the JPGBV focuses on translating into action enabling policy, legislative, and accountability environment for elimination of GBV and improvement of SRHR. The outputs to this outcome are well aligned with the NDPII focus of having in place strategies for improved implementation and enforcement of DVA 2010, and actions to ensure gender inclusive economic development. They are also aligned to the need of action frameworks and plans such as the Settlement Transformation Agenda (STA) and the Comprehensive Refugee Response Framework (CRRF), REHOPE, RMNCH Sharpened Plan, SDSP 2016-2020 and the JLOS Fourth Strategic Development Plan, Governance and Security Program, Access to Justice Sub-program and the Administration of Justice Program.
- Outcome two of the JPGBV is to achieve reduced social tolerance for GBV and improved sexual reproductive health and rights (SRH&R). Both NDP II and NDP III note the persistent high levels of GBV driven by socio-cultural norms and poverty related stresses, low access and use of SRHR services by young people. Thus, the JPGBV outputs to this outcome are aligned with the NDP III. Similarly, the outputs are aligned to the National policy on the elimination of GBV and its National Action Plan (2016) and to the RMNCH Sharpened Plan (2016-2020).
- Outcome three of the JPGBV programme of increasing utilization of quality integrated GBV and SRH&R services in the target districts is critical for achieving universal health coverage which is prioritized by NDP II and HDP III. This outcome is aligned with the JLOS Fourth Strategic Development Plan, Governance and Security Program, Access to Justice Sub-program and the Administration of Justice Program which have a focus on people centered justice, law, and order service delivery system, a component of essential quality multi-sectoral services.
- Outcome four of the JPGBV programme focuses on strengthening coordination, partnerships, learning and innovation for integrated SRHR and GBV multi-sectoral response and prevention. The NDP II committed to developing a framework for coordinated interventions through a national policy to eliminate GBV and strengthen the capacity of women for increased competitive entrepreneurship and provide appropriate technologies to women. Similarly, the National Plan of Action for Sexual and Gender-Based Violence and Violence Against Children (2019/2030), aims at improving the

multisectoral programming to ensure access to holistic care across the continuum of care for survivors/ victims of GBV and VAC. The outputs for this outcome are critical and remain relevant to the integrated SRHR and GBV multi-sectoral response and prevention.

(ii) The extent to which the JPGBV responds to the needs of the most vulnerable populations, including women, youth, and people living with disabilities and hard to reach populations, and the changing context

The JPGBV made deliberate efforts to involve women, men, girls and boys including disadvantaged hard to reach (furthest behind) and vulnerable populations such as GBV survivors, persons living with disabilities (PWDs) and persons living with HIV/AIDS (PLHA) in its activities, ensuring a comprehensive and inclusive approach. By building networks and partnerships with organizations focusing on women and youth, the program effectively reached vulnerable populations. Women and girls were specifically targeted through awareness campaigns, training sessions, and access to SRHR clinics, including family planning, maternal healthcare, STI testing and treatment, and counseling services. Additionally, targeted outreach and education sessions empowered women and girls with vocational training, enabling them to gain economic independence. Children and adolescents also benefited from school-based and community-based education programs, counseling, HIV testing, educational scholarships, and vocational training, with a particular focus on orphans and vulnerable children. The establishment of community-based child protection committees, including community child activists, helped to monitor and address violence against children. Youth were actively involved in several activities aimed at preventing early marriages, teenage pregnancies, and STDs. The quotes below illustrate the programme's contribution to the most vulnerable population:

> "The JPGBV has been quite responsive to the needs of the most vulnerable populations. Specific strategies were implemented to ensure inclusivity, such as targeted outreaches in remote areas and special programs for women, youth, and people living with disabilities. The use of community health workers has been particularly effective in reaching the communities" (KII with district probation officer).

> "Women and girls were targeted through awareness campaigns and several trainings, access to SRHR clinics to family planning, maternal health care, STI testing and treatment, and counseling services and through the skilling program. Children and adolescents were reached through school-based and community-based education programs focusing on counseling and HIV testing and education educational scholarships, and vocational training to orphans and vulnerable children. People Living with HIV/AIDS (PLWHA) were reached through health care access, stigma reduction campaigns and promoting acceptance and support within the community. Persons with Disabilities (PWDs) were targeted through inclusive services, awareness and sensitizations" (KII with VHT, Amuria district).

> "The woman is most at risk in that she is the most affected in all violent activities in a family. The programme included women by sensitizing them and their husbands on the effects of violence in a family. The programme took care of the girl by skilling them to sustain themselves" (FGD with women 25+ years, Dokolo district).

> "The programme conducted targeted outreach and education sessions specifically for women and girls. Empowerment initiatives, such as vocational trainings were tailored to support women and girls in gaining independence. Community-based child protection committees were established, we the community child activists are part of this task force to monitor and address cases of violence against children" (FGD with girls 14-19, Amuria)

> "The youth are at risk or disadvantaged. When they don't receive SRRH services, they end up falling victim of early marriages, teenage pregnancies, and contracting STDs which can lead to either death, rejection among other things. The JPGBV involved the youth in sensitization activities in which they received guidance on what to do to avoid temptations. The drop in the number of teenage pregnancies and early marriages is a testimony that the interventions worked" (FGD with SASA activists, Amuria).

Special attention was given to PWDs to ensure they received tailored support. The programme ensured that PWDs were included in all the project activities. Workshops and training sessions were adapted to address the needs of PWDs as illustrated below:

> "Some workshops and training sessions were specifically designed to address the needs and rights of PWDs and PLWHA. They included information on how GBV affects these groups differently and provide tailored support and resources. Services such as counseling, legal aid, and healthcare specifically consider the needs of PWDs and PLWHA, Health programs that deal with HIV/AIDS integrated GBV prevention and support services. Community and cultural leaders are educated about the vulnerabilities of PWDs and PLWHAs (KII with VHT, Amuria district)"

> "In most cases. the disabled were given more attention, a case in point was when a dumb girl was made pregnant by some boy, this was followed up until the boy was identified and pledged to support the girl and the baby" (FDG with girls, 14-19 years, Yumbe)"

> "Well, the programme targeted the most vulnerable, that is women, children, PWDs and the elderly. It was a good programme because the focus area was targeting the marginalized groups, most especially women and girls" (KII with Senior Gender focal person Yumbe).

Whereas male involvement was initially limited, the JPGBV made concerted efforts to engage men effectively, ensuring inclusive approaches for all community members. The program introduced several initiatives to enhance male participation. One notable effort was the formation of male action groups, which included men who were exemplary in their behavior, such as those who did not engage in domestic violence and actively supported their wives. These role models played a crucial role in reaching out to other men, discussing the benefits of respectful and supportive relationships, and encouraging positive changes in behavior. Additionally, the programme conducted training sessions specifically designed for men. These sessions focused on educating men about their rights and responsibilities, enhancing their understanding of GBV, and promoting active participation in its eradication. By involving men as key stakeholders and change agents, the programme fostered a more inclusive and supportive community environment. This intentional approach ensured that men were not only participants but also advocates for gender equality and prevention of GBV:

> *"*They brought the men on board; the male action groups were formed to bring on board men who are exemplary. These are the men who go to their colleagues to talk to them about respectful and supportive relationships. These are the men who support their wives" (KII with gender focal person).
>
> **"**We have scenarios where through this intervention, some men have become role model men to the extent that they are now championing the causes of GBV, they try to scale down GBV and they handle GBV matters at the local level, even before the victims can get to the LCs" (KII with deputy CAO)"
>
> "The programme actively involved men in discussions and activities aimed at challenging harmful gender norms and promoting respectful relationships through various initiatives. Workshops on how homes are supposed to be free from violence and inequality, encouraging men to embrace healthier expressions of masculinity. In other words, the discussions on fatherhood emphasized positive fathering roles and nurturing family environments" (FGD with men 25+, Kiryandongo)"

(iii) Extent to which planned interventions adequately reflect the outputs and outcomes stated in the project design.

Through interviews held with different stakeholders at the national, district, and community levels, the evaluation established that the planned and implemented interventions reflect the outputs and outcomes stated in the project design. The programme interventions were suitable for addressing GBV or VAC and improving access to SRHR services as illustrated below:

"The engagement of community leaders and men and boys helped to promote a supportive environment for change. I think the training of health workers and community leaders to provide better SRHR services and support to survivors of violence also helped a lot" (FDG with SASA activists Amuria district).

"Ever since CDFU came into the village with its activities, the community activists are actively sensitizing about GBV among family members. We have seen a change in the level of violence in many families, thus many are happy for the timely intervention of CDFU. The LCs are empowered to handle cases of GBV and where they fail, they refer to the police to enable the victim get justice" (FGD with beneficiaries, Yumbe)"

"We organized numerous workshops and community dialogues that involved men, women, youth, and local leaders. We have been able to shift perceptions and encourage more supportive attitudes towards gender equality and women's rights. Through mentorship programs where I am a mentor, we provide guidance and support to young people, particularly girls, encouraging them to pursue education and resist early marriage and other harmful practices. I serve as a role model, demonstrating the benefits of gender equality and respect for women's rights. Community sensitization especially on GBV has transformed the lives of many drunkards in the community by changing them to become responsible husbands" (KII with mentor, Amuria district)"

"I can say that the programme has been very instrumental in building the capacity of women, we have structures in the community, women trained in VSLA, women trained in GBV, and women trained in financial literacy. The programme has benefited quite a number of women in the area where it was implemented (KII with CSO staff, Moroto)".

Evaluation Objective 2. Effectiveness of the UNJPGBV programme

a) Extent to which the UNJPGBV programme achieved its expected results

A review of the outcome indicators shows that the project made significant progress toward its goal of contributing to the elimination of GBV and improvement of the SRHR of women, girls, boys and men in Uganda. While one programme target—reducing incidences of sexual violence within the past 12 months—was not met, all other set targets were successfully achieved (Table 3).

Incidences of gender-based violence have reduced significantly: Overall, the percentage of women (15-64 years) who reported to had experienced any form of violence, either from a spouse or anyone else in the past 12 months significantly reduced by 10.3% from 61.2% at the baseline to 50.1% at the endline. The incidence of physical violence among women in the past 12 months reduced by 5.4% from 35.8% at the baseline to 30.4% at the endline. This is similar to what was reported in UDHS 2022 of 34.1% in the UNJPGBV implementation regions. Similarly, the incidence of emotional violence among both women and men (15-64 years) and boys and girls (10-14 years) reduced from 60.1% and 60.2% to 40.8% and 41.2%, respectively. However, the incidences of sexual violence against women and girls in the past 12 months remained almost the same between the baseline and endline (14.2% vs 13.4%). This is higher than 9.0% reported in UDHS 2022 in the UNJPGBV regions. This is likely due to some of the project activities focusing on communities with high incidences of GBV.

Table 4. Progress towards achieving the programme goal

#	Indicator	Baseline (2019) ǂ	Mid-term (2022)	Endline (2023)	Endline Target (2023)	Difference: Endline vs Baseline
1.	**Incidence of gender-based violence:** Percent of women and men (15-64) who have experienced any violence (committed by a spouse or anyone else) in past 12 months.	60.2	58.3	47.9 (41.1 in men, 50.1 in women)	8.0	12.3**
2.	**Incidence of sexual violence:** Percent of women and men (15-64) who have experienced sexual	14.2	11.4	9.4 (3.1% in men, 13.8% in women)	8.6	-4.8

#	Indicator	Baseline (2019) ǂ	Mid-term (2022)	Endline (2023)	Endline Target (2023)	Difference: Endline vs Baseline
	violence (committed by a spouse or anyone else) in the past 12 months					
3.	**Incidence of physical violence:** Percent of women and men (15-64 years) who have experienced physical violence from last partner (wife/husband) in the past 12 months	35.8	34.8	28.1 (17.5% in men, 30.4% in women)	14.4	-7.7*
4.	**Incidence emotional violence:** ● Percent of women and men (15-64 years) who have experienced any emotional violence in the past 12 months	60.1	52.3	40.8 (same for men & women)	42.6	-19.3**
	● Percent of boys and girls (10-14 years) who have experienced any emotional violence in the past 12 months	60.6	46.2	41.2	45.0	-19.4**
5.	**Teenage pregnancy rate:** Percent of girls aged 10-14 years who have given birth or are pregnant with their first child	3.2	3.5	3.2	3.2	-0.3
6.	**Unmet need for family planning:** Percent of women (15-49 years); married/ or are in a union, who want to stop or delay childbearing but are not using any FP method	39.5	23.7	20.3	37.0	-19.1**

****** statistically significant at 5% level; ***** significant at 10%; ǂre-computed, excluding Kampala city

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

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

Further, according to the household survey, 67.4% of the respondents reported a reduction in GBV over the past 2-3 years, attributing this decline to the program's interventions. Among these respondents, 80.4% highlighted the importance of sensitization efforts delivered through media, community dialogues,

religious congregations, and messages from cultural leaders in reducing GBV (Figure 1). Additionally, 50.3% of the respondents noted increased vigilance and responsiveness from community leaders, which reflects a growing intolerance toward GBV. Changes in men's attitudes and practices to avoid violence were also reported. The consistent presence and engagement by MAGs facilitators, male champions, and SASA! Facilitators play a crucial role in managing any potential repercussion against those trying to conform to new norms promoted by the program.

The observation that significant changes were made in the incidences of emotional and physical GBV and not sexual GBV may indicate that the UNJPGBV GBV prevention activities were effective in shifting social norms and attitudes to physical and emotional violence, but the intervention did not go as far as affecting perpetration of sexual violence. The limited impact on SGBV was directly linked to minimal progress in reducing sexual intimate partner violence (IPV) and a rise in instances of sexual harassment against young women (from 6.6% at the MTR to 10.2% at the endline). The lack of change in sexual IPV may be due to the challenges faced by community champions, volunteers, and facilitators of programs like MAGs and SASA! in effectively discussing and addressing this sensitive issue, and due to the fact that UNJPGBV did not focus on IPV.

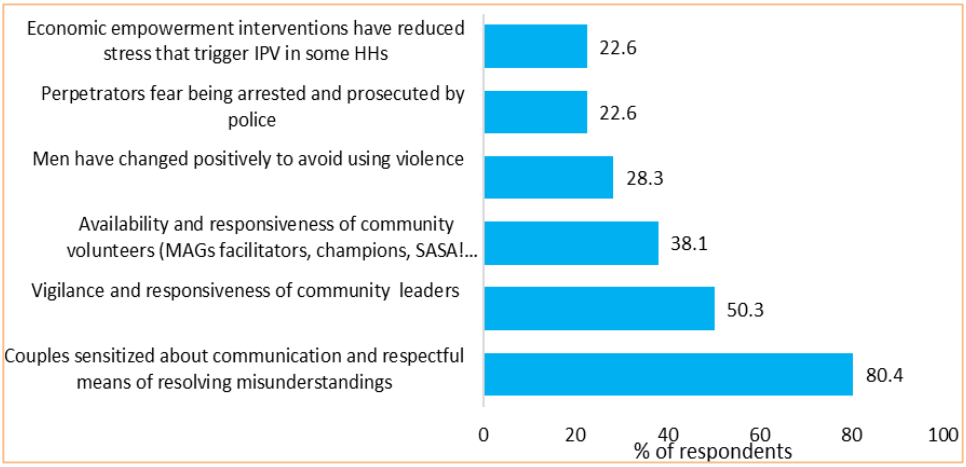


Figure 4: Reasons why GBV has reduced in the community (Household survey data)

The teenage pregnancy rate declined marginally during the programme period: The percentage of girls aged 10-14 years who had given birth or were pregnant with their first child at the time of the survey reduced from 3.5% at MTR to 3.2% at the endline. In FGDs, some respondents observed that while instances of early and forced marriages appear to have decreased, the teen pregnancy rate among girls aged 10-14 have not changed dramatically. This is attributed to persistent poverty in some households, which leads some young girls to marry early or engage in early sexual activity to meet their material needs.

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

> "When you visit health facility, contraceptives are available. We are given condoms and also the advice which has helped to reduce the number of early pregnancies", (FGD with young men, Yumbe)

Unmet need for family planning reduced significantly: The unmet need for family planning among women of reproductive age (15-49 years) who are currently married or are in a union considerably dropped from 39.5% at baseline to 20.3% at the endline, surpassing the endline target of 37.0%. The

estimate of the unmet need for contraceptives is similar to what was reported in UDHS 2022 of 24.0% in the UNJPGBV regions.

There was some evidence that the programme contributed to reduced unmet needs for family planning by integrating messages about FP at the community dialogues, and media, integration of SRHR into livelihood and education opportunities and training of the health workers to provide integrated GBV-SRHR services. Of the 386 respondents who visited a health facility for SRH services in the past 12 months, 67.4% reported being screened for GBV, while for those who went for GBV services, all were offered SRHR services. This is evidence that systematic integration of SRHR into GBV programming has taken root. The uptake of SRHR services increased significantly over the project period.

> "These activities are great in that they have enabled the woman to have a say on the number of children to have in a family which was not there before it was only a man… Men have accepted to escort their women for antenatal and do HIV test together as a couple. The sensitization made men women and young to look for these services because they saw the advantages of it in regard to helping in having manageable family. SRHR has been embraced by many couples as a result both led to reduction of violence in many families", (FDG Women 25 and above, Amuria).

The engagement of the men in SRHR of their partners has played a crucial role in reducing unmet need for FP methods, in the sense that men were barring their partners from accessing contraceptives.

> There was rigid mindset of the men to reject family planning to the extent there was a man who rudimentarily removed the implant inside the wife because she went to get the service without consenting him and when he realized there was an implant, he had to remove it. Another man went and beat up the health worker who insert the implant. But, however because of the intervention by the project, there changes as people, especially men, were sensitized about the benefits of family planning. Some have embraced it (KII Gender Focal Person, Yumbe)

There were differentials in the project outcome achievements across the different districts. Results are summarized in Table 5. There were improvements in all the districts except Moroto that reported only marginal changes.

Table 5. Progress towards achieving the programme goal by the sampled districts (Baseline (B) vs Endline (E)

District	Prevalence of physical GBV in past 12 months		Prevalence of emotional GBV in past 12 months		Prevalence of sexual GBV in past 12 months (women & girls)		Current contraceptive use (all sexually active women)		Current contraceptive use (all sexually active women)	
	B	E	B	E	B	E	B	E	B	E
Abim	46.7	43.2	70.0	65.0	23.3	32.4	46.7	46.8	50.0	13.6
Amuria	42.1	44.4	77.2	61.1	31.6	8.3	44.4	37.5	57.7	27.6
Bundibugyo	35.0	31.8	55.0	35.2	27.5	20.5	40.0	46.9	37.5	30.6
Gulu	43.8	15.4	71.2	26.0	34.3	6.5	39.3	37.5	40.5	30.1
Kiryandongo	22.2	23.1	44.4	43.4	18.5	13.3	43.3	53.9	33.3	26.2
Kotido	67.4	28.1	86.1	40.2	46.5	8.5	34.2	40.7	25.0	24.5
Moroto	34.3	51.9	54.3	60.8	14.3	19.0	8.6	12.0	16.7	7.7
Yumbe	38.3	19.8	72.3	26.2	28.7	9.1	39.4	42.6	50.9	16.8
Total	35.8	28.2	60.1	40.8	14.2	13.8	36.5	40.4	39.5	20.3

b) Extent to which the interventions supported by UNJPGBV contributed to the achievement of planned results, including the reach to the planned geographic areas and target groups

Outcome 1: An enabling policy, legislative and accountability environment for elimination of GBV and improvement of SRHR is translated into action.

There is strong evidence that the programme has improved the legal and policy environment for GBV and SRHR in Uganda. The UNJPGBV has contributed to the development, reviews and enactment of relevant policies and laws through advocacy, strategic partnerships and collaborations, technical and financial support to the relevant institutions that fast tracked the enactment of the laws. The programme supported the 13 districts to develop ordinances and by laws on alcohol abuse, GBV prevention and promotion of SRHR. The policies/laws and strategic documents where the programme contributed to are listed in Table 6.

Table 6. List of strategic documents, policies and standards that UNJPGBV supported.

Policies/strategies that address gender inequality	Policies/strategies that address GBV	Policies/strategies that directly address SRHR issues
● National Gender Policy-2007	● Legal age of marriage	● National Child Policy-2020
● National Youth Policy-2001	● Parental authority in divorce	● National Adolescent Health Policy-2004
● National Child Policy- 2020	● Inheritance rights of widows	● National Policy on Elimination of GBV-2016
● National Adolescent Health Policy-2004	● Inheritance rights of daughters	● National Health Policy 2012
● National Policy on Elimination of GBV-2016	● Laws against domestic violence	
● National Country Development Policy-2015	● Laws against rape	
● Equal Opportunities Policy -2006	● Law against rights of women & girls	
● Uganda National Cultural Policy 2006	● Laws against sexual harassment	
● National Health Policy 2012.	● Sexual Offences Bill -2019	
● Employment Act 2023	● Law against trafficking in persons	
● Market Act 2023.		
● Marriage and Divorce Bill-2009		
● Succession Amendment Act-2022		

The programme supported the review and compiling of the maternal perinatal death surveillance and response (MPDSR) reports and also contributed resources towards the Uganda RMNCAH-Sharpened-Plan-II 2022/23 – 2026/27, including the printing of the plan. In addition, the programme supported the review of the MHC, Maternal Child Health passport.

> "The UNFPA/UNJPGBV has supported us to develop quite a number of strategic frameworks including the development of the Adolescence Health Policy, Reproductive Health Policy, which were later mainstreamed in the main National Health Policy. (KII, MoH)"

Strategic collaborations, strong advocacy and lobbying initiatives were critical to passing these laws, showcasing the importance of strategic partnerships in promoting gender equality at the legislative level. For example, collaborative efforts led by Uganda Women's Parliamentary Association (UWOPA) alongside the Domestic Violence Act Coalition, Civil Society Organizations, Development Partners, and the Uganda Parliament, were crucial in the passing of the Succession Amendment Act 2022, Employment Act 2023 and the Market Act 2023

The programme contributed to improved implementation of GBV and SRHR laws, policies and standards by government institutions and civil society organizations (CSOs) at both the national and sub-national levels (Output 1.1) through financial support to enactment and implementation activities, training and mentorship of duty-bearers (justice actors, midwives, CDOs), financing of CSOs as IPs of the UNJPGBV activities, dissemination and orientation of duty-bearers on policies and strategies, technical support supervisions, support the development of implementation guidelines, and advocacy.

> "Uganda nurses and midwife council working with ministry of health going to the different districts because UNFPA supported the development of the geographical information system for the nurses and midwives. So, this geographical information system was to see where these midwives and nurses are whether they were fully licensed so this was done under UMC and ministry of health different districts were brought on board to ensure that this geographical information system is introduced and implemented. (Group Interview – UNFPA)"

> "We benefited from training, the technical team and health workers were trained to support integrated delivery of GBV and SRHR services" (KII with district assistant DHO, Abim).

Table 7. Progress towards achieving programme outcome 1 and related outputs

No	Indicator	Baseline (2019)	MTR (2022)	Endline 2023	Endline (Target) 2023
	Outcome 1: An enabling policy, legislative and accountability environment for the elimination of GBV and improvement of SRHR is translated into action				
1.1	**Policies in place for addressing GBV:** Number of policies for addressing GBV that are published and disseminated	9[14]	13	13	15
1.2	**Policies in place for addressing SRHR:** Number of policies for addressing SRHR that are published and disseminated	4[15]	8	8	10
	Laws, ordinances and by-laws that criminalize GBV and promote SRHR amended and enacted in line with international standards:				
	a) Laws passed by parliament:				
	Gender equality and GBV	11[16]	12	14	12
	SRHR	1	2	2	2
	b) Bills pending enactment	3[17]	3	4	3

14 These polices address some of the GBV practices, they include i) National Gender Policy-2007, ii) National Youth Policy-2001, iii) National Child Policy- 2020, iv) National Adolescent Health Policy-2004, v) National Policy on Elimination of GBV-2016, vi) National Country Development Policy-2015, vii) Equal Opportunities Policy -2006, viii) Uganda National Cultural Policy 2006, ix) National Health Policy 2012. Employment Act 2023 and the Market Act 2023.

15 The following policies directly address SRHR issues: i) National Child Policy- 2020, ii) National Adolescent Health Policy-2004, iii) National Policy on Elimination of GBV-2016, iv) National Health Policy 2012.

16 The laws that target to address GBV include i) Legal age of marriage; ii) Parental authority in divorce; iii) Inheritance rights of widows; iv) Inheritance rights of daughters; v) Laws against domestic violence; vi) Laws against rape; vii) Law against trafficking in persons; viii) Law against rights of women and girls; ix) Laws against sexual harassment. All these laws have been developed according to international standards.

17 Sexual Offences Bill -2019, ii) Marriage and Divorce Bill-2009, iii) Succession Amendment Bill-2018.

No	Indicator	Baseline (2019)	MTR (2022)	Endline 2023	Endline (Target) 2023
	c) Ordinances approved by Attorney General	1	4	14	14
	d) By-laws passed by the district councils approved by Attorney General with the aim of strengthening efforts to eliminate GBV	0	4	13	28
	e) Number of laws amended to promote SRHR in line with international standards.	3	3	3	3
1.5	**Government actions on recommendations of; and commitments on GBV and SRHR from Treaty Bodies, UN Organs, CSO, Equal Opportunities Commission, Human Rights Commission etc.**				
	No. of government actions on international commitments and how they are aligned to international standards.	6[18]	10	10	12
	Output 1.1: Improved implementation of GBV and SRHR laws, policies and standards by government institutions and CSOs at national and sub-national levels				
1.1.1	Number of target sectors and ministries, departments and agencies which utilized laws,	6	13	13	14
	Percentage of national-level CSOs applying laws, policies and standards relating GBV and SRHR in their programming	100	100	100	100
1.1.3	Number of DLGs in the target districts applying laws, policies and standards relating GBV and SRHR	14	14	14	14
1.1.4	Percent of institutions where relevant tools to respond to GBV and SRHR cases responding to are available & accessible	100	100	100	100
Output 1.2: Sustained advocacy and accountability for gender equality and wo implementation of laws rights on GBV, HP and SRHR by CSOs and civil society					
1.2.1	Number of advocacy actions by CSOs on legal reform and accountability implemented	0	3	3	3
Output 1.3: Improved gender-inclusive public infrastructure/economic development p towns and cities					
1.3.1	Number of initiatives invested in; by selected cities and towns to enhance the safety of women and girls	5	6	6	3

Outcome 2: Reduced social tolerance for GBV and improved sexual reproductive health and rights

In order to measure improvements in social tolerance to GBV and improved SRH&R, women empowerment and decision making, perceptions, demand and access to GBV and SRH&R services at baseline and mid-term were compared. These are summarized in Table 8 below.

a) Women empowerment

Sixty eighty percent of women, an increase from 56.2% at MTR, reported to have received cash earnings from employment and agriculture production. Overall, women empowerment in terms of having control over their own earnings and participation in decision making significantly improved. The percentage of women with control over their own earnings increased from 36.8% at baseline to 79.1% at endline, surpassing the programme endline target of 50.0%. Similarly, women participation in household decision making increased from 31.6% at baseline to 69.4% at the endline, surpassing the programme endline target of 50.0%. At least 10,657 girls were enrolled in the programme supporting ELA in 2023, this accumulates to 26,045 girls who benefited from ELA. The programme achieved more than its set target of 15,000 girls. However, women ownership of assets remained below the set target of 85.0%, but there

[18] Maputo, Beijing, 1325 Report, 1820 Report, CEDAW, International Conference on Great Lakes (ICGLR).

were significant improvements from MTR (Figure 5). The% of women's cash savings increased from 40.8 % MRT to 56.4% at endline and the number of women who own land/house increased to 68.4% at end line from 45.1% at baseline.

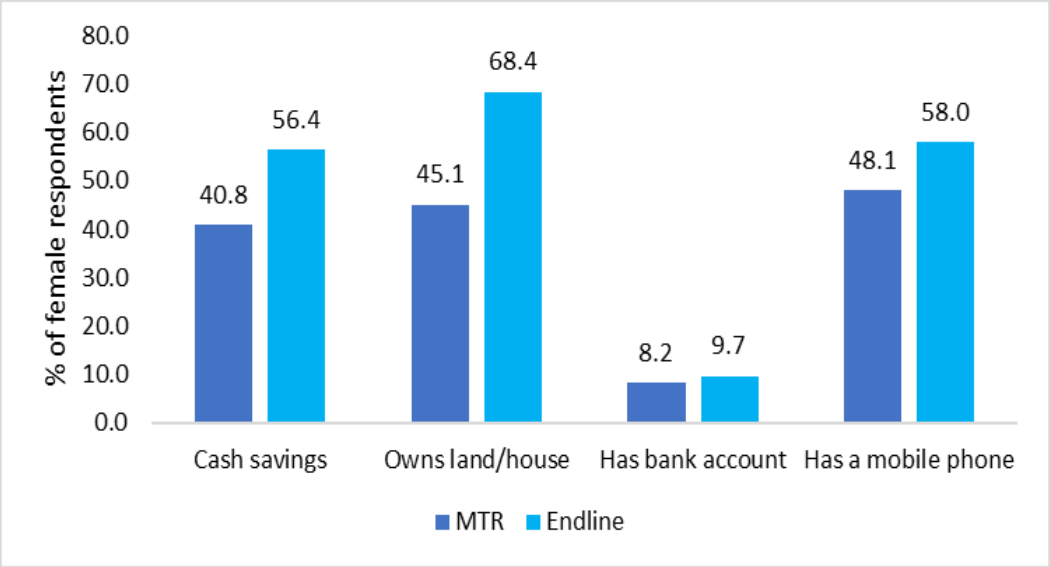


Figure 5. Women ownership of assets (household survey data)

Table 8. Progress towards achieving programme outcome 2 and related outputs

No	Indicator	Baseline 2019	Midterm 2022	Endline (2023)	Endline target (2023)
Outcome 2: Reduced social tolerance for GBV and improved SRHR					
2.1	**Women empowerment index: C**urrently married women (15-64 years) who received cash earnings for employment during the 12 months before the survey:				
	Percentage of currently married women (15-64 years) who received cash earnings for employment during the 12 months before the survey:	52.0	61.3	76.0	60.0
	a) Have control over their own earnings	36.8	54.5	52.0	50.0
	b) Ownership of assets (own house/ jointly, own land or jointly, have and use a bank account, own a mobile phone)	78.1	74.1	77.8	85.0
	c) Participation in household decisions-own healthcare, major household purchases and visit to the woman's family/ relatives	31.6	64.0	65.0	50.0
2.2	**Women and men who demonstrate social tolerance to GBV:** Percentage of the women and men (15-64 years) who agree that a husband is justified to beat his wife because of the following reasons:				
	a) If she goes out without telling him	17.0	22.8	20.1	7.0
	b) If she argues with him	11.2	18.2	16.0	5.0
	c) If she neglects the children	4.7	27.8	26.0	3.0

No	Indicator	Baseline 2019	Midterm 2022	Endline (2023)	Endline target (2023)
	d) If she burns the food	4.9	16.0	12.1	3.0
	e) If she refuses to have sex with him	4.3	18.4	13.0	2.0
Output 2.1 Communities and institutions are mobilized to prevent GBV and promote SRHR					
2.1.1	Percentage of the population in the target districts seeking help and accessing GBV and SRHR services				
	a) Medical	76.0	83.3	83.3	80.0
	b) Legal	2.5	14.1	14.1	10.0
	c) Psychosocial support	4.1	23.8	28.3	10.0
2.1.2	Number of community-led initiatives and actions being implemented to prevent GBV and promote SRHR	3	5	5	6
Output 2.2: Women and girls including marginalized and at-risk populations have access to livelihood and economic opportunities for GBV prevention and improved access to SRH information and services					
2.2.1	Number of adolescent girls and women reached with life skills programs that build their health, social and economic assets with support from the programme	0	15,388	26,045	15,000

b) Social tolerance to GBV

The evaluation findings showed that the percentage of women and men who agree that a husband is justified to beat his wife was lower than that reported at MTR (36.0% vs. 30.0%) but were still higher than the programme endline target (Figure 6). The UDHS 2022 results in the UNJPGBV programme regions gives this estimate as 33.1%. This indicator shows progress in reducing social norms and attitudes, but the slight reduction implies need for continued support and well sequenced interventions. Overall, this highlights that there is gradual but positive change in the social norms and attitudes.

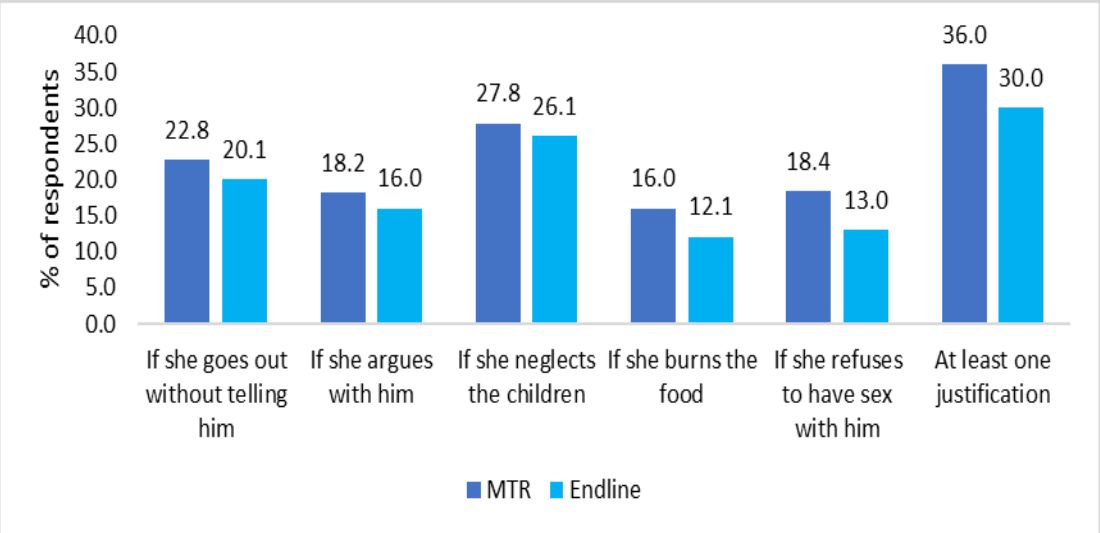


Figure 6. Women and men who agree that a husband is justified to beat his wife (household survey data)

There is moderate evidence that the 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, MAGs. Through community level interventions including SASA!, multi media campaigns, MAGs, male champions, Community dialogues, ELA activities, the programme has reached over 17 million people, and has capacitated community change makers/champions advocating for non -violence in their communities. Respondents observed that before the programme supported activities conducted by SASA activists and MAGs, all the domestic work would have been left for the women. However, this is changing with continued community engagement by community resource persons, especially male champions and MAGs facilitators. The male champions serve as agents of change 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.

> "The saying that the man is the head of the family and that all responsibilities are on him is not the case now, things are now equal" (FGD with male SASA Gulu)

> "The project caused tremendous decline in GBV cases both at the household level and the all communities in which the project was implemented. "Some men these days help women in providing for the families instead of lying down under trees, which was a common practice. These days' men are also involved in some income generating activities like brewing" (FGD with SASA, Moroto)

There is moderate evidence that indicates the UNJPGBV contributed to strengthening cultural and religious leaders' engagement in GBV and SRHR. Respondents clearly stated that the 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. The programme supported a Council of Traditional Leaders in Africa Uganda Chapter (COTLA-Uganda) to develop and launch a 3-years Costed Strategy and Operational Manual, 2023 that also targets reduction in harmful social norms and harmful practices.

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 UNJPGBV worked with religious leaders through their consortium – the Inter-Religious Council (IRCU). They provided a platform for social norm change especially those that favour GBV or limit access to SRHR. The Programme worked closely with cultural leaders to shift social and gender norms related to SRHR and GBV. For example, in close collaboration with the Ministry of Gender, Labour, and Social Development, the programme engaged cultural leaders in Karamoja and Acholi in dialogues to promote positive social norms that drive GBV, teenage pregnancies, and child marriage. 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.

> "Engaging religious and cultural leaders in the fight against GBV has been another good one. It has helped shift community attitudes towards more supportive and protective norms for women and children. As a result of the project's interventions, there was a marked reduction in the acceptance of GBV within the community. People began to recognize and challenge behaviors that encourage violence. The project included initiatives to engage men and boys in SRH discussions and services, challenging traditional gender norms and promoting shared responsibility for reproductive health. Men and boys participated in peer mentorship programs that educated them about SRH issues and encouraged them to support their partners and peers in accessing services", (FGD with SASA, Amuria).

"Culture was really fighting the program, because the program was coming to transform the cultural norms and harmful practices and yet this culture is being adored, we had to work with the elders, we had to work with men, boys to ensure that they are part of the program", (KII with CSO Staff, Moroto).

c) Access to GBV and SRHR services

The percentage of the population seeking help and accessing GBV and SRHR services increased between the baseline and endline and surpassed the programme targets: Access to medical services increased from 76.0% to 88.0%; access to legal services increased from 2.5% to 23.1% and access to psychosocial support services increased from 4.1% to 45.3%. The targets for community-led initiatives and actions implemented to prevent GBV and promote SRHR and those for adolescent girls and women reached with life skills programmes that build their health, social and economic assets were reached.

"People now access services like family planning, going for Antenatal with men, go for voluntary testing and also know where to run to incase of any violence inflicted on them. Most families are now accessing family planning and getting them from the health facilities free of charge", (FDG MEN KANYA-KANYA ABIM).

"It is suitable because previously people feared to report such cases but now people are reporting. Now if you ask these people, they are able to tell you. she will be open and they are able to access health, justice and any other support", (IDI with GBV survivor, Yumbe).

Outcome 3: Increased utilization of quality integrated GBV and SRHR services:

There was strong evidence that the program led to improved uptake of family planning and access to healthcare and legal services through demand creation, engagement of men, training and mentoring of justice actors, health and social welfare workers to provide friendly services including safe spaces for GBV survivors, integrated SRHR-GBV services. There were clear indications that uptake of health care services increased. In 2023, there is an increased number of family planning users to 719, 725 from 416,882 in 2022 see the total family planning users in 2023. There was an improvement in the number of fourth antenatal care visits to 146, 239 from 137,872 in 2022 and there was slight improvement in postnatal to 376,857 from 333,570 postnatal in 2022 and 195,008 institutional deliveries (Figure 7).

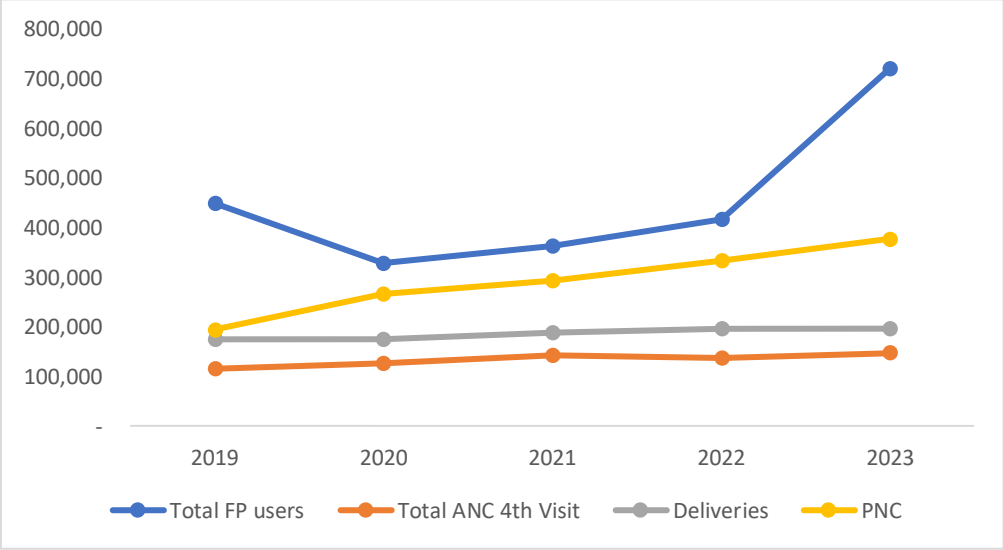


Figure 7. Utilization of SRHR services at the health facilities (HMIS data)

There was evidence that the programme changed attitudes and misconceptions about modern contraceptives. This led to improvements in uptakes. One woman noted:

> I used to be against contraceptives simply because of the beliefs and the misconceptions that were common in my community. The programme helped me to overcome these and I took up family planning and that is what I used to encourage and appeal to the mindsets of other women to use family planning [contraceptives]", (FGD with SASA Activists Kotido)

> "Family planning uptake is going on well, because of promotion by the programme and other organizations targeting young women. People no longer produce unnecessarily, people are now spacing children not like those days when they would just produce many children anyhow", (FGD Female SASA Gulu).

In 2023, a total of 15,620 people (F-10,617, M-5,003) in the program districts accessed legal aid in the form of legal advice and representation in court, and referral services through UNJPGBV support. Women and girls represented 68% of all people who received legal aid services. The availability of, and access to gender responsive legal services means that women and girls have a clear avenue to get help and feel safer within their communities.

There was skilling of midwives through annual Midwives symposia, technical training and mentorship of over 840 health workers (12 health workers per selected health facility in five (5) health facilities per district across 14 UNFPA supported districts) in the provision of lifesaving basic and comprehensive Emergency Obstetric and Newborn care services. Further, MoGLSD conducted training for 30 district staff on psychosocial support and case management.

However, the programme did not achieve the targeted contraceptive prevalence rate (CPR) of 55.8%. At the endline CPR was 40.4%. However, the CPR of 40.4% was a significant improvement from a significant improvement from the baseline. Only the target CPR for single girls/young women was achieved (Table 7). The percentage of sexual GBV survivors who accessed healthcare within 72 hours dropped from 90.6% at baseline to 55.0% at endline. Whereas the SGBV at the endline was mostly by the intimate partner, strategies that encourage women to go for healthcare are needed. The percentage of GBV survivors who seek legal help within 24 hours significantly increased from 2.5% at baseline to 19.4% at the endline, surpassing the set target of 10.0%.

There was evidence that access to justice has improved significantly over the last five years, and the districts and JLOS KIIs acknowledge the important contributions that would have not been achieved if it were not for UNJPGBV. The percentage of GBV survivors accessing legal services increased from 2.5% at the baseline to 14.1% at the endline. Similarly, satisfaction with services increased from 56% at the baseline to 78% at the endline. Delays in the process were still noted by a few respondents in the survey. The programme also supported the training of the community-based volunteers (CLVs) to enhance their knowledge and skills on gender responsive survivor centered mediation and referral in a manner consistent with national and international human rights standards, thereby bolstering their capacity to provide effective support at the grassroots level. Training of police officers, prosecutors has enhanced their capacity to investigate and prosecute VAWG cases in a survivor centered manner. Examples include use of anatomical dolls, prioritizing witnesses who are women, girls and disabled persons, use of audio-visual linkages or the judge's chambers to avoid secondary victimization.

> "We have seen progress in the way cases are being compiled, prepared and presented in courts by trained detectives. They compile good case files as compared to those not trained; training has significantly impacted on the quality of the evidence processing and its presentation" (Group interview – Police National Level).

Table 9. Progress towards achieving programme outcome 3 and related outputs.

No	Indicator	Baseline (2019)	Midterm (2022)	Endline (2023)	Endline Target (2023
Outcome 3: Increased utilization of quality integrated GBV and SRHR services in the target district					
Contraceptive prevalence rate:					
	a) Percentage of women aged 15-49 years who use any contraceptive method (modern or traditional)	36.7	32.2	40.4	55.8
	b) Percentage of women 15-49 years using contraception, by marital status:				
	• Single	22.4	25.1	37.4	37.5
	• Married	47.5	58.1	50.3	68.3
	• Separated	24.6	6.0	19.4	40.0
	• Widowed	6.0	7.7	3.3	10.3
3.2	**GBV survivors who accessed healthcare services:** Percentage of GBV survivors who accessed healthcare within 72 hours	90.6	87.7	100.0	100.0
3.3 GBV survivors who accessed legal services:					
	a) Percentage of GBV survivors who sought legal help (police and legal services) within 24 hours	2.5	65.9	19.4	10.0
	b) Percentage of GBV survivors who received psychosocial support at least once after GBV incident	76.1	57.1	89.4	100.0

Outcome 4: Strengthened coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention

The outputs for strengthening coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention were achieved. There was evidence of strengthened coordination, partnerships, and adaptive learning as noted by some of stakeholders.

> "The districts have been supported to generate, analyze and share data from the NGBV dataset and other sources to inform programming. The district level DGBV coordination group enables use of these data in programming. The coordination group enables the DCDO to bring together GBV stakeholders and address issues [KII, MGLSD]"

> "The programme was comprehensive in a way that they were a lot of networking among the agencies, among the partners, and other stakeholders. We always have quarterly coordination meetings with our partners on GBV and then child protection so these programs were also able to know who are the partners that are also engaged in this GBV Program This has helped us to layer out and avoid duplications, … but also to have a harmonized approach [KII, CDO, Gulu]"

The programme provided both technical and financial support for coordination meetings, review meetings and supported development and functioning of communication platforms to enhanced coordination. National GBV Reference Group was re-vamped with expanded membership including office of the prime minister and justice actors, while the support to the quarterly HIV technical working group meetings that included technical staff from MoES as well as the MOH, MGLSD, UN agencies and CSOs reviewed and recommended for further endorsement of the Adolescent SRH booklets to be distributed in all schools. The Programme also provided funds for quarterly menstrual health management steering committee multisectoral coordination meetings under the leadership of MoES. These meetings brought together brought in menstrual hygiene management (MHM) coalition members which aimed at reviewing the

progress on the implementation MHM activities and sharing of updates and reports at national level. Input was also received on the costed MHM strategic plan from the specific line ministries and CSOs. Further, support was provided to review meetings held with 36 DLG stakeholders aimed at increasing awareness of the SE framework, SE operational guidelines and understanding the whole school approach in the delivery of SE in schools. Action plans were developed to rollout SE in schools.

Table 10· Progress towards achieving programme outcome 4 and related outputs.

No	Indicator	Baseline 2019	Mid-term 2023	Endline (2023)	Endline Target (2023)
4.1	Number of DLGs where community actors are equipped with skills and tools to mediate land and property rights	0	14	14	14
4.1.1	Proportion of MDA and DLG development plans and BFPs integrating GBV and SRHR	0	100	100	80
4.1.2	Number of national knowledge and innovation products initiated by the private sector and academia on GBV and SRHR for social change	0	3	3	3
4.2	A functional national integrated GBV and SRHR data system is in place; HMIS, Education Management Information System (EMIS), NGBVD, SAUTI, and community Information System	0	1	1	1
4.2.1	Number of districts with NGBVD which have up- to-date data on GBV/SRHR indicators (within previous 3 months); which can be retrieved for analysis at the time of data collection	0	14	14	14
4.2.2	Number of districts collecting data on GBV and SRHR through Community Information System.	0	14	14	14
4.2.3	Number of districts in the programme area collecting and disseminating GBV and SRHR data	0	14	14	14

Most of the outputs for strengthening coordination, partnerships, learning and innovation for integrated GBV and SRHR multi-sectoral response and prevention have been achieved. Several coordination platforms and partnerships were in place, quarterly coordination and review meetings were reported in all districts visited. The programme provided both technical and financial support to ensure functionality of the pertinent national and sub-national coordination mechanisms. The medical-legal task force, the National GBV Reference Group, and GBV in humanitarian settings working group and district GBV/SRH multisectoral coordination platforms are in place and functional. The programme has also supported the meetings of technical working groups or committees such as HIV technical working group and menstrual health management steering committee in 2023.

The programme also worked collaboratively with the Civil Society Budget Advocacy Group (CSBAG) to develop a Gender and Research Data Hub prototype. This hub serves as a centralized repository for gender-related Citizen Generated Data (CGD), providing a comprehensive resource for trained CSOs. Collaborations with the Economic Policy Research Centre (EPRC) has led to four policy briefs, that cover vital topics such as the impact of limited access to services for victims of Gender-Based Violence (GBV) on Uganda's gender Sustainable Development Goal (SDG) targets, strategies for leveraging informal networks

and duty bearers to protect survivors of Intimate Partner Violence (IPV), addressing violence against women during elections, and halting the declining labor force participation rates among female Persons with Disabilities (PWDs) in Uganda.

The program strengthened communication, collaboration and coordination among the justice actors. The adoption of the prosecutor led investigations; joint case conferencing has resulted in better management of GBV cases.

Evaluation Objective 3: Coherence of the JPGBV programme

Assessment of coherence of the JPGBV focused on the extent to which the JPGBV advanced an integrated approach to SRHR at national and district level and within the participating UN organizations. The evaluation noted that the programme adopted an integrated approach in the prevention of GBV and promoting an uptake of SRHR services. Both UN agencies (UNFPA and UN Women worked with government agencies (especially MGLSD, UPF, ODPP, MOH, MoLG, MOJCA) and civil society organizations (CSOs) such as BRAC, IRC, CDFU, FIDA, Justice Centers Uganda, UGANET, CEDOVIP, Uganda Law Society, ACORD, IST, LANDNET, FAWE, TPO, RLP, Naguru Teenage Center as implementing partners during the planning, coordination and implementation of interventions. During implementation, UN agencies (UNFPA and UN Women) also worked in partnership with local governments through Decentralized Offices (DOs) in Adjumani, Gulu, Kyegegwa, Moroto, and Yumbe districts. UNFPA and UN Women also continued to work with other government structures such as the Community development Officers (CDOs), gender focal point persons, District Health Officers (DHOs) as well as other INGOs/ NGOs during the implementation phases. The partnership between UNFPA and the Ministry of Health as well as the DHOs played a key role in terms of integrating the component of sexual and reproductive health into GBV programming as well as in the existing initiatives at the MOH. For example, the Ministry of Health led teams to implement the national SRHR, GBV, and HIV integrated strategy and guidelines.

> "The major focus what was really driving that focus was largely around integrated sexual reproductive health into the existing initiatives at the ministry of health and other departments but also into other government ministries department and agencies. So, I was particularly for example involved in leading teams to implement the first ever national SRHR, GBV, HIV integrated strategy so this is really one of the key outputs that we really we managed to achieve through this programme." (KII, with Ministry of Health Staff)

In terms of SRHR, the programme adopted an integrated approach to the uptake of SRHR services through training of health workers, integration of SRHR services at health facilities, and conducting community outreaches mostly in hard-to-reach places. In terms of GBV, UN agencies (UNFPA and UN Women) in collaboration with government and other agencies contributed to advocacy for enacting and improving legislation that aims to prevent GBV through platforms such as the inter-agency GBV coordination body, Gender Development Partners Group, GBV in Emergencies working group, National GBV High Reference Group and the GBV working group at National Level and in refugee settlements and promote uptake of SRHR services.

The evaluation also noted that UN agencies (UNFPA and UN Women) conducted joint field visits in collaboration with different stakeholders including staff from the Ministry of Gender, Labour and Social Development (MGLSD), the Swedish Embassy, and other implementing partners such as BRAC, IRC, CDFU, Uganda Law Society, FIDA as well as Abim and Kaabong district local government structures (such as education, health, justice), child and family protection units (CFPUs), Police to during coordination, implementation and monitoring of programme activities. The evaluation also noted that the success in

the promotion of GBV preventive measures was also due to engaging champions in key institutions such as police and DPP, and MGLSD who took center-stage in making commitments in eliminating GBV.

> "I think an enabler has been champions within the institutions who have appreciated GBV in all its manifestations and who have demonstrated a commitment to eliminating GBV that has really helped us to move the program forward and this is even further strengthened when you have specialized units within the institutions that specially deal with GBV, like here am talking about police and am also talking about DPP, so you have specialized units with specialized skills and with commitment." (KII with UN Women staff)

In an effort to promote uptake of SRHR services, UN agencies (UNFPA and UN Women) working in partnership with institutions with relevant mandate reviewed policies related to SRHR including the National Policy on Elimination of Gender Based Violence and GBV Action Plan (2016), Sexual Reproductive Health and Rights (SRHR) policy and the Adolescent Health (ADH) policy. The integration of SRHR into GBV programming involved building the capacity of midwives through offering pre-service training to them, and internship at different institutions.

> "The training of midwives was one of the strategies employed especially through the pre-service training of midwives for 25 midwives in some of the districts. These midwives first they were identified by the different districts and then the coordination was done both by Accord and UNFPA… They were trained on a bursary scheme and also deployed in those very different districts. We also partnered with MOH to supported the capacity building of health workers in integration of GBV and SRH services" (Group discussion with UNFPA staff)

Further, the integration of the UNJPGBV also leveraged on the resource's interventions, approaches, lessons, from other programmes not to duplicate effort but also avoid wastage of resources and improve delivery and efficiency. Specifically, the Joint programme on GBV leveraged on the activities and resources EU Spotlight and the ANSWER programme to redirect resources appropriately, avoid duplication of output and wastage. For example, the evaluation team noted that the SIDA grant leveraged the development of training guides while the EU Spotlight or the Access to Justice spearheaded the rolling out the training guides – which helped with deepening and reaching a wider audience. The SIDA grant was also used to secure equipment such as cameras which complimented the activities of the EU Spotlight.

> "One, of the interventions by the Joint program on GBV was around activities related to guidelines, policies and basically strategic documents in the ministry of health work plan because resources were going through UNFPA … being able to a portion resource appropriately so that we can leverage resources from the various programmes such as the ANSWER Programme and EU Spotlight", (Group interview with UNFPA staff)

The programme created an enabling environment that promoted accountability and reporting mechanism to ensure to help with measuring progress. A good and conducive environment enabled conducting activities geared towards the elimination of GBV and improve access and use of SRHR services, as well as sustain advocacy activities that promote gender equality and human rights. The evaluation noted that the UNJPGBV was key in strengthening the capacity of district officials who participated in the programme on GBV prevention and uptake of SRHR services. The programme provided training sessions to health workers on management of SRHR and GBV cases.

> "The integrated nature of the Joint program on GBV contributed to expanding or strengthening capacities of the district to deliver integrated SRH and GBV services, we know that for most of the programs that we have is either a GBV exclusive programing or an SRH exclusive programing but this one was integrated and we see that it provided much needed resources in post conflict settings like Pader, Gulu but also refugee hosting setting like Kiryandongo where we work and other districts to provide the training resources for the health workers. We had investment around enhancing capacities of health workers on clinical management of Sexual and gender-based violence incidences ensuring that they did not only get the services but also are followed up to ensure that the cases get the justice which makes this program very relevant to the needs and context on the ground." (KII with UNFPA staff)

However, implementation of program activities was disrupted by the COVID-19 pandemic, which led to delays in implementation and engagements. Implementation of the program by UN Women and UNFPA was also affected by the passing of the Anti-Homosexuality Act (AHA)[19]. However, the programe made some adaptations to cope through mostly relying on field offices, partners on ground. For example, one of the key informant respondents had this to say:

> "Based on my own experience I see that one thing that fundamentally disrupted this program and required us to change things and try to adapt to new ways was largely COVID-19. We were able to work around some of the key challenges that COVID-19 brought about through relying more on at field offices and engagements with partners on the ground and willing off a number of things that we used to do at national level and also adapting to more for example digital ways of awareness creation because there were restrictions that came with community level engagements but apart from COVID-19 which was more of a general disruption" (KII with UN Women staff)

The evaluation noted the lack of shelters in some districts made it difficult to offer integrated services for survivors of GBV particularly who needed psychosocial support and provision of safety.

> "At some point there were issues of in coordination you know pulling all these UN programs together there were sometimes challenges in coordinating with other UN entities, so that the recommendation we need there should be need to strengthen coordination with the different players", (KII with MOH Staff)

> "Maybe we also need a scale up of the shelter management and operations to become a government program so we could recommend for national level of engagement with the relevant authorities including ministry of gender so that the shelter operations and management becomes part of the government program because it has been really unstable to have funds for the shelter", (KII with CSO staff, Gulu).

> "Then another challenge has been the limitations in terms of facilitation of these institutions, in terms of personnel, equipment, even just plain resources it has been very problematic such that even when you have an intervention it is like a drop in the ocean because the need is so great and then on the other hand government is not giving sufficient resources", (KII with UN Women staff).

Evaluation objective 4: Coordination of the JPGBV programme

The evaluation examined the extent to which the UNJGBV programme contributed to the functioning and consolidation of UNCT coordination mechanisms.

Functioning and consolidation of UNCT coordination mechanisms

The evaluation noted that the success of the UNJPGBV largely hinged on the multi-sectoral coordination at the national level between UN agencies (UNCT: UNW and UNFPA), coordination at the national level with relevant line ministries and stakeholders through the National GBV Reference Group and sub-committees such as the Medical-Legal sub-committee. Coordination is further reinforced through the joint monitoring and supervision by UNW and UNFPA. The GBV coordination arm at national level is led by the MGLSD and brings together stakeholders from government, UN agencies and international and national CSOs involved in GBV policy advocacy and programming. The multi-sectoral coordination was instrumental in providing timely information, sharing promising practices as well as gaps and recommending adjustments in the program. Through multi-sectoral coordination, current planning and coordination frameworks were initiated during the implementation of the UNJPGBV in the Justice Law

[19] United Nations Join Programme on Prevention of Gender-Based Violence in Uganda 2019-2024 2023 Annual Report

and Order Sector, such as the Governance and Security Program, Access to Justice Program, Administration of Justice Program and Transition to Program based budgeting. It is anticipated that as these are rolled out, it will further contribute to improved coordination.

The evaluation found out that the joint programme also benefited from multi-sectoral coordination at district level through regular/ periodic meetings to discuss implementation of the activities of the programme, know about the progress of the programme as well as sustainability. The coordination meetings at the district can bring on board other partners such as the DPC, CFPU among others. The evaluation noted that the coordination meetings have been possible through settings aside some small funds from the district budget, making use of district structures such as space/ halls that host meetings, making commitments as well as engaging some key personnel and has been possible through.

> "…coordination platform sustainability yes, Gulu is one example of a district that will continue and is continuing to implement what the Joint program on GBV initiated by designating a day in a month for the meetings every first Wednesday of the month. Kiryandongo is doing it once in a quarter, Pader is thinking about doing it twice in a year…so, how does the district do it is using the sustainable structures, we do have the meeting at the district within the community hall …so there's will and intense to sustain this initiative at the district level in the district budget." (Group Interview with UNFPA staff)

> "We always have quarterly coordination meetings with our partners on GBV and then child protection so these programs were also able to know the partners engaged in this GBV program and then also SASA and that is where we were able to know that yes, since Dreams is doing this under CDFU, we can do this, we can really support our community on this, … ensuring that there's no duplication it was through coordination meeting. We had a lot of inclusions in the community, this program was using all the structures of the community right from the LC 1 in the community, Para-social workers in the community, the Para-legal in the community so this program was able to instead of forming, instituting another system in the community they used the existing one that was something I have liked there's no need of again forming, training, use the existing community structures", (KII with CDO, Gulu).

> "We formed coordination committees at district and sub-county levels that facilitated regular dialogue and coordination among stakeholders. We made Efforts to integrate GBV, VAC, and SRHR services within existing health and social services improved accessibility. Coordination mechanisms ensured that all stakeholders shared a unified vision and objectives, aligning district-level activities with regional and national goals. Joint planning sessions between regional and district teams facilitated the integration of GBV, VAC, and SRHR activities, ensuring a holistic approach to addressing these issues, developed standardized guidelines and standard operating procedures for GBV, VAC, and SRHR interventions, ensuring consistency in implementation across the district", (KII with DCDO, Amuria).

> "GBV or SRH of different stakeholders which seats on monthly basis to discuss issues of GBV and SRH. We also have quarterly coordination meetings which is where all the partners in protection come together to share experiences, discuss challenges, relations and how to move forward", (KII with Gender Focal Person, Yumbe).

The JPGBV program facilitated joint and multi-sectoral planning/review and coordination meetings at both the national and district level. This was essential in avoiding duplication of efforts and maximizing use of available resources. The evaluation team noted that to a large extent, UNFPA and UN Women have been jointly planning together. For example, UN Women, UNFPA and the MGLSD developed a JPGBV M&E plan as part of the comprehensive M&E system to facilitate scheduling and implementation of joint M&E activities. The two UN Agencies, together with the MGLSD developed annual monitoring plans.

Evaluation Objective 5: Efficiency of the programme

The evaluation examined the extent to which the programme and its interventions delivered maximum results for the resources and inputs used, for example, in terms of funds, expertise and time among others. The evaluation further examined the extent to which the programme outputs and outcomes have been

achieved in the most economic and timely way, including an assessment of how funds, expertise, personnel, and implementation modalities contributed to, or hindered the achievement of results.

a) Funding, reporting and administrative arrangements

The evaluation noted that the UNJPGBV has a robust system in place to ensure checks and balances and timely accountability. The evaluation team noted a transparent mechanism that reports all money received, expenditure as well as the variance. The evaluation noted that most of the money was used at the districts and communities to facilitate programme implementation. In total, UNFPA received US$13,679,894between 2019 and 2023 while UN Women received a total of US$12,708,719 between the same period (20192023). The total expenditure for direct costs or programme costs for UNFPA was US$10,815,211 (US$8,958,094 for the period 2019-2022 and US$1,857,117 for 2023) while the total expenditure for human resource and other staff related costs was US$2,083,210 (US$1,652,309 for the period 2019-2022 and US$430,901 for 2023) and indirect support costs was US$868,325 (US$722,311 for the period 2019-2022 and US$146,014 for 2023).

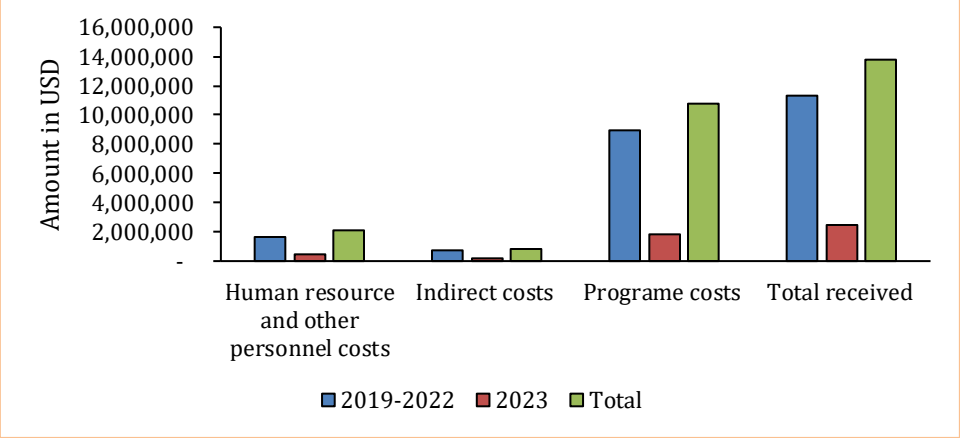


Figure 4: Percentage expenditure of funds by UNFPA. Source: UNFPA Finance Department

The programme received a total of US$4,579,133 in financial year 2023 (US$2,434,032 allocated to UNFPA and US$2,145,100 allocated to UN Women). The evaluation found out that approximately 78.3% of the total funding received in 2023 has already utilized.

However, during interviews particularly with IPs, the evaluation noted that almost all IPs interviewed had a perception that limited funding remained a challenge to implementing some of the programme activities, including meeting the cost of covering the wide geographical scope/coverage of activities, and meeting the cost for hard-to-reach areas with poor terrain, for example in Bundibugyo. This was evident in one of the key informants interviews we held:

> "I think our donor needs to do much more on this one, and in many times, we would have to wait for like 3 months .no first of all this programme wanted to achieve much more than them sources could allow and think we did spread thinly, because we're supposed to go to like how many sub counties, 50 sub-counties and the resources could not allow, so they were spreading very thin. So, for example we were supposed to do "SASA! together" but we were asked to do lite "SASA!" not the real one but we need a concentrated "SASA!" to be able to make enough change" (KII with CDFU Staff)

"When it comes to funding given the resources that are needed, … the resources are insufficient for us to do a very good job. Next time budget better, motivate the staff even better because some of the staff who are in Bundibugyo, are looking out in terms of seeking for greener pastures", (KII with Staff Justice Mission, Bundibugyo)

"Given the resources that are needed. if you look at how much money for example in terms of salaries our staff have been paid, you will go to Bundibugyo I don't know if you have been there; go and see the terrain they operate in…sometimes we cross rivers, the resources are insufficient for us to do a very good job." (KII with JCU Staff)

The evaluation also noted some delays in the release of funds to the implementing partners which caused further delays in implementation. While this is true, in most cases the delay in releasing funds was largely due to the delays in accounting for monies received earlier by the implementing partners, yet this was a condition for getting the next batch of funds.

"in many occasions funds delayed but I cannot purely say it was the fault of the donor delaying funds, sometimes it would be a delay on our part in like accounting and having them liquidate us but sometimes from their side where we would account and liquidation takes some time so in many occasions funds would be delayed but we can say we shared responsibility because sometimes it would be a fault on our side and other times it would be a fault on the side of the UN agencies" (KII with UGANET Staff)

"Delay in fund release for implementing activities was a failure to implement this programme. Timing was poor. It came at the wrong time when COVID-19 was there and this led to closure of the project when the implementation had just started", (KII with LCV, Abim)

b) Utilization of funds

The evaluation noted that all funds allocated to the UNJPGBV and UN Women for the period 2019 to 2023 were utilized for the intended program outcomes by both the UN agencies (UNFPA and UN Women). Utilization of funds that were received by UNFPA and UN Women was at 97% and 85% respectively. In terms of the funds received by UNFPA, about 82.3% of funds were utilized under outcome 3, 76.5% under outcome 4 and 68.4% under outcome 2.

"Well according to the number of times I have interacted with the program beneficiaries and project staff, I can say that about 70% of the program was implemented as it was planned and the resources well allocated to cater for the activities. This is because they have their staff of well-trained officers well distributed to the areas of operation and one can see the evidence of their work through reduced number of cases or GBV and increased use of SRHS", (KII with Probation officer, Kiryandongo).

We used the money properly and had no issues related to accountability, we had issues of returning money because it was coming in late making it hard to complete all the money. There were no wastage or idle resources in the program we were able to meet our targets with the resources available", (KII with MoGLSD Staff)

"What I know is that the Joint program on GBV was a bit flexible, flexible in the sense that the donor was not very like rigged for instance if they say this money should go towards this, should not move to another activity … for me I thought it was quite helpful", (KII with UNFPA staff)

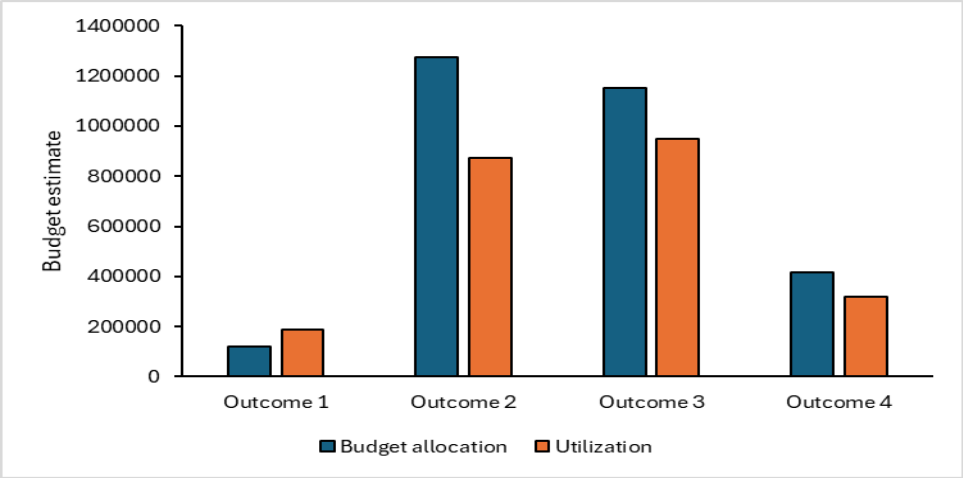


Figure 5: Utilization of funds by UNFPA. Source: UNFPA

c) Personnel

Given that this was a collaboration, UNFPA and UN Women as UN agencies contributed to a pool of staff that worked together during implementation. UN agencies (UNFPA and UN Women) also worked with all Implementing Partners (IPs) for both UN agencies (UNFPA and UN Women). UNFPA contributed the following staff members: two programme specialists on GBV and SRHR, three programme analysts on GBV and SRHR, one finance analyst and one M&E. UN Women contributed three programme specialists, two programme analysts, one M&E officer, one driver and one programme associate. The programme worked in partnership with several IPs especially CSOs as well as local governments. CSOs IRCU, IRC, AIC, BRAC, ACORD and Outbox, UBOS, JCU, Parliament of Uganda/ UWOPA, ULS, FIDA Uganda, CDFU, CEDOVIP, CCFU, CSBAG, IST, LANDNET, FAWE, TPO, RLP, UGANET, Naguru Teenage Center, media and private sector were supported to recruit staff to implement the project activities. Strategic partnerships with MoGLSD, MoH, MoES, UBOS, NPA, NPC, MoJCA, DLGs UPF, ODPP, JTI, JCU, Parliament of Uganda, EPRC, Makerere University Gender Mainstreaming Division, Makerere University Ran Lab, KCCA and DLGs contributed to the project by participating in the coordination and implementation of interventions. UNFPA and UNW staff in decentralized offices also undertook providing technical oversight and routine monthly field monitoring visits to the IPs and programme sites.

d) Appropriateness of the programme indicators in measuring results

The evaluation established that all monitoring indicators for the programme were well aligned to the joint programme. For a better monitoring system, UN agencies brought on board the district local government particularly the DCDO to participate in the interventions of the projects. District staff of the decentralized offices in Gulu, Moroto, Yumbe, Adjumani and Kyegegwa also undertook routine monthly field monitoring visits to the programme sites to identify key successes, challenges and also make recommendations to guide improvement and successful implementation of the programme.

> "Actually, the program was well fitted, organized, we had coordination meeting that were organized quarterly, where we had partners with other stakeholders, political leaders, the security, the elderly and also religious leaders, the stakeholders … we even had technical team", (KII with Assistant DHO Yumbe)

> "We always have what we call coordination meetings, we always carry out quarterly coordination meetings and discuss issues affecting the girl child, affecting education, affecting health, affecting communities and also implementation of agreed action plans, like the follow-ups in case there are other victims, there is also the department of community-

based services, it's always equipped. Even the operationalization of the bi laws in Education", (KII with Local Government Staff)

The evaluation noted that a robust system was put in place to build capacity that could support the capture of data on GBV at national and sub-national levels. Despite this remarkable success, the evaluation noted a number of gaps mostly related to the data at the sub-national level. First, the data collected at the local government level is not fully utilized to support decision making. Second, there is no clear and funded roadmap in place to define the collected data at different levels, that is, cascading the data from district to the sub-counties and parish and all the other lower levels.

While the joint programme had a well-laid out monitoring and evaluation system for informing programming, the evaluation noted some gaps. The joint programme could have benefited more from more systematic documentation of changes happening the implementation contexts and the adaptations that were done to address changes in the context. Clear collaborative learning and adaptation strategies were not laid out to facilitate practice-based learning, continuous learning and adaptation. These would help to explain the contribution of various interventions or mechanisms of change to the project outcomes. The M&E reporting system may also be limited in measuring the impact of the interventions without a strong impact evaluation design at the start of the project to enable more robust impact measurements.

> "I think that for future programs of this nature, it would be good for us to include in the design evidence- based studies that help us to really produce new knowledge from our experience from implementation. We might consider going beyond evaluations and monitoring to doing some quasi-experimental studies one or two, they are expensive but worth it if we are to continue in this direction. I think that we could improve on our reporting mechanism and particularly talking about template to consider indicator-based reporting as well, because without the indicators we can find ourselves running around with real GBV issues but not focused on what we set for ourselves to measure through the indicators." (Group interview with UN Women staff)

e) Decentralized offices

UN agencies (UNFPA and UN women) used the staff at decentralized offices (DOs) in Gulu, Moroto, Yumbe, Adjumani and Kyegegwa districts as satellite centers to conduct continuous monthly monitoring visits, coordination, supervision, technical guidance and support to the programme sites and programme activities. Decentralized offices provided a platform for collaboration and coordination with the district structures, for example, the Community Development Officers (gender focal point persons), the District Health Officers and Assistants, and NGO partners.

f) Advancing integration of gender equality and human rights dimensions

The evaluation noted that the programme has been instrumental in integrating and advancing gender equality and the human rights of people. For example, in partnership with the Ministry of Gender, Labour and Social Development (MGLSD) and the National Planning Authority (NPA), the program contributed to the Midterm review of the third National Development Plan (NDP III) and facilitated the development of a position paper on the integration of gender and equity issues in the forthcoming NDP IV. During the commemoration of the 16 Days of Activism, the programme also made recommendations to enact the legislation that prevents GBV but also establish shelters and increase funding to address child marriage and teenage pregnancy. For example, through community platforms, a total of 10,657 vulnerable girls at risk of violence or GBV, accessed gender-transformative messages to reduce child and forced marriage and teenage pregnancy, GBV, gender inequality and increase economic opportunities.

Among other achievements, the programme created a critical mass of community champions and activists to challenge the existing social norms, patriarchal norms, and promote gender equality and women's rights, engaged men to challenge existing patriarchal tendencies, conducted advocacy outreaches to prevent GBV, strengthened gender and human rights evidence generation through data collection and use, created awareness about human rights and gender equality through cultural communities. For example, through community cultural organizations, Cross-Cultural Foundation of Uganda (CCFU) supported a total of 317 (M 170 & F 147) young people in Acholi, and a total of 1100 young people (501F, 599M) in Buganda in raising awareness about gender equality and human rights and assisted the Alur kingdom to prevent child marriages through developing a code which regulates traditional marriage ceremonies to one event and issuance of mandatory traditional marriage certificates. At the national level, a GBV database has been supported to collect and analyse GBV data that can inform programming. At the district level, coordination groups focus on bringing different stakeholders together and address issues to make an effective referral mechanism by bringing actors together coordinated by the DCDO. The evaluation also noted that through the technical support from Justice Centres Uganda, 200 community-based volunteers (CLVs) from 20 sub counties (118, 82F) enhanced their knowledge and skills on gender responsive survivor centered mediation and referral in a manner consistent with national and international human rights standards, thereby bolstering their capacity to provide effective support at the grassroots level.

Evaluation Objective 6: Sustainability of the programme

The key sustainability strategies adopted by the JPGBV programme included (a) working within the existing national frameworks, structures and systems, (b) partnerships and collaborations and (c) capacity building at the national, subnational and community levels. Based on the findings, there is a likelihood for most results to be sustained after the programmes have ended.

(i) Building capacity of institutions and individuals

The JPGBV's strategic focus on capacity development at multiple levels, the establishment of robust data management systems, and the reinforcement of multi-sectoral coordination structures ensured that local institutions were well-equipped to sustain and replicate the program's results. These efforts embedded GBV and related issues into the core operations of local governments and their partners, promoting long-term sustainability and independent continuation of the program's achievements.

UNFPA promoted the sustainability of the programme's effects through developing capacity at various levels. This involved enhancing the skills and capabilities of both national and sub-national partners through customized training and mentorship programs across all sub-counties. These initiatives focused on improving GBV management skills which will enable local institutions to sustain the program's results. The program further facilitated the creation and reinforcement of multi-sectoral coordination structures at district and sub-county levels. These platforms brought together key stakeholders from government agencies, UN organizations, civil society, and communities to collaboratively plan, implement, and oversee interventions. This approach institutionalized the coordination of GBV, child protection, and sexual reproductive health efforts within the local government system. The continued advocacy for integration of GBV coordination into existing district planning frameworks, such as District Development Plans and the District Technical Planning Committee further facilitated the embedding of these issues into the core functions and priorities of local governments, ensuring their continuation beyond the programme's span as some respondents reported:

> "I am so grateful that UNFPA in the 5 years implemented measures to ensure sustainability post-SIDA support by focusing on capacity development at multiple levels. This includes strengthening institutional capacities of national and sub-national partners through tailored training and mentorship programs in all sub counties. They have tried in enhancing technical expertise and management skills, these efforts empower local institutions to independently replicate and sustain program results: (KII with CAO)"

> "The programme supported the establishment and strengthening of multi-sectoral coordination structures at the district and sub-county levels. These platforms brought together key stakeholders from government, UN agencies, civil society, and the community to jointly plan, implement, and monitor the interventions. This has helped to institutionalize the coordination of GBV, child protection, and sexual reproductive health efforts within the local government system" (KII with district CDO).

> "Several measures have been put in place to ensure the sustainability of programme benefits Continuous training for local health workers, and community leaders to ensure ongoing service delivery, Integrating SRHR and GBV/VAC activities into existing government programs and budgets, encouraging community-led initiatives and forming local support groups to sustain awareness and support. Working with national and sub-national governments to adopt and implement supportive policies and frameworks (KII with DEO)"

UNFPA played a crucial role in developing program indicators and establishing a GBV database. Training was provided to district staff and other implementing partners on GBV and VAC. Additionally, the program established a district-level GBV information management system, which enhanced the capacity of stakeholders to collect, analyze, and report on GBV data. This system provides a structured approach for monitoring GBV incidents and ensuring data-driven decision-making:

> "UNFPA supported in developing program indicators and also supported the development of a Gender-based violence database. They also trained district staff and some of the implementing on Gender-based violence and Violence against children. (KII with UNFPA staff)"

> "Establishing robust monitoring and evaluation (M&E) systems within local institutions to track progress, measure impact, and adapt interventions based on data-driven insights (KII with district probation officer)"

The programme ensured that local institutions, particularly the police, have the necessary skills, resources, and collaboration frameworks to sustain and replicate the program's results independently. The police officers were trained in managing GBV cases, investigation techniques, and crime scene management. These skills are vital for effective evidence collection and overall handling of GV cases. The comprehensive training and support provided to police officers enables them to handle GBV cases with greater expertise and coordination, entrenching these capabilities into the institutional fabric of local law enforcement and community support structures.

> "They did a lot of capacity building for officers in handling cases that are related to gender-based violence. Bridging and creating harmony with the different stakeholders that handle gender-based violence" (KII with police representative)"

> "We had several trainings that have been supported by UNFPA and UN WOMEN. The most recent one we had involved police officers, their spouses and their children. The training was for one week and it went a long way in awaking and equipping officers with the techniques of investigation and also scene of crime management. The training also involved techniques of how to get information from a victim who is a child, the kind of environment you should have when getting information or recording a statement of such a person and how to interact in friendly environment, etc. This support aided our nature of work and evidence collection" (KII with Police representative)"

The programme targeted the health system by building the capacity of health workers to deliver integrated SRHR, GBV and VAC services. One of the critical initiatives was training and mentorship of midwives across various districts. UNFPA coordinated with local health authorities and organizations to identify and train midwives on integrating GBV and SRHR services. This training, supported by the Ministry

of Health and midwife associations, equipped health workers with the skills needed to provide comprehensive care, ensuring that these services continue beyond the program's duration.

> "Okay, let me begin with the pre-service training of midwives that was done for 25 midwives in some of the districts. The midwives were identified by the different districts and then the coordination was done both by Accord and UNFPA. The training was followed by on-site mentorships of the trained midwives. This was done by MoH. The on-site mentorships focused on integration of GBV and SRH services" (KII with UNFPA staff representative)"

> "Several measures have been put in place to ensure the sustainability of the programme benefits; continuous training for local health workers, educators, and community leaders enhanced their skills and knowledge. We have developed a network of peer educators within communities to continue awareness and education efforts" (KII with DEO).

The program further built the capacity of local organizations to manage and implement GBV and SRHR initiatives as highlighted in the quotation below:

> "Capacities being developed include training health workers on SRHR and GBV response, building the capacity of local organizations to manage and implement programs……for example local organizations can advocate for and implement GBV and SRHR initiatives (KII with probation officer)"

At the community level, the program trained a wide range of individuals through the community structures such as SASA activists, male action groups, para social workers, VHTs, community-based volunteers, and individuals that had existing roles in the community such as teachers and local health workers. By training and equipping these volunteers with legal knowledge and skills, the programme ensured that they could effectively support their communities in handling GBV cases, thus ensuring a sustainable support system. These individuals in the community can respond quickly to issues, provide immediate assistance, and report cases for further action. The programme also targeted village-level interventions by selecting and training women groups to handle GBV and SRHR issues within their communities.

Additionally, there were efforts to build leadership capacity. The local council leaders, cultural and religious leaders, and other influential community members received training to champion GBV, child protection, and SRHR agendas within their communities. Their involvement ensured that these issues remained a priority in the community and were effectively addressed at the local level.

> "The biggest one I think I could give is the idea to use community-based volunteers. Yeah, we have enough of those, about 100, I believe. But they have been helpful because they make reports, so we see the work that they're always doing in the instances because outreaches expensive, and they need funding. Our biggest measure is our community-based volunteers. We train them and equip them with as much legal knowledge as we can so that they can help their communities even when we are not there" (KII with legal officer).

> "The local leaders and us the VHTs have been trained to continue the work even after the project ends. We already have the knowledge and the skills and we are permanent here, so we will continue working. (KII with VHT Amuria district)"

The JPGBV created awareness on GBV and SRH through organizing talks, using social media, and forming peer support groups. These approaches supplemented the established community structures to increase awareness on GBV and SRH in the communities.

> "Regardless of the project coming to an end, the knowledge we received from the activists won't end but will be with us and we shall use it to keep our families free from violence. The benefits gained will be used as testimonies for fighting GBV. The benefits will be used to help those who didn't get the opportunities by mediating in their families. The achievements will be used for case studies in other areas where the project didn't reach" (FGD with beneficiaries, Yumbe).

"The knowledge I got will be used for years and won't be lost. The ideas and skills I gained are used to render services to other in-need persons either within the community or outside the community. We shall continue interacting with our leaders on issues of GBV, SRHR and VAC to remind ourselves on how to deal with these issues in our families" (FDG with men 25 years and above, Amuria)"

"We have to share what we learned with everyone. We can organize talks and use social media to post about GBV prevention or healthy relationships to reach many people" (FGD with boys aged 15-19, Amuria district).

(ii) Implementation of positive and innovative approaches

The evaluation established that the JPGBV implemented innovative and positive approaches to address GBV, VAC, and SRHR, including community-based support groups, capacity building for healthcare providers and community leaders, and embedding services into existing health systems. The use of community-based volunteers and community leaders is pivotal, as these volunteers and leaders were trained to provide legal knowledge and support to their communities, ensuring prompt response to GBV and VAC issues. Community leaders and volunteers were also trained to advocate for GBV and VAC prevention and SRHR education, thereby acting as first point of contact in their communities to address any issues related to GBV. Community-based support groups for survivors of GBV and VAC that were established offer peer support and facilitate access to services. The interviews revealed that the programme integrated GBV, VAC, and SRHR services into existing district health services ensuring that these interventions become part of the routine healthcare system. These innovative approaches foster the sustainability of the program's benefits in the communities and may be replicated in other regions.

"One innovative approach was the establishment of community-based support groups for survivors of GBV and VAC. These groups provide peer support and facilitate access to services. To replicate these approaches, similar community-based support groups can be established by training local leaders and volunteers" (KII with district probation officer)"

"Building the capacity of community leaders and volunteers to advocate for GBV and VAC prevention and SRHR education, and to act as first responders in their communities was a good innovation to ensure sustainability" (KII with district CDO).

(iii) Establishment of partnerships and collaborations

The JPGBV established meaningful partnerships at national, sub-national and community levels. At the national level, the key partners include the Ministry of Gender, Labour and Social Development (MGLSD); Ministry of Health (MoH), Ministry of Education and Sports (MOES); Uganda Bureau of Statistics (UBOS); National Planning Authority (NPA); National Population Council (NPC); Ministry of Justice and Constitutional Affairs (MoJCA), Uganda Police Force (UPF), Office of the Director of Public Prosecution (ODPP); Justice, Law and Order Sector (JLOS), Uganda Law Reform Commission (ULRC) Parliament of Uganda, Civil Society Organizations (CSOs); Academia, Faith Based Organizations (FBOs), Media, Private sector and Cultural Institutions. At the subnational level, the programme closely worked with the District Local Governments, CSOs, NGOs, Religious and Cultural Institutions and several Implementing Partners (IPs), among others. At the community level, the programme engaged with the leadership structures including the political, culture and religious leaders, community health workers, community development officers, peer educators, and the police, among others. It is anticipated that these structures will continue to address GBV and promote SRHR beyond the programme span.

It is important to note that the partners played various complementary roles based on their position, strengths and capacity. For example, the MoGLSD provided overall strategic oversight, direction and coordination of multi-sector actors at national and sub-national level; the CSOs were responsible for advocacy, community mobilization and services delivery to complement government efforts on GBV prevention and response and promote SRHR; the FBOs complemented services delivery, social norm and

behaviour change, awareness raising and promotion of SRHR while the cultural and religious leaders were largely responsible for social norm and behaviour change, awareness raising and promotion of SRHR. The private sector played key roles in service provision, innovation, financing, social mobilization and prevention of sexual exploitation and abuse and the media was responsible for awareness raising, behavior change and education.

Partner coordination was effectively maintained through regular meetings at all levels, joint planning, implementation, monitoring and supervision of interventions. According to several respondents, the strategy of forging partnerships resulted in sustainability of outputs and outcomes. The programme strategy of working within the existing structures at district and community levels created sustainability potential for key interventions at the community level as reported below:

> "The engagement with several partners at the district and community level will ensure that some of the interventions will continue. Even when the programme ends, the established structures will continue to implement the interventions" (KII with District political leader)

> "Most of the community activities are spearheaded by local community structures. Through engaging the local actors in awareness creation and implementation of activities at the community level, some of the programme interventions will continue." (KII with local leader)

5.0 IMPLEMENTATION CHALLENGES AND LESSONS LEARNT

5.1 Implementation Challenges

Notwithstanding the progress made by the programme towards achieving its intended outputs and outcomes, the evaluation noted some implementation challenges that merit mention. These are highlighted below:

a) **Protracted policy approval process:** Although progress was registered in advocacy for policy reforms and for enactment of laws and guidelines related to creating an enabling environment for GBV prevention and response and addressing SRHR issues, the approval process is very lengthy. For example, the process of getting the Sexual Offenses Bill (SOB) to be passed by parliament and assented to by the president into to law has been very long and slow. Although the parliamentary and legal affairs committee signed off the reports for the Sexual Offenses Bill (SOB) and the Marriage and Divorce (MAD) bill, these are not yet passed into law. Relatedly, there has been slow progress in rolling out the sexuality education framework.

b) **Delayed passing of ordinances:** Although several ordinances on alcohol abuse, GBV prevention and promotion of SRHR were developed in the 13 target districts, very few have been passed into formal ordinances by the District Local Government and City Councils and the majority are pending approval by the Office of the Attorney General:

c) **Impact of the COVID-19 pandemic:** The COVID-19 mitigation measures put in place between 2020 and 2021, including restrictions on movement, school closures and a ban on public gatherings delayed implementation of the programme activities and disrupted access to essential GBV and SRHR services. In addition, COVID-19 increased the risk and vulnerability of women and girls to gender-based violence and violence against children as a result of increased tensions, distress and anxiety within families. A surge in teenage pregnancy was reported nationally. Furthermore, the COVID-19 response measures deepened inequalities in economic, social and cultural rights, including access to food, healthcare, education, employment, livelihoods and justice. The COVID-19 effects had significant negative impact particularly on the community engagement interventions and indicators for social norm change, parliamentary work on legal reforms, and roll out of data systems. The programme adopted innovative and alternative approaches such as use of digital platforms to ensure continuity of essential GBV and SRHR services. Some key informant interviews conducted with MTR participants also shared similar concerns.

d) **Weak information management systems for GBV:** There is limited capacity to systematically and consistently collect and use of data to inform programming decisions for GBV. The National GBV database is not fully functional to support regular collection, analysis and dissemination of quality GBV data.

e) **Weak stakeholder coordination at sub-national level:** Although coordination of GBV and SRHR programming has improved at the national level and in some districts, inconsistent stakeholder coordination meetings was reported in some districts, particularly at the sub-county level. Coordination challenges related to frequency, regularity and accountability for decisions taken during coordination meetings, as well as adequacy of resources to facilitate effective coordination were

reported. More support (funding and capacity strengthening) is required to improve coordination at the sub-county, parish and community levels

f) **Limited coverage of key interventions due to inadequacy of resources:** Due to insufficient resources to support scale-up, there is limited coverage of some key programme interventions such as the empowerment and livelihood for adolescent (ELA) model for building the social, health, education and economic assets of vulnerable young people and the SASA! methodology for conducting community outreach work to end violence against women and girls.

g) **Insecurity and arid conditions in Karamoja region:** Insecurity in the Karamoja region in the recent months negatively impacted programme implementation. The insecurity restricted movement of people, aggravated poverty, hunger and exposed women and girls to sexual abuse. Most implementing partners scaled down travel and that affected coverage of some interventions. Implementation of community-based programme activities, such as dialogue meetings and club activities were halted for a while. To address this challenge, most IPs and LGs intensified working with community-based structures that are based in the communities and did have to travel long distances that would expose them to insecurity.

h) **Absence of functional GBV shelters:** GBV Shelter facilities provide survivors with medical, legal and psychosocial support services including temporary accommodation to reduce stigma, protect survivors from further harm as they access justice, medical treatment and coping with the healing process. However, some of the target districts do not have GBV shelters and this affects provision of medical, legal and psychosocial support services to survivors. It was reported that the actors get stuck with survivors and have to fend accommodation for them. Even in districts where the shelters exist, they are not fully functional. Gaps in case management and mental health support to address trauma, depression and isolation in a safe and secure environment are apparent. Oftentimes, focus is placed on physical health and socioeconomic support for survivors.

> "UN women provided motorcycles, response to scenes of crime but inadequate shelters, to support vulnerable victims that are full to capacity, we need more shelters and to improve their capacity, it cannot accommodate both sexes. Regular transfers in police, you train and then trained people have been transferred", (Group interview with Implementing Partner staff)

i) **Community barriers:** Harmful cultural practices, inequal gender relations, poverty and poor health seeking behaviours for SRH conditions and GBV are still prevalent in the target districts. There has been slow progress in changing some harmful social norms in the target communities. The programme's main approaches used to facilitate social norms change included community dialogues and trainings. Although these approaches have demonstrated effectiveness, one of the drawbacks to these approaches is that they usually include a relatively small number of direct participants and there in some districts, it was reported that there are no clear and systematic mechanisms to facilitate sharing of information and skills to others in the community. In some cases, participants in community dialogues may not engage others in their networks to ensure that there is a multiplier effect to achieve change at scale. organized diffusion of information, skills and learning has been recommended as a

cost-effective strategy to expand the positive effects of community-based interventions for achieving sustainable normative shifts[20].

5.2 Lessons learnt

- An integrated approach to GBV and SRHR at both the national and district levels, through capacity building, facilitation of joint and multi-sectoral coordination, review and planning meetings, and joint platforms facilitates the delivery of quality SRHR and GBV services.
- Joint trainings of justice actors have improved communication, coordination and cooperation in service delivery. The joint capacity building for justice actors facilitates effective communication and coordination of the efforts among the justice actors in providing services to survivors and provides access to justice for the survivors of GBV.
- Psychosocial services are critical if we are to provide holistic GBV services to survivors. It was noted that the survivors that are provided with adequate psychosocial support have a higher likelihood of developing resilience including being to follow up their cases to a logical conclusion, both in litigation and mitigation matters.
- Sustaining community social norms change interventions through community activism has resulted in communities being aware, identifying violence and coming up to report cases to the authorities.
- Contextualization of interventions to specific contexts of communities in the various districts and sub-counties increased relevance and effectiveness of programme activities.
- It is important to develop clear social and behaviour change objectives that contribute to achieving of the program goals and objectives.
- Working through existing structure at all levels, national and subnational and community, builds a good foundation for capacity building, ownership and sustainability
- Integration of livelihoods and economic empowerment with SRH and GBV prevention activities created incentives for increased participation of young people and youth in the UNJPGBV activities providing more opportunities to achieve the desired changes in norms and behaviours targeted by the programme.

20 Cislaghi, B. (2019). The potential of a community-led approach to change harmful gender norms in low-and middle-income countries. ALIGN: Advanced Learning and Innovation on Gender Norms, 2019-04.

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The conclusions are presented according to each of the specific objectives of the mid-term review of the JPGBV

The conclusions are presented according to each of the specific objectives of the mid-term review of the JPGBV

Relevance

- The evaluation noted that the JPGBV in is tandem with the UN and national development plans and priorities for eliminating GBV and VAC and increasing access to SRHR. The UNJPGBV in is in line with the country's NDPII/NDPIII; UNFPA's Strategic Plans (2020- 2025); UNDAF 2020-2025 and the SDGs. The programme is aligned the policies and laws on GBV including the national policy on elimination of GBV, the Domestic Violence Act, the amended Succession Act, the Disability Act among others. Its strategies are in line with the Male Engagement Strategy, the National HIV Strategic Plan, the National Health Policy to mention but a few.

- The focus of the UNJPGBV is in line with the needs of the Ugandan population as articulated in Vision 2040. The UNJPGBV is also complementary to the other programmes addressing GBV and SRHR such as the Spotlight Initiative and the ANSWER Programme. It is also aligned the Comprehensive Refugee Response Framework (CRRF) and the Refugee and Host Population Empowerment (REHOPE) Framework that emphasize engagement and targeting both refugees and host population needs.

- The program was designed in due consideration of the needs and priorities of the target districts and communities to address the high prevalence of GBV and improve SRHR. The designed programmes respond to consolidate positive social and gender norms and engage in changing the harmful social and gender norms in relation to GBV and sexual and reproductive health. The programme also did well in adapting its strategies to respond to the surge in GBV and teenage pregnancies due to effects of the COVID-19 pandemic and its control measures. However, the scale of the effect of COVID-19 and its effect on gender relations, teenage pregnancies, livelihoods, incomes, food security, coupled with the current economic crunch requires much more reflection on how to deal with the emerging needs among adolescents, young people and adults.

Effectiveness

- The programme made considerable strides in contributing to advocacy for review and enactment of laws, policy reforms for GBV prevention and response and promotion of SRHR. However, the process of getting some crucial bills to be passed by parliament and assented to by the president into to law has been delayed. The programme also succeeded in contributing to rollout of the sexuality education framework in schools although rolling it out to the out of school adolescents has been relatively slow. Several ordinances on alcohol abuse, GBV prevention and promotion of SRHR were developed in 13 districts although most are pending approval by the Solicitor General.

- The programme contributed to reducing sexual and physical violence in the target districts. Whereas there was a slight increase in any form of violence observed at mid-term (in the last 12 months), there was a considerable decline in sexual (sexual harassment and denial to use contraception) and physical violence (kicking and slapping). On the hand, emotional violence remained high among both men and women. Despite these achievements, there remains part of the population that continues to believe

in negative and hegemonic masculinity social norms that drive and sustain GBV in families and communities

- The programme contributed to a reduction in teenage pregnancy among girls aged 10-19 years. Similarly, there was a reduction in the unmet need for family planning among married or women in union aged 15-49 years. This achievement notwithstanding, there are still negative gender and social norms, and structural barriers that that affect access and use of modern contraception among women and men in the reproductive health age group.

- The programme contributed to women's empowerment. This was as a result of programme activities such as cash transfers that aimed at increasing women's control over their resources and earnings. The evaluation noted that women's control of earnings increased. Similarly, the programme contributed to an increase in women participation in household decision making.

- The programme contributed to an increase in access to medical, legal and psychosocial support services. As a result of the programme, there was a considerable increase in message sharing on GBV experience and prevention (in terms of counselling, mediation, arrest the perpetrator, medical treatment, legal advice and referral).

Coherence

- The JPGBV advanced an integrated approach to SRHR at both the national and district levels through capacity building, facilitation of joint and multi-sectoral coordination, review and planning meetings, and platforms, facilitation of review and dissemination of policies, plans and guidelines. At the district level, the program led to improved capacity and attitudes of district teams, joint planning and coordination of an integrated approach to SRHR, facilitation of joint and multi-sectoral community meetings and dialogues. At the national level, SRHR and GBV have been integrated through the strategies and guidelines that are being used to promote provision of integrated GBV and SRH services to offer a holistic package of services to meet the rights beneficiaries.

- The UNJPGBV has attempted to leverage and work in tandem with other related programmes such as the ANSWER programme, the Access to Justice programme and the UN Spotlight Initiative to rationalize the support in the target districts to ensure synergy with other stakeholders and avoid duplication. There is evidence for complementarity of related programmes focusing on GBV and SRHR.

Efficiency

- The programme had a robust system in place for ensuring checks and balances and promote accountability in a timely manner. Submitted quarterly reports provided a quick mechanism for review and accountability during the implementation of the programme. The funds allocated to the implementation of the programme were well utilized for the intended programme activities. While funding allocated from the Sweden Embassy was substantial, funding allocated to GBV and SRHR interventions to interventions implemented by IPs and at the district was perceived to limited.

- There was an effective performance monitoring system in place. Routine monitoring, and supervision visits were conducted. Performance review meetings were held national and subnational levels. These meetings provided a platform for accountability. However, there was a gap in putting in place innovative collaborative learning and adaptation strategies to foster complex aware M&E as well as

systematic documentation of pathways of change contributing to the various outcomes. The current M&E design was also perceived not to offer robust evidence for an impact evaluation.

Sustainability

- The programme operated within the existing policies, frameworks and systems to contribute to elimination of GBV and improvement of the SRHR of women, girls, boys and men including disadvantaged and vulnerable population in the target districts. The programme functioned within the existing national strategic frameworks, policies, systems and structures at national, district and community levels. The programme heavily leveraged on the existing legal, medical and psychosocial support systems to deliver its mandate. This is particularly important for securing sustainability of the programme outcomes while promoting ownership at the various levels.

- Establishing meaningful collaborations with partners of complementary strengths at various levels holds sustainability potential for some of the key program outcomes. The programme established meaningful partnerships at national, sub-national and community levels. At the national level, the key partners included MGLSD, MoH, MOES, UBOS, NPA, NPC, MoJCA, UPF, ODPP, JLOS, ULRC, Parliament of Uganda, CSOs, Academia, FBOs, Media, Private sector and Cultural Institutions. At the subnational level, the programme collaborated the programme collaborated with the DLGs, CSOs, NGOs, Religious and Cultural Institutions and IPs, among others. At the community level, the programme engaged with the leadership structures including the political, culture and religious leaders, community health workers, community development officers, peer educators, and the police, among others. It is envisioned that these structures will continue to address GBV and promote SRHR beyond the programme span

- The legacy of the JPGBV programme was its ability to build capacity of institutions and individuals at various levels. The strengthened institutional and human resource capacity at the various levels is capable of supporting long term sustainability of the programme outcomes.

- The programme adopted a system strengthening approach and functioned to enhance the structural and technical capacity of organizations and institutions to plan, coordinate, implement, monitor and evaluate response to GBV and promotion of SRHR at all levels. The programme functioned to develop human resources and infrastructure capacity for institutions and structures at the various levels of planning and implementation. District-led programming was considered a viable sustainability strategy to enable grassroot strengthening of GBV and SRHR service delivery.

- Several implementation challenges were identified including: Delayed passing of ordinances; COVID-19 mitigation measures put in place between 2020 and 2021 delayed implementation of the programme activities and disrupted access to essential GBV and SRHR services; Limited capacity to systematically and consistently collect and use of data to inform programming decisions for GBV especially at the district and community levels; Insufficient resources to support increase in coverage and scale-up of effective interventions; Insecurity in the Karamoja region in the recent months negatively impacted programme implementation; Absence of functional GBV shelters in some target districts and Harmful practices and social/gender norms that continue to drive GBV and SRH challenges in the target communities.

6.2 Recommendations

- Engaging top management of the MGLSD and the Attorney General to expedite the review and passing of the ordinances that were developed by the target districts is very critical. It is also important to explore and understand institutional social norms change that was developed but has seldom been implemented at the district and community level. [Priority; High; Actors: MGLSD, Attorney General, Civil Society (Women's Rights Advocates), UN Women, UNFPA]

- Strengthening the information management system through building capacity of staff to be able to collect, use and analyze GBV data to inform programming and policy, especially at the district level, is critical. Further, there is need to engage the Police, Director of Public Prosecutions (DPP) and the Judiciary to develop a data tool that can be used to collect administrative data on GBV. This will improve documentation of GBV cases, referrals, and use of quality data. There is also need to harmonize the tools to be able to capture the GBV Data in the National GBV data base to harmonize reporting and avoid duplication. [Priority: High; Actors: Local Governments, UNFPA, UN Women, Police, DPP, Judiciary]

- Despite the major inroads made in strengthening the capacity of JLOS institutions especially the police through trainings and logistical support and supplies, the evaluation team noted that there is still need specially to increase support in terms of procurement of supplies and scaling up trainings and capacity strengthening to facilitate delivery of HIV prevention and response services under its mandate.

- Efforts to increase coverage of interventions in the target districts are required. There is also need to consider expanding the interventions to do total coverage of the current programme districts. It is also important to explore and understand institutional social norms change. [Priority: Medium; Actors: UNFPA, UN Women]

- Efforts to increase effectiveness, reach and scale of social norm change interventions to address the harmful social norms that drive tolerance of GBV and harmful practices and constrain uptake of SRHR services are required. There is need to review and consider other social norm change strategies that have demonstrated effectiveness in Uganda such as the "Responsible, Engaged and Loving (REAL) Fathers Initiative[21]" was tested in Northern Uganda as a mentoring program focused on reaching young, first-time fathers before their expectations related to parenting and relationships are well established[22]. The programme should also draw lessons from the DREAMS model also tested in several regions of Uganda to add to the strategies used to engage in social norm change. Similarly, there is need to explore mechanisms to facilitate effective organized diffusion of information and learning from the various change agents to the various audiences at the household and community level. To do this, the programme should consider undertaking qualitative and quantitative social network analysis to deepen understanding of the social networks that can be used to facilitate diffusion of information, learning and social norm change. It is also important to explore and understand

[21] https://www.usaid.gov/global-health/health-areas/family-planning/fathers-can-prevent-violence-too-lessons-real-fathers

[22] This approach has demonstrated evidence to improve prevention of intimate partner violence among couples; Improve fathers' use of positive parenting, their confidence in using nonviolent discipline and couple communication; Foster acceptance of non-traditional gender roles in parenting by fathers and the wider community; and Increase acceptability and use of voluntary modern family planning methods by REAL Fathers couples (also see: https://iidcug.org/proj/scaling-up-real-fathers-approach-in-uganda/)

institutional social norms change in key institutions including the JLOS institutions and health provider norms and design social norm change strategies to facilitate provider norm change. These will contribute to delivery of adolescent and youth friendly as well as survivor centered services. [Priority: High; Actors; MGLSD, UNFPA, UN Women, Local Government]

- Based on the lessons learned on implementing GBV shelters, there is need to review the current model and guidelines for the GBV shelters to adapt them to suit the local context, to be cost-effective and sustainable. Given the limited coverage of GBV shelters in different regions, there is need to co-create sustainable community protections structures beyond the GBV shelters to supplement the existing GBV shelters in providing counseling, and psychosocial support. Developing and testing a community-based model that can enhance pathways for safety and referral of GBV survivors is required [Priority: High; Actors: MGLSD, Local Government, UNFPA, UN Women]

- Given that the programme targets populations that are vulnerable to psychosocial challenges, there is need to build on the current successes and lessons to scale up integration of mental health and psychosocial support in all programmatic GBV and SRHR interventions. Provision of psychosocial support should target both beneficiaries and staff since both categories of people are likely to experience the same challenges. For better results, there is also a need to work effectively with community-based structures such as VHTs, Community Activists, ELA Clubs to offer more psychosocial support in GBV programming. [Priority: High; Actors: UNFPA, UN Women, MGLSD, Ministry of Health, CSOs, Local Government]

- For future programmes, there is a need to review the staffing levels of the IPs to ensure the staff numbers and competences match the scope of work. Similarly, there is a need to assess and build capacity of the IPs in financial management and accountability procedures. For future programmes, there is a need to review the staffing levels of the IPs to ensure the staff and competences match the scope of work. It is also important for IPs to work with community structures or build their capacity and incentivize them to carry this kind of work forward beyond the project timelines. [Priority: High; Actors: UNFPA, UN Women, CSOs, Local Government]

- In order to strengthen the current MEAL systems, there is need to invest in collaborative learning and adaptations, complexity aware monitoring strategies and systematic documentation of the pathways that are contributing to changes in outcomes at every stage of programme implementation, including outcome harvesting approaches [Priority: High; Actors: UNFPA, UN Women, CSOs]

- Given the stagnation of teenage pregnancy or child marriage with no significant decline, it is important to increase focus on structural factors that combine with harmful social norms to drive teenage pregnancy. Given the nexus between school dropout and teenage pregnancy, there is need for any follow up programme to the UNJGBV to intensify interventions in schools that integrate SRHR and GBV prevention in schools. Lessons can be drawn from some of the interventions/strategies implemented in schools under the ANSWER Programme, a sister programme to the UNJGBV implemented by UNFPA.

- There is need to review the approaches and strategies used to engage with cultural and religious leaders to make them more effective. We recommend the approach of starting with identifying

positive cultural resources and values that support GBV prevention and SRHR and then building on these to strengthen capacities to foster change of harmful social norms. This positive framing that starts with recognition of positive cultural resources that support GBV prevention and response as well as SRHR that can build on existing cultural resources as entry points strengthen relationships with cultural leaders and help to create platforms for dialogue on change of harmful social norms. They also can initiate a process of reducing backlash arising from social sanctions associated with violation of social norms. This is in line with the cultural approach to development and mindset change promoted by UNESCO23 as well as the Parish Development Model in Uganda. This approach was also pioneered in Uganda under the cultural approach to HIV prevention and care24 in which culture was considered as a pillar for development and cultural resources were identified and consolidated but this was also used as a platform to initiate an sustain dialogue on harmful social norms. This provided a platform to promote positive cultural resources and values but also deepen a reflection on harmful social and gender norms.

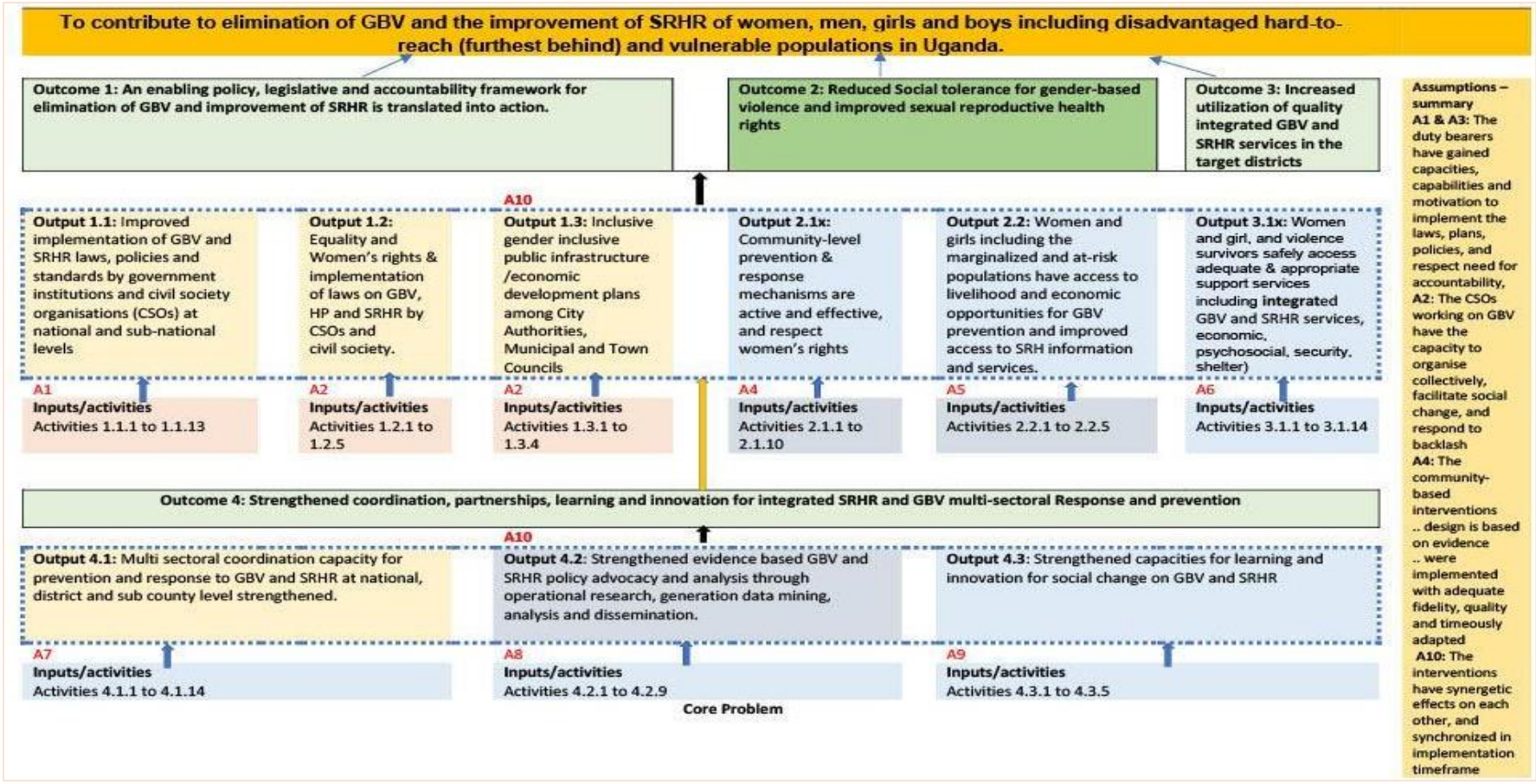
- There is need to strengthen integration of livelihoods and economic empowerment with SRH and GBV prevention and response activities including ELA clubs, legal aid for GBV survivors among others.

- Existing evidence suggests that models such as the SASA! model is good and impactful, but it could be resource intensive during implementation. Based on this background, there is need to conduct implementation science to test the effectiveness of the different packages of GBV prevention from which to choose a low-resource intensive model or package that can be rolled out for GBV prevention.

[23] https://unesdoc.unesco.org/ark:/48223/pf0000224438_eng
[24] https://unesdoc.unesco.org/ark:/48223/pf0000125589

7.0 ANNEXES

Annex I: Program theory of change



Annex II: Evaluation matrix

RELEVANCE

EVALUATION QUESTION 1: To what extent was the UNJPGBV programme:

a. Aligned to national priorities (including Vision 2040, NDP III) sectoral priorities; coherence with needs of target groups4, SDGs, and UNFPA & UNWomen Strategic plans (2018 – 2021, 2022-2025).

b. Planned interventions adequately reflect the outputs and outcomes stated in the project design, the UNFPA and UN Women CPD8 and CPD9?

c. Able to respond/adapt to changes in national needs and contexts, including humanitarian emergencies and COVID-19? What was the quality of such a response.

d. Integrated gender and human rights-based approaches

e. Gender responsive in its design and implementation? Was it: gender negative, gender blind, gender-targeted gender-responsive, or gender transformative?

f. Respond to the needs of the vulnerable populations including women, youth, people living with disabilities hard-to-reach populations?

Assumption	Key Performance Indicators	Data sources	Data collection method
A5: The (heterogeneous) needs of the target population including vulnerable and marginalized groups, and those of relevant government agencies at national and district level were considered in the design of the Programme.	○ Evidence-based interventions, identifying pathways to changing norms and empowering beneficiary socially and economically. ○ Extent to which objectives and strategies of each component of the UNJPGBV programme are consistent with relevant national and sectorial policies. ○ Extent to which the objectives and strategies of the UNJPGBV (both initial and revised) were discussed and agreed upon with the national partners. ○ Evidence for an adequate and accurate needs assessment, identifying the varied needs of diverse stakeholder groups prior to the programming. ○ Evidence of extent to which the interventions planned within the AWPs were targeted at the most vulnerable, disadvantaged, marginalized and excluded population groups in a prioritized manner	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, Implementing partners (IPs) etc.) ○ Documents (National and international plans, frameworks, etc.) ○ Beneficiaries of GBV and SRH&R services ○ Annual workplans (AWPs)	○ KIIs ○ FGDs ○ Desk review ○ Analysis of various documents and reports -

Other additional Assumption: 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 GBV and SRHR landscape and the social, political and economic environment during the period of implementation.	○ Interventions programme documents adapted to local contexts, including the needs and interests of the disadvantaged. ○ Views and perceptions of beneficiaries on the extent to which their needs and interests were tackled. ○ Extent to which the reallocation of funds towards new activities (in particular humanitarian ones) is justified. ○ Extent to which the UNJPGBV programme team managed to ensure continuity in the pursuit of the initial objectives of the programme while responding to emerging needs and demands and maintaining a human rights-based approach	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs etc.) ○ Documents (National and international plans, frameworks, etc.) ○ Beneficiaries of GBV and SRH&R services ○ AWPs	○ KIIs ○ FGDs ○ Desk review ○ Analysis of various documents and reports
EFFECTIVENESS **EVALUATION QUESTION 2: To what extent have:** a. Expected results been achieved? What internal and external factors facilitated or hindered the achievement of UNJPGBV programme results? b. internal and external factors facilitated or hindered the achievement of UNJPGBV programme results? c. The interventions supported by UNJPGBV contribute to the achievement of planned results (outputs and outcomes). Were the planned geographic areas and target groups successfully reached? How adequate is the theory of change underlying the results chain logic? d. What are the key lessons learnt and best practices that can contribute to knowledge base of the UNFPA, UNWomen and partners and be applied in future programme and policy development? e. How has the functionality of the governance structure, including the donor role, affect the effectiveness of the programme? f. What lessons have been learned from these partnerships to date and the possibilities to replicate them?			
Assumption	**Key Performance Indicators**	**Data sources**	**Data collection method**
A1: Duty bearers (JLOS, Police (forensic, family and child protection units), CDOs, Probation officer and health workers have gained the capacities (incl. technical and counselling skills), capabilities and improved attitudes and motivation to provide GBV and	○ Evidence of capacity building and transformative approaches of duty-bearers in changing gender and social norms, and other roots causes of GBV ○ Perception of usefulness of training and mentoring received. ○ Evidence of changes in ways of working and perceptions towards SRHR/GBV services	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, health facility reports, CSO reports, JLOS	○ KIIs ○ FGDs ○ Most significant change stories/ MSCs ○ Desk review and analysis of various

SRHR services of sufficient quality in line with government and UNFPA/UNWOMEN strategies and policies. They have the capacities and capabilities to encourage demand of services through outreaches in hard-to-reach areas	○ Evidence of shifts in the staff norms and attitudes that negatively influence duty-bearers in providing SRHR and GBV service of sufficient quality	reports, budget reports, DCDO reports, etc.) ○ Secondary data – GBV database, DHIS2, program M&E data ○ Beneficiaries of GBV and SRH&R services	documents and reports ○ Analysis of secondary data ○ Household survey
A2: The CSOS working on GBV have the capacity to organize collectively, facilitate social change and respond to backlash at the community level and capacity to organize communities and champion advocacy at the district and national levels	○ Evidence of capacity building and transformative approaches of service providers in changing gender and social norms, and other roots causes of GBV ○ Evidence of CSO or civil society self-initiated advocacy activities ○ Extent to which community and community volunteers have taken on leadership of addressing conflict and challenge the norms	○ Interviews with CSOs and civil society ○ Documents (program reports, baseline report, police reports, health facility reports, CSO reports) ○ Beneficiaries of GBV and SRH&R services	○ KIIs ○ FGDs ○ MSCs ○ Desk review and analysis of various documents and reports
A4: 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 – interconnectedness of interventions to support supply, enabling environment and demand) ○ Quantitative and qualitative evidence of changes in GBV experiences, contraceptive uptakes, knowledge, attitudes, behaviors and norms related to gender and SRHR among project beneficiaries. ○ Evidence of unforeseen consequences and their documentation in Programme plans and reports.	○ Stakeholders and duty-bearers ○ Documents (program reports, baseline report, police reports, health facility reports, CSO reports, JLOS reports, budget reports, DCDO reports, etc.) ○ Secondary data – GBV database, DHIS2, M&E data ○ Beneficiaries of GBV and SRH&R services	○ KIIs ○ FGDs ○ MSCs ○ Desk review and analysis of various documents and reports ○ Analysis of secondary data ○ Household survey
A6: Comprehensive, gender-sensitive, high-quality GBV and SRH services are in place and accessible in underserved areas with a focus on the (varied needs	○ Quantitative and qualitative evidence of changes in numbers accessing SRH/GBV services ○ Evidence of capacity building and transformative approaches of service providers in changing gender	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff,	○ KIIs ○ FGDs ○ MSCs

of) young people and vulnerable and marginalized groups	and social norms, and other roots causes of GBV ○ Perceived quality and satisfaction with available services by the GBV survivors ○ Evidence of effective referral systems ○ Evidence that the quality of SRHR/GBV services offered in the public health facilities, law, order and justice system have improved.	health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, health facility reports, JLOS reports, budget reports, DCDO reports, etc.) ○ Secondary data – GBV database, DHIS2, M&E data ○ Beneficiaries of GBV and SRH&R services	○ Desk review and analysis of various documents and reports ○ Analysis of secondary data ○ Household survey
A7: District coordination structure meet regularly and meaningfully involve community leaders and district leadership, and buy-in	○ Utilization of the existing structures, resources and frameworks ○ Evidence of multi-sectoral planning and programming led by the districts. ○ Partnerships established and maintained. ○ Evidence of meetings held and participants. ○ Perception of usefulness of meetings ○ Exit strategies to hand over the interventions to (local) partners have been developed during planning process. ○ Partners' capacities have been developed with a view to increasing their ownership of the interventions initiated in UNJPGBV programme	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, health facility reports, CSO reports, JLOS reports, budget reports, DCDO reports, etc.)	○ KIIs ○ FGDs ○ MSCs ○ Desk review and analysis of various documents and reports
A8: Duty bearers at the subnational and national level engaging actively and using evidence to respond or adapt the policies, strategies for delivery of GBV/SRH services.	○ Extent to which duty bearers are actively involved. ○ Extent to which some adaptations or innovations have been generated or implemented. ○ Extent to which government livelihood programs have integrated gender transformative approaches aimed at GBV prevention.	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, health facility reports, CSO reports, JLOS	○ KIIs ○ FGDs ○ MSCs ○ Desk review and analysis of various documents and reports ○ Analysis of secondary data

		reports, budget reports, DCDO reports, etc.)	

EFFICIENCY

EVALUATION QUESTION 3: To what extent:

a. has UNJPGBV 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?

b. To what extent did UNJPGBV esources have a leveraging effect?

c. To what extent was the progress and results of the programme effectively and efficiently measured and reported?

d. How and to what extent did the UNJPGBV facilitate the use of its funding, personnel, administrative arrangements, time and other inputs to optimize achievement of results described in the programme document?

e. To what extent did the intervention mechanisms such as ELA, MAGs, CQI, SASA, CLV, Cas, CLs, partnership strategy, execution/implementation arrangements; joint programme modality) foster or hinder the achievement of the programme outputs.

f. What adaptations were made to enhance achievement of results, including those specifically related to advancing integration, and gender equality and human rights dimensions?

g. What impact does the current governance structure and administrative set up for the programme (with UNFPA as the Administrative and Convening Agent) have on joint ownership among all the participating UN organisations?

Assumption	Key Performance Indicators	Data sources	Data collection method
Assumption 1: Beneficiaries of UNFPA support received the resources that were planned, to the level foreseen to be assessed and in a timely and sustainable manner.	○ Percent of resources utilized and how the resources were converted into results. ○ Percent of the programme cost against the budget, adherence to financial guidelines, plans and budget, etc. ○ 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' activities that the improves the delivery of the programme	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, CSO reports, JLOS reports, budget reports, etc	○ KIIs ○ Desk review and analysis of various documents and reports

Assumption 2: UNJPGBV programme contributed to effective coordination between actors in the pursuit of the achievement of programme results	○ Evidence of coordination and complementarity among the programme components of UNJPGBV and coherence among government ministries ○ Evidence of progress towards the delivery of multi-year, predictable, core funding delivered to implementing partners. ○ Evidence of coordination between actors and activities that the improved the delivery of the programme.	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, IPs, etc.) ○ Documents (program reports, baseline report, police reports, CSO reports, JLOS reports, budget reports, etc.	○ KIIs ○ Desk review and analysis of various documents and reports
Assumption 3: 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 ○ UNFPA CO Interviews ○ IPs	○ Document review ○ KIIs
COHERENCE **EVALUATION QUESTION 5:** a. How well has the programme advanced an integrated approach to SRHR at national and sub national level and in the participating UN organizations? b. How well did this programme collaborate, coordinate and leverage efforts with agencies, stakeholders and partners not involved in the programme, within the UN reform process? c. To what extent did joint programming take place among the participating UN organizations to achieve the expected results of the intervention?			
Assumption	**Key Performance Indicators**	**Data sources**	**Data collection method**
Assumption 1: The resources provided by UNFPA have had a leveraging effect to be assessed.	○ Extent of joint ownership among all participating UN organizations. ○ Extent of joint programming has taken place among all participating UN organizations. ○ Extent of how the program has advanced an integrated approach to SRHR at national and sub-national level. ○ Extent to which the programme has collaborated, coordinated and leverage efforts with agencies, stakeholders and partners.	○ Stakeholders and duty-bearers (UN agencies and donors, MDAs, DLG staff, health workers, JLOs staff, CSOs, implementing partners, etc.) ○ Documents (program reports, baseline report, police reports, CSO reports, JLOS reports, budget reports, etc	○ Document reviews ○ KIIs

	○ Evidence that the resources provided by the programme triggered the provision of additional resources from the government. ○ Evidence that the resources provided by programme triggered the provision of additional resources from other partners, including other donors or INGOs.		
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	○ M&E reports ○ AWPs ○ APRs ○ Other donors ○ Other UN agencies working in the same area ○ NGOs and other actors	○ Document review ○ KIIs
SUSTAINABILITY **EVALUATION QUESTION 6:** a. To what extent have UNJPGBV-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)? b. To what extent did the programme build capacity for Government structures and other partners to be able to maintain the change made by the programme interventions if any? c. To what extent have the partnerships built by UNJPGBV programme promoted national ownership of supported interventions, programmes and policies? d. To what extent have the partnerships built by UNJPGBV programme promoted national ownership of supported interventions, programmes and policies? e. What are the lessons learned from the programme? How can the lessons have learned from used for strategic positioning for future programming in humanitarian and development nexus? f. To what extent has the programme contributed to Community monitoring, accountability and community ownership?			
Assumption	**Key Performance Indicators**	**Data sources**	**Data collection method**
Assumption 1: Programme has contributed to sustainable capacity development in the IPs	○ Evidence of capacity development initiatives supported by programme and of the likelihood of sustainable results. ○ Evidence of IP resources and capacity to continue	○ AWPs and APRs ○ staff ○ IPs at national and district levels	○ Document review ○ KIIs

at national and district levels, and among primary beneficiaries	and develop relevant programmes and projects		
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 UNJPGBV supported interventions. ○ Evidence of increased resource and budgetary provisions related to SRHR and GBV as a result of UNJPGBV supported interventions	○ AWPs and APRs ○ National, sectoral and county policies, plans, budgets and reports ○ IPs at national and district levels	○ Document review ○ KIIs