Government of Uganda/United Nations Joint Population Programme Mid-term Review

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The MTE was largely participatory involving wide consultations with various stakeholders. The validation workshop attended by staff from four of the JPP districts as well as national staff held on 25th of September 2013 epitomized the spirit of the participatory approaches adopted.

Acronyms

AHSPR	-	Annual Health Sector Performance Report
ANC	-	Antenatal care
APADOC	-	Alliance of Parents, Adolescents and the Community
AWP	-	Annual work plan
AYFS	-	Adolescent Youth Friendly Services
BTL	-	Bilateral tubal ligation
BTVET	-	Business, Technical, Vocational Education and Training
CAO	-	Chief Administrative Officer
CBOs	-	Community-based organizations
CBRP	-	Community-based Reintegration Programme
CDFU	-	Communication Development Foundation for Uganda
CDO	-	Community Development Officers
CSO	-	Civil society organisations
DBAWP	-	District budget annual working papers
DBFPs	-	District Budget Framework Papers
DCDO	-	District Community Development Officer
DDPs	-	District Development Plans
DEO	-	District Education Officer
DfID	-	Department for International Development (United Kingdom)
DHO	-	District Health Officer
DP	-	District Planning Officer
DPO	-	District Population Officer
EMIS	-	Education Management Information System
EmOC	-	Emergency Obstetric Care
EMONC	-	Emergency Obstetric and Neo-natal Care
ESAPR	-	Education Sector Annual Performance Report
FGD	-	Focus group discussion
FGM	-	Female genital mutilation
FP	-	Family planning
FY	-	Financial year
GEM	-	Girls Education Movement
GBV	-	Gender-based violence
GNI	-	Gross national income
GoU	-	Government of Uganda
HC	-	Health Centre
HDI	-	Human Development Index
HHs	-	Households
HMIS	-	Health Management Information System
HSSIP	-	Health Sector Strategic and Investment Plan
HSSP	-	Health Systems Strengthening Project, World Bank
ICPD	-	International Conference on Population and Development
ICT	-	Information, communication technologies
ILO	-	International Labour Organisation
IP	-	Implementing partner
IOM	-	International Organisation of Migration
IUD	-	Intra-uterine device
JPP	-	Joint Programme on Population
KAP	-	Knowledge, attitude and practice
KII	-	Key informant interview
LC	-	Local Council
LMIS	-	Labour Market Information System
MCH	-	Maternal and child health
MDAs	-	Ministries, Departments and Agencies

MDG	-	Millennium Development Goal
M&E	-	Monitoring and Evaluation
MFPED	-	Ministry of Finance, Planning and Economic Development
MIS	-	Management Information System
MLHUD	-	Ministry of Lands, Housing and Urban Development
MNCH	-	Maternal, neo-natal and child health
MoES	-	Ministry of Education and Sport
MoGLSD	-	Ministry of Labour, Gender and Social Development
MoH	-	Ministry of Health
MoLG	-	Ministry of Local Government
MPDR	-	Maternal and perinatal death review
MTE	-	Mid Term Evaluation
NAPYE	-	National Action Plan on Youth Employment
NDP	-	National Development Plan
NGOs	-	Non-governmental organizations
NPA	-	National Planning Authority
PEAP	-	Poverty Eradication Plan
PFP	-	Private for profit
PMTCT	-	Prevention of mother to child transmission of HIV
PNC	-	Post natal care
PNFP	-	Private not for profit
PopSec	-	Population Secretariat
PPS	-	Probability proportional to size
RH	-	Reproductive health
RMNCHA	-	Reproductive Maternal, Neonatal, Child and Adolescent Health
Sida	-	Swedish International Development Agency
SMC	-	Safe male circumcision
SRH	-	Sexual and reproductive health
TASO	-	The AIDS Support Organization
ToRs	-	Terms of Reference
TPR	-	Teenage pregnancy rate
UBOS	-	Uganda Bureau of Statistics
UDHS	-	Uganda Demographic Health Survey
UHMG	-	Uganda Health Marketing Group
UK	-	United Kingdom
UN	-	United Nations
UNAIDS	-	The Joint United Nation Programme on HIV/AIDS
UNDAF	-	United Nations Development Assistance Framework
UNFPA	-	United Nations Population Fund
UN-Habitat	-	United Nations Human Settlement Programme
UNHCR	-	United Nations High Commissioner for Refugees
UNHS	-	Uganda National Household Survey
UNICEF	-	United Nations Children Fund
UNPS	-	Uganda National Panel Survey
UPE	-	Universal primary education
UPMA	-	Ugandan Private Midwives Association
URCS	-	Ugandan Red Cross Society
URSB	-	Uganda Registration Services Bureau
USE	-	Universal secondary education
VHT	-	Village health team
WFP	-	World Food Programme
WHO	-	World Health Organization
YFC	-	Youth friendly corner
YFHS	-	Youth friendly health service

1. Executive summary and recommendations

The Government of Uganda (GoU)/United Nations (UN) Joint Programme on Population (JPP) is a complex and fragmented four-year programme with different interventions implemented by GoU and civil society organisations in 15 districts with support from nine UN agencies. The JPP is funded by the United Kingdom Department for International Development (DfID) for a total of US$ 39.1 million with additional funding from eight UN agencies totalling US$ 23.9 million.

The JPP is aligned with the Ugandan *National Development Plan* and the *UN Development Assistance Framework* (UNDAF) and substantial attempts have been made to "deliver as one".

The four JPP outcome areas are implemented alongside other complementary government and donor supported programmes focusing on health systems strengthening, maternal and reproductive health. It was therefore not possible to undertake a contribution analysis as part of this mid-term evaluation (MTE) and it was difficult to make comparisons between the 15 districts as they did not all receive the same package of interventions.

This being said, the JPP has made efforts to simplify the programme and to make it more focused. The original proposal was very ambitious and tried to address some of the determinants of poor sexual and reproductive health outcomes through addressing malnutrition amongst pregnant women, lactating mothers and children under age two years in Karamoja region, emphasised increasing access to education for vulnerable girls in eight districts, and developing skills for improved livelihoods of vulnerable populations in Arua and Gulu.

The sexual and reproductive health component of the JPP (covered in Outcomes 1 and 2) primarily address family planning and maternal health with a strong focus on responding to the needs of young people through interventions in health facilities, schools and the community. The creation of 80 Youth friendly corners (YFCs) in health facilities and schools has increased young people's (especially boys) access to sexual and reproductive (SRH) information and services, though serious concerns remain about their functionality, the availability and accuracy of data (as the HMIS does not yet capture young people's use of services and gaps in data recording were noted) and sustained local ownership of services. Considerable progress has been made in mobilizing young people (especially young men) to attend YFCs in health facilities and 36,236 visits[1] were made since programme inception in seven districts (with 46.5% of them being made in the first six months of 2013). The MTE survey found that 25.3 per cent of young people aged 10 to 24 years interviewed had ever visited a YFC: 502 young men and 447 young women. There is considerable variation between districts with Mubende, Kotido, Arua and Yumbe having more young people attending YFCs, whilst in Amudat, Kanungu, Kitgum, Abim and Bundibugyo the numbers were low.

There are differences between YFS supported by the Uganda Red Cross Society and established earlier in eight districts and those supported more recently in seven districts. The need to introduce standards for all YFS and strengthen the system for supervision and monitoring of services is critical as some youth friendly services visited were not functional, trained staff had left and equipment provided was outdated, or insufficient. To sustain youth interest in the YFCs there is need to increase the variety of educational films and provide appropriate sexual and reproductive health (SRH) information.

The school-based YFC prove an excellent basis for the integration of SRH as part of the roll-out of the national Life Skills-based Education curriculum for secondary schools. The YFCs will be able to provide a pool of already trained and in most cases, motivated teachers to support this.

[1] This figure includes both new and repeat clients.

Despite all these efforts, the levels of young people's accurate knowledge of three methods of family planning knowledge remains extremely low at 6 per cent and most of this information was obtained through the radio. There is a clear gender and age dimension to young people's knowledge with young males having higher accurate levels of knowledge (9.6%) than their female counterparts (3.5%) for all three methods – largely due to their much higher levels of accurate knowledge of male condoms. Younger females (10 to 14 years old) have lower levels of accurate knowledge of all three methods of contraception (2.3%) than those aged 15 to 24 years (6.2%). Greater attention should be paid to the needs of adolescent girls and concerns have been raised about the ethics and effectiveness of routine pregnancy testing of school girls.

Considerable improvements have been made in the proportion of health facilities without stock-outs of three contraceptive methods (from 59.5% in 2012 to 74.5% in 2013). The number of new FP clients has increased by 60.8 per cent since 2011 (but only by 1.6% since the baseline survey in 2012). The percentage of women using modern contraceptive methods remains low at 16.3%. Data obtained from exit surveys of women leaving static family planning clinics show a high level of satisfaction with the services received (95.6%) and their main recommendation was to increase the number of health workers. Of the women not using FP, 13.5 per cent attributed this to "fear of side effects" and some women are having longer-term methods removed (in 2012 it was 6.9% of implants and 18.3% of intra-uterine devices). Some concerns were expressed that insufficient time was allocated to individual counselling during reproductive health camps and increased attention should be paid to the cultural context and local myths. Community mobilization by Village Health Teams (VHTs) and male actions groups (MAGs) has resulted in 28.4 per cent of pregnant women being accompanied by their husband to antenatal care. There was a reduction in the number of functional MAGs from 52 at baseline to 44 in 2013 and concerns expressed about their sustainability.

Maternal health data show that the percentage of deliveries occurring in health facilities in the 15 JPP districts was 40.9 per cent in 2012/2013: an increase from 32 per cent (2010/11) and from 37.5 per cent since the baseline survey one year ago. However the findings are challenging with two districts (Yumbe and Bundibugyo) having a lower percentage of deliveries occurring in a health facility from 2010/11 to 2012/13 and in Bundibugyo the absolute number had decreased from 4,283 to 3,959 during this two-year period. The percentage of girls aged 15 to 19 years who have ever been pregnant remains high at 23.8 per cent. There has been an overall, but slight increase in the number of women attending four antenatal care (ANC) clinics and again the variation between districts is considerable. Exit interview data show that 80 per cent of women were satisfied with the services received, despite waiting an average of 48 minutes to be seen by a health care provider (maximum length of time 90 minutes). The also noted the need to recruit more health workers (66.7%). The continuing shortage of midwives and skilled birth attendants needs to be accorded higher priority and there is need to standardise the equipment supplied under the JPP to support quality maternal health care and to strengthen the neo-natal care component.

There have been considerable community mobilization efforts to encourage pregnant women to go to health facilities for ANC and institutional deliveries, but there are insufficient trained health care providers in post to meet the existing demand. Food supplements have been a main incentive for mothers utilizing maternal and child health services, however, there needs to be constant education of the mothers and the population at large that these incentives cannot be sustained. Transport to health facilities for obstetric emergencies is lacking in some remote areas in Kaabong and Kotido. Greater linkages need to be made at district level so that the programme is embedded in future district plans. This could be achieved in the final year of the programme by more frequent visits to the districts by the JPP team to meet with health and local government managers.

The bursary intervention for vulnerable girls to access secondary schooling is well thought through and strategically implemented. It is recommended that the JPP sets aside money so that all girls in the programme can complete their education. The JPP, especially UNICEF should advocate with the Ministry of Education and Science (MoES) to use the findings and lessons learned from this pilot in eight districts to implement a national programme of bursaries for vulnerable girls. Girls on the bursaries programme expressed concern towards their out-of-school siblings and friends who had not had similar opportunities. The headmasters were unequivocal in calling for a scale-up of the programme to help the other bright, but disadvantaged out-of- school girls.

During the course of JPP implementation it was found that the youth skills-building component (Outcome 3) was too fragmented, grassroots-based and small-scale being implemented initially by five UN agencies (ILO, IOM, UN-Habitat, UNHCR and UN-Women). The MTE found that the Outcome 3 achieved some good results, albeit on a small scale. The decision to curtail Outcome 3 and focus on a transformative policy approach was frustrating for the actors who had invested so much in the programme, but it was a sound decision and shows the responsiveness of the JPP and the capacity to re-programme in a prioritised manner. Concerns have been expressed that the policy approach will take time whilst vulnerable populations are not able to engage in decent work. If the proposed UN Joint Programme on Youth comes to fruition then it must include a strong component on youth employment and job creation in the most vulnerable regions of Uganda and take into account the lessons learnt from the MTE assessment of youth skills and employment creation interventions.

All 15 districts are allocating and disbursing funds to population issues and 72 per cent of district leaders were able to understand the linkages between population and development.

A harmonised data base has been established and is functional in 11 districts.

As of the end of December 2012 (the latest time when data were available), 59 per cent of programme targets had been achieved, indicating slow JPP implementation. The three main challenges facing the JPP identified in this MTE are: 1. data adequacy, quality, availability and use for planning purposes; 2. Capacity of the health services to deliver quality maternal, neo-natal, child and adolescent health services; and 3. Insufficient monitoring and supervision and a lack of follow-up on monitoring report and visit recommendations.

It is recommended that the final year of the JPP should be more focused and prioritized with increased government ownership especially at district level. Re-programming in the final year of JPP implementation should focus on improving quality and integration in family planning, maternal, neo-natal and adolescent health care, addressing staffing shortages in all districts and the equipment needs in the seven WHO supported districts. Youth friendly services should be sustained through a harmonized and standardized approach. Mechanisms need to be strengthened for supervision, accountability and sustainability of the community component with increased involvement of District Community Development Officers. Greater efforts should be made to increase GoU/MoH ownership of the programme so that it is fully sustainable by the end of 2014 with strengthened regional oversight of district level activities with a focus on quality of sexual and reproductive health services, improved and timely data collection, monitoring and supervision of service delivery and community mobilization efforts.

Future (post 2014) programming needs to go to scale with addressing educational and employment opportunities for youth (especially vulnerable girls and young women) and also on providing quality integrated sexual and reproductive health services, with a concentrated effort to reduce teenage pregnancy and improve maternal and neo-natal health.

Full recommendations are shown in **Chapter 12** of this report.

2. Introduction and background

2.1 Background

In January 2011, the United Nations (UN) and Government of Uganda (GoU) approved a four-year (2011-2014) United Nations Joint Programme on Population (JPP), *"Investing in People"* whose goal is to contribute to accelerating the onset of a beneficial demographic transition in Uganda. The programme is a partnership between UN Agencies, GoU, non-governmental organizations (NGOs) and development partners with UNFPA as the administrative agency. The GoU/UN JPP is co-funded by UN agencies and the government of the United Kingdom (UK) which has committed £30 million over 4 years[2] through its Department for International Development (DfID). The JPP was designed to contribute the achievement of GoU targets under the *National Population Policy for Social Transformation and Sustainable Development* (Republic of Uganda, Ministry of Finance, Planning and Economic Development, 2008) and the *National Development Plan 2010/11-2014/15* (Republic of Uganda, Ministry of Finance, Planning and Economic Development, 2010). It was also intended to help facilitate institutional reform in the UN through the "delivering as one (DaO)" agenda.

The UN agencies participating in the JPP include the United Nations Population Fund (UNFPA) as the administrative agent, and nine other participating UN agencies: International Labour Organisation (ILO), International Organisation for Migration (IOM), United Nations Children Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR), United Nations Human Settlement Programme (UN-Habitat), United Nations Joint Programme on HIV/AIDS (UNAIDS), United Nations Women (UN-Women), World Food Programme (WFP) and the World Health Organisation (WHO). Implementation of the programme is done in collaboration with selected government Ministries, Departments and Agencies (MDAs) which include the: Ministry of Education and Sports (MoES); Ministry of Finance, Planning and Economic Development (MFPED); Ministry of Gender, Labour and Social Development (MoGLSD); Ministry of Health (MoH); Ministry of Lands, Housing and Urban Development (MoLHUD); Ministry of Local Government (MoLG); National Planning Authority (NPA); the Population Secretariat (PopSec); Uganda Bureau of Statistics (UBOS); selected district Local Governments and over 20 civil society organisations (CSOs) and community-based organisations (CBOs) who either work with participating UN agencies, or with government ministries. For a full list of implementing partners and sub-contractees involved in the programme see (**Annex 1**).

Although the JPP is a national programme with several interventions at national level targeting mainly policy issues, implementation of the JPP was initially focused on 15 out of the 112 districts in Uganda, namely: Abim, Amudat, Arua, Bundibugyo, Gulu, Kaabong, Kanungu, Katakwi, Kitgum, Kotido, Moroto, Mubende, Nakapiripirit, Oyam and Yumbe. District selection was guided by district needs, priority geographical areas identified in the Ugandan *National Development Plan* (north and north eastern Uganda) and UN agency convergence per district.

[2] Equivalent to US$ 39,076,238

Following a request from the Ministry of Health (MoH), the family planning component of the JPP was extended to four additional districts in the high fertility region of Busoga: Iganga, Jinja, Luuka and Namutumba. This was approved at the January 2013 Steering Committee meeting.[3] Programme implementation began in these districts in May 2013 with the implementing partners being Marie Stopes Uganda (Jinja and Luuka) and Reproductive Health Uganda (Iganga and Namutumba).

Figure 1: Map of Uganda showing where the GoU/UN Joint Programme on Population is active by UN agency and intervention

Source: GoU/UN JPP, 2011

[3] See minutes of Fifth GoU/UN JPP Steering Committee meeting 24 January 2013.

National level implementation has focused on the production of technical guidance documents on adolescent and maternal health, family planning and capacity building of staff in these areas. The WHO has also provided support to regional activities including the JPP districts as well as support to Soroti regional hospital in emergency obstetric care (EmOC) and maternal and perinatal death review (MPDR).

2.2 Goal and outcomes of the Joint Population Programme

The goal of the JPP is to *contribute to accelerating the onset of a beneficial demographic transition in Uganda.* There are four expected outcomes and the description below is from the initial programme document of the Government of Uganda/United Nations *Joint Programme of Supporting the National Population Policy*, 2011:

Outcome 1: Fertility reduced in line with individual/couple choices especially among young people. Within the JPP framework, this outcome will be achieved through increased access to family planning, sexuality information and youth friendly services for sexually active population especially young people; expanded provision and uptake of family planning including social behaviour change materials, increased supply of family planning commodities such as male and female condoms and community mobilization for involvement of males and young people in sexual and reproductive health and rights.

Outcome 2: Prepared and protected healthy mothers, children and youth. The JPP aims to address health and education that directly contribute to fertility reduction, while preparing, protecting and focusing on the health of mothers, children and youth to become useful citizens. The JPP supports acceleration of efforts to improve maternal, new-born and child health and survival; and creation of the conditions conducive for retention and completion of education especially for girls (including providing bursaries for girls' education).

Outcome 3: Youth and vulnerable groups have competitive skills and opportunities to participate in the economy for sustainable livelihood. This outcome component aims to address the barriers to socio-economic development of young people particularly focusing on creating employment opportunities through increased access to skills development opportunities and business and financial services.

Outcome 4: Adequately resourced, coordinated and managed national population programme. The final outcome component aims to address gaps in data, data analysis and its integration into national and sub-national planning, programming and monitoring mechanisms. The outcome also aims to address increased commitment of decision-makers to integrate population issues in the development plans through evidenced-based advocacy efforts, as well as strengthening youth participation in planning and decision-making. This outcome also aims at ensuring that urban physical development plans address the needs of the youth and vulnerable populations. The other critical component of this outcome is to ensure the coordination of and synergy in the implementation of the JPP.

Following a DfID internal Annual Review in November 2012 (DfID, 2012) it was decided to reduce the focus on Outcome 3 above and a revised logical framework was developed with activities for youth skills development being phased out in the first six months of 2013.

2.3 Purpose and scope of the Mid Term Evaluation

The purpose of the assignment was to conduct a Mid-term Evaluation (MTE) of the JPP (see **Annex 2** for the Terms of Reference). The evaluation team were requested to:

- Assess what changes have taken place so far as a result of the programme outputs;
- Analyse what different factors have combined to bring about the changes;
- Assess how the changes have affected different target groups positively or negatively.

The MTE was undertaken between July and September 2013 in all JPP 15 districts (**Figure 1**). The districts where activities had only commenced in 2013 (Iganga, Jinja, Luuka and Namutumba) were not included in the MTE, nor were the activities conducted in Soroti region. The MTE assesses the effects to date and provides a critique of key elements of the programme to identify successes, areas of good practice and challenges.

The MTE assesses the effects of all programme efforts towards the achievement of the outputs and outcomes and focuses on how the outputs have been achieved in comparison with the baseline results. However, the baseline survey was only conducted amongst eight monitoring and evaluation (M&E) districts in the second half of 2012 and the results were available on 8th October (Republic of Uganda and the United Nations Joint Programme on Population, 2012). It was requested that comparisons be made between MTE results and the baseline survey. It is the view of the MTE team that the time period is too short between the two surveys to make meaningful comparisons in a development programme of this nature. Despite this, the team have made every effort to use data collection methods matching those used during the baseline assessment and have provided progress against indicators for the M&E districts as well as the 15 JPP districts.

This MTE report is organized into twelve chapters: 1. Executive summary and recommendations; 2. Introduction and background; 3. Methodology; 4. Country context and policy framework; 5. Key findings and progress towards programme outcomes; 6. Fertility reduced in line with individual/couple choice especially among young people; 7. Prepared and protected healthy mothers, children and youth; 8. Youth and vulnerable groups have competitive skills and opportunities to participate in the economy for sustainable livelihood; 9. Adequately resources, coordinated and managed national population programme; 10. Management and coordination; 11. Monitoring and evaluation; and 12. Conclusions and recommendations.

3. Methodology

3.1 Overview of the methodology

The methodology was designed to address the overall objectives of the MTE and to measure progress towards JPP outcome and output indicators. A combination of qualitative and quantitative techniques was employed, with emphasis placed on participatory data collection and case studies to describe lessons learned and the contribution of different components of the programme.

The assignment was organised in four stages: inception, field work, data analysis and report writing. The inception stage involved discussions between the MTE team and the JPP management team to clarify and confirm assignment objectives and methodology respectively. The inception stage also provided an opportunity to discuss and approve the data collection tools. The inception report was submitted, presented and approved by the JPP Technical Committee. Data were collected from all the UN and key government JPP partners, key informants and beneficiaries of the programme in the 15 JPP districts and at national level. A number of data collection methods were used including a literature review, key informant interviews, focus group discussions, structured interviews, observations and case studies. Data were entered in EpiData 3.02 and exported to STATA 10 and SPSS version 17. Quantitative data from the household survey, exit interviews, and the Education and Health Management Information Systems (EMIS and HMIS) were analysed using descriptive statistics. Qualitative data from focus group discussions and key informant interviews were analysed using systematic thematic data analysis techniques (involving content, discourse, narrative framework and grounded theory analyses).

This report was prepared using the results from the analysed datasets and information from the case studies. The draft report was presented at a validation meeting of representatives of government, UN and civil society held on 25th September 2013 and comments received were incorporated into this final report.

3.2 Sample design

In order to determine the progress made on selected baseline indicators, it was important to undertake a survey at household and health facility level, and therefore sample size was important. While most of the identified evaluation indicators were from institutional or secondary data sources, five of them were required from household survey as shown below.

The household survey data were collected for estimation of the following the following key indicators in the JPP M&E matrix:

- % of young men and women (10-24 years) with accurate information on family planning in 15 districts
- contraceptive prevalence amongst women in the reproductive age group (15 to 49 years)
- % of girls aged 15 to 19 years who are or ever have been pregnant

A health facility survey was conducted to collect data on the following key indicators:

- number of Health Centres III and IVs providing youth friendly services in target districts
- proportion of health facilities without stock-outs of three most commonly used contraceptives methods (condoms, Depo-Provera and contraceptive pills)

Exit interviews were also conducted with clients of maternal and reproductive health services and young people using Youth friendly health services to determine their satisfaction with these services.

Following the preliminary literature review, and in line with the survey sample used during the JPP Baseline survey, the sample size was calculated using a proven sample calculation formula by the Taro Yamane formula (1967) as indicated below:

$$\mathbf{n=} \quad \frac{z^2 p\,(1-p)N}{z^2 \mathrm{P}(1-\mathrm{P}) + \mathrm{N}(e)^2}$$

Where,

n = the required sample

N = the Household population size

e = level of precision or permissible error which was set at 0.03

z = the value of the standard normal distribution given the chosen confidence level. Our confidence level was 95 such that z = 1.96 at 95% level

p = proportion probability of success estimated at 0.5

The Yamane (1967) formula assumes a normal distribution and was therefore considered suitable for determining the appropriate sample size. Therefore for the MTE the assumption was that HHs are normally distributed and were internally homogeneous in the 15 selected districts. Given that HHs would be randomly sampled in the villages to be visited, a 95% confidence level at 3% level of precision/degree of error has been assumed.

Note: The household[4] population in the 15 JPP districts is estimated at 876,861. Therefore:

$$\frac{1.96*1.96*0.5\,(1-0.5)\,876{,}861}{1.96*1.96*0.5(1-0.5)+876{,}861*0.03*0.03}$$

$$\frac{842137.3044}{0.9604+789.1749}$$

n= 1065.81

[4] In 2009/10, the average household size in Uganda has been estimated at 5.0 and it has remained more or less the same size when compared with previous surveys.

A non-response rate of 5% was added, to cater for any forms of non-response, thus bringing the **final sample size** to: 1065.81 + 53.290 = **1,119 households.** The final sample size (1,119) was selected from the 15 target districts using the proportional allocation formula.

A parallel sampling strategy was employed in order to reduce the cost of covering the sample while keeping, its precision intact. Under this strategy samples were selected from the same households as parallel samples and no individual sample unit was selected more than once for interview. See **Annex 3** for details on households sampled per district and health facilities.

Attempts were made to interview all people in the selected 1,119 households if they fell into the following appropriate categories:

- women of reproductive age (15 to 49 years) on fertility behaviour and maternal health service utilization
- girls aged 15 to 19 to assess teenage pregnancy
- young women and men (10 to 24 years) on access to accurate information and quality sexual and reproductive health (SRH) services

If a household member of the appropriate age category was not available for interview at first visit then the interviewer made another appointment to conduct the interview.

A total of 4,932 people were interviewed in the household survey. This sample includes considerably more young females (2,223) aged 10 to 24 years than males (1,524) as the interviews were conducted at the household level and more girls were at home at the time of the survey. Given the sensitivity of some of the questions about sexual and reproductive health, the young women were divided into two samples: those aged 10 to 14 years (1,549) and a sub-set of women aged 15 to 24 (674) from the sample of women of reproductive age (15 to 49 years) - see **Table 1**. In addition, health workers at 145 Health Centres (HCs) III, IV and district hospitals were interviewed.

An indicator for Outcome 4 required a survey of community leaders to determine "the proportion of leaders that are aware and understand inter-linkages between population and development concerns". The local leaders that participated in the survey were selected from three local council (LC) levels (LC I, LC III and LC V) of district administration in both the urban and rural sub- counties. At each level, the Chairperson, Women and Youth representatives were scheduled to be interviewed. The target was to interview 21 leaders in each district (3 at LC V, 6 at LC III and 12 at LC I), which totalled 315 for the 15 districts. However, a total of 280 leaders were interviewed, with 12% of leaders not available for interview at the time of the survey, either due to busy schedules or travel out of their workstation.

Table 1: Final sample size by household and leaders per District

District	Females aged 15 to 49 years	Females aged 10 to 14 years	Males aged 10 to 24 years	Health Centres per district	Leaders
Arua	329	204	201	36	16
Yumbe	138	173	146	10	21
Gulu	166	117	130	16	21
Kitgum	143	125	148	10	21
Oyam	143	75	72	7	21
Abim	65	51	44	5	21
Kaabong	169	101	101	7	15
Kotido	101	101	92	6	21
Moroto	70	70	71	6	18
Nakapiripirit	66	67	65	7	17
Amudat	20	19	20	3	18
Katakwi	82	63	48	10	19
Mubende	195	264	213	12	20
Bundibugyo	90	54	78	5	16
Kanungu	82	65	95	5	15
TOTAL	**1,859**	**1,549**	**1,524**	**145**	**280**

Source: MTE survey, 2013

3.3 Data collection tools for the Mid Term Evaluation

To ensure as much consistency as possible with the baseline survey the same data collection tools were used for questions relating to indicator assessment, including knowledge, attitude and behaviour (KAP) tools. However, a number of revised questions and additional tools were developed, in line with the different primary and secondary data requirements of the MTE:

- Key informant interview guides for national and local level stakeholders;
- Focus Group Discussion (FGD) guides for young boys, girls, men, women
- Exit survey guides for clients of maternal health and youth friendly services
- Document review checklists for various key documents;
- Health facility checklist and observation guide.

The wording of some questions used in the baseline survey was revised to reduce ambiguity or leading questions. Increased quality control of the tools used by the MTE team and the Evaluation Reference Group delayed the commencement of field work by a few days, but this was considered essential.

Data relating to health facility utilisation were also obtained from the Health Management Information System (HMIS). This included information on the number of institutional deliveries, percentage of births attended by a skilled birth attendant. Information on numbers of children in school was obtained from the Education Management Information System (EMIS). The MTE team have concerns however about the completeness of the data obtained through the HMIS

and EMIS because many errors were found in the health facility registers with incomplete or inaccurate entries. Also the annual HMIS data available to the MTE team was incomplete and not based on all 15 JPP districts.

3.4 Pre-testing of tools

All new tools were pre-tested in Wakiso district, Kira town council before embarking on the fieldwork stage. The survey tools pre-tested were:

- Women's questionnaire (age 15-49)
- Young girls questionnaire (age 10-14)
- Young men's questionnaire (age 10-24)
- Health facility checklist
- All Focus Group Discussion guides

Pre-testing helped to re-word questions, improve the sequencing of questions, insert skips and understand the interpretation of questions in a localized setting. Tools were further pre-tested in the various districts, to ensure that the researchers had the same understanding of the questions in their local languages. The final tools used are shown in **Annex 3.**

3.5 Data collection

At national level the MTE team interviewed representatives of all UN agencies involved in the JPP as well as some key implementation partners (MoH, MoES, Marie Stopes Uganda, Red Cross Uganda and Reproductive Health Uganda). For a list of the key informants interviewed at national level some districts see **Annex 4**.

In each district, an urban and rural sub-county were chosen randomly (see **Annex 5)** for list of sub-counties included in the MTE survey). In each sub-county two local councils (LC 1s) were selected for the household survey. A health facility checklist was administered at HC IIIs, HC IVs, district and regional referral hospitals.

A total of 145 health facilities were covered (see **Annex 6** for a list). The plan was to cover all health centres at these levels in all the districts. The team covered all regional referral hospitals; all district hospitals; all HCs IVs, but missed out on a few HC IIIs in the target districts due to inaccessibility.

The challenges faced during field work are described below:

1. Some of the district officials both (political leaders and technocrats) were not readily available for the interviews. Whereas technical staff are involved in many activities, the political leaders only go to the districts when there are council meetings, or for official discussions. Therefore it was only possible to interview those in nearby areas who were able to travel to the district to participate. In the rural areas, the local leaders complained of long distances to travel to meet with interviewers, so only those in the vicinity of the village chairman were interviewed.
2. It was difficult to obtain information about the JPP from some key informants at district level as they lacked knowledge about the programme. This included some District Health Officers (DHOs), District Planning Officers (DPs), District Population Officers (DPOs) and

Community Development Officers (CDOs). This was a field work challenge in the sense that it affected the quality of information we were able to obtain from some key informants.

3. Some of the records in the health facilities were not up to date. In most cases the researchers had to add up data manually and in other cases the people responsible for the data were not available. It was also noted that some health centres were using old MoH registers that did not have a column for age for maternity records.
4. Some youth friendly corners (YFC) were closed during the period of the survey and the YFCs in schools had different opening hours which made it difficult to plan for interviews. While we had expected that the opening hours would be uniform, this was not the case as some were open at lunch time (1-2 pm), others from 5-6 pm. This meant that the research team had to wait or come back the following day to conduct the interview.
5. The research was conducted at the onset of the rainy season which made some roads impassable, especially in northern Uganda and the Karamoja region. This made it difficult to access some health centres in rural sub-counties. In one case the research team car overturned along the Namalu-Tokora road in Nakapiripirit due to the bad road conditions.
6. Some officers in charge of health centres were not available for interview, and this made it difficult to obtain data from these health centres.
7. Delays were experienced in obtaining secondary data, especially from the Education and Health Information Systems (EMIS and HMIS). This seriously impeded the timely completion of the final report. Also some of the data received from the HMIS was not complete (that is, based on complete inputs from all 15 JPP districts).

3.6 Case studies

The MTE team were also requested to undertake case studies to demonstrate the relevance, effectiveness, efficiency and sustainability of specific interventions being implemented, particularly Youth Friendly Corners, Male Action Groups (MAGs) and cost-effectiveness of family planning delivery by mode of delivery and service provider. The MTE team attempted to make a cost-effectiveness study of family planning, but neither Marie Stopes Uganda nor Reproductive Health Uganda could provide sufficient information to make this a meaningful exercise. The case studies were undertaken for thematic programme areas and findings are integrated into this report under the appropriate Outcome area.

3.7 Contribution analysis

It was not possible to conduct a contribution analysis as part of the MTE as the programme is not the same in each district and different actors (implementing partners and donors) are working in each district and some donors are conducting similar interventions in non-JPP districts.

For instance, the World Bank Health Systems Strengthening Project (HSSP) is working in five out of the 15 JPP districts (Arua, Gulu, Kitgum, Moroto and Mubende). The project began in February 2011 and will run through to the end July 2015. The aim of the project is to deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, new-born care and family planning through improving human resources for

health, physical health infrastructure, and management, leadership and accountability for health service delivery.[5] The MTE data need to be reviewed in light of the additional support being provided by the World Bank project and an assessment made of the benefits of extending successful World Bank project interventions to the other ten JPP districts in 2014.

Two other donors, the UK DfID and the United States of America International Development (USAID) in September 2012 awarded US$ 39 million for a two and a half year family planning campaign aimed at increasing the contraceptive prevalence rate in Uganda and preventing about 1.8 million unplanned pregnancies by March 2015. The *Accelerating the Rise in Contraceptive Prevalence* programme is also expected to save over 3,700 mothers from dying due to pregnancy-related complications and is being implemented by Marie Stopes Uganda (MSU) and the Uganda Health Marketing Group (UHMG).

Under the campaign, Marie Stopes Uganda will train health service providers in health centres across the country to enhance their capacity to promote family planning. They will also increase clinical outreach to provide contraceptives, especially in rural areas where family planning coverage remains low. Emphasis is placed on the most cost-effective private family planning service, improving the range of available choices, particularly so that more women can access long-term and permanent contraceptive methods, and will ensure that the poorest groups benefit most. The programme is seen to complement the DfID-funded JPP and the USAID funded reproductive health programme (DfID, 2011).

Some UN agencies are working in non-JPP districts. For example, UNICEF is working in over 30 districts on strengthening birth registration.

[5] World Bank (2013. *Implementation status and results Health Systems Strengthening Project*. Kampala: World Bank.

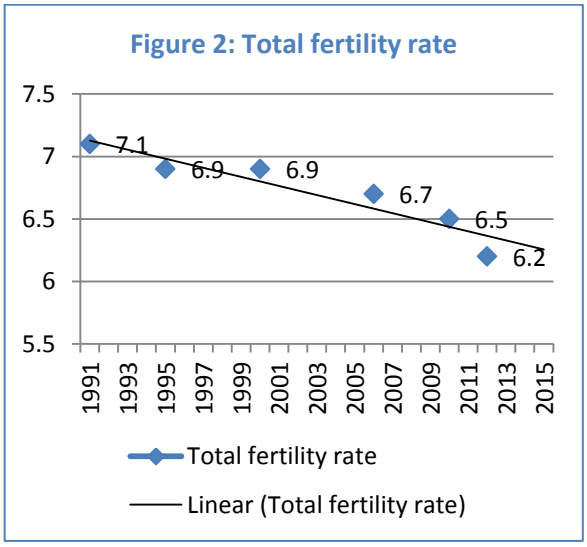
4. Relevance of the Joint Population Programme to country context and policy framework

4.1 Relevance to country context

The human development index (HDI) value for Uganda was 0.456 for 2012. This puts Uganda in the low human development category ranked at 161 out of 187 countries and territories. Between 1985 and 2012, Uganda's HDI value increased from 0.3 to 0.456, an increase of 52 per cent or an average annual increase of about 1.6 per cent (UNDP, 2013).

Various human development improvements have been made. For example: between 1980 and 2012, Uganda's life expectancy at birth increased by 4.4 years; mean years of schooling increased by 2.8 years; and expected years of schooling increased by 7.2 years. The economy has grown and Uganda's gross national income (GNI) per capita increased by about 125 per cent between 1985 and 2012 (UNDP, 2013). There has been progress in reducing poverty across all the regions of the country. In 1992/93 56.4 per cent of the population were estimated to be living below the poverty line. This decreased to 44 per cent in 1997/98, 31 per cent in 2005/06 and was 24.5 per cent in 2009/10. Between 2005/6 and 2009/10 the largest improvements in welfare were experienced in the central and eastern regions and West Nile. However, many reports refer to an increase in wealth inequalities, especially affecting the north of the country. In the North East, 76 per cent of the population are estimated to be living below the poverty line and 92 per cent of the poor live in rural areas (*National Development Plan*, 2010 and *Poverty Status Report*, 2012).

According to the Uganda Bureau of Statistics (UBOS) the total estimated population was 34,131,200 in mid-2012 (UBOS, 2013). The last census was taken in 2002 and was due to be repeated in 2012, but has been delayed for two subsequent years due to a lack of funds. The total fertility rate remains high (6.2) and the population is expected to increase to 49.2 million by 2022 (UNFPA, 2009) - see **Figure 2**).



Source: UDHS, 2006, 2007 and HMIS

Delays in reducing total fertility are attributed to among other factors: gender inequalities; the general low status of women; a pro-natalist culture; insufficient access to family planning and persistent poverty. Contraceptive prevalence remains low (24% for all women, 30% among currently married women and 52% of sexually-active unmarried women) with a high unmet need for family planning (34% of currently married women) (UDHS, 2012). High fertility contributes to population pressures and health care challenges and access to contraception prevents maternal, new-born and child deaths by reducing unintended and high-risk pregnancies and unsafe abortions, and by enabling women to space their children (Countdown to 2015, July 2013).

The most important demographic issue for Uganda is related to its age structure rather than the overall population size. Worldwide, Uganda is the leading country with the youngest population with 78 per cent below age 30 years and over half (52%) aged 15 years and below. There are estimated to be 6.5 million (21.3% of Ugandans) aged between 18 to 30 years (UBOS, 2012). The young age structure has created a high young age dependency ratio projected to be 91.9 per cent in Uganda in 2012 and 98.8 per cent in the JPP districts. Yumbe and Oyam were projected to have the highest age-dependency ratio[6] in 2012 (close to 110%) with four other districts with over 100 per young age dependency (Mubende, Kanungu, Bundibugyo and Kitgum) implying that for every 100 people of working age (15 to 64 years) there are over 100 young dependents below the age of 15 years (UBOS, 2007). This young age structure places a heavy burden on the working age population and constrains savings and investment for economic development and will hamper Uganda's aspiration to become a middle income country by 2017.

Although a large youthful population is an opportunity for change, progress and social dynamism, it can also be a risk for the country and Uganda must accelerate the demographic transition. This will involve a shift from high to low mortality and fertility levels. Such a shift will contribute to achieving a demographic dividend, which is the economic benefit accruing from a significant increase in the ratio of working age adults relative to young dependents.

The GoU *Health Sector Strategic Plan III 2010/11-2014/15* highlights family planning (FP) as a low-cost and cost-effective intervention to avert the high maternal mortality ratio and infant mortality rate. Despite the cost-effectiveness of FP, the allocation, disbursement and government utilization of funding for FP remains inadequate (Nambatya-Nsubuga, 2013).

The JPP thus provides supports to FP and focuses on increasing access to FP of sexually active people, especially young people, to address the unmet need by increasing commodity security and providing sexuality information and youth friendly services (Gou/UN JPP, 2011).

Functioning health systems are essential for the delivery of quality reproductive health care, especially for the rural poor. Uganda has undergone considerable reform in the health sector.

[6] Age dependency ratio, young, is the ratio of younger dependents--people younger than 15--to the working-age population--those ages 15-64. Data are shown as the proportion of dependents per 100 working-age population. http://data.worldbank.org/indicator/SP.POP.DPND.YG

These reforms were designed to improve effectiveness, responsiveness, and equity in the health care delivery system, including abolishing user fees in government units, improving management systems, decentralizing service delivery and promoting public–private partnerships. These reforms have helped to improve sector performance and outcomes. They are credited as being pro-poor, especially by improving access and reducing cost (World Bank, 2013)[7].

The Ministry of Health (MoH) together with support from the United States of America International Development (USAID) Systems 20/20 and the Makerere University School of Public Health published in 2012 the *Uganda Health System Assessment 2011.* The assessment was conducted to identify strengths and challenges of the Ugandan health system and provides a baseline for monitoring health system performance. The report is important because it identifies the need to link health outcomes with health systems performance indicators (such as staff posts filled, the functionality of the health management information system (HMIS), management systems in place and timely submission of orders for medicines). All districts are then ranked and compared with the national average (see **Annex 7**). Under this ranking system Kampala district is ranked first, but it is notable that there is a surplus of staff (123%) in approved posts whilst seven out of the 15 JPP districts have less than 50 per cent of staff in approved posts. The district with the lowest levels of staff in post is Mubende with only 28 per cent of posts filled followed by Amudat with 33 per cent. Moroto regional hospital has 46 per cent of posts filled and Kaabong general hospital had only 34 per cent of posts filled (MoH et al, 2012).

Just over half (57%) of JPP District Health Officers posts were filled (MoH et al, 2012). This indicates a fundamental challenge facing the JPP in terms of improving maternal and child health outcomes and increasing access to sexual and reproductive services in the context of insufficient staff in post. It is not surprising that those districts with better staffing levels are seen to perform better on the selected health performance indicators. For example, Gulu has 73 per cent of posts filled and is ranked fifth nationally, Abim has 60 per cent of posts filled and is ranked 11th and Katakwi has 71 per cent of posts filled and is ranked tenth. As this report shows later, it will be difficult for the JPP to meet its health targets without addressing the shortage of health service personnel.

The *Uganda Health System Assessment 2011* report also makes reference to measures designed to address "misappropriation and leakage" in the system, the need to harness private-for-profit (PFP) health sector resources, to reduce out of pocket payments through pro-poor financing mechanism and to create incentives to fill staff vacancies particularly in under-served districts. Despite attempts to improve quality there is "much more to be done" to improve the quality of public services. One of the measures mentioned to address this is the need for regular and effective supportive supervision and the allocation of sufficient resources to Regional Health Management Teams to support and supervise districts. Another recommendation was to improve the referral system to ensure continuity of care (MoH et al, 2012).

[7] http://www.worldbank.org/en/country/uganda/overview

The World Bank reports that there has been a perceived deterioration of governance and an increase in corruption (including the perceived growing culture of impunity for grand corruption and pervasive "quiet corruption") which threatens to tarnish Uganda's image as a development model and challenge its future development efforts (World Bank, 2013). Concerns over corruption have also been raised as Uganda is ranked 134 out of 170 countries on the Corruption Perceptions Index (Transparency International, 2013).

According to the World Bank, Uganda's economy has to transform to a higher productivity level while integrating all regions into the development process in order to achieve higher development outcomes. This is a challenge which magnifies as the population swells. The transformation will hinge on how the country manages its resources, in particular the fast-growing and youthful population and the recently discovered oil. To reap the demographic dividend, Uganda must invest in fertility reduction, human capital formation, and productive employment creation. To reap the oil dividend, Uganda must maximize the social benefits through appropriate investment and prudent macro-economic management, as well as transparency and management of expectations (World Bank, 2013).

4.2 Relevance to global priorities

The JPP is well aligned with the Millennium Development Goals (MDGs) and was designed to contribute towards the achievement of four out of the eight MDGs 1, 3, 5 and 7 (GoU/UN JPP, 2011). These goals are specifically to "eradicate extreme poverty and hunger, and achieve full and productive employment and decent work for all including women and young people" (MDG1); "promote gender equality and empower women" (MDG3); "improve maternal health" (MDG5); and "ensure environmental sustainability" (MDG7). The relevant MDG targets for JPP actions are as follows:

- MDG 1.B "Achieve full and productive employment and decent work for all, including women and young people"
- MDG 1.C "Halve, between 1990 and 2015, the proportion of people who suffer from hunger"
- MDG 3.A "Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015"
- MDG 5A "To reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio"
- MDG 5B "To achieve by 2015, universal access to reproductive health."
- MDG 7D "By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers"

The JPP was designed specifically to address the following MDG target indicators:

1.5 Employment-to-population ratio[8]
3.1 Ratios of girls to boys in primary, secondary and tertiary education
5.1 Maternal mortality ratio

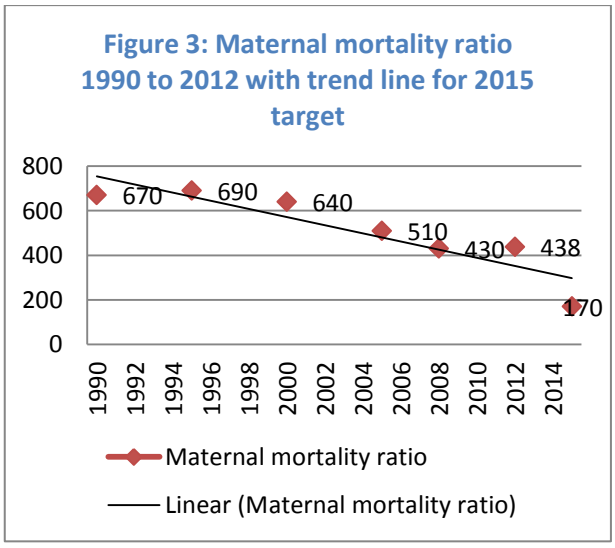
[8] The MTE was unable to find data available on MDG indicators 1.5 and 7.10.

5.2 Proportion of births attended by skilled health personnel
5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage (at least one visit and at least four visits)
5.6 Unmet need for family planning
7.10 Proportion of urban population living in slums[9]

The JPP intervention to eliminate gender disparities in education focuses on secondary education through the provision of 1,000 bursaries for vulnerable girls and is administrated by UNICEF through a NGO called the Girls Education Movement (GEM).

In terms of Uganda's overall progress towards the MDGs the response has been varied. The population of people living in poverty declined to 24.5 per cent in 2009/10. Hence, Uganda has surpassed the 2015 MDG 1 target of halving the 56 per cent poverty rate recorded in 1992/93, even though per capita GDP growth averaged only around 4 per cent over the past two decades due to rapid population growth (World Bank, 2013). Other analyses of multidimensional poverty (including measures of education, health and standards of living) found that in 2011 69.9 per cent of households in Uganda lived in multidimensional poverty and an additional 19 per cent were vulnerable to multiple deprivations (UNDP, 2013).

Uganda is clearly off track towards meeting the maternal and child health-related MDGs (MDGs 4 and 5). In terms of maternal health, Uganda will not meet the MDG target of a reduction in the maternal mortality ratio (MMR) by three-quarters, between 1990 and 2015. **Figure 3** shows a slight increase in the MMR from 2008 to 2012 and the trend from 1990 to 2015 indicating that the target of 170 MMR will not be met by 2015. Progress towards the child health MDG targets are also unlikely to be met.[10]



Sources: HMIS, UDHS (2006, 2012) and MDG Report (2012)

[9] For a full list of MDG indicators see http://mdgs.un.org/unsd/mdg/host.aspx?Content=indicators/officiallist.htm
[10] http://mail2.unfpa.or.ug/pub/Reports/2010MDGReportUG.pdf

Uganda is also off track to achieve MDG 3A to eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. One of the indicators to measure this is to attain 100 per cent net enrolment rate[11] in primary education by 2015. Since 2000, Uganda has registered substantive progress in increasing the number of pupils enrolling for primary education. The 2012 *Annual Schools Census Report* indicates that a total of 8,317,420 (male 4,161,057 and female 4,156,363) pupils were enrolled in primary schools as compared to 6,559,013 pupils (male 3,395,554 and females 3,163,459) in 2000. The net enrolment rate increased from 85.5 per cent in 2000 to 95.5 per cent (88.8% male and 82.4% female) in 2012. In 2002, 2006, 2010 and 2012 there was a decrease in enrolment rates, but there was a gradual ratio improvement from 90 per cent in 2004 (male 92.5% and female 87.6%) to 95.5 per cent (88.8% male and 82.4% female) in 2012. The current sector performance gap is 4.5 per cent (male 4.9% and female 4.1%) short of the 100% target for 2015. If the statistics in the last two years (-2% decrease) is anything to go by, Uganda could well fall short of the 2015 target. However, with just 4.5 per cent shortfall, Uganda could yet meet the MDG target if significant effort is put into improving the enrolment rates especially in the rural districts.

No Ugandan target for improvements in the lives of urban slum dwellers (MDG 7D) has been set so it is not possible to measure progress.

4.3 Synergies with national priorities

The JPP is aligned with the Ugandan *National Development Plan 2010-2014* and with the United Nations Development Assistance Framework (UNDAF) see **Table 2** showing the relationship between them. The NDP places considerable emphasis on vulnerable populations, equity, sustainable livelihoods, gainful employment and "sustainable population". However, in the UNDAP the interventions to promote a sustainable population such as interventions for family planning and improved maternal health are largely subsumed under "quality social services, including social protection interventions" and "employment opportunities to cope with the population dynamics."

The UNDAF was designed specifically to support Uganda to deliver on the *National Development Plan*, with a focus on Equity and Inclusion, Peace and Recovery, Population and Sustainable Growth (UNDAF, 2009). The *National Development Plan* (NDP) objective 1 stresses the need to focus on equity and objective 4 on improved health and social outcomes in the north of the country where poverty and instability are highest. This emphasis is reflected in the geographical focus of the JPP where 12 out of the 15 JPP districts are from impoverished districts in northern and north eastern Uganda (with eight districts in the Karamoja region).

[11] The net enrolment ratio is defined as the ratio of pupils in primary school aged 6-12 years to the country total population 6-12 years.

Table 2: UN Joint Population Programme alignment with national priorities

National Development Plan 2010-2014	UNDAF outcome	GoU/UN JPP outcome	GoU/UN JPP outputs
1. Increasing household incomes and promoting equity	**Outcome 2:** By 2014, Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV/AIDS, environment shocks and recovery challenges.	**Outcome 3**: Youth and vulnerable groups have competitive skills and opportunities to actively participate in the economy for sustainable livelihoods	3.1: Access to skills development, infrastructure and employment opportunities for youth increased 4.3: Youth and vulnerable groups benefit from planned urbanisation and human settlement development
2. Enhancing the availability and quality of gainful employment	**Outcome 2:** By 2014, Vulnerable segments of the population increasingly benefit from sustainable livelihoods and in particular improved agricultural systems and employment opportunities to cope with the population dynamics, increasing economic disparities, economic impact of HIV/AIDS, environment shocks and recovery challenges.	**Outcome 3**: Youth and vulnerable groups have competitive skills and opportunities to actively participate in the economy for sustainable livelihoods	2.1: Conditions conducive for retention and completion of education under UPE and USE institutions enhanced especially for young people 3.1: Access to skills development, infrastructure and employment opportunities for youth increased
3. **Improving stock and quality of economic infrastructure**			
4. Increasing access to quality social services	**Outcome 3: By 2014,** Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services including social protection interventions.	**Outcome 1:** Fertility reduced in line with individual/couple choices, especially among young people **Outcome 2**: Prepared, protected and healthy mothers, children and youth	1.1: Increased access to family planning, sexuality information and youth friendly services for sexually active population, especially young people 1.2: Community groups mobilized for male and young people's involvement in advancing sexual and reproductive health and rights 2.2: Improved access to a quality package for maternal, new-born and child health services

National Development Plan 2010-2014	UNDAF outcome	GoU/UN JPP outcome	GoU/UN JPP outputs
5. **Promoting science, technology, innovation and ICT to enhance competitiveness**			
6. **Enhancing human capacity development**	**Outcome 1:** By 2014, capacity of selected Government Institutions and Civil Society improved for good governance and realization of human rights in order to reduce geographic, socio-economic and demographic disparities in attainment of Millennium Declaration and Goals by 2014.	**Outcome 4:** Adequately resourced, coordinated and managed National Population Programme	3.1: Access to skills development, infrastructure and employment opportunities for youth increased 4.1. Increased commitment of leaders at national and sub-national levels to address population trends and patterns and allocate budget 4.4: Strengthened Partnership, Coordination and Implementation of the Joint Programme on Population
7. **Strengthening good governance, defence and security**	**Outcome 1:** By 2014, capacity of selected Government Institutions and Civil Society improved for good governance and realization of human rights in order to reduce geographic, socio-economic and demographic disparities in attainment of Millennium Declaration and Goals by 2014.	**Outcome 4:** Adequately resourced, coordinated and managed National Population Programme	4.2: Increased availability and utilization of reliable and disaggregated data, including demographic and socio-economic variables, at national and sub national levels
8. **Promoting sustainable population and the use of environmental and natural resources**	**Outcome 3: By 2014,** Vulnerable populations in Uganda, especially in the north, increasingly benefit from sustainable and quality social services including social protection interventions.	**Outcome 1:** Fertility reduced in line with individual/couple choices, especially among young people	1.1 Increased access to family planning, sexuality information and youth friendly services for sexually active population, especially young people 1.2 Community groups mobilised for male and young people's involvement in advancing sexual and reproductive health and rights

Sources: GoU National Development Plan, 2009 and UN Development Assistance Framework, 2009

The JPP was designed also to address issues of youth skills development and employment in response to the NDP objectives on increasing household incomes and improving access to gainful employment. However, this component of the JPP was small (2,419) beneficiaries in relation to the overall problem of high youth unemployment of 83 per cent (*National Household Survey* 2009/10, UBOS) and was scaled down at the beginning of 2013 in favour of a national approach to youth employment. Increased access of vulnerable girls to education has been addressed through the provision of 1,000 bursaries.

The main emphasis of the JPP has however been on sexual and reproductive health outcomes in response to the slow progress made towards the achievement of MDG 5 in particular and the continuing high levels of fertility.

The national *Poverty Eradication Action Plan (PEAP) 2007/2008* which was the precursor of the NDP set health targets for the percentage of institutional deliveries (40%), posts filled by a qualified health worker (85%) and health centres without stock-outs of medicines (65%). These were subsequently revised under the NDP and additional targets set (see **Table 3**). The latest data available for these targets are from the annual *Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15*. The health component of the JPP is well aligned with these national targets and has mechanisms in place to monitor progress towards them.

Table 3: Uganda reproductive health targets

	2011	HSSIP 2015 target	JPP
Maternal mortality ratio	438	131	438
Neonatal mortality rate	27	24	
Infant mortality rate	54	41	
Under 5 mortality rate	90	56	
Total fertility rate		6	
	NDP 2014 targets		
Contraceptive prevalence rate	30	34	16.3
% deliveries in health facility		40	40.9
% approved positions filled by qualified health worker	58	56	
% health centres without stock-outs of medicine	70	72	74.5[12]
Annual reduction in absenteeism rates	N/A	28	

Sources: National Development Plan, 2010, HSSIP, 2010 HMIS data 2012/13 7 JPP MTE Health facility survey 2013

Up until recently the high fertility levels and large youthful population have not necessarily been seen as hampering development in Uganda. This has been attributed to a perceived need for a large population to provide a market for goods and services and thereby contribute towards development. As a result the linkages between high infant and maternal mortality and population growth have not been explicit in national strategies and policies. Increased national attention has been paid to the issue of maternal mortality since the involvement of the First Lady and Minister for Karamoja Affairs (Janet Museveni) at the launch of the *Roadmap to accelerate reduction of maternal*

[12] This figure only refers to stock-out of the three most commonly used contraceptives, not medicines in general

and neonatal mortality and morbidity in 2008, the Regional consultation on *Women deliver* (March 2012) and the *Stand Up for African Mothers* campaign in October 2012. Another important woman playing a role in advocating for increased attention to be paid to maternal health is Her Royal Highness, Sylvia Nagginda, Queen of Buganda.

Government recognition of the need to address population growth and the unmet need for family planning in Uganda was formally recognised by President Yoweri Museveni's "historic commitment" made at the July 2012 London Family Planning Summit, to reduce Uganda's unmet need for family planning from 40 per cent to 10 per cent by 2022.[13] The President announced that the government would increase annual expenditure on family planning supplies from US$ 3.3 million to US$ 5 million for the next five years. The Minister of Health (Christine Ondoa) said the aim is to create "an enabling policy environment to allow women to exercise family planning choices, increasing financial investment in health, human resource development and management, increasing commodities and supplies and effective delivery to reduce stock-outs." [14] A major step towards the achievement of a conducive policy environment was taken on 23 July 2013 with Parliament passing the *National Population Council Bill 2011*. If this Bill becomes an Act of Parliament it will become the blue print for integrating population factors into development planning, in accordance with the *National Development Plan*. This provides further support to the goal of the JPP to "contribute to accelerating the onset of a beneficial demographic transition in Uganda" (GoU/UN JPP, 2012). It also provides a clear mandate for the next NDP to explicitly address population issues and for the next UNDAF to accord higher priority to issues of population, sexual and reproductive health (with a special focus on maternal and neonatal health) in line with the post- 2015 international development agenda.

4.4 Delivering as one

In addition to the JPP being in line the *National Development Plan* and UNDAF, it is also consistent with the UN approach of Delivering as One (DaO). Joint programming is one of the modalities for the UN to "deliver as one" and is the collective effort through which UN organizations and national partners work together to prepare, implement, monitor and evaluate the activities aimed at effectively and efficiently achieving the Millennium Development Goals (MDGs) and other international commitments arising from UN conferences, summits, conventions and human rights instruments. The key principles of DaO are: One Programme; One budgetary framework; One Leader; One Voice; and One House/Shared common services). [15]

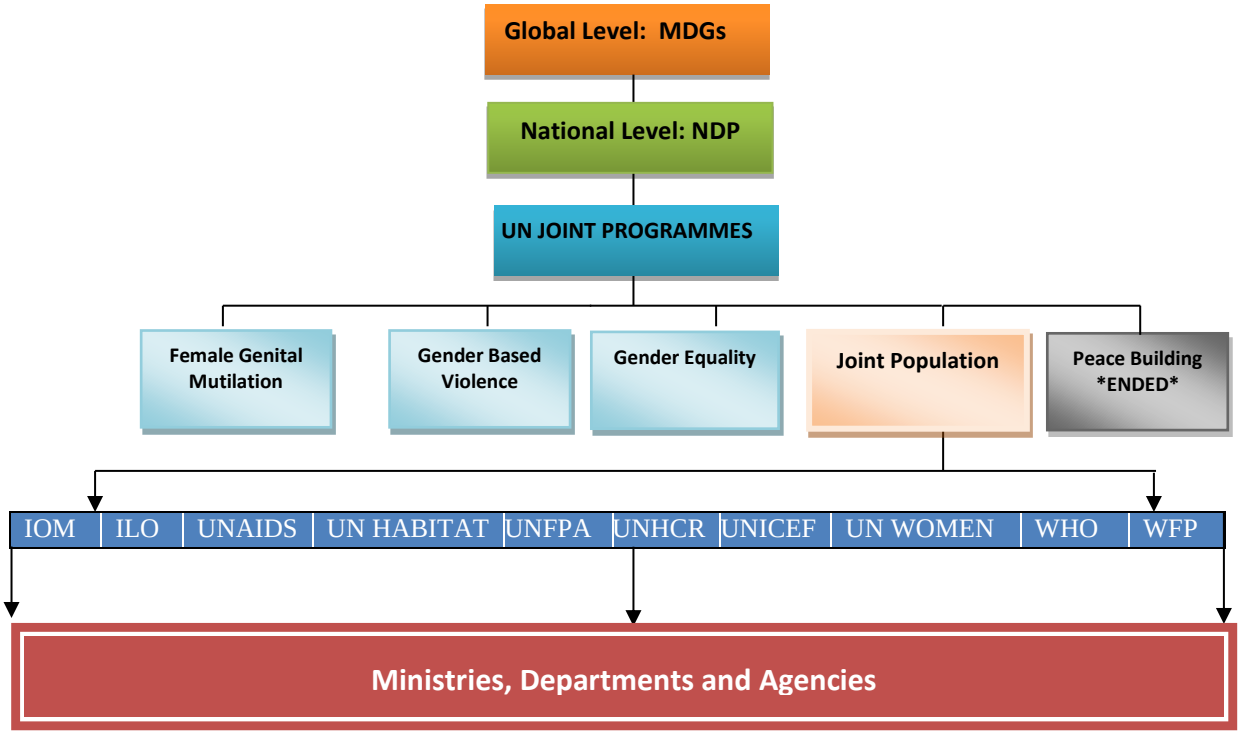
Through the JPP, UN agencies have a common goal as well as common outcomes and outputs with a single annual work plan. As a result, agencies build on each other's comparative advantages and reduce duplication of effort. Joint monitoring together with government and a Joint Steering Committee enhance effectiveness of government engagement and coordination. This integrative approach includes reaching out to the non-resident agencies which might not have an international

[13] http://www.newvision.co.ug/news/635437-U-S--UK-give-Uganda-sh97b-for-family-planning.html
[14] http://www.irinnews.org/report/96437/uganda-family-planning-pledges-need-on-the-ground-action
[15] http://www.youtube.com/watch?v=wnhmrrOQhSk

presence in the country. In the case of Uganda this includes ILO and UN-Habitat and they have been able to contribute their specific expertise through local officers.

Figure 4 shows how the UN JPP is aligned to global and national development strategies.

Figure 4: Position of GoU/UN Joint Programme



Information obtained from key informant interviews with government officials and UN partners was positive about the joint approach. A representative of the MoH said that duplication had been reduced since the JPP started. "It is well co-ordinated, there is joint planning, one team, reporting has been streamlined, financing is easier to handle and accountability is clearer." The only negative comments were about the slow release of funds and late disbursement which can mean that a quarter of programme implementation is missed. The Population Secretariat mentioned the value added of the JPP with ten agencies and government working together. Through the Steering Committee "we know which agency is doing what, where."

Partner UN agencies were generally favourable about the JPP and remarked that it has "made UN agencies work together and to coordinate what we do. It has helped us to programme our own contribution, so we don't duplicate what others are doing" (UNFPA). "The JPP works fine…we have a contribution to make to join resource mobilization, but it takes time" (WHO). The JPP was regarded as beneficial for the WFP as the different partners enhance the efforts of the others and so produce a collective gain for the beneficiaries. In the regions where WFP is implementing the programme, the increased demand for health facility deliveries is catered for by partners such as WHO (norms and standards, technical assistance, capacity building to all 15 JPP districts) and UNFPA (essential equipment and beds for delivery for health facilities in the eight M&E districts). The coordinator of the JPP said "It was difficult in the beginning – now agencies are engaging in areas that are outside

their mandate and contribute to the joint work plan. I think we are getting there…In the first year we tried to accommodate everyone and the programme was designed by what everyone could bring to the table, rather than develop the programme and then agencies identify their contribution" (JPP team).

Critical comments about the JPP approach were made by staff in one of the smaller agencies who felt that the "JPP is purely an administrative mechanism – one agency and one donor created the JPP. There is need for more discussion on the priorities between agencies and a division between administration and decision-making. The joint programming structure takes up a lot of time for a very small benefit. There are multiple Steering Committees and technical meetings. Every Joint Programme has a Steering Committee and the Representative is supposed to attend all of them and Technical Team meetings…so we are sitting in a lot of meetings."

The donor noted that "improvements have been made in the way they are working together. All agencies align to the UNDAF." However, DfID were concerned by the high level of overhead and management costs. A point also made in some of the literature on DaO "administrative savings are yet to be calculated because there is no budgetary framework that clearly accounts for the overhead costs of the different agencies and programmes" (Sequeira and Schornich, 2009).

Following the mid-term review of the current UNDAF in Uganda, the UN has developed an *UNDAF Action Plan for 2013-2014*, including an *Action Plan for Northern Uganda*. Under the latter the emphasis is on increased joint and effective support to the *Peace, Development and Recovery Plan* (PRDP-II). To this end, UN agencies will try out in the region new ways of doing things differently in terms of planning, programming, working together, and of 'DaO'. This work will be extremely important for the last year of the JPP as there will be synergies between it and the PRDP-II and opportunities for joint lesson learning. The JPP will be able to contribute to the *Action Plan for Northern Uganda* which proposes to: 1. undertake an analysis/mapping of WHAT different UN Agencies and other development partners are doing or plan to do in 2014 and WHERE they are doing or will be doing it; 2. establish baselines for the various indicators of key results (where none exist presently); and 3. develop an implementation plan for the *Northern Uganda Action Plan*, including how to advance/ pilot Delivering as One in Gulu and Moroto.[16]

[16] http://jobs.undp.org/cj_view_job.cfm?cur_job_id=40305

5. Key findings: progress towards programme outcomes

The MTE team were requested by some members of the JPP Technical Team to focus the review on impact achieved by the JPP after two and a half years of implementation. In many ways it is premature to measure impact in a development programme such as this, especially as the first year was primarily spent in establishing systems, training staff and procuring equipment, although some components such as the development of key tools in sexual and reproductive health were already under development before the JPP began (a common feature of DaO programmes). Delays were encountered in conducting the baseline survey and this was only undertaken after 18 months of programme implementation, rather than at the outset of the JPP.

A summary of the mid-term status of programme outcomes is shown **Annex 8 Tables 1** and **2** and an overview of progress towards all programme indicators in shown in **Annex 9 Table 1.**

6. Fertility reduced in line with individual/couple choices especially among young people

Within the JPP framework, this outcome is being addressed through increased access to family planning, sexuality information and youth friendly services for the sexually active population especially young people; expanded provision and uptake of family planning including social behaviour change materials, increased supply of family planning commodities such as male and female condoms and community mobilization for involvement of males and young people in sexual and reproductive health and rights.

The total fertility rate (TFR) for Uganda (measured by the Uganda Demographic Health Surveys, UDHS based on proxies using regional estimates) was 6.7 (2006) and 6.2 (2012) - see **Table 3** in **Annex 8**. In the JPP districts the TFR was slightly higher for both these years at 7.3 (2006) and 6.5 (2012). The highest TFR in 2012 was found in Katakwi, followed by Arua and Yumbe and the districts were chosen for inclusion in the JPP based on high TFR amongst other factors. Data collection for the last UDHS was conducted in 2011, so it is not possible to attribute any reduction in TFR to the JPP.

Similarly with the teenage pregnancy rate (TPR) - a key indicator for access to family planning amongst adolescents – **Annex 8 Table 4** shows that there has been an overall decrease in the 15 JPP districts rate between 2006 and 2012 from 30.2 per 1,000 live births to 26.5 per 1,000 live births. It was not possible to calculate the TPR as part of the MTE, but the household survey data show that 287 (20.6%) of the women aged 15 to 40 years had been pregnant before they reached age 20 years.

Contraceptive prevalence rate (CPR)[17] is another outcome level indicator. The most recent data available on CPR in the JPP districts is that contained in the UDHS 2012. There are no district specific

[17] Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49. http://www.un.org/esa/population/publications/wcu2010/Metadata/CPR.html

data for this indicator as regional estimates were used and hence all districts in the same region have the same CPR. Data obtained from the UDHS in 2006 show that there was an increase in the CPR in nine out of the 15 JPP districts by 2012. However, the other six districts, all in the Karamoja region showed a decline in the CPR - see **Annex 8 Table 5**). It was not possible to calculate the CPR from the data obtained in the MTE survey, but what is available is the percentage of women of reproductive age using contraception - this was found to be 16.3 per cent using some form of contraception by the end of June 2013 and 36.1 per cent of women who had never used any form of contraception. There was a noticeable increase in the districts of Karamoja since the last UDHS conducted in 2011, as well as in Arua. Caution should be exercised in interpreting these figures as one is based on regional estimates (UDHS) and the MTE survey was based on a sample of 1,859 women aged 15 to 49 years of whom 774 (41.6%) said they were currently using any form of contraception (including traditional methods, withdrawal and rhythm method).

Progress towards programme outputs

6.1 Young people with accurate information on family planning

Box 1: Young people with accurate information on family planning

Indicator 1.1.1: *Percentage of young people (10-24 years) with accurate information on family planning in 15 JPP districts measured by the total number of young people with accurate information on three methods of family planning: 1. Correct knowledge of use of condoms, 2.Correct knowledge of use of Emergency Pill, 3.Correct knowledge of use of contraceptive pills.*	**Results**: There has been an increase young people's (aged 10 to 24 years) accurate knowledge of three methods of contraception from 1.3 per cent in 2012 to 6 per cent in 2013.

Findings

- There is a clear gender and age dimension to young people's knowledge of family planning with young males having higher accurate levels of knowledge (9.6%) than their female counterparts (3.5%) for all three methods – largely due to their much higher levels of accurate knowledge of male condoms.
- Younger females (10 to 14 years old) have lower levels of accurate knowledge of all three methods of contraception (2.3%) than those aged 15 to 24 years (6.2%).
- Young people's levels of knowledge of the three methods were highest in Oyam (28.2%) and Kitgum (20.2%) and lowest in Abim (none), Gulu (0.63%), Yumbe (0.76%), Kanungu (1.06%) and Katakwi (1.36%).
- In some districts negative attitudes towards young people's use of condoms and contraception persist and make it difficult for them to obtain information and access to them.
- The main source of information on sexual and reproductive health for young males aged 10 to 24 years was the radio, followed by peers. For young females (15 to 24 years) the main source of information was a health facility.
- Educational materials for young people on family planning have not yet reached all districts and need to be translated into local languages with culturally appropriate messages and images.

Lessons learnt

- The need to ensure that young people have access to correct information about family planning cannot be over-emphasised. The information received by radio is very important in raising awareness and needs to be complemented by increased access to accurate information from Youth Friendly Services.

Recommendations

1. Step up the translation of educational materials for young people on family planning and ensure that they address local myths (such as the use of "moo ya") and are culturally acceptable in terms of language and images.
2. Pay increased attention to the needs of young girls aged 10 to 14 years for accurate age and gender-specific information, including through female peer educators at Youth friendly corners and health staff trained in youth-friendly approaches.

Young people's knowledge of family planning

The 2006 *Uganda Demographic Health Survey* found that 92 per cent of females and 96% of male adolescents aged 12 to 19 knew of at least one method of contraception and almost all adolescents who knew of a method could mention at least one modern method. Overall, the most commonly known methods among adolescents in Uganda were the male condom, the pill and injectables, which are all known by more than half of all female and male adolescents.

The JPP Baseline line survey found that out of 1,661 young people aged 10 to 24 years **only** 1.3 per cent had accurate knowledge of three methods of family planning (24.2% for male condoms, 7.9% for contraceptive pills and 3.6% for emergency pills). Results from the MTE household survey amongst young boys and girls aged 10 to 24 years show that there has been an increase in accurate knowledge of three methods of contraception from 1.3 per cent in 2012 to 6 per cent in 2013. There is a clear gender and age dimension to young people's knowledge of family planning with young males having higher accurate levels of knowledge (9.6%) than their female counterparts (3.5%) for all three methods – largely due to their much higher levels of accurate knowledge of male condoms. Not surprisingly, younger females (10 to 14 years old) have lower levels of accurate knowledge of all three methods of contraception (2.3%) than those aged 15 to 24 years (6.2%) - **Table 4**.

Table 4: Young people's accurate knowledge of contraception by age and gender

Accurate knowledge of 3 methods of contraception	Girls aged 10 to 14 years N =1,549		Females aged 15 to 24 years N = 674		Males aged 10 to 24 years N = 1,524		Knowledge of all 3 methods	
	No.	%	No.	%	No.	%	No.	%
Male condom	329	34.1	263	47.6	693	66.0	1,285	34.31
Contraceptive pill	143	16.7	163	30.0	182	17.3	488	13.03
Emergency contraceptive pill	77	10.9	71	13.8	177	16.9	325	8.68
TOTAL	**36**	**2.3**	**42**	**6.2**	**147**	**9.6**	**225**	**6.01**

Source: JPP MTE household survey, 2013

Young people's levels of knowledge of the three methods were highest in Oyam (28.2%) and Kitgum (20.2%) and lowest in Abim (none), Gulu (0.6%), Yumbe (0.76%), Kanungu (1.1%) and Katakwi (1.36%) - see **Annex 9 Table 2**. The figures for accurate knowledge of three methods of contraception by young people in the eight M&E districts included in the baseline survey are marginally higher at 6.2 per cent (**Annex 9 Table 3**).

In Abim it was reported key district officials had negative attitude towards the distribution of condoms amongst young people and as a consequence young males had difficulties accessing in

them and some were using pieces of white polythene as a barrier lubricated with Shea nut oil “moo ya”.

Another indicator that contributes to increased use of FP services by young people is their knowledge of the different methods of contraception and where to access them. The JPP has focused on various different interventions to increase young people’s knowledge of family planning methods and to increase their use of services. These include community mobilisation, radio programmes, training of health workers and peer educators to provide youth friendly services.

Sources of information on family planning for young people

The main source of information on sexual and reproductive health for young people aged 10 to 24 years was the radio. For young males this was 58.6 per cent and was slightly higher if they lived in rural areas (60.9%) than urban areas (56.3%). For young males the next most popular source of information was peers/outside the home (10.7%) and school (9.9%). For girls aged 10 to 14 years the radio was also the most important source of information (36.9%) followed by school (28.6%), parents/guardian (9.3%) and peers (6.4%).

For young females aged 15 to 24 years the main source of information on sexual and reproductive health was a health facility (40.5%) followed by radio (38.%). Health facilities were only mentioned as a source of information on sexual and reproductive health by 5.7 per cent of girls ages 10 to 14 years and 1.3 per cent of young males aged 1.3 per cent.

These data vary considerably from the JPP Baseline survey which found that health facilities were the main source of information of sexual and reproductive health for 51.6 per cent of males and females aged 10 to 24 years. However, in this earlier baseline survey questions were not asked about radio programmes as a source of information.

The JPP has produced a wide range of information, education communication materials (IEC) and these are listed in the references. However, these have not yet been distributed to all districts and youth friendly service delivery points.

In terms of one-to- one interaction as a source of information about sexual and reproductive health there is a clear gender and age difference. Young males preferred to receive this from peers (28.5%), health workers (24.1%), parent/guardian (14.6%), school teacher (12.3%) and a relative (11.8%). For girls aged 10 to 14 years the most preferred person to discuss issues of sexual and reproductive health with was a parent/guardian (36.8%), followed by a school teacher (21.3%), health workers (15.7%) and peers (14.3%).

Only 2.4 per cent of young males and less than one per cent of girls aged 10 to 14 mentioned staff at a Youth Friendly Corner (YFC), but this could be due to them not having yet visited one. Religious leaders were not seen as people to go to for such information by all respondents regardless of age and gender.

6.2 Youth Friendly Health Services

Box 2: Youth friendly health services

Indicator 1.1.2: *Number of Health Centre (HC) III and HC IV providing youth friendly services (YFS) in 15 JPP districts.*	**Results**: There has been an increase in the number of HC IIIs providing YFS from 37 in 2012 to 60 in 2013, and in HC IVs from six in 2012 to 20 in 2013. In addition there were 11 district and four regional referral hospitals offering YFS.
Although the MTE team were informed that 80 YFS had been established the team has serious concerns about their functionality.	

Findings

- Six Youth Friendly Corners (YFCs) were not functioning properly: two due to no trained staff in post, three due to the absence of a room for counselling and in Nakapiripirit HC III the YFC is located under a tree, hardly an appropriate place.
- Most[18] of the YFCs are small with inadequate space for private counselling of young people. The Ugandan Red Cross has recommended in their last three reports that "District Health Officers should support YFS interventions by working with schools and health facilities to identify and provide adequate space." There was no evidence of any actions being taken by the MoH or UNFPA to address this shortcoming.
- Several irregularities were noticed in record keeping and the need to disaggregate information on new and repeat clients was identified.
- Where records on attendance were available from the Uganda Red Cross Society and the MTE survey it was found that peer educators were more likely to be male and that twice as many boys as girls attended YFCs. Given the need to focus more attention on teenage pregnancy, a more gender-sensitive approach should be adopted.
- Information from exit interviews with a small number of young people who have used YFS found a high level of satisfaction (86%) with the services they received.
- There is a high turnover of staff and peer educators and consequently the need to train more in youth-friendly approaches.
- In the YFCs where equipment has been provided to watch educational films have only been provided on condoms, family planning, HIV/STIs and male circumcision. The young people are now bored with these films and in some instances (Oli HC IV in Arua) they have started watching Nigerian films and in other districts they mentioned watching entertainment films.
- Games and sport equipment provided under the JPP now need replacing and in some instances pool tables have not been used due to insufficient space.

Lessons learnt

- The introduction of YFCs was seen as top down by some District Health Officers who would like greater district involvement in YFCs to ensure their sustainability.
- Youth friendly clinics located in HC IVs and district hospitals tend to focus on all health conditions, not only sexual and reproductive health.
- There is not a standardized service package for YFCs in schools, health facilities and communities. This problem was identified in the 2012 JPP Annual Report and is still awaiting action.
- Any future games and entertainment programmes provided at YFCs need to be gender-sensitive and be user-friendly for young females to encourage them to come to the YFC. The provision of pool tables was questioned as an appropriate game for YFCs as in some YFCs older males

[18] According to the Ugandan Red Cross All YFCs apart from Kaabong hospital, Ngai HC III and Yumbe HC III, "do not have adequate space for running a YFC and ensure its functionality. Some of the rooms are not convenient enough in terms of access by youth and privacy." URC Annual Report 2012 and 1st and 2nd Quarterly reports for 2013.

were coming to play pool and deterring young people (especially girls) who wanted sexual and reproductive health advice.

- Peer educators are being used creatively in some health facilities to register young people and direct them to the appropriate department. In some districts they are actively involved in maintaining the grounds of the health facility and assisting in the pharmacy. In order to keep their motivation, consideration should be given to building their skills in income generating activities so they can raise funds for outreach activities and cover their costs.
- School-based YFCs in Abim, Kaabong and Kotido were seen to have improved discipline and hygiene amongst pupils.
- School YFCs are being used in some districts for widespread pregnancy testing of girls and HIV testing of males and female pupils. This raises ethical issues about whether the pupils have received proper counselling before being tested and also it is questionable that repeat testing is an effective intervention for positive behaviour change.
- The main problems that young people face in using the services were insufficient drugs (28%) and not enough health workers (16%).
- Signs announcing the presence of youth-friendly services should not been erected until the service has fulfilled all the criteria for such services.

Recommendations

1. Establish a system for accrediting a health service as "youth-friendly" along the lines of Baby-friendly hospitals. The key criteria should include: staff and /or peer educators trained in youth-friendly approaches and in post; culturally appropriate information materials; confidentiality of information; privacy, especially for a private space(separate room) for counselling; accessibility with opening hours based on young people's needs. Only after being accredited should facilities be able to be called youth-friendly and signs can be erected.
2. Strengthen supervision by the MoH and DHO to ensure that services are fully functional and that records are being correctly maintained. Regular monitoring should be in place to ensure that standards are maintained and records are correct.
3. Strengthen Red Cross capacity to supervise more YFCs to ensure that a standard model of service delivery is being provided.
4. Create and regularly maintain a district list (data base) of all peer educators trained in youth friendly services identify turnover in PEs and the need to identify and train new PEs. (Consider using innovative technology - Ureport/MTrac – for peer educators).
5. Train up more PEs and put mechanisms in place to increase their retention and motivation.
6. Establish district and regional networks of YFC PEs. This will provide an opportunity for PEs and also an opportunity to learn from examples of good practice and to provide training updates.
7. Establish district and regional networks of health workers providing YFS. This will provide an incentive for the staff and also an opportunity to learn from examples of good practice identified in the MTE report and also to provide training updates.
8. Review the practice in some schools of repeat pregnancy testing and ensure that counselling is provided and informed consent obtained before any tests are performed on students.
9. The proposal for scale-up of YFHS to non-JPP districts should not proceed until data collection problems in the existing 15 districts have been resolved and there is a proper MoH system in place for monitoring YFHS quality, supervising services and ensuring continuity of care when trained staff leave.
10. Provide YFCs with a standardised set of equipment and supplies that take into account the needs of girls and young women.
11. Procure a new set of films on sexual and reproductive health and use monitoring visits to exchange films with other districts.

12. In 2004 it was recommended that District Reproductive Health Committees be established[19] to pay attention to the sexual and reproductive health needs of young people. Consideration should be given to the re-establishment of these committees (or strengthening of other structures) to ensure greater district involvement in the YFS programme and increased community level buy-in.

There are a total of 145 health facilities above the level of HC III the 15 JPP districts. Data obtained from the persons in charge of health facilities indicated that 94 out of 145 (64.8%) had youth friendly health services (YFHS) at their facility. At hospital level 14/20 have established YFHS (four at regional level and 10 at district level), at Health Centre IV level 20/23 and 60/106 at Health Centre III level. This means that almost two-thirds (65%) of Health Centres III and IV out of a total of 145 have established YFHS (Table 5). It should be noted that upgrading of health centres is on-going.

These YFHS will be a combination of Youth Friendly Corners (YFCs) - either a shelf/corner or separate room in a health facility, or a container in the grounds of the health facility; supported a separate Youth Friendly Health Clinic for young people aged 10 to 24 years; or staff trained in youth friendly approaches who integrate this approach into different departments in the overall health facility.

Table 5: Number of health facilities providing youth friendly services in 15 JPP districts

Response	Do you have Youth friendly health services at your health facility?				
	Regional Referral Hospital	District or other Hospital	Health Centre IV	Health Centre III	Total
Yes	4	10	20	60	94
No	0	2	3	46	51
Total	**4**	**12**	**23**	**106**	**145**

Source: MTE survey, 2013

Depending on which agency has supported the development of the YFC they have received different indoor and outdoor games, information materials and equipment with YFC in health centres having received more from the Uganda Red Cross Society than those established through WHO support.

Arua and Gulu districts have established the greatest number of YFHS (11 and 10 respectively). However, there are overall more HC IIIs and HC IVs in these districts, so the overall percentage of YFHS in these districts is 32 and 83 respectively. According to the data obtained during the MTE all HC IIIs and IVs were providing YFHS in Kitgum, Oyam, Amudat, Bundibugyo and Kanungu. However, the data in Annex 9 Table 4 should be treated with an index of suspicion as the field workers noted that some of the officers in charge who were interviewed did not appear to be fully aware of what a youth friendly service was and may have over-estimated its existence in their facility. Data have not yet been analysed on the extent to which all of these services were functional. Although field notes indicate that six Youth Friendly Corners (YFCs) were not functioning properly: the YFC in Nabilatuk Health Centre IV in Nakapiripirit district had been closed for two months because the person in charge had been transferred: and the YFC (only a shelf) in Orwamuge Health Centre III in Abim district had not been functioning since 19 May 2013 when the trained staff member had left. In

[19] See the *Adolescent Health Policy for Uganda.*

Amudat district, (Loro health C III) the YFC operates from a drug store (very small room). In Amudat hospital YFC, the counselling room for is the same room used for general hospital counselling services. The YFC in Katakwi hospital was under renovation and services were halted until the renovations were to be completed in two weeks. In Nakapiripirit HC III the YFC is held under a tree and counselling takes place under another tree.

UNFPA's partner, Uganda Red Cross Society (URCS) and Naguru Teenage Health Information Centre began providing YFCs in health facilities in three JPP districts (Katakwi[20], Kotido and Oyam) in 2010/11[21], this increased to eight JPP districts in 2012 and 2013 (Kanungu, Moroto, Mubende and Yumbe). During the first year of the JPP the YFCs in health facilities were not fully operational due to the need to train health staff and peer educators and obtain equipment. Activities in 2011 focused on raising awareness of sexual and reproductive health issues and it was reported that 44,511 young people were reached through outreach activities (Uganda Red Cross Society Annual Report, 2011).

A key feature of the YFCs supported by URCS is the presence of trained peer educators (PEs). Initially ten were trained per health facility and two are supposed to work each day in the YFC from 0800 to 1700 Monday to Friday. In addition, some YFCs are open at weekends. A key challenge faced is the need for constant motivation and retention of PEs. They are paid 5,000 Ugandan shillings (USh) per day when they work to cover food and transportation (i.e. 20,000 USh per month). The URCS says that this is not competitive as other PEs are paid 75,000 USh per month by World Vision. The high turnover of PEs is shown in **Annex 9 Table 5** where out of 47 YFHS visited as part of the MTE there were 149 male and 120 female trained PEs in post – an average of 5.7 per facility with considerable variation between districts from a high of 46 trained PEs in Katakwi to only three in Amudat. So there is need to train up more PEs (especially girls0 and put mechanisms in place to increase their retention and motivation. Retention of PEs is higher in the eight M&E districts (**Annex 9 Table 6**) so there may be some lessons to be learnt from the URCS about mechanisms to retain PEs.

By the end of 2012, 14 YFCs had been established in health facilities by the URCS and the YFCs in health facilities in Katakwi had already been transferred to the local authority. The figures for young people's attendance at YFCs from January 2012 to June 2013 are shown in **Table 6.**

Table 6: Attendance at Youth Friendly Corners in Health Facilities in seven[22] JPP Districts from January 2012 to end June 2013

	Boys (one-to-one counselling)	Girls (one-to-one counselling)	Boys-Group sessions	Girls-Group sessions	Total
2012	1,431	1,292	10,743	5,917	19,383
2013 (6 mths)	4,671	1,676	6,692	3,814	16,853
TOTAL	**6,102**	**2,968**	**17,435**	**9,731**	**36,236**

Sources: Uganda Red Cross Annual Reports for 2012 and Quarterly Reports for 1st and 2nd Quarter, 2013)

[20] Katakwi were supported by the Red Cross to provide YFC in schools only - not HCs III and IV. The District has taken over implementation of all YFS in health facilities, so data are not available from Red Cross records.
[21] Funded under the UNFPA 7th Country Programme.
[22] Kaabong, Kanungu, Kotido, Moroto, Mubende, Oyam and Yumbe.

According to data from the Uganda Red Cross, the largest age group of attendants at YFCs were aged 15 to 19 years and a higher numbers of boys than girls attended either for one-to-one counselling (twice as many) or group sessions. Data from the MTE household survey shows that only 28 in every 100 women (28.2%) in the age range 15 to 24 have ever been in a youth friendly corner. Mubende district (60.00%) has the biggest percentage of women aged 15 to 24 who have ever been in a YFC followed by Bundibugyo (46.7%) and Kitgum with the least percentage (2.7%).

In addition to providing services at health facilities, the YFCs supported by the Red Cross also conduct outreach to worksite groups and the local community. In 2012, 12,150 young people (8,381 males and 3,769 females) were reached through worksite groups. In 2013, 10,355 young people were "mentored and reached" through 41 worksite groups in the first quarter. Of these 670 males and 581 females were mentored as peer educators and 4,525 males and 3,411 females were reached through group discussions, drama and one to one communication. A total of 4,253 young people were reached in the community with HIV/STI counselling and testing and a total of 1,253 (628 males and 625 females) were tested for HIV. Community referrals of young people to health facilities totalled 1,232 (799 males and 433 females).

In the second quarter of 2013 a total of 6,133 young people were "mentored and reached" through 41 worksite groups. Of these 233 males and 222 females were mentored as peer educators and 3,512 males and 2,268 females were reached through group discussions, drama and one to one communication. A total of 3,987 young people were reached in the community with HIV/STI counselling and testing and a total of 713 (345 males and 368 females) were tested for HIV. Community referrals of young people to health facilities totalled 102 (35 males and 67 females).

A successful example community mobilization of this was seen in Kotido where peer educators and Village Health Teams (VHTs) had mobilized 241 young males to attend a circumcision camp in early July 2013.

Similarly encouraging data were obtained about school-based YFCs, although there could be double counting as there is no separate recording for new and repeat clients. In 2013, schools began extensive testing for HIV, STIs and pregnancy (Table 7). A total of eight girls out of 2,626 were found to be pregnant (0.3%), although it may be that girls are tested each term in which the denominator would be about half. The cost-effectiveness of large scale testing for HIV, STIs and pregnancy needs to be considered and the ethical issue of informed consent should be reviewed.

Table 7: Attendance at Youth Friendly Corners in Schools in seven JPP Districts January 2012 to end June 2013

	YFC counselling		Target counselling		HIV/STI testing		Pregnancy testing	Referrals		Total referred
	Boys	Girls	Boys	Girls	Boys	Girls	Girls	Boys	Girls	
2012	14,257	16,278	-	-	-	-	-	-	-	-
2013 (6 mths)	7,810	7,652	2,668	2,958	2,601	2,607	2,626	1,014	1,007	2,021
TOTAL	**22,067**	**23,930**	**2,668**	**2,958**	**2,601**	**2,607**	**2,626**	**1,014**	**1,007**	**2,021**

Sources: Uganda Red Cross Annual Reports for 2012 and Quarterly Reports for 1st and 2nd Quarter, 2013)

Systematic data are not available on attendance at YFS established in Abim, Amudat, Arua, Bundibugyo, Gulu, Kitgum and Nakapiripirit supported by MoH/WHO. The MoH registers developed to track registration are not yet feeding into the HMIS system and are not in place in all YFS.

Data from the YFC in Abim were obtained by going through the MoH register which had been in use since 9th January 2013. The majority (86.3%) of the 313 attendees were new clients with an average of eleven clients per day (**Annex 9 Table 7**). At the time the facility was visited there was only one client who had a dental, not reproductive health problem. The nurse working in the YFC also runs the out-patients department (OPD) for young people and there the numbers are much higher, but cover all health conditions not only sexual and reproductive health (SRH). Young people with SRH problems are referred to the YFC for counselling.

The data obtained from the household survey show that 949 (25%) young males and females aged 10 to 24 years had ever been to a Youth Friendly Corner (YFC): 502 young men and 447 young women (**Annex 9 Table 8**). There is considerable variation between districts with Mubende, Kotido, Arua and Yumbe having more young people attending the YFC, whilst in Amudat, Kanungu, Kitgum, Abim and Bundibugyo the numbers were very low. However, these data should be treated with caution for three reasons: 1. the overall population size is higher in Arua, Mubende and Yumbe and consequently there will be more young people; 2. the young people interviewed may not have perceived the need to visit a YFC; 3. the MTE review team was not provided with an up to date list of the location of YFC in health facilities, so it could be that households selected were not in the immediate vicinity of the YFC.

Case study 1 - Youth friendly services

Relevance

Worldwide, Uganda is the leading country with the youngest population of 78 per cent below age 30 years and half (52%) of the population are aged 15 years and below (UBOS, 2012). About 6.5 million (21.3%) Ugandans are in the age group 18 to 30 years. The number of young people in Uganda is projected to reach 7.7 million by 2015. "Most of Uganda's young population aspires for various forms of services in terms of education, employment and family formation. This is the challenge for the country to address urgently" (*The State of Uganda Population Report 2012*, 2013).

Interest in adolescent health in Uganda dates back to the 1990s when concerns were raised that young adults constituted almost one-fifth of the population and represented a rapidly growing segment of the population. Projections were made that the number of adolescents would have doubled from that in 1995 to 7.3 million in 2015. (A figure already surpassed by current projections). Young adults were regarded as holding "the key to the country's future population growth" (UDHS, 2006).

UN definitions of young people are:
Adolescents 10 to 19 years
Youth 15 to 24 years
Young people 10 to 24 years.

In Uganda, young people are defined as 18 to 30 years for employment and other reasons. However, for health service provision the definition of young people aged 10 to 24 years is used and this age group is targeted for youth friendly health services.

The first *National Adolescent Health Policy* was published in 2000 and was updated by the *National Adolescent Health Policy for Uganda* in 2004. This aim of this latter policy was to mainstream adolescent health concerns in the national development process in order to improve the quality of life and standard of living of young people in Uganda. The Ministry of Health identified Reproductive Health as a priority programme and increased access to quality Adolescent Health Services was regarded as one of the strategies to reduce the high maternal mortality in Uganda.

There is a department of Adolescent Health and Development in the Ministry of Health which coordinates adolescent health programmes and a multi-sectoral committee - the National Steering Committee on Adolescent Health (NASCAH) - was established in the mid-2000s. District Technical Planning Committees were tasked with creating sub-committees on Adolescent Health for "the purpose of spearheading, facilitating and coordinating Adolescent Health activities at the district level" (*Adolescent Health Policy for Uganda*, 2004).

Need for reproductive health interventions for young people

Adolescent girls account for a significant proportion of maternal deaths, which are largely due to preventable causes such as malnutrition, infections and haemorrhage coupled with inadequate health care and supportive services, particularly in the rural areas. Unsafe abortions contribute significantly to maternal morbidity and mortality among adolescents. For teenage pregnancy, girls aged 15 to 19 are the group concentrated on and the need for interventions to reduce this rate is evidenced by the results of the MTE household survey data for women aged 15 to 49 years in the 15 JPP districts. For example, out of a total of 1,841 women aged 15 to 49 years interviewed, 77.2% had ever been pregnant. Of these, the mean age of first pregnancy was 18.62 years (with a minimum age of 10 years recorded in Mubende district). Out of those who had ever been pregnant 20.6 per cent had their first pregnancy under age 20 years. Pregnancy meant for a quarter of these women (25.6%) that they “dropped out" of school and one fifth of women (20.5%) mentioned health problems as a consequence of their first pregnancy (MTE Survey data, 2013).

An earlier study (the *National Adolescent Health Survey*) showed 60 per cent of adolescent women "in union" who were pregnant, wanted the pregnancy either later or not at all, indicating that this group of adolescents needs special attention on pregnancy prevention (Neema, 2006).

The JPP focuses on young people with the aim of increasing their access to sexual and reproductive health services and information and thereby contributing to delayed first childbearing for girls, increased spacing between babies, improved maternal health outcomes and overall reductions in the rates of teenage pregnancy and total fertility amongst young people. The achievement of the JPP output indicators was through three areas: 1. Production of written and verbal (via local radio programmes) information for young people on sexual and reproductive health services; 2. Establishment of Youth Friendly Services; and 3. Community mobilization for young people to know about sexual and reproductive issues and the available services.

Different approaches improving young people's sexual and reproductive health

The Youth Friendly Services (YFS) model adopted in Uganda is a three-pronged approach looking at the need for youth friendly services to be implemented in three environments: the school; health facility; and the community. The JPP has supported the establishment of Youth Friendly Corners

(YFCs) in schools and Health Centres (HCs) III and IV in the 15 districts. The YFCs are designated spaces convenient and attractive for young people in public health facilities where sexual and reproductive health and HIV information and services are provided (UNFPA, 2013). These have been complemented by integrated Youth Friendly Health Services (YFHS) in some health facilities in the JPP districts. These can either be stand-alone clinics designed for young people (such as in Abim and Kaabong District Hospitals) or staff have been trained in a youth-friendly approach and YFS are integrate throughout the health facility.

The YFCs supported by the Ugandan Red Cross in health facilities in seven districts also provide extensive community outreach to worksite groups and young people in the local community. A main constraint has been shortage of space and lack of privacy for the YFC – some are provided in a container in the grounds. Some youth prefer this because it is apart from the main health facility and offers some privacy (for example, at Kasambya HC III and Kotido HC IV). However, as the photographs from Kotido shows conditions can be very cramped.

Photographs: Inside and out of Kotido Health Centre IV YFC

Some of the health facilities (such as in Abim and Kaabong) have provided a separate room for youth friendly services. In Abim the young people go to the general OPD clinic for 10 to 24 year olds first (where all medical conditions are dealt with not only SRH). Then if necessary they are referred to the YFC for counselling. In this room an average of 40 new clients were seen each month for the first six months of 2013. However, the register shows that their ages ranged from 9 to 40 years! This was not the only “youth" service that did not keep to the 10 to 24 age group. In some of the YFCs in health centres older clients wanting services were turned away, but this did not seem to apply to the showing of films when any-one interested seemed to be able to watch.

In addition to YFCs in health centres, YFCs have been established in eight districts and school health clubs have been established to raise pupils’ awareness of sexual and reproductive health. Pupils from YFCs can be referred to the school nurse or to the nearest health facility.

Effectiveness

The JPP supported the Ministry of Health Reproductive Health Division in the development and finalisation of seven policy guidance documents and technical standards and training materials for service providers in 2011 and four leaflets for adolescents on sexual and reproductive health issues. With JPP support a revised *National Adolescent Health Strategy: 2011 to 2015* was printed in 2011 (see **Annex 10**).

The principles of youth and adolescent friendly health services are clearly defined in the *National Training Curriculum for Health Workers on Adolescent Health and Development* and the Uganda Red Cross has also identified some fundamental principles of YFS (see *Implementation Guide*, no date). An Adolescent Health Working Group was established in the MoH in April 2013 and comprises of health staff and NGOs implementing YFHS. The group has over 30 members and provides a platform for deliberating on adolescent health issues. The group are keen to use the materials developed under the JPP in other districts.

The Ugandan Red Cross has developed a system of quarterly monitoring and supervision and produced comprehensive reports of progress. More attention in all YFCs should be paid to registration and accurate recording of data.

Some of the YFCs are not properly functioning. In Nakapiripirit HC III the YFC was under a tree, with no shelter, no privacy and when it rains, the YFC is closed. The counselling is done under a different tree. In Nabilatuk HC IV (Nakapiripirit district), the YFC had been closed for two months because the person in charge of the YFC had been transferred. A similar problem was encountered at Orwamuge HC III (Abim) where the YFC (a shelf) had not been operational since the trained health worker left two months previously.

Photographs of Orwamuge HC III in Abim where the YFC is a shelf and has not been operational since May, yet a sign advertises the services.

In Amudat district, (Loro health C III) had a YFC operating in a drug store (very small room). In Amudat hospital YFC, the counselling room for is the same room used for general hospital counselling services. The YFC in Katakwi hospital was under renovation and services were halted until the renovations were to be completed in two weeks.

Cost effectiveness

It was not possible to conduct an analysis of how cost-effective the YFS are due to the absence of data on the number of clients. The total allocation for the services was US$ 1.5 million for the first two years and the number of young people using the health services in 23 URCS YFCs was 36,236 for two years. Data are not available for Katakwi as they have been handed over to the MoH and data are not yet available for 49 MoH/WHO YFCs. The start-up costs include training of staff, peer educators, equipment, production of technical and information materials. As the programme continues the costs will mainly be for refresher training, equipment replacement, monitoring and supervision. The question of whether district health authorities are prepared to take on the 20,000 Ugandan shillings (USh) per month for peer educators has yet to be addressed.

Out of 172 young women (15-24 years) interviewed that had ever been to a youth friendly corner, almost two-thirds (63.95%) went to a YFC at a health facility. In Arua and Gulu they were more likely to have visited a school-based YFC.

Satisfaction with Youth-friendly services

Information was obtained on satisfaction with YFCs by conducting an exit survey of 65 young people (22 males and 41 females) aged 10 to 24 after receiving sexual and reproductive health (SRH) services. The main services received were information (29%), counselling (29%) and antenatal care (16.9%). The majority of young people (86%) were satisfied with the services they received. The mean waiting time to see a health worker was 34 minutes and the young people's satisfaction with various aspects of services provided was: time given by the health care provider (94%); privacy (97%); information given (97%); counselling (78%); and health care provider attitude (92%). Only 23.5 per cent were given a leaflet about SRH at their visit (mainly on HIV and STIs) and half of them met a peer educator at their visit.

The main problems that young people faced in using the services were insufficient drugs (28%) and not enough health workers (16%). These problems need to be addressed to ensure that their needs are met and they continue to be motivated to use the services.

6.3 People reached with sexual and reproductive health messages

Box 3: Number of people reached with sexual and reproductive health messages

Activity level indicator: *No. of people reached with messages on maternal health, family planning, gender-based violence, HIV, and adolescent sexual and reproductive health through radio programmes. Annual Target: 1,500,000*	**Result:** In 2012 it was estimated that 2.5 million people were reached by the *Healthy Choices* programme each week.

Local radio as a mechanism of raising awareness of sexual and reproductive health

Since 2011 UNFPA support has been provided to eight UNFPA supported districts for the use of local radio for transmitting information on sexual and reproductive health. A baseline needs assessment was conducted in the eight district to determine the need for sexual and reproductive health information and how best to respond to these needs. It was decided to adopt a three-pronged approach using community mobilization (through Village Health Teams, VHTs), the establishment of a *Healthy Choices* programme by local radio stations in six districts (in Karamoja region there is one station covering three districts), and the final component is monitoring (quarterly visits and tracking the number of listeners).

The radio programmes started in 2011 and were due to end in 2012, but received additional funding from the Swedish International Development Agency (Sida). In 2012, a total of 144 programmes were aired on the six community radio stations implemented by the Communication Development Foundation for Uganda (CDFU) under the JPP. According to Synovate (an independent market research firm) about 2.5 million people were reached by the programme each week in 2012. To ensure the messages permeate the community, VHTs mobilize radio listener groups in advance of a radio programme to tune in to the programmes. This has stimulated further discussions on family planning and maternal health following the programme (UNFPA, *Annual Report,* 2012).

The District Health Officer in Kotido (Dr Philip Olinga) mentioned the importance of the local radio programmes and how local health educators had worked with CDFU and the station in Moroto to ensure that culturally acceptable messages were transmitted as the initial materials from Kampala were not appropriate for the Karamoja region. For example, he emphasised the need to build on traditional messages in the context of high levels of polygamy. One such traditional message after childbirth would be that the husband "should not go to her (the wide) until the child can bring him a cup of water." The messages used should reinforce the concept of spacing as this is seen to be culturally acceptable and as the example shows already used in traditional messages.

Half (49.7%) of women of reproductive age (15 to 49 years) mentioned health workers as their main source of information on family planning followed by 39.2 per cent who indicated that radio programmes are their main source of information. The greatest importance of health workers as a source of information on FP was in Yumbe (91%) and radio only 6.8 per cent. In Mubende, Bundibugyo, Moroto and Kanungu the radio was cited as a more important source of information (74% to 50.6%) than health workers (43.5% to 21.4%). In Kaabong district, the main source of information was both radio and health workers with the same percentage (34.8%). The differences in these responses could be due to the older age of the women in their reproductive years and their greater use of health facilities as a source of information on sexual and reproductive health. Another survey of knowledge of family planning methods amongst males and females aged 15 to 49 years also found that the radio was their main source of information: 73 per cent of males and 78 per cent of females (UNFPA, 2012).

Whilst the *Healthy Choices* radio programme reached large numbers of people with sexual and reproductive health information in a short period of time, several challenges have been encountered in programme implementation. These include: the high turnover of staff in local radio stations (some staff do this on a voluntary basis and are not paid); sometimes the techn6ical experts do not turn up for their slot in the programme (due to poor weather conditions and other factors); the stations are often dependent on using generators; and in one instance a member of a local radio station "ran off with the equipment." Another challenge is that demand creation through the media is only one part of the solution as listeners may feel encouraged to seek health care but "the services are not there" (Key informant interview, UNFPA).

> As a representative of the MoH cautioned, if everybody came to YFS "there would be a crisis as there are insufficient health workers and some of them are not motivated."

Despite these constraints, consideration should be given to the scale up of radio programmes in 2014 to the other seven JPP districts if the JPP team consider sexual and reproductive health services in the remaining seven districts to be sufficiently functional and of good quality to respond to the potential increased demand.

6.4 New users of family planning

A new user of family planning is a client who accepts at least one modern method of contraception from a service delivery point for the first time.

Box 4: New users of family planning and stock outs of contraception

Indicator 1.1.3: *Number of new users of modern methods of contraception at end of current year expressed as a percentage of the number of new users of modern method of contraception at the end of the previous year.*	**Results**: The HMIS figures indicate that there was a 1.6 per cent increase in the new users of FP methods in the 15 JPP districts during the last year (from 2011/12 to 2012/13) and a 7.8 per cent increase in the eight M&E districts assessed at baseline. The baseline percentage increase from 2010/11 to 2011/12 was 47 per cent.
Indicator 1.1.4: *Proportion of health facilities without stock-outs of three most commonly used contraceptives methods (male condoms, contraceptive pills and Depo-Provera).*	The baseline result for this indicator was 59.5 per cent. Within the year between the baseline and the MTE the figure had increased to 74.5 per cent with two districts having achieved no stock-outs (namely Kaabong and Kotido).

According to the JPP, the percentage increase in the number of new family planning (FP) users is calculated as the difference between new FP users at the end of the current year and new FP users at the end of the previous year, all expressed as a percentage of new users in the previous year.
This indicator is problematic and in future the number of new users of family planning should be expressed as a percentage of the number of women in the reproductive age group (aged 15 to 49 years) for each year. Also the purpose of the MTE is to assess progress since programme inception and not just in the year between baseline and the MTE. If this indicator is used then the number of new users has increased by 60.8 per cent since programme commencement.

Findings

- Community mobilization by VHTs is contributing to the increase in numbers of women and couples coming forward for family planning.
- The reproductive health camps are attracting considerable numbers of new clients with a broader range of services than family planning (for example breast and cervical cancer screening). Between 2011 and the end of 2012, Reproductive Health Uganda (RHU)increased the number of women having a tubal ligation three-fold, having an implant and intra-uterine device inserted four-fold and using injectables increased six-fold.
- In 2012 a total of 1,781 women (6.9%) who had an implant inserted by RHU had it removed and 18.3 per cent of women who had an IUD inserted had it removed.[23]
- "Fear of side effects" was the most important reason for not using contraception given by women eligible to use contraception.
- There has been a dramatic reduction in the percentage of contraceptive stock-outs which can be attributed in part to UNFPA support for the Contraceptive Procurement Strategy and its implementation.

Lessons learnt

- There is insufficient evidence to be able to demonstrate an increase in the provision of long-term methods by government health facilities. A system to track this should be put in place so that evidence of capacity building by RHU and MSU can be measured.
- The Reproductive Health Consortium was established in 2010 and some agencies are experiencing delays in transferring funds thereby limiting their effectiveness in programme implementation.

[23] The high number of removals was also identified in the JPP Annual Report 2012 and "requiring further attention". Urgent action needs to be taken on this as dissatisfied users can undermine programme success.

Recommendations

1. Revise the indicator for measuring the number of new users of FP to be based on the total number of women as a percentage of women aged 15 to 49 years.
2. Improve disaggregation of data by "new" clients and a distinction made between women who are using any form of modern contraception for the first time and those who are a using a method which is "new" to them.
3. HMIS data should indicate whether the contraceptive was provided from a government static facility, reproductive health camp or a private-not-for-profit provider. This would enable the MoH to see where capacity has been built in government health facilities and where further strengthening is required.
4. Pay more attention to the concept of "spacing" not "stopping" births, addressing cultural concerns about contraception and ensuring that adequate time is devoted to each client to explain the range of different methods available, their appropriateness and possible side effects.
5. Determine the reasons for the high level of removal of IUDs and fear of side effects and take remedial actions. This could be done through independent research commissioned to ascertain the reasons for removal and whether pressure from husbands and family members is a contributing factor.

According to the HMIS, there were 185,496 new users of modern family planning in the 15 JPP districts in the financial year (FY) 2012/13. This was an increase from FY 2010/11 (112,707) and from the previous year (FY 2011/2012) when the number of new family planning users was 182,516 - see **Table 8.**

Table 8: Percentage increase in number of new users of modern family planning methods between FY 2010/11 and FY 2012/13

District	No. of new users of modern FP in FY 2010/2011	No. of new users of modern FP in FY 2011/12	No. of new users of modern FP in FY 2012/13	% increase in no. of new users of FP in last year
Arua[24]	9,266	14,438	29,361	103.4
Yumbe	4,324	7,867	6,304	-19.9
Gulu	37,305	34,200	58,973	72.4
Kitgum	3,544	3,652	8,669	137.4
Oyam	4,191	7,385	6,466	-12.4
Abim	2,462	4,447	2,451	-44.9
Kotido	2,021	3,049	2,848	-6.6
Kaabong	2,290	1,906	1,783	-6.5
Moroto	2,017	5,685	3,909	-31.2
Nakapiripirit	3,875	5,266	8,909	69.2
Katakwi	2,479	27,427	11,045	-59.7
Amudat	655	21,937	11,154	-49.2
Mubende	22,373	26,242	17,250	-34.3
Kanungu	9,144	14,789	10,751	-27.3
Bundibugyo	6,761	4,226	5,623	33.1
15 JPP districts	**112,707**	**182,516**	**185,496**	**1.6**

Sources: National HMIS data 2011/12, 2012/13 also available on http://hmis2.health.go.ug/ [Accessed 3 October 2013]

[24] The figures for Arua are based on the HMIS for FY 2009/10 and 2010/2011.

The figures indicate that there was a 1.6 per cent increase in the new users of FP methods in the 15 JPP districts during the last year and a 7.8 per cent increase in the eight M&E districts assessed at baseline (**Annex 9 Table 9**). These figures clearly show the problem with JPP indicator as the percentage increase in new users since programme commencement in 2011 is 60.8 per cent (although it should be noted that the JPP uses calendar years and the GoU uses financial years from July to June so the period of time is not consistent). The greatest increase is in Amudat where there has been an almost 18-fold increase in new users of FP. Amudat had the lowest number of new users in JPP districts in FY 2010/11; by the end of June 2013 the district ranked 12th out of 15. Other districts that made considerable progress were Arua, Katakwi, Kitgum and Nakapiripirit with the number of new users increasing over four-fold in Katakwi, trebling in Arua and more than doubling in Kitgum and Nakapiripirit. For unknown reasons, four JPP districts (Abim, Bundibugyo, Kaabong and Mubende) had a lower number of new users in FY 2012/13 than 2010/11.

Data obtained from reproductive health camps conducted by Marie Stopes Uganda (MSU) and Reproductive Health Uganda (RHU) for the second quarter of 2013 is encouraging and show that there were 17,703 new users of contraception in 11 of the 15 JPP districts and an additional 1,971 new users in the four districts added in 2013. The emphasis by MSU and RHU is on long-term methods of contraception and implants were the most common new method used (36.9%) followed by injectables/Depo-Provera (15.9%) in the 11 JPP districts (**Annex 9 Table 10**). It appears that MSU and RHU are attracting about 44 per cent of all new family planning clients through their mobile camps. Whilst this is good news, concerns have been expressed by the seemingly high rates of implant and intra-uterine device (IUD) removal undertaken by RHU. For example, in 2012 a total of 1,781 women (6.9%) who had an implant inserted had it removed and 18.3 per cent of women who had an IUD inserted had it removed.[25] The MTE field workers commented that some respondents felt that insufficient time was devoted to counselling and advising on the different methods during these camps. Requests for removal of long-term methods indicate dissatisfaction with the method and can contribute to negative perceptions of contraception and fuel myths and "fear of side effects" (see later).

Service provision – reproductive health camps

In 2010 a Reproductive Health consortium was established to bring together key NGOs providing FP and reproductive health services in Uganda. The members of the consortium are the AIDS Information Centre (AIC), the Marie Stopes Uganda (MSU), Reproductive Health Uganda (RHU) and Uganda Health Marketing Group (UHMG). These four agencies have been providing support to the UNFPA 7th Country Programme and more recently to the JPP under the leadership of RHU which has been providing reproductive health services in Uganda under that name since 2007 and from 1957 under Family Planning Uganda. The change of name of the organisation was to reflect a broader focus on reproductive health including screening for breast and cervical cancer, HIV counselling and testing, STI testing and treatment.

For both MSU and RHU the main emphasis in family planning (FP) services is on long-term and permanent methods. For RHU implementation under the JPP started in January 2011 in six JPP districts (Arua, Gulu, Kanungu, Mubende, Oyam, and Yumbe) and was extended to two non-JPP

[25] RHU Annual Statistics for 2012.

districts in 2013 (Iganga and Namutumba). Reproductive health camps are organized in health facilities in the six JPP districts – see figures for 2011 through to mid-year 2013 (**Annex 9 Table 11**). The RHU teams are well equipped with kits for vasectomy and tubal ligation which are usually retained by the RHU, but can also be donated to a health facility in case of need.

Marie Stopes Uganda (MSU) became a JPP implementing partner in 2013 and started working in Luuka and Jinja in the Busoga region[26] in June[27] to support government, private-not-for-profit (PNFPs), and civil society organisations (CSOs) to provide family planning services through static clinics, routine activities, and event-specific outreaches and camps. The MSU integrates FP services with HIV/AIDS activities, as well as cervical cancer screening.

Both RHU and MSU work through reproductive health camps and support local leaders, Village Health Teams and Population Champions to mobilize women and men to come to the camp with their partner on an appointed day. Clients are educated on the various methods, and groups and individuals are given counselling. Contraceptive services are then provided for the counselled clients and the services include permanent methods like vasectomy and bilateral tubal ligation as well as intra-uterine devices, implants, contraceptive pills and condoms.

Both organisations build capacity of the public health sector to provide long acting and permanent methods of family planning with the aim of transferring skills to government staff so they are able to offer long-term methods of family planning.

Reproductive Health Uganda (RHU) also supports the integration of sexual and reproductive health and rights into other health care services and harnessing the inputs made by other partners in providing integrated services through outreach. They train champions of sexual and reproductive health and rights to advocate for services and rights at district level and in a range of fora such as National days where in an integrated approach is showcased using information on FP and HIV amongst young people. **Table 18** shows FP services provided by RHU over the period 2011-2013. This table does not differentiate between new and repeat clients and can therefore include double counting for when a client comes for more than one service or receives a contraceptive method that requires repeat visits.

Client satisfaction is assessed by MSU by conducting periodic exit interviews following service provision. Five different approaches are used by MSU to increase contraceptive uptake: 1. A mobile team provides free of charge FP services through an outreach camp with a mobile vehicle equipped to provide surgical procedures equivalent to those provided at a health facility. The MSU team usually returns to the same site once every two to three months. About 20 sites are visited each month. Capacity building is provided to staff at the health facility to build their skills in long-term methods; 2. Reproductive health services are also provided by MSU through a network of static clinics which provide comprehensive FP services as well as other reproductive health services. The services at the services are provided for a fee based on the ability of the local community to pay for the services. Fifteen such clinics are available country-wide. 3. Partial social franchising is available

[26] MSU also works in other JPP districts under the UNFPA 7th Country programme.
[27] The June 2013 report showed they had seen over 371 new clients in the two districts during one month.

through the Blue Star programme and private sector providers are engaged to provide FP services using a voucher system. The vouchers are available to the clients at a cost less than $1. 4. Extension FP services are provided to communities through community health workers or Village Health teams (VHTs). This service is available in eight districts for injectable contraceptives (Depo-Provera). 5. Social marketing of FP products such as, Lifeguard condoms.

District health teams are involved through their participation in the radio talk shows and during joint supervisory visits. All data on the services provided by MSU and RHU should be captured and incorporated into the district HMIS, although there were initial problems with this it now seems to be working better. During the MTE checks were made to see if MSU had left their record sheets behind. In all instances they were available, although inaccuracies were noted in Abim district in transferring the MSU data into the FP register at the health facility, this leading to under-reporting.

Mid-term evaluation results

Of the 1,859 women of reproductive age interviewed (aged 15 to 49 years), 1,188 (63.9%) women had ever tried to use something to delay pregnancy whilst over one-third (36.1%) had never used any method to avoid pregnancy (**Annex 9 Table 12**). Out of the 1,188 women who had ever used any method to avoid or delay pregnancy, 744 women (62.6%), were currently using at least one method (this could include modern and traditional methods) and 444 women were not using any method at the time of the survey. There is considerable variation between districts with 85.1 per cent of women interviewed in Oyam and 82.2 per cent in Bundibugyo currently using methods to prevent pregnancy compared with only 34 per cent in Moroto - although the numbers for Moroto are too small to be statistically significant (**Annex 9 Table 13**). The most commonly used methods were: injectables (28.3%); implants (17.7%); male condoms (16%); and contraceptive pills (14%). Ten per cent of women were using traditional methods such as the rhythm method (6.6%) or withdrawal (3.5%). These traditional methods are more commonly practised in Arua by 28.2 per cent of women using any method and in Yumbe (23.4%) and Kaabong (18.8%) **(Annex 9 Table 14**).

The most common reason given by the 444 women of reproductive age who were not currently using any form of contraception (although they had done so before) was because they were not married (18.4%) or not having sex 10.7 per cent. A worrying 13.5 per cent said that they were not using contraceptive methods due to fear of side effects, or they had health concerns. Opposition of husband/partner did not appear to be a significant factor affecting contraceptive use (5.5%) and was only slightly higher than the women's own opposition to contraception (5.1%). The fear of side effects/health concerns was highest in Amudat district (44.5%), followed by Oyam (23.9%), Gulu and (22.8%) and Moroto (19.5%) **(Annex 9 Table 15**).

6.5 Stock-outs of contraceptive methods

Box 5: Stock-outs of contraceptives at health facilities

Indicator 1.1.4: *Proportion of health facilities without stock-outs of three most commonly used contraceptives methods (male condoms, contraceptive pills and Depo-Provera).*	The baseline result for this indicator was 59.5 per cent. Within the year between the baseline and the MTE the figure had increased to 74.5 per cent with two districts having achieved no stock-outs (namely Kaabong and Kotido). The districts of Bundibugyo and Oyam experienced more stock-outs than any other JPP districts (see **Table 9**).

Findings

- The JPP has supported the Ugandan Contraceptive Procurement Plan through US$ 3.8 million supply of family planning commodities (18% of the total cost of FP supplies for Uganda).
- The JPP has also supported national logistics and management of family planning supplies which has improved FP commodity security and distribution.

Table 9: Percentage of health facilities without stock-outs of three most commonly used contraceptives methods (male condoms, Depo-Provera, pills) by district

District	Male condoms		Contraceptive pills		Depo-Provera		Overall	
	No	%	No	%	No	%	No	%
Arua	27	75	29	80.6	35	97.2	24	**66.7**
Yumbe	8	80	8	80	9	90	7	**70**
Gulu	12	75	16	100	16	100	12	**75**
Kitgum	8	80	9	90	8	80	7	**70**
Oyam	5	71.4	5	71.4	6	85.7	5	**71.4**
Abim	4	80	4	80	4	80	3	**60**
Kaabong	7	100	7	100	7	100	7	**100**
Kotido	6	100	6	100	6	100	6	**100**
Moroto	6	100	6	100	5	83.3	5	**83.3**
Nakapiripirit	6	85.7	7	100	7	100	6	**85.7**
Amudat	3	100	2	66.7	3	100	2	**66.7**
Katakwi	9	90	7	70	9	90	7	**70**
Mubende	11	91.7	12	100	12	100	11	**91.7**
Bundibugyo	3	66.7	4	80	4	80	2	**40**
Kanungu	5	100	4	80	5	100	4	**80**
Overall	**120**	**82.8**	**126**	**86.9**	**136**	**93.8**	**108**	**74.6**

Source: MTE Health facility survey, 2013

6.6 Community Groups for male and young people's involvement in sexual and reproductive health and rights

Output 1.2: *Community Groups mobilized for male and young people's involvement in sexual and reproductive health and rights*

6.6.1 Male Action Groups

Box 6: Male Action Groups

Indicator 1.2.1: *Number of functional Male Action Groups (MAGs) advocating for sexual and reproductive health and rights*	The MTE found that 52 Male Action Groups (MAGs) had been established and were functional in September 2012 (time of the baseline survey). By July 2013, only 44 were functional with eight having ceased to operate in the year between baseline and the MTE. This raises serious concerns about their sustainability in the long term.
Findings and lessons learnt – see Case Study below	

Recommendations

1. Support MAGs to start up income generating activities (IGA) with savings and investment schemes. Some of the savings can be used to meet the costs of transport, information, education and communication materials.
2. Train MAG members in ANC, FP, STIs, nutrition, financial management and book keeping.
3. Provide MAGs with T-shirts and identity cards upon successful completion of training.
4. Strengthen district level support, monitoring and supervision for MAGs through the involvement of the District Community Development Officer.

Case study 2 - Male Action Groups Their role in increasing referral to health services and uptake of family planning and women's access to maternal health

Involving men as active partners in sexual and reproductive health:

Male involvement in reproductive health is ingrained in the Programme of Action that was agreed at the *International Conference on Population and Development* (ICPD, Cairo 1994). This included "male responsibilities and participation "as critical aspects for improving reproductive health (RH) outcomes, achieving gender equality, equity, and empowering women (UN ICPD, paras 4-29). In Uganda male involvement in reproductive health was defined in the *Uganda strategy for Male Involvement 2011/2015* and defined as the fulfilment of roles and responsibilities of men in sexual and reproductive health and rights including HIV/AIDS prevention, care and support.

In Ugandan culture issues about sex and reproductive health have traditionally been the responsibility of women to inform girls, especially to prepare them for menstruation and childbirth. This has led to stereotyping which affects the implementation of reproductive health, family planning and HIV programmes. Most FP programmes have targeted women leaving the men on the periphery and this has resulted in the slow progress in getting men to support their wives to seek maternal health services and to accompany them for HIV counselling and testing (Sentumbwe-Mugasa, 2013).

Behavioural change at family and community level is paramount to increase contraceptive uptake and antenatal care (ANC) attendance and improve sexual and reproductive health. There is increasing evidence from research that adequate and accurate information on sexual and reproductive health for men and women will reinforce the efforts in these areas. With needed support, men and boys can play a major role in promoting safer sexual practices at individual, family and community levels (Sentumbwe-Mugasa, 2013).

In 2011 the JPP contributed to the development of *The National Strategy for Male Involvement in Child Health, Sexual and Reproductive Health and Rights including HIV/AIDS 2011-2016* whose goal is "to improve male participation in child and maternal health including sexual and reproductive health and rights and HIV/AIDS through providing strategic directions to all stakeholders in Uganda".

As a result, communities, men and young people have been mobilized to support sexual and reproductive health and rights through Male Action Groups (MAGs) and Alliance for Parents, Adolescents and Communities (APADOC). The JPP, through WHO has supported the creation of MAGs in target districts, to act as catalysts for reproductive health and rights programmes under the JPP.

Photograph: Some of the members of the Male Action Group in Mubended, Kitanga sub-county

Effectiveness of MAGs:

Where MAGs have been formed and are functional, they have helped to increase referrals to maternal health services and improved the uptake of family planning care. A case study of a MAG in Mubende district, Kitanga sub-county revealed that the MAG had performed well in delivering on its objectives which include:

- changing male attitudes towards women's health care seeking
- reducing stigma in men when seeking health services
- identifying a pregnant women for referral to health centres
- mobilizing males to promote good health services

The group was well organized, with a constitution, a leadership committee and membership of 20 original members. Although the MoH guidelines require each MAG to have 25 members, this group started with 20 registered members in July 2012, and only increased to 25 members in 2013.

The group had a target of referring 700 mothers to health centres between July 2012 and June 2013. Although the MAG lacked information on how many mothers had been referred for ANC in the health centres, evidence from Kalonga HC III (Mubende) shows that the number of first-time pregnant women attending 1st ANC increased from 703 in 2011/12 to 789 in 2012/13. Those attending 4th ANC increased from 320 in 2011/12 to 424 in 2013/13 (*Health facility HMIS reports 2011/12-2012/13*).

Men have been encouraged to accompany their wives to attend ANC and those who do so, are given first preference for attention at the health centres.

The number of women delivering in health facilities increased from 258 in 2011/12 to 347 in 2012/13 at Kalonga HC III (HMIS records Kalonga HC III).

Photograph: Some clients for antenatal and maternal health care at Kalonga HC III in Mubende district

Communities were sensitized about family planning and any negative perceptions were addressed. New users of family planning increased albeit slightly from 263 in 2011/12 to 278 in 2012/13 (HMIS records, Kalonga HC III).

Further effectiveness of MAGs can be demonstrated in the area of Safe Medical Male Circumcision (SMC), where men have been mobilized to go for circumcision in line with the Ministry's strategy for fighting HIV AIDS (*National Safe Male Circumcision Policy,* 2010).

Efficiency

In terms of efficiency, MAGs have lacked logistical support to cover the entire sub-counties where they are located. They argue that the distances are long and they need allowances to mobilize men for sensitization. This has limited their activities and is a major threat to their existence. However, some MAGs have managed to facilitate creation of other smaller MAGs at parish levels. A case in point is the MAG in Kitenga sub-county Masindi district, which managed to create another MAG in Kayunga village, in the same sub-county. This new MAG is named "assika obulamu" which means "a person who cares about life". It is intended to encourage men and women living with HIV/AIDS, to live positively and seek medical attention and counselling. The MAG also sensitizes the community against stigmatisation of people living with HIV/AIDS. However, there was a lack of focus on JPP health outcome areas by some of the MAGs and we noted that they have several objectives that may not be directly linked to the JPP, such as, income generation and environmental hygiene. We recommend that these groups are more focussed on sexual and reproductive health, if future resources are to be committed to support their work.

The functioning MAGs have created a change in perception and stereotypes that men had towards ANC, FP and maternal and child health (MCH) care. Men have been sensitized and are becoming more involved in mobilizing the community. However, a few hitches remain that must be addressed if the MAGs are to have more impact.

The limited funds to facilitate transportation, information and communication activities of the group: The discussion with the MAG in Mubende, found that the group is limited in what they can do and how far they can reach due to lack of funds: this affects their effectiveness.

Limited coverage of the MAGs is partly due to limited funds for outreach to distant villages and to mobilise other groups. In the event that MAGs are supported to start income generating activities, it is hoped that their impact will be higher in terms of coverage and reach. One of the groups mobilized by the MAG in Mubende (KIMAFHESE) failed to register due to lack of funds.

Lack of commitment form members towards group's activities: There is a lack of commitment to attend meetings and group activities. On average, only 12 members out of 25 attend the monthly meetings. This problem could be solved, if funds were generated to re-fund transport costs.

Lack of identity documents and public health knowledge cause lack of community trust in the MAG. The men argue that some communities do not take them seriously since they are not health workers and the requested something to identify them like cards or T-shirts.

6.6.2 APADOC Committees

Box 7: Alliance of Parents, Adolescents and the Community

Indicator 1.2.2: *Number of functional young people's groups advocating for sexual and reproductive health and rights*	Alliance of Parents, Adolescents and the Community (APADOC) Committees have been created in 12 of the 15 JPP districts; exceptions are Oyam, Kanungu and Yumbe districts. Out of the 12 districts where APADOC committees had been established they were not functional in four districts (Bundibugyo, Kaabong, Katakwi and Moroto). Overall, APADOC Committees were only functional in eight districts.
Recommendations 1. APADOC Committees need to be more closely integrated into district and community level structures to strengthen monitoring and supervision and ensure sustainability.	

The World Health Organization has been instrumental in supporting the establishment of the Alliance of Parents, Adolescents and the Community (APADOC) approach. This approach was adopted in other countries in sub-Saharan Africa in 2003 (Mozambique, Namibia and Zimbabwe) through a project funded by The Ford Foundation. An inter-country workshop was organized in November 2006 to share experiences, and document lessons learnt from the three years of implementation of APADOC. From the lessons learnt, the WHO/AFRO Regional Office developed an improved guideline for implementation of APADOC in order to link the approach with Adolescent Friendly Health Services standard implementation as the community-based component of this process (WHO/AFRO, 2007).

The APADOC approach was introduced into Uganda as part of the JPP with WHO support and the Ugandan Private Midwives Association (UPMA) is the implementing partner.

Case study 3 - APADOC committees

The Alliance for Parents, Adolescents and Communities (APADOC) aims to increase involvement of adolescents, their parents and the communities where they live for the promotion of adolescent's health. It intends to address issues of HIV/AIDS, unwanted/early pregnancies, substance use and to improve utilization of services by adolescents and young people. The APADOC approach is based on the evidence that positive relationships with parents, schools and friends, positive cultural values and spirituality are factors that protect adolescent against health risky behaviours.[28]

Relevance

According to WHO, the goal of the APADOC is to improve the health of young people by promoting access to reproductive health information and services for adolescent health and development through creating alliances between adolescents and older people, in line with the MoH guidelines for APADOC. In districts where APADOC Committees were active there were verbal reports from District Health and Community Development Officers of a positive change in behaviour and practices by the young people and parents' attitudes towards adolescent issues like early pregnancies, substance abuse, HIV/AIDs and sexually transmitted infections (STIs).

[28] Alliance for Parents, Adolescents and Communities brochure, Ministry of Health, 2011.

Effectiveness

The process of formation of APADOC committees was participatory involving various stakeholders. This process enabled religious leaders, politicians, district education officers, security officers, opinion leaders, and young boys and girls to deliberate on sexual and reproductive health issues. This collective appreciation has galvanized efforts of APADOC Committees in the districts.

The behavioural change messages through information, education and communication (IEC) materials have been effective in delivering the message of change. APADOC members were supplied with flyers and material on behavioural change. In schools, posters on "delay sex", "keep in school", "avoid early pregnancies", "don't use drugs" have been put up. This has increased the knowledge and appreciation of these issues by the young people. School APADOC clubs have been formed, promoting use of drama and plays to promote young people's healthy behaviour. In Arua, ten schools have APADOC clubs. APADOC clubs in schools were provided with 1 million Ugandan Shillings (USh) to implement activities that included among others, sensitisation and peer counselling.

APADOC Committees and MAGs have an important role to play in raising awareness about sexual and reproductive health in the community. This is most effective when they are linked with YFCs and health facilities.

Formation of other APADOCs: District level APADOC committees have facilitated formation of other APADOC committees at sub-county level in the Arua Municipality which has aided the formation of eight other APADOCs Adumi, Aivu, Arivu, Aroi, Katrini, Logwi, Pajulu and Vurru sub-counties. In other districts sub-county APADOC committees (especially those in rural sub-counties) are not fully functional and this is reported to be due to lack of logistical support to hold meetings and conduct outreach activities in the communities.

Efficiency

Linkages between APADOCs and Youth friendly corners have been noted. The APADOC committees reach out to youth in communities, identify their problems and refer them to YFCs for assistance. The peer educators trained under the YFCs have been instrumental in reaching out to the youth, educating and sensitizing them.

APADOC school clubs have been opened to bring students and teachers on board in order to address challenges faced by adolescents. Issues of substance use, HIV/AIDS, early pregnancies are discussed and students are sensitized periodically. Sports equipment is supplied to these clubs including footballs, netballs, volley balls and chess boards. These clubs help improve student discipline and commitment to achieving education objectives.

Sustainability

The main setback threatening the sustainability of APADOC committees is the lack of funds to facilitate meetings and outreach programmes. For example, the APADOC committee in Arua municipality rescheduled the weekly meetings of the executive committee to be held monthly due to limited resources. It was reported that councillors cannot attend APADOC district meetings if there are no allowances. Delays in disbursement of funds have also been a setback.

There is also a question about who is responsible for supervising and monitoring the work of the APADOC committees according to their agreed roles and responsibilities. In Abim it is the health worker in charge of the Youth Friendly Services which adds another task to her already busy schedule.

In Abim the District Health Officer has been active in mobilising men through the APADOC so that they know that every pregnant woman should be accompanied by her husband when going for ANC. The issue of alcohol use was raised in Abim and needs to be addressed so that peer educators and APADOC members are giving a good example. A “peer” educator was reported to be “very old and an alcoholic” by the youth who were not comfortable with this situation. A member of the MTE team was told it was not possible to meet with the male members of the APADOC in Abim as they would be drunk after returning from the fields.

7. Prepared and protected healthy mothers, children and youth

The JPP aims to address health and education that directly contribute to fertility reduction, while preparing, protecting and focusing on the health of mothers, children and youth to become useful citizens. The JPP supports acceleration of efforts to improve maternal, new-born and child health and survival; and creation of conditions conducive for retention and completion of education especially for girls (including providing bursaries for girls' education).

7.1 Bursaries for vulnerable girls

Output 2.1 *Conditions conducive for enrolment, retention and completion of education under universal primary education (UPE) and universal secondary education (USE) institutions enhanced specially for girls*

Box 8: Bursaries for vulnerable girls

Indicator 2.1.1: *Number of girls retained in school through secondary school bursary programme in the eight monitoring and evaluation districts*	**Results**: A total of 1,000 girls (854 for secondary schools and 146 for Business, Technical, Vocational Education and Training, BTVET) were retained in secondary schools and BTVET institutions in the eight JPP districts by December 2012.
Findings and lessons learnt – see Case Study below	
Recommendations 1. The JPP should pay for the already enrolled girls to complete O or A-Level and BTVET. 2. Financial and business management skills should be offered to those students completing BTVET to enable them manage their businesses. 3. A clear mechanism of referring students to schools should be developed and to avoid the inconvenience of having to transfer students to other schools mid-way through their enrolment. 4. Repeat the Empowerment camp in 2014 to sensitise the girls in receipt of bursaries and encourage them to complete school. 5. Clear mechanisms for funding should be communicated to the schools to avoid any inconvenience and uncertainty that girls have faced as a result of delayed payment of fees. Better communication with the schools to manage the welfare and fees issues with the headmasters is proposed to ensure that girls are not sent home for defaulting on any of the school requirements. 6. The girls' bursary programme should be scaled-up to cater for more disadvantaged girls in future, and be integrated into the proposed National Youth Programme.	

Case study 4 - Increasing girls access to education through bursaries

Girls' education is a major priority in government strategies for gender equality and to increase primary school enrolment rates, especially under the universal primary education programmes. Girls have for long been regarded as tools for bride price and money, and therefore their education was not always a priority. However such trends are changing and recent enrolment statistics in 2011 indicate gender parity with enrolment rates for boys at 97.1 per cent and for girls at 97.5 per cent.

Relevance of Girls Secondary school Bursaries

At secondary school level the enrolment of females is lower than the males, one of the reasons is that girls are married off early in some regions like in Karamoja. For example, once a girl achieves 12 years in the Pokot culture of Karamoja she is deemed old enough for marriage often after undergoing Female Genital Mutilation (FGM)[29]. Under the JPP UNICEF has been providing secondary school bursaries for disadvantaged girls from eight of the JPP districts since 2011. The Girls Education Movement (GEM) is the implementing partner for the girl's bursaries with overall responsibility for management of the programme.

In line with JPP Outcome 1, the longer girls are kept in school, the more likely they are to delay marriage and thereby reducing fertility. Additionally, educated girls will more likely make more informed choices of when to have their next child and how to respond to issues of reproductive health and rights in their families, as compared to uneducated girls.

Effectiveness: Process of issuing bursaries

Advertisements are run in the eight districts, on radio and on district notice boards. A selection committee chaired by the by the District Education Officer (DEO) is tasked to do the selection. The selection criteria are based on the best performing students among applicants and the poorest students (those who are orphaned or have no guardians to meet their school fees needs). In some cases, daughters of prominent leaders in the districts who applied for bursaries were denied them because they did not meet the criteria. Officials from GEM carry out background checks for the selected girls to ensure that they qualify academically and are from poor families. In cases where inconsistencies are noted between a girls' submission and the background check, a replacement is found from the next girl who is deemed more suitable for the bursary. Twelve teenage mothers were given hope by enrolling them in the scholarship programme, and four girls with special needs were included in the programme.

Achievements and completion

A total of 1,000 girls (854 for secondary schools and 146 for Business, Technical, Vocational Education and Training, BTVET) were retained in secondary schools and BTVET institutions in the eight JPP districts by December 2012. The total number of scholarship beneficiaries increased from 837 in 2011 to 1,000 girls in 2012. Twenty-four scholarship beneficiaries sat senior four out of the 1,000 enrolled since 2011. To date, four have completed BTVET and five have completed A Levels. Four girls were given start-up kits, and these girls have been linked to experienced local artisans for practical training and exposure to the market conditions in their various fields.

In the case of drop-outs, the girls are replaced by those on the waiting list. By the time of the MTE, 40 dropouts had been replaced since the start of the programme, with Karamoja schools having the highest numbers of drop-outs; Moroto (14) and Oyam (11) have had the highest pregnancy rates. In 2013 the drop-out rate was reduced mainly due to the impact of an Empowerment camp held in 2013 for all the sponsored girls, in which they received sensitisation and capacity building on family planning, reproductive health issues, and the relevance of education.

[29] A Prohibition of Female Genital Mutilation Act was passed in 2010

The mechanism of selection of schools where these girls should study is not yet clear to some stakeholders. It was noted that some of the good performing students in up country schools are sometimes transferred to schools in Kampala to give them better education. While this is a positive sign to give the girls better education, consultations with parents/guardians and headmasters should be held before decisions are taken on where these girls will be posted. In Yumbe for example, some of the girls posted to schools in Kampala, did not like the decision to leave their home district. The school officials confirmed that this takes away their best performing students who would have lifted the education standards of the schools/district through good performance.

Delays in sending fees have affected the learning environment for the girls. For example in Aringa secondary school (Yumbe), the fees for the second term was received on 30th June 2013, mid-way through the term. It was also noted that scholastic materials come late into the middle of the term, affecting the learning environment of the girls.

Efficiency

Inclusion of BETVET Scholarships was a good decision that ensures that girls acquire immediate skills (two years after their O-Levels) to enable them build careers in vocational work which has been credited for enabling job creation rather than job seeking in Uganda. It also enables girls who have no capacity to pay tuition fees at higher institutions of learning, to obtain certification and practical qualifications in various vocations.

The average fee per school-term is 405,237 UShs, an equivalent of 4,862,844 UShs for the four years. The cost of scholastic materials at the start of school is 583, 4000 UShs (this includes one-time purchases such as a mattress and blanket). The cost per term of scholastic materials, transport and pocket money is approximately 333,400 UShs, which amounts to 4,000,800 UShs over 12 terms. The total cost for educating a single girl is therefore approximately 9,448,044 UShs, for the four years in ordinary secondary education. A comparison with the cost of education for non-bursary students was not possible, as no literature was available with this information.

Sustainability

“There is no sustainability if we cannot help these girls complete O-Level, what is the point of having enrolled them in the first place? It will create a negative image if they drop out midway.” Such were the words of one key informant as she reacted to the plans to stop the girl’s bursaries programme in 2014. Stakeholders consider that this programme should at least help the enrolled girls to complete O-Level in the worst case scenario and A-level/BTVET if possible. “It is better they get a certificate for A-level or BTVET qualification, to increase the chances of employment”, remarked one of the headmasters in a supported school.

The fact that these are bright students makes it likely that once supported to complete A-level, some of them could make it to institutions of higher learning through government sponsorship programmes. Indeed, in Uganda today, a senior 4 graduate would struggle to get employment. The minimum level for clerical employment is now shifting to A-level. BTVET completion would guarantee skills that can enable these girls to become self-employed.

A total of 1,000 girls have benefitted from the programme since 2011 in eight JPP districts. However, the number of needy students is very high and headmasters are desperate for help for more girls who cannot pay fees. This shows how much appreciation the headmasters and communities respectively have for this programme.

Summary

The majority of the girls want to do A-Level and go on to higher education. As these are bright girls, they should be able to obtain government sponsorship for further education after A-level.

7.2 Quality package for maternal, new-born and child health services

Output 2.2: *Improved access to a quality package for maternal, new-born and child health services*

The indicators for this output are not organized in a logical manner and it would be clearer if they started with antenatal care, followed by institutional deliveries and concluded with low birth weight. The MTE has kept to the format of the JPP work plan but it does not flow smoothly. In addition it would be clearer if all health interventions were part of the same Outcome and started with adolescent/youth friendly services and family planning and then moved on to maternal and child health.

7.2.1 Institutional deliveries and attendance at birth by a skilled birth attendant

Box 9: Deliveries in health facilities

Indicator 2.2.1: *Percentage of deliveries occurring in health facilities*	**Results**: The percentage of deliveries occurring in health facilities in the 15 JPP districts was 40.9 per cent by mid-2013: an increase from 32 per cent (2010/11) and from 37.5 per cent since the baseline survey one year ago.
Indicator 2.2.2: *Percentage of births attended by a skilled birth attendant*	**Results:** The same as above – an assumption being that trained providers are delivering in health facilities. This may not always be the case (due to absences of trained staff) but no further data were available.[30]

Findings

- There has been progress in increasing the number of births taking place in a health facility and attended by a skilled provider. The variation between districts is considerable from 7 per cent in Amudat to 82 per cent in Gulu. Also Yumbe and Bundibugyo had a lower percentage of institutional deliveries in 2012/13 than in 2010/13.
- Data from the household survey found that home births were reported to be highest in Amudat, Katakwi and Nakapiririt.
- Comprehensive technical guidelines and training materials have been developed under the JPP (**Annex 10**).
- Training of midwives is yielding positive results, but many are still in training and the benefits of this intervention are yet to be fully realised.
- Shortages of trained staff are still being experienced.
- In-service training in emergency obstetric and neo-natal care (EMONC) has continued throughout 2013.
- Inaccuracies in record keeping were noted in maternity units of most districts (for example, not recording age or parity and attendance at ANC by visit).

[30] Data from the UDHS (2012) show that nationally 59 per cent of births were attended by a skilled provider and 57 per cent of births took place in a health facility.

- Reproductive health equipment was only provided for HC IVs and hospitals in eight UNFPA supported districts. Other districts require the same equipment to provide quality of care.
- Community mobilization in some remote areas needs further strengthening and transport to health facilities was mentioned as a problem in the Karamoja region.
- In 2012 42,000 Maama kits were distributed to seven JPP districts Arua, Bundibugyo, Gulu, Kanungu, Katakwi, Kitgum, Mubende, Oyam, and Yumbe.
- Delays have been encountered in the procurement of the expanded Maama kits and at US$ 100 per kit they are too expensive and not sustainable. It is fared that once the kits arrive the contents will be sold to purchase essential items including food.
- Some districts are providing Maama kits during antenatal care when women live a considerable distance from the health facility.
- Insufficient attention paid to neo-natal care and essential equipment needs to be in place.

Lessons learnt – see Case Study 5 below

Recommendations

1. The JPP should continue to advocate with Population Champions, the Ministry of Finance, MoH and local governments to prioritise recruitment and retention of health workers as part of the government commitment to Family Planning 2020.
2. Reproductive health equipment (including for neo-natal care) should be provided to the other seven districts so that a standardized package is in place across all JPP districts.
3. A feasibility study of the emergency transport needs of the Karamoja region and other remote districts should be undertaken and if appropriate motorcycle ambulances should be procured as part of an income generating activity/community development initiative.
4. A feasibility study should be undertaken on the appropriateness of waiting mother's shelters for when demand for maternal health care services increases.
5. The MoH should revert to using the basic Maama kits after the expanded kits have been distributed.

The HMIS data for 2012/13 show that the percentage of deliveries occurring in health facilities in the 15 JPP districts was 40.9 per cent just above the HSSIP target of 40% by 2015. This is an increase from 32 per cent (2010/11) and from 37.5 per cent since the baseline survey one year ago - **Table 10.** Two districts (Yumbe and Bundibugyo) have had a lower percentage of deliveries occurring in a health facility from 2010/11 to 2012/13 and in Bundibugyo the absolute number had decreased from 4,283 to 3,959 during this two year period. This requires local investigation as to the reasons and remedial actions should be taken. The percentage of deliveries occurring in health facilities in the eight M&E districts was higher than the 15 JPP districts at 46.5 per cent (See **Annex 9 Table 16).**

Maternal health data obtained from the HMIS show that a high percentage of births are attended by a skilled birth attendant in Gulu (82%) to a very low 7.0 per cent in Amudat (but up from 6.5% at baseline). The information obtained from women of reproductive age in the MTE household survey is less varied and shows that 86.8 per cent of the 371 women who had given birth in the last year had delivered in a health facility, 8.4 per cent delivered at home and 3.8 per cent in the home of a traditional birth attendant (TBA). Home births were highest in Amudat, Katakwi and Nakapiririt (all above 25 per cent, but the numbers are too small to be statistically significant and births in the home of a TBA were highest in Kotido, Moroto and Nakapiripirit.

Table 10: Percentage of institutional deliveries 2010/11 to 2012/13

	FY 2010/11			FY 2011/12			FY 2012/13		
District	No. of expected deliveries in unit	Deliveries in Unit[31]	% births attended by midwife or other skilled attendant	No. of expected deliveries in unit	Deliveries in Unit	% births attended by midwife or other skilled attendant	No. of expected deliveries in unit	Deliveries in Unit	% births attended by midwife or other skilled attendant
Arua[32]	35,264	13,039	37.0	35,264	13,031	37.0	25,888	14,981	57.9
Yumbe	5,289	1,844	34.9	24,468	8,502	34.8	25,094	8,641	34.4
Gulu	16,845	11,210	66.5	18,702	16,038	85.8	19,769	16,203	82.0
Kitgum	10,803	5,829	54	11,154	6,727	60.9	11,399	7,013	61.5
Oyam	17,150	6,878	40.1	17,761	7,504	42.3	17,434	7,992	45.8
Abim	2,711	1,484	54.7	4,340	1,893	43.7	2,556	2,011	78.7
Kaabong	16,747	1,112	6.7	15,326	1,457	9.5	18,178	1,980	10.9
Kotido	9923	2,618	26.4	10,597	2,787	26.3	10,731	3,762	35.1
Moroto	13,010	567	4.4	6,635	712	11.2	6,293	1,115	17.7
Nakapiripirit	7,183	798	11.1	7,391	934	12.6	7,471	1,308	17.5
Amudat	5,514	193	3.5	5,514	359	6.5	5,192	361	7.0
Katakwi	7,498	2,462	32.8	8,536	3,334	39.2	8,132	3,326	40.9
Mubende	27,589	6,883	24.9	29,171	8,319	28.5	28,086	9,750	34.7
Bundibugyo	11,473	4,283	37.3	12,072	5,393	44.7	15,909	3,959	24.9
Kanungu	11,921	4,354	36.5	11,727	4,910	41.9	11,358	4,817	42.4
15 JPP districts	**198,920**	**63,535**	**32.0**	**218,658**	**81,900**	**37.5**	**164,812**	**87,219**	**40.9**
Uganda DHS						**58.0**			

Sources: HMIS for FY 2010/11, 2011/12, 2012/13 and Uganda Demographic Health Survey, 2012.

[31] This figure may include deliveries by private practitioners.
[32] HMIS for FY 2010/2011

The government *Millennium Development Goals Report for Uganda 2010: Special theme: Accelerating progress towards improving maternal health* identifies the strategic actions that need to be undertaken to improve maternal health and reduce maternal mortality. Seven main areas are identified: provision of adequate health financing; strengthening the health referral system; elimination of financial barriers for pregnant women accessing maternal health services; improved supply chain system to provide equipment and supplies at adequate levels; recruitment, training and retention of an adequate number of health staff; improvement of the basic infrastructure for maternal health service delivery and access; and the promotion of communication, education and public awareness to facilitate and improve service use.

The JPP addresses some of these factors through training of midwives and their subsequent bonding, the provision of equipment to eight districts, community mobilization through Village Health Teams (VHTs) and MAGs. However, these interventions (especially the provision of equipment) have not been uniform in their implementation. The photographs show the difference between Kotido HC IV on the left where UNFPA has provided equipment for obstetric care and Abim hospital maternity ward on the right. Not only does Abim lack suitable equipment it also does not have running water.

Kotido Health Centre IV

Abim hospital maternity ward

The JPP Annual Report for 2012 refers to the problems with long distances between homes and health facilities as contributing to non-attendance at ANC clinics and delays in reaching health facilities at the time of delivery. This was seen to be particularly acute in the Karamoja region and in Bundibugyo, Oyam and Yumbe districts. An example of lack of transport was observed in Kaabong where five women had been mobilized to attend for vaginal fistula repair. They were at Kaabong hospital at 0930 waiting for transport to Moroto where the camp was being conducted, but by 1530 they still had not departed. This was due to logistical problems and poor management, not only the shortage of transport.

The DHO in Kotido indicated that 70 per cent of institutional deliveries were coming from women in two parishes and attributed this to the poor condition of roads and the absence of transport. He recognised the need to further mobilize men and communities to provide resources to secure transportation for pregnant women at the time of delivery.

The JPP could learn lessons from an initiative started in Moroto district, by the NGO Brac where motorcycles were distributed as part of an income generating activity (IGA) for livelihood improvement to youth and community health workers. As a condition of receiving the motorcycle, the *boda-boda* rider is obliged to transport pregnant women and sick children for free to the health facility. The cost of transport is subsidized by Brac as one way of improving maternal and child health in the community. The other suggestion received from one DHO was to support the provision of motorcycle ambulances (a motorcycle with a side car where the pregnant woman can lie down) to transport women to the health facility for delivery. These are being used in South Sudan with UNICEF UK support.[33]

The JPP has supported the provision of 200 yellow phones for VHTs to improve referral to health facility. However, health workers indicated that they also need means of communication to refer women in obstetric emergencies. The MTE was not able to assess the functionality of the yellow phones and this requires further investigation at district level to assess that they are still functioning and being used appropriately by the VHTs.

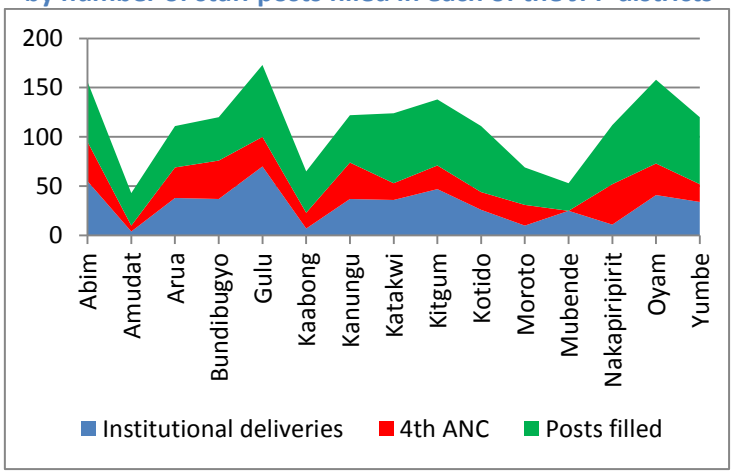
At the moment maternal health services are being under-utilized due to the 40 per cent institutional delivery rate. However, if community mobilization continues and the number of trained midwives is increased, there could be a future situation where demand outstrips supply. At the moment some at-risk pregnant women (high parity, breech presentation) are staying in the maternity ward in some districts prior to delivery as beds are available. When demand increases this will no longer be possible and the JPP should consider the future establishment of waiting mother's shelters (or maternal waiting homes), especially for women who live far from the health facility. These have been successfully tried in other countries such as Ethiopia, Malawi and Zimbabwe (Van Lonkhuijzen et al 2012) and in Rwanda (Chambers, 2012). Such shelters/homes may be a future option for Uganda once demand for institutional delivery increases. They appear to be most effective when combined with nutrition gardens and health education interventions and their effectiveness is dependent on the provision of quality obstetric and neo-natal care in the health facility. However, obstetric emergencies cannot always be predicted and waiting shelters are no substitute for functioning telecommunications and transportation systems.

Lessons can also be learnt from Rwanda where considerable success has been achieved in increasing institutional delivery and antenatal care attendance, and halving maternal mortality over a five-year period. The reasons for these successes have been attributed to government commitment to maternal mortality reduction, policy coherence, community health insurance, strong supervision and monitoring of maternal health systems (with monthly reporting on progress towards agreed performance goals), functioning communications and transportation, incentives for attending ANC, encouragement of partners at ANC and fines are imposed for home births (Chambers, 2012). A strong emphasis has been placed on building the capacity of community health workers (CHW) and there is a maternal health worker in every village who identifies and educates all pregnant women and follows up on their progress.

[33] Motorcycle Ambulances for Pregnant Women in South Sudan: Final report prepared for the Guernsey Overseas Aid Commission, March 2013. http://www.gov.gg/CHttpHandler.ashx?id=82788&p=0

From the *Uganda Health System Assessment* (2011) data there appears to be a clear association between staff posts being filled and higher levels of institutional deliveries and attendance at four antenatal care visits (**Figure 5**). Generally there is a positive relationship between antenatal attendance and institutional delivery, but in Gulu there was a 70 per cent institutional delivery rate, but only 30 per cent of pregnant women attended for four antenatal visits. Whilst in Kaabong, Moroto and Nakapiripirit women were more likely to attend for antenatal care than give birth in a health facility.

Figure 5: Number of institutional deliveries and attendance at 4th antenatal care visit by number of staff posts filled in each of the JPP districts



Source: Ministry of Health et al, *Uganda Health System Assessment 2011.*

The percentage of midwifery posts filled by JPP district is shown in **Annex 9 Table 17** and shows variations between only 39 to 40 per cent of posts filled in Abim, Bundibugyo and Kaabong to 90 per cent in Mubende. Under the JPP considerable training of midwives has taken place and this is beginning to yield positive results as the training midwives take up post. For example, up until March 2013 no deliveries had been conducted at Lokitalebu HC II (Kotido district). Since the arrival of a midwife there have been 36 deliveries in three months indicating the need for trained staff to be in post. In Kotido, 26 midwives are still undergoing 3-year midwifery training and five completed in March 2013. In Yumbe, 26 midwives are also still under-going training and ten completed in 2013.

An interesting initiative was noted in during the MTE field visit to Kaabong. In January 2013 the MoH and local NGO, TASO (The AIDS Support Organization) advertised for 600 health professionals to be recruited in 22 districts for a two year period. This was part of a Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) initiative to eliminate mother-to-child transmission of HIV and achieve universal access to HIV care and treatment. The five JPP districts that have benefited from this programme are: Arua, Kaabong, Moroto, Nakapiripirit and Yumbe.

Early in 2013 the MoH/TASO recruited one Clinical Officer and one midwife and support staff for all five HC III facilities in Kaabong. Since then there has been an improvement in service provision, but other district health staff are concerned that the TASO supported staff are paid more than them and their health insurance is also covered. The long-term sustainability of this initiative remains to be

seen, as well as whether the recruited candidates are absorbed into mainstream public service upon expiry of the two year contract.[34]

Whilst extremely positive improvements have been made in reducing stock outs of FP commodities, some health centres are experiencing problems with access to other medicines and equipment. For example, Orwamuge HC III in Abim had not received any supplies of essential drugs from the National Medical Stores for the past month, Kaabong hospital had no reagents for testing for Syphilis and they were out of stock for CD4 cartridges for measuring CD4 counts amongst people living with HIV. In Kotido HCIV they had stock outs of misiprostol, irregular supplies of oxytocin, antibiotics and resuscitation fluids for neo-natal care. Abim hospital mentioned shortages of Emergency Obstetric Care (EmOC) kits, neo-natal resuscitation fluids and did not have any neo-natal bulb suctions. In many health centres visited staff and patients complained about drug shortages and some said that many patients only visit when they know that drugs are in stock. This is substantiated by data obtained from the MTE Health facility survey which found that 82.7 per cent of facilities did not have anti-retrovirals and 41.4 per cent did not have reagents for testing STIs (**Annex 9 Table 18**).

7.2.2 Low birth weight babies

Indicator 2.2.3: *Percentage of low birth weight babies in health facilities*

The household survey data show that of babies born in the last 12 months, 11.2 per cent were underweight at birth. The numbers were too small to show statistically significant differences between districts. Data obtained from the HMIS show that the overall percentage of low birth weight babies in all JPP districts was 6.6 per cent (similar to the 6.7% recorded in 2011/12) and the highest percentages of low birth weight babies were in Amudat (12.2%) and Moroto (11.3%) which had almost doubled since the previous year – **Table 11**.

Table 11: Percentage of low birth weight babies in the JPP district health facilities 2011/11 to 2012/13

	FY 2011/12			FY 2012/13		
District	No. of all live births in unit	No. of Babies born with low birth weight (<2.5kg)	% low birth weight in health facilities	No. of all live births in unit	No. of Babies born with low birth weight (<2.5kg)	% low birth weight in health facilities
Arua	12,814	451	3.5	14,160	1,005	7.1
Yumbe	8,328	559	6.7	8,500	549	6.5
Gulu	16,038	875	5.5	15,111	796	5.3
Kitgum	6,727	1,068	15.9	7,031	590	8.4
Oyam	7,204	677	9.4	7,698	660	8.6
Abim	1,845	159	8.6	1,914	164	8.6
Kotido	2,787	179	6.4	3,685	211	5.7
Kaabong	1,421	122	8.6	1,831	152	8.3
Moroto	693	48	6.9	1,106	125	11.3

[34] http://www.theugandanjobline.com/2013/01/327-taso-uganda-jobs-enrolled-nurse.html

	FY 2011/12			FY 2012/13		
Nakapiripirit	924	18	2	1,243	63	5.1
Katakwi	3,317	277	8.4	3469	254	7.3
Amudat	353	24	6.8	353	43	12.2
Mubende	7,938	407	5.1	9,258	473	5.1
Kanungu	4,776	236	4.9	4,645	228	4.9
Bundibugyo	5,178	285	5.5	3,803	183	4.8
15 JPP districts	**80,343**	**5,385**	**6.7**	**83,807**	**5,496**	**6.6**

Sources: District HMIS Records for FY 2011/12 and FY 2012/13 and National HMIS data

7.2.3 Attendance at fourth antenatal care visit

Indicator 2.2.4: *Increase in number of pregnant women attending four antenatal visits in the 15 JPP districts*

The national HMIS data shows that there was a slight increase (4.4%) in the number of pregnant women attending four antenatal care clinics during their pregnancy since baseline in 2012 and an overall increase by 16 per cent since the JPP began in 2011. Again there is considerable variation between districts with numbers decreasing to below the 2010/11 level in Oyam, Nakapiripirit, Katakwi, Mubende and Bundibugyo – **Table 12**.

Data from the MTE household survey show a higher number of women of reproductive age (57.8%) reported attending four or more ANC visits during their last pregnancy. However, this statistic could be unreliable due to problems with recall, especially if their last pregnancy was some time ago (**Annex 9 Table 19**).

Table 12: Increase in number of pregnant women attending four ANC visits in the 15 JPP districts 2010/11 to 2012/13

District	No. of pregnant women attending 4 ANC visits			% increase in no. of pregnant women attending 4 ANC visits 2011 to 2013
	2010/11	2011/12	2012/13	
Arua	7,748	10,972	11,300	3.0
Yumbe	4,147	4,782	5,551	16.1
Gulu	5,539	8,144	8,372	2.8
Kitgum	3,092	3,049	3,979	30.5
Oyam	5,673	7,971	5,372	-32.6
Abim	1,091	1,748	1,791	2.5
Kotido	1,839	2,458	3,762	53.1
Kaabong	2,776	2,589	3,488	34.7
Moroto	1,281	1,278	2,427	89.9
Nakapiripirit	2,971	3,114	2,721	-12.6
Katakwi	2,378	2,058	1,922	-6.6
Amudat	306	319	373	16.9
Mubende	10,847	8,452	9,750	15.4
Kanungu	4,487	3,890	4,668	20.0
Bundibugyo	4,647	4,524	2,743	-39.4
JPP districts	**58,822**	**65,348**	**68,219**	**4.4**

Sources: District HMIS Records for FY 2010/11, FY 2011/12 and FY 2012/13 and National HMIS data

Husbands accompanied 28.4 per cent of women to ANC and 80 per cent of women were satisfied with the services received, despite waiting an average of 48 minutes to be seen by a health care provider (maximum length of time 90 minutes). Their main recommendation for improving services was to recruit more health workers (66.7%). The continuing shortage of midwives and skilled birth attendants needs to be accorded higher priority. There are considerable community mobilization efforts to encourage pregnant women to attend health facilities for ANC and institutional deliveries whilst at the same time there are insufficient trained health care providers to meet the existing demand. According to health facility data in Kotido and Kaabong a higher percentage of husbands accompanied their wives to ANC due to the food supplements distributed (see Case Study): 49.4 per cent in Kotido (HMIS data for 2012/13) and an estimated over 90 per cent in Kaabong (heath worker in charge verbal report).

Case study 5 – Synergies between maternal health services and nutritional interventions

The World Food Programme (WFP) is partnering with other UN agencies to contribute to Outcome 2: Prepared and protected health mothers, children and youth.

Since the JPP began in 2011, the WFP has been working in all the 41 health facilities above Health Centre II in the Karamoja region (Abim, Amudat, Kaabong, Kotido, Moroto, Nakapiripirit and Napak[35]) since inception 2010/11. The main role played by WFP has been to provide food supplements to mothers and children. The food supplements are pre-positioned at health facilities where mothers access them when they attend for ANC, when they come to deliver and attend post-natal clinics (PNC).

How the WFP component contributes to the NDP priorities and MDGs

The WFP provides highly fortified nutrition supplements to pregnant and lactating mothers and to children. This supplementation to mothers and children improves their nutritional status and is critical especially in the Karamoja region where indicators on nutrition in the population are way below those in other regions in the country and lie below the national average. The programme has however addressed not only nutrition, but is contributing to increased utilization of health services in the region especially for maternal and child health.

The programme aims to reach 38,000 women and children under the age of two years with food supplements every month in the Karamoja region and improve maternal and child health service utilization.

Achievements to date

The programme has had an impact in the following areas and increased:

- Ante-natal clinic attendance, including a higher numbers of 4th ANC visit

[35] Napak is not one of the 15 JPP districts

- Post-natal care visits
- Delivery in a health facility which is likely to translate into a delivery by a skilled birth attendant
- Utilization of child immunization services.
- Consultations at health facilities for 'not so serious conditions' even on days that they do not expect food supplements. Health seeking behaviour is therefore improving with mothers and members of the community realizing the benefits for seeking health care.

The capacity of the health workers in nutrition has been built by training them and providing facilities with anthropometric equipment.

Any unintended effects of the programme

The increased utilization of health facilities especially by mothers and children for proven interventions such as ANC and childhood immunizations is a bonus and is likely to contribute to pregnant women delivering in health facilities. Increased use of health services provides an opportunity for education and initiation of healthy practices such as, breast feeding in the first hour after childbirth.

In addition, there is improved participation c males in health care seeking as a result of th approach. The pregnant women are required an encouraged to come with their spouses for AN in order for them to receive the foo supplementation. This was clearly demonstrate at Kaabong hospital where it was reported tha 90 per cent of men come with their wife. Th increased number of mothers attending the pos natal clinics can be used as an entry point fc introducing other beneficial services such a family planning.

Photograph of the ANC clinic at Kaabong hospital with men accompanying their wives

As a result of the service and the increasing demand for services, some districts have responded by upgrading health facilities that were at HC II level to HC III level in order to benefit more from the programme and also to cater for the higher demand for the services. This to some extent decongests some health facilities by providing alternative sources of health care. However, increased demand for reproductive health services must be met with quality services on the supply side in order to maintain motivation. The supply of Maama kits through the JPP was seen as one such incentive and a supplement to the work of the WFP.

Challenges encountered and how they were addressed

The programme is based at health facilities. Mothers therefore have to walk long distances to the health facility in order to access the services. This also means that pregnant women and mothers who do not visit health facilities are doubly disadvantaged as they not only miss out on the benefits of health care but also miss out on the nutritious food commodities.

Understaffing and limited technical capacity of the health care staff may also negatively affect the programme outcomes.

Some pregnant women/mothers have attempted to seek services from different health facilities with the aim of accessing more food supplements. This led to the demand outstripping the available supply and has deprived women who are legitimate beneficiaries from receiving food supplements. In order to address this, the district authorities devised a mechanism by which all health facilities in a given district would distribute the food supplements on the same day. This leaves insufficient time for mothers to move from one health facility to another and has stopped the abuse of the system.

The WFP is allocated a proportionately smaller budget compared to other UN agencies. However, the WFP programme contribution is synergistic and has demonstrated an impact on maternal and child health which goes beyond the provision of food supplements. As a result of the success of the programme, the WFP is currently running out of the food supplement supplies and this could impact negatively on the programme as a whole. Also as a result of budget constraints, it is difficult for the WFP to allocate sufficient time and focus to the JPP.

Sustainability and exit strategy

Communities are just beginning to appreciate the usefulness of the programme and so the end of the JPP in 2014 will come too early to reap the full benefits. However, prepositioning of the programme activities in pre-existing government structures was purposeful so that systems are in place after the programme ceases. Some inputs like the village phones, hospital equipment and ambulances may remain, but there will be a continuing need to train midwives on nutrition and community education.

The health and nutrition package in the JPP should continue to be emphasized, especially through educating people and empowering them to be able to purchase or produce on their own food and to practice good hygiene as well as other good health and nutrition good practices. Vulnerable populations need to be continuously educated that the food supplements are only available for a limited period of time and that there is need to look beyond the end of the programme.

Good practice examples should be scaled-up and used to improve those areas where progress has not be so good.

In order to plan beyond 2014, the MoH needs to gradually start owning the activities that are being implemented by the JPP with the aim of ultimately integrating them into MoH programming.

The JPP can be a lesson to future UN joint programming. One of the most important lessons learned is that UN partners should focus on the interventions and processes likely to contribute to achievement of joint outcomes rather than concentrate on the traditional niches of the different partners.

8. Youth and vulnerable groups have competitive skills and opportunities to participate in the economy for sustainable livelihood

This outcome is aimed at addressing the barriers to socio-economic development of young people, particularly focusing on creating employment opportunities through increased access to skills development, employment opportunities and business and financial services.

8.1 Current situation

Box 10: Summary of Outcome 3 findings and recommendations

Indicator 3.1.1: *Percentage of youth accessing skills development and employment opportunities in 15 JPP districts.*	**Result:** 19.3 per cent of youth (18-30 years) surveyed in 2012, were accessing skills development and employment opportunities.
It is recommended that another indicator be developed for the outputs on the Labour Market Information System (LMIS) and this should be included in the final evaluation of the programme.	

Findings

- Implementing partners under this Outcome included UN-Habitat, UNHCR, ILO, IOM, UNICEF and UN- women at the start of the programme in 2011 and 2012. In 2013 only IOM and ILO were implementing partners.
- Abim, Arua, Gulu, Mubende and Oyam were the beneficiary districts under the JPP.
- Approximately 2,000 youths have been trained and enabled to access employment.
- Practical and vocational skills for employment were provided in line with the recommendations of the *National Youth Policy.*
- Vulnerable groups (refugees, adolescent mothers) were reached in line with the *National Employment Policy* that supports gender equality.
- Livelihoods of some women and men were changed through employment creation.
- Some models of training were found to be more sustainable than others.

Lessons learnt

- Organising youth into groups enabled more sustainable businesses to be established.
- Additional training in business and financial management was important in enabling business continuity.
- It is important to understand the market dynamics (i.e. sources of raw materials, costs of production and marketing) before training in specific skills are imparted.
- Some skills are appropriate, but not easily converted into employment opportunities for youth due to high business start-up costs.
- Some businesses require a high level of organisation, marketing, product and brand management, bulk purchasing and supplying to be able to break even.
- Use of local partners is efficient in skills training and employment creation programmes.

Recommendations

1. Integrate skills training and employment creation in the proposed National Youth Programme.
2. Prepare the *National Action Plan on Youth Employment* (NAPYE) to take into consideration lessons learnt from the MTE of Outcome 3.
3. Support the completion of the LMIS framework, NAPYE, Labour Market Needs Assessment (LMNA) survey and the Labour Force Survey (LFS) report and use the recommendations from these four main reports to prepare and phase the activities for 2014.
4. Use the LMIS data to generate future training areas and youth employment creation projects
5. Benchmark LMIS implementation with other countries, i.e. in Rwanda.
6. Add an output indicator on the LMIS intervention to be included in the final evaluation of JPP.

The MTE team carried out a case study of the relevance of skills training and employment creation for youth. In the 2013 work plan however, the youth skills development activities were dropped in favour of a more transformational approach of supporting national policy level interventions for the youth. The case study is presented in the box below.

Case study 6 – Relevance of skills training for youth

The 2009/2010 *Uganda National Household Survey Report* revealed that the general proportion of youth (national definition 18-30 years) rose from 44 per cent in 2005/2006 to 48 per cent in 2009/2010. According to a 2008 World Bank Report, Uganda is among the countries with the youngest population and the highest youth unemployment rate of 83%. According to the *National Youth Policy*[36], the major causes of a high youth unemployment rate are lack of employable skills, lack of access to resources like land and capital, lack of focus by the existing programs on the informal sector and agriculture.

Overall, two thirds of the youth (67.8%) are illiterate with male youths more literate than females at 76.7% and 59.9% respectively (*National Youth Policy*, 2001). The formal youth education system available has been criticised for producing job-seekers rather than job-creators.

The JPP addresses the barriers to socio-economic development of young people, particularly focusing on their participation in access to skills, employment and livelihood improvement opportunities, including in urban geographical locations. The achieve this, UN-Habitat, UNHCR, ILO and IOM supported youth and other vulnerable groups to access skills and employment opportunities especially in northern Uganda. We closely examined the relevance of the support provided, efficiency and effectiveness of implementation and the sustainability of interventions.

Relevance

The support for youth skills development and employment creation was in line with the key priority areas of the *National Youth Policy* which includes: promotion of creation of skills centres to enable access to information and acquisition of practical skills; and support for vocational training and establishment of apprenticeship to enable the youth acquire a range of skills and essential tools.

Different approaches have been used for youth skills development and employment creation by the different partners. The ILO trained young mothers in Gulu to make crafts using local raw materials (pine leaves) and young women in Oyam in making energy-saving cooking stoves using locally made products. The UN-Habitat supported training of youth in: entrepreneurship and business management; practical skills (making soap, candles, juice, and chalk); vocational skills including tailoring, metal fabrication, carpentry, joinery, motor vehicle mechanics, catering, and information, communication technology, ICT); and student attachments to local artisans. UNHCR offered youth

[36] Ministry of Gender, Labour and Social Development (2001). *National Youth Policy.*

scholarships in Arua district in vocational training skills relevant to a refugee settlement i.e. brick laying, carpentry and joinery and primary teacher training. The IOM through its Community-based Reintegration Programme (CBRP) supported vulnerable women from Gulu to access labour market and employment opportunities.

The skills were relevant both at policy and the community levels. At the policy level, the training reinforced the need to build practical and vocational skills that help create jobs as outlined in priorities of the *National Youth Policy*. The vocational training supported by UN-Habitat in Arua and the practical skills supported by ILO in Gulu and Oyam were particularly good examples. At the community level, the skills were relevant and led to immediate employment in many cases. Products from the practical trainings such as soap, candles and chalk making were very marketable and essential. Carpentry, welding and brick-making products and services are needed in the local community. The relevance of skills is unquestionable, although other factors have undermined some of the training interventions.

Effectiveness

There was effectiveness in the selection of beneficiaries who fitted into the target category of youth and vulnerable groups. 2000 youths including (young men and women, refugees and teenage mothers) were among the groups reached with skills development and employment creation. Selection of participants was done by a Youth Committee in Arua under UN-Habitat support and the project partners of ILO in Gulu. In Arua, the selection of youth for practical skills took into consideration the education level (below O level was acceptable), place of residence (consideration was given to youth in urban areas), and gender (50% of the applicants had to be female). This underlines the choice of youth with low levels of education living in urban areas as a target group for skills development and employment creation.

Young mothers (aged 15 to 25 years) were targeted in Gulu for the craft business; female-headed households were targeted for community based reintegration by IOM in Gulu, while young women (18 to 35) years were targeted for the energy-saving stoves project in Oyam district. This underscores the gender equality and inclusion of vulnerable groups in the selection of beneficiaries.

The partners achieved their planned targets in terms of numbers reached in Arua, Gulu, Mubende and Oyam. Under UNHCR, 60 national youth and 40 refugees from Arua district obtained vocational skills training for two to three years. Additionally, 58 continuing students were provided with start-up kits for various trades. A total of 158 youth were therefore supported under UNHCR. These youth were trained in courses including: primary teacher training, early childhood teacher training, carpentry and joinery, building and concrete making, plumbing, tailoring and garment cutting, motor vehicle mechanics, and electrical installation. Some of these courses were based on the needs of the refugee camp setting. The late confirmation of and receipt of funds from UNHCR led to delays in many cases and some the students missed the first academic year in vocational technical schools and had to ask for an extension which proved costly.

Under UN-Habitat, 55 women received training in making energy-saving stoves, 55 youth (male and female) were attached to vocational institutions and local artisans to access vocational skills trainings, 400 male and female youth received 5-day training in skills for making products (soap,

liquid soap, candles, juice), and 200 young mothers received 5-day training in entrepreneurship and business management skills. The training was delivered on time, certificates were offered and the youth acquired new skills.

The ILO provided a Training of Trainers (ToT) for three young people in Business Development Services (BDS) in Gulu, Kitgum and Oyam on Generate Your Business Idea (GYBI) and Start and Improve your Business (SIYB) models. Through these models, a total of 241 youth (117 female and 124 male) from Gulu, Kitgum and Oyam were trained in business development using the GYBI and SIYB modules. These business skills have been effective in helping the young businesses (born out of ILO support) to grow and be sustainable. Typical examples are the craft business in Gulu and energy-saving stoves business in Oyam that have remained fully operational, after the programme intervention.

The ILO supported training of women in craft-making from Gulu district. In total, 94 women were trained from Palaro and Patiko sub-counties. They were given start-up kits that included scissors, packets of elastic pill, packets of safety needles, wrappers, and bundles of palm leaves. They make products like shopping baskets, handbags, trays and hats which are sold in Gulu, Kampala, south Sudan and emerging markets in the USA. A total of 101 women from Oyam district were trained in making energy-saving stoves. The women (18 to 35 years) were organized in two groups from Loro and Iceme sub-counties. The energy-saving stoves are sold in markets in northern Uganda and Kampala, offering a source of revenue and livelihood for the young women.

The IOM, through its CBRP produced results reflecting encouraging strides towards the reintegration of beneficiaries into society. Forty-six women (46 Doers and Transmitters) identified as potential leaders worked with their communities and formed 47 peer support groups (PSGs). In April and May 2001, these PSGs underwent extensive agricultural and animal management training tailored to their needs and interests. Over 743 female-headed households were reached with this support. In June 2013 IOM activities ceased following the decision to stop some activities under Outcome three and therefore the MTE team could not visit the beneficiaries for further assessment.

The different approaches described above made effective use of local partners which reduced operational costs and increased contact hours with the trainers. A typical example was the craft making training where local partners (trainers from Masindi district) were used to deliver training for six months at a minimal cost. Other partners involved included Windle Trust international and Telesat International who provided training for several youth.

Efficiency

In terms of efficiency, the training was delivered with limited resources and to good satisfaction of the trainers. Most of the trainees interviewed were pleased with the type and quality of training they had received, and were able to put into practice what they had learnt. An example was in Arua, where youth were trained for one week in making soap and other products. During the MTE there was evidence that the youth had made some of these products regardless of the challenges they faced with marketing and business management. The quality of products being produced by the youth at St. Josephs' vocational institute was commendable. One of the beneficiaries (Ajobe Hamid)

from St Joseph's vocational institute was able to design doors, lockers and roofing metallic stands, after one year of enrolment.

One area of future improvement is to have Youth Training Centres in line with the *National Youth Policy*. Such training centres would save having to hire space for the training. In Arua district for example, a Youth Centre is under construction, using materials produced by the youth trained under UN-Habitat support. The youth have made bricks and managed all carpentry and metal works. Such Youth Centres can enable youth interaction to share experiences and skills, information on business, and sexual and reproductive health and provide a space for exhibitions of their products.

Use of ToT for the business start-up and business improvement training by ILO was commendable and an efficient approach. In this approach, about 241 youth were trained in business development skills by locally trained trainers using GYBI and SIYB modules. Financial systems were in place and each partner implemented its own unique systems. However, financial disbursements in some cases were made late and this reportedly affected the implementation of activities. Some of the local partners claimed they had not been paid all the money for projects implemented and completed by the time of the MTE in August 2013.

Impact of the Programme

The positive effects included changed livelihoods. Most of the youth (women and men) who acquired and put these skills to good use, were able to improve their livelihoods. There were many cases where beneficiaries' livelihoods had improved. Some beneficiaries had started other businesses to support their primary source of income. A typical example of a women positively affected is in the box below.

> Akello Stella from Lubanga Pewany in Patiko Sub County was among the women trained in craft-making by ILO. She uses the skills acquired to make good quality crafts. She receives 70,000-90,000 UGX on a monthly basis and has bought two females pigs from her savings. She also farms ground nuts for additional income. She claims there is "peace in her house these days" because of her ability to meet their daily needs.

Employment creation: beneficiaries have started businesses, thus creating employment for other people who sell and market their products. A number of youth are employed in selling crafts, cooking stoves, bricks, carpentry and welding products and other services. In Gulu, it was reported that an external market for the crafts had been secured by a client in the USA which could potentially open up further employment opportunities.

Promotion of environmentally friendly products: the energy-saving stoves are designed to reduce the demand for charcoal - a product responsible for de-forestation. The energy-saving stoves are environmentally friendly as they use less charcoal than the normal stoves and can use saw dust instead of charcoal.

Some negative effects were noted with the women beneficiaries, who reported increased abuse, from their husbands due to disagreements on how to share the money acquired from their businesses. It was reported that some men reproach their wives for "becoming rich", not being respectful anymore and not consulting them on their business engagements. In Gulu, some women trained in making crafts experienced domestic violence. Some men complained about the long hours

their wives were taking off their domestic duties to engage in training, some cases of divorce were reported. In future, men should be included in the programme so they understand the time commitment required from their wives.

Sustainability

The skills training and employment creation interventions reached around 2,000 youth in two years, which is less than 0.02 per cent of the total population of youth in Uganda. This was viewed as a "drop in the ocean" and these activities ceased in mid-2013. It was therefore important that partners with on-going programmes planned their exit strategies with a 'do no harm approach'. Consequently, ILO, UN-Habitat, UNHCR and IOM have phased out activities in 2013, although some beneficiaries continue to thrive in their businesses. Those doing well include the craft-making project in Gulu and the energy-saving stoves in Oyam. It is reported that IOM beneficiaries of reintegration are also doing well after the programme intervention.

Funding from the JPP for students enrolled in vocational schools under the support of UNHCR will continue until the end their courses. This will ensure that enrolled students complete their courses even after the funding period has ended. It is recommended that future programmes involving youth sponsorship ensure funds are available for the entire duration of the course.

The practical skills training offered in Arua in cottage industry products have suffered due to a lack of sustainable mechanisms. It is advisable that the youth trained in skills are also given business management and marketing skills to enable them to manage their businesses. The GYBI and SIYB models of ILO can be co-opted by other models of skills building as additional courses in future.

Some pictures of the beneficiaries of the training programmes

Photograph: Youth sponsored for Carpentry and Joinery at St. Joseph's vocational school in Aura, by UN-Habitat

Photograph: Young woman in Arua shows off the 'out of work' machinery and remains of her soap making

Photograph: A young man, attached to the local artisans in Arua, designs a metallic bed.

Photograph: Young mothers in Gulu shows some of their handmade crafts in a market

Youth Centres are an important innovation that would enable youth to interact and share experiences, show case their products and skills and coordinate training programmes. The Arua Youth Centre is a good example that should be supported to ensure that youth have a place where future training can take place.

8.2 National level interventions, a new focus!

The JPP under Outcome 3 will support the: 1. development and completion of the *National Action Plan on Youth Employment* (NAPYE); 2. establishment of a Labour Market Information System (LMIS); 3. completion of a Labour Market Needs Assessment (LMNA) survey; and 4. UBOS to undertake analysis, production and dissemination of the National Labour Force Survey (LFS) Report.

8.2.1 Rationale for interventions

The development of the NAPYE will enable the operationalization of the 2011 *National Employment Policy* (NEP), specifically focusing on youth employment. The NEP recognises that youth constitute the highest percentage of the labour force and employment creation must be relevant to the current needs of the labour market.

The development of a LMIS is relevant and in line with the *National Employment Policy*. The policy underlines the need to have accurate and timely information on jobs, job-seekers, labour mobility, employment levels, real wages, hours worked and desired skills, in the public and private sectors. The LMIS will enable monitoring of the employment situation, trends, and the design of appropriate policies. A LMNA survey will provide vital information to feed into the demand side of the LMIS. The National Labour Force Survey will provide information that feeds into the "supply" side of the LMIS. Both reports will provide vital information on the labour situation in Uganda.

The process of developing the NAPYE is under way and initial consultations have been completed, led by ILO and MoGLSD. Despite a few delays in holding workshops, the activities are still on course to be completed in accordance with the work plan. By the time of the MTE, the stakeholders had identified the key focus areas of the NAPYE and what remains is to formulate the NAPYE based on those focus areas, and to have it approved by December 2013. The NAPYE will be vital in guiding youth employment programmes in the next 5 years.

The process of developing a LMIS framework is on-going, led by IOM. The framework will put into place the design aspects and information needs pertinent to make the system operational. A number of consultative workshops have been held with key stakeholders. A consultant to lead the process has been recruited, the inception report was completed and the first draft of the analytical assessment was underway during the MTE. A final Labour Market Information Assessment Framework Report will be completed in December 2013. This will be fundamental in guiding the development in 2014 of the LMIS which will provide fundamental information for policies and activities related to youth skills development and employment creation. The LMNA survey report and the Labour Force Survey report will provide critical information for operationalizing the LMIS.

Responsibility for conducting the LMNA Survey is led by IOM and MoGLSD in consultation with other partners. A LMNA Technical Task Force was formed and a LMNA draft survey report for two sectors (hotel and food processing) will be finalised in October 2013. The draft survey report will be validated and a final LMNA report produced by December 2013. A scale-up of the LMNA survey is

recommended in 2014, to include all other sectors, using the same approved methodology. This should be done to enable timely feeding of information into the LMIS.

The Labour Force Survey was conducted by UBOS in 2012. Given the significance of this report to the development of the LMIS, IOM has taken the lead to analyse the data, discuss and publish the policy implications of the findings. The LFS report will be reviewed in a workshop in October and printed in November 2013. A workshop to discuss the policy implications of the LFS will be held in December 2013. The policy implications will be important in guiding the functionality of the LMIS.

We recommend that efforts to implement the computerised LMIS be prioritised in 2014. The specific Outcome 3 activities should be agreed once the various reports (LMNA Survey report, LFS report, LMIS framework and the NAPYE) are completed in December 2013.

The establishment of a Coordination Unit for the LMIS system should be considered to ensure ownership and successful implementation in 2014. This unit should have staff with the capacity to run such a project with massive information needs. The MoGLD currently has staff shortages and available staff are too busy with other projects. Support for technical staff attached to MoGLSD, should be planned, to ensure successful implementation and full operationalization of the LMIS.

Benchmarking with countries where a LMIS has been successfully implemented and used to reduce the unemployment rate is recommended. In East Africa, Rwanda has a LMIS in place, under the Rwanda Development Board. The LMIS should be able to provide quantitative and the qualitative information and intelligence on the labour market that can assist labour market agents in making informed plans, choices, and decisions related to their business requirements, career planning, education and training offerings, job search, recruitment, labour policies and workforce investment strategies. *See box below on the importance of the LMIS to different stakeholders in Rwanda.*

Importance of the LMIS to different stakeholders in Rwanda

Importance of LMIS to the government

LMIS assists the Government of Rwanda by:

- Providing active labour market policies concerning closing the skills gap;
- Evaluating results of labour related policies and programmes;
- Providing key indicators on demand and supply labour in Rwanda.

Importance of LMIS to the employees or job seekers

LMIS assists employees or job seekers to:

- Make decisions about future career development by providing information on labour market needs;
- Identify current and future job market opportunities;
- Provide analysis of the labour market based on the economic development of Rwanda.

Importance of LMIS to education providers

- Helps education providers align course provision with labour market needs through the analysis of labour market trends

Importance of LMIS to employers

LMIS assists employers to:

- Make decisions about upgrading their employees' skills;
- Access information on skills available on the labour market;
- Access information on different labour characteristics such as labour policies, labour costs.

Source: www.lmis.gov.rw

9. Adequately resourced, coordinated and managed national population programme

This outcome component aims to address gaps in data, data analysis and its integration into national and sub-national planning, programming and monitoring mechanisms. The outcome also aims to address increased commitment of decision-makers to integrate population issues in the development plans through evidenced-based advocacy efforts, as well as strengthening youth participation in planning and decision making. This outcome also aims at ensuring that urban physical development plans address the needs of the youth and vulnerable populations. The other critical component of this outcome is to ensure the coordination of and synergy in the implementation of the JPP.

9.1 Commitment of leaders to address and fund population issues

***Output 4.1**: Increased commitment of leaders at national and sub national levels to address population trends and patterns and allocated budget.*

Box 11: Commitment of leaders to address population trends and allocate budget

***Indicator 4.1.1:** Proportion of target districts allocating and disbursing funds to population issues by expenditure*	**Result:** 100 per cent of districts are allocating and disbursing funds to population issues. This was 30.6 per cent at baseline in 2012.
***Indicator 4.1.2:** percentage of leaders aware and understand the inter-linkages between population and development concerns*	**Result:** 72 per cent of local leaders are able to identify a population phenomenon. Up by one per cent since baseline.

Findings

- All JPP districts allocated funds to population issues in 2012 although the amounts varied from district to district.
- Guidelines on Population Integration have been developed and disseminated to assist planners integrate population issues into their programmes.
- 104 Population champions have been nominated at national and local government levels. They include prominent persons, politicians and entertainers. Champions in parliament have mobilized for increased budgetary allocation for reproductive health resulting in 49.5 billion USh being allocated to the MoH for recruitment and remuneration of health workers.
- A supportive environment has been created in local governments for discussion of population and reproductive health issues.
- In Arua a Byelaw has been passed fining men whose pregnant wives do not attend ANC clinics.

Lessons learnt

- A 2012 review of District Budget Framework Papers (DBFPs) and District Development Plans found that most districts allocate funds as a lump sum and it is difficult to identify the precise sum allocated to population issues.
- It is more appropriate to focus on funds expended on population issues, rather than disbursement.
- Ten out of 60 champions at district level have not been trained and not all of champions are active.
- Most of the district-based champions are poorly resourced.
- Population champions in Kanungu receive 260,000 USh a quarter and are considerably more active, while in other districts they are not paid.

Recommendations

1. PopSec should develop a system of monitoring progress of Population Champions and provide examples of good practice in advocacy to demonstrate their effectiveness as a strategy for behaviour change mobilization.
2. Standardize training, facilitation and mode of operation of Population Champions across JPP districts to make them more relevant and effective.
3. Provide champions with some milestones to be achieved in the course of the final implementation year of the JPP.
4. At the end of the 2014 evaluate the impact of this innovative strategy.

9.1.2 Advocacy by Population Champions

According to JPP records a total of 104 Population Champions have been nominated (**Annex 9 Table 20**), but they have not all been trained or are fully functional. In Kotido champions have been "identified" but they are not functional -" it is tough getting them around here...." The need for more male champions and increased male dialogue was recognised as men “control access to resources – they need to sell goat or cow for funds to get the woman to hospital”. (Kotido District Health Officer, July 2013). He also mentioned the need to link advocacy on population issues with **gender** as men want lots of children as girls traditionally fetch 150 cattle on marriage.

The benefits of Population Champions in creating a supportive environment was pointed out in relation to Arua where a Byelaw was passed so that husbands have to pay a fine if their wife does not attend for antenatal care (ANC).

Some of the Population Champions interviewed had not received training in their roles and responsibilities and therefore lacked understanding of what they should be doing, i.e. in Amudat district the Population Champions had not yet been trained and while they had appointment letters, they lacked knowledge of what they were meant to do.

Case study 7 – Effectiveness of advocacy by national and local champions

At the national level, the JPP has lined up an impressive list of champions ranging from politicians, to business women, to entertainers. These include Ms. Maggie Kigozi (former Executive Director, Uganda Investment Authority). She was sensitized to the JPP and issues of sexual and reproductive health and their linkages to the development of the country. Ms Kigozi often speaks on radio and makes appearances on television and at public events as a guest of honour. Whenever she makes a presentation to the public on investment promotion, she blends in population and reproductive health messages so that investors understand that prudent management of the population must be undertaken if the country is to benefit economically and socially from investments made.

Members of Parliament have also been recruited as champions. Two of them in particular, Hon. Sylvia Namabidde and Hon. Sarah Nyombi, have helped in popularizing and de-stigmatizing the

discussion of reproductive issues in public. These MPs serve as crucial links between the rural grass-root constituents and the policymaking elite in Kampala.

Entertainers have also been recruited as Population Champions. A typical example here is Ms. Juanita Kawalya. She is a popular musician playing with the Afrigo Band. She promotes women and reproductive health issues, often appearing on posters and speaking out in different fora. She even composed and sung a song on these issues which became a popular hit in Uganda.

Similarly, in the districts, leading personalities have been recruited as champions on the same cause. In Mubende district, Hajjat Semakula has engaged people of all faiths in discussions on family health and the importance of birth spacing. It was quite a novelty for most people to see a moslem hajjat speaking boldly on population issues.

Achievements

Although it may not be possible to demonstrate causality at this point, it is undeniable that a good part of the acceptability of open discussion of population and reproductive health issues, both in Kampala and in JPP districts, is attributable to the inputs by these champions. There is anecdotal evidence that this openness was not only absent only a few years ago, but is still lacking in non-JPP districts.

Challenges

The work of the champions is very knowledge intensive and demands for information may outstrip the basic information that the champions are equipped with. Consequently, in cases of intense debates, the champions could risk undoing the work they have done if they cannot live up to challenges advanced by opponents of reproductive health and population issues. The role of the population champions has to move beyond basic sensitization to mobilization for behaviour change if they are to remain relevant.

Some of the champions in districts have been trained, and others have not. The champions interviewed did not have specific knowledge of population issues and were more concerned with other issues like gender-based violence and the environment. In Kitgum, the champions do not understand their roles and have not received training. This is the same with champions in some other districts, who have never been reached or followed up.

Some champions are promoting strategies like “Abstinence and Being faithful” which may not be what the JPP strategy subscribes to. It is clear that majority of the champions have not been properly briefed and trained by the JPP to give them a clear strategy and work plan to follow.

Although the champions in Kampala are well resourced, rural-based champions are resource-challenged which may seriously undermine their ability to influence people’s attitudes. In Kanungu, it was reported that the champions are paid 260,000 USh per quarter received through the district population office. For many other champions the lack of transportation prevents them from conducting outreach.

There were no youth coalitions and networks involved in sub-county and District Development Plans (indictor 4.1.3) through JPP support. Some youth coalitions have recently been created with UNICEF support.

9.2 Availability and use of disaggregated data

Output 4.2: *Increased availability and utilization of disaggregated data, including demographic and socio-economic variables, at national sectoral and sub-national levels*

Indicator 4.2.1: *Proportion of district Development plans (DDPs developed based on socio-economic, demographic and other data sources.*	**Result:** 87 per cent
Indicator 4.2.2: *Percentage of districts with Strategic Plans for Statistical Development*	**Result:** Ten districts: Amudat, Kaabong, Katakwi, Kotido and Mubende do not yet have Strategic Plans for Statistical Development

The Uganda Bureau of Statistics (UBOS) is the government agency charged with the compilation of official statistics and quality assurance of all statistics contributed by different producers to the National Statistical System. The UBOS has been working, with support from UNFPA, to train and give technical backstopping to districts in the JPP to increase the availability and utilization of disaggregated data. The main output of this UBOS activity has been a harmonized data base at district level to be used by district staff for different purposes.

Case study 8 – Capacity of districts to use data for planning, budgeting and decision-making

Case study from Yumbe district

UBOS conducted training in Software management for both the Planning Unit and Administration and Accounts Department. The District Planning Officer reported that the training was good and quite useful. A follow up training was conducted for the second edition of the software, which enabled them print sub-county reports, comparative reports and add indicators to the system.

The District Planning Officer outlined the benefits accruing from this training as follows:

- The system has helped us in developing the Budget Framework Papers (BFPs); it has facilitated the development of statistical abstracts which were submitted to UBOS
- The data generated from the system is useful and helps in decision making, planning and budgeting
- It is a one stop centre for all district data and can produce reports of different data at any time. When stakeholders require data, it takes a few minutes to have this printed.

User friendliness: users noted that the system is easy to use, if the training is properly done. "In Yumbe, for example, out of the 15 members of the statistical committee, six are able to use the system"(District Planning Officer).

Challenges

The Yumbe District Planner noted the following challenges:

- data that is supposed to be fed into the system is quite expensive and with no budget for data collection at district level, this could affect the system and its ability to provide update data;
- the system therefore is currently based on secondary data which may not be the most up to date;
- it is proposed to have the data bases decentralized to sub-counties, however, decentralization of the data base is a challenge in some sub-counties that lack electricity and computers. In the meantime, staff from sub-counties have been assimilated in the system and attend report dissemination meetings to keep them up to date.

Recommendations

The District Planner made the following recommendations:

1. Continuous training is needed to keep the users up to date and to ensure that all the departments are able to support the system needs.
2. It is advisable that the improved 2nd edition of the software is installed into all user departments.
3. Yumbe district was among the first district to use the system. The fact that it is functioning well, makes it a success story which can be used for benchmarking by other districts who are still struggling to use the system.

The biggest resource in assisting UBOS to update district statistical data is the national population and housing census. Unfortunately, the census which was due to be conducted in 2012 was postponed and it is not certain when it will next be conducted.

A summary of UBOS's efforts towards promoting availability and utilization of harmonized data in all the 15 JPP districts is shown in **Table 13**.

Table 13: Activities by the Uganda Bureau of Statistics (UBOS) towards a District harmonized data base

District	Harmonized data base	UBOS SUPPORT	Statistical abstract
Arua	In place and functional	UBOS trained the Population Officer in data management	Was created, it is available and functioning
Yumbe	Functional	Six of the 15 statistics committee members able to use the system	Available
Gulu	Functional	Training in use of the data base in planning	Available
Kitgum	Harmonized data base good and working but its information is not updated but they are in the process of updating their information	Technical Support like training and Mentorship like on the Harmonized data base support supervision and equipment like computers	Available
Oyam	Not functional	They have helped in establishing the harmonised data base and development of strategic plan for statistics	At draft level

District	Harmonized data base	UBOS SUPPORT	Statistical abstract
Abim	Functional	Technical support (analysis, collection data entry and data management)	Has helped in the gathering of data which is important in the planning processes. Provision of the computers has greatly helped in the management of the district data
Kaabong	Functional	Training on harmonized data tools/ data base	None
Kotido	Functional	Training of district statistical committee supervision of data base management twice a year	Not yet available
Moroto	Functional	UBOS trains the district in data management and analysis of data. It is currently managing the Harmonised data base and provides solutions to the planning department. It helps in the production of the population strategic plan and also generates indicator data base. It helps in backstopping the district in the use of figures	Draft submitted to UBOS for review
Nakapiripirit	Functional	Technical support (Capacity Building) on the development of the Statistical abstract, Harmonized Data base and on data management	Available, although needs updating
Amudat	No information. Planner not available for interview and not on phone and email		No information-Planner not available for interview and not on phone and email
Katakwi	Functional	Capacity building on how to use the Harmonized local government data base	none
Mubende	Functional	1. database that is, how it should be designed and the formatting, training to ensure that the database results are harmonized with other districts and how to develop the indicators	Not available
Bundibugyo	In its initial stages - not yet functional		Only a draft available
Kanungu	Functional	Helped in capacity in data generation and analysis; helped to develop the district statistical strategic plan	District strategic plans for statistics available in draft form waiting for approval from UBOS

Source: District Key Informant Interviews, MTE, 2013

Two key informants mentioned the importance of having a statistician at District level. The system in Bundibugyo with a bio-statistician was cited as an example of good practice.

Whilst the harmonized data base is becoming fully operational many frustrations were expressed by key informants about the adequacy of data and difficulties in obtaining data from HMIS "in a timely manner." The donor (DfID) felt that an expensive data base has been established under Outcome 4

and problems still persist as was discussed at the last Steering Committee meeting (minutes not yet seen by MTE Team).

Others noted that districts submit data late and incomplete: “staff have insufficient knowledge about indicators. They do not complete the registers correctly.” “There is no central repository of data” and is “UBOS is slow”.

The absence of a data collection system for adolescents was recognised as a "gap “in the system (PopSec). It is expected that data will be available on young people who attend Youth friendly health services from January 2014 and this should be disaggregated by age (10 to 14, 14 to 19 and 20 to 24 years) and gender.

The WHO appointed a consultant to undertake an assessment of the current data system and made specific recommendations for improvement which now need to be implemented. These include addressing requirements for transport, computers, modems for Internet connection and space for date storage (WHO, 2013).

9.3 Urban Physical Development Plans meet the needs of young and vulnerable people

Output 4.3: *Youth and vulnerable groups benefit from planned urbanization and human settlement development*

Indicator 4.3.1*: Number of Urban Physical Development Plans developed and implemented addressing the needs of young and vulnerable people.*

The original JPP programme document 2011 included support to urban planning and progressive human settlement for safe and stable population as an output under Outcome 3. In the 2013 JPP work plan, this output was shifted to Outcome 4, under which youth and vulnerable groups would benefit from planned urbanisation and human settlement development.

The GoU *Population Policy Action Plan* sub-goal nine has an output on standardised urban infrastructure and housing and eradication of unplanned settlements. In northern Uganda, as a result of rebel activities by the Lord’s resistance army, several unplanned settlements and slums have been created in the urban areas. The JPP, through UN-Habitat developed interventions in which districts would be supported to develop Urban Physical Development Plans that address urbanisation needs as well as those for the youth and vulnerable groups.[37] UN-Habitat has supported the districts of Gulu and Arua to develop such plans. A consultant was appointed in 2012 to develop the plan for Gulu.

Due to delays in the physical planning process, none of the two districts had an approved plan by September 2013 when the MTE was carried out. From the key informant interview with the Urban Planner of UN-Habitat, the process to have a plan approved takes about eight months. While Gulu’s plan was in the final stages of approval, that of Arua was still at the consultative stage with the

[37] A lesson learnt in 2012 was that youth living in rural areas are not catered for because rural sub-counties do not have physical development plans (GoU/UN JPP Annual Report, 2012).

Municipality. The long procurement processes and bureaucracy involved in dealing with local governments is partly responsible for the delays in fast tracking this process. The Gulu Urban Physical Development Plan should be ready by November 2013, while that of Arua is expected by the end of 2014. The main recommendation is to train the urban planners and responsible officials on the concepts and relevance of urban planning. This is against the backdrop of very low capacity in urban planning, which makes appreciation of the concept and participation in the process very low.

It is recommended that once the Gulu Urban Physical Development Plan is approved, it should be disseminated to all relevant stakeholders to enable buy-in and ownership and create appreciation of youth and vulnerable people's issues in the district. In Arua district, the Youth Centre that is largely being built by the youths should be reflected in the Arua Urban Physical Development Plan.

Given the length of time taken to develop these plans and have them approved it is not proposed that other districts should commence development of Urban Physical Development Plans in the final year of JPP implementation.

Related studies and interventions

Slums

A study on Slums in Uganda *Defining the Urban poor for intervention targeting in Uganda* was completed in 2011 by UBOS with support from UNICEF and UNFPA and later disseminated. UNICEF is supporting "an on-going macro-economic simulation study to provide compelling evidence of benefits of investing in children, both to target investments to most useful areas, but also provide strong instrumental arguments for investing in children on national economy/society." (GoU/UN JPP Annual Report 2012). This study was expected to be completed by mid-2013.

Birth registration

UNICEF has supported the Ugandan Registration Services Bureau (URSB) to draft a *National Birth and Death Registration Policy*. Linked with this, UNICEF has also supported the issuance of birth registration services in various districts, including all 15 JPP districts. This has included training of district and health facility staff in 135 HCs in the use of a mobile vital records system (MVRS). The system works in such a way that for every child who is born, information is entered into a mobile phone and sent to the central registration system at the URSB. Once the URSB receives the information a message is sent to the health facility where the baby was born to confirm the information and enable the processing of a birth registration certificate. The system supports URSB to generate real time data that can be used by health, education and other sectors to support improved planning and delivery of services. Data from the system is in the public domain and can be accessed on the webpage www.mobilevrs.co.org.

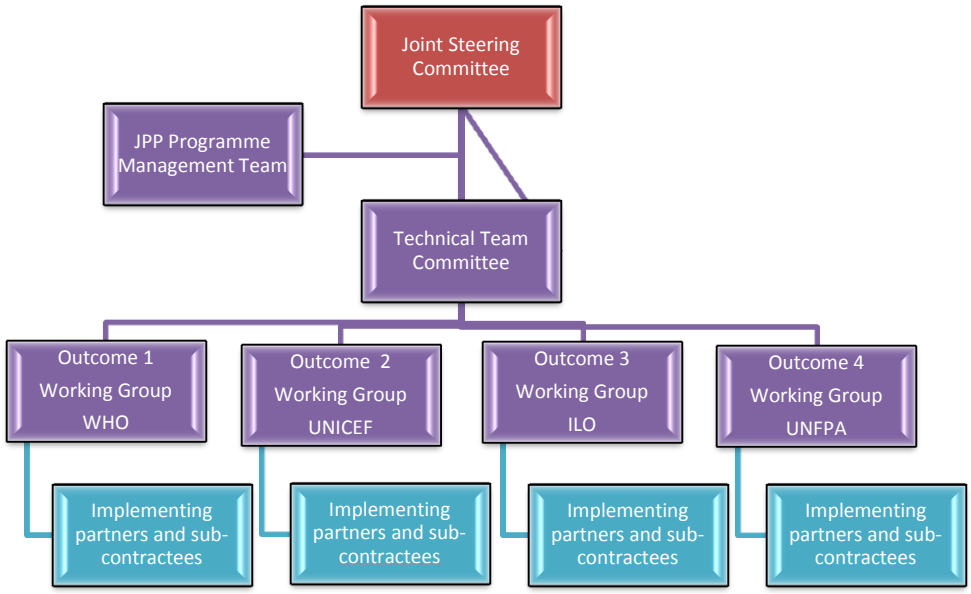
10. Management and coordination

Output 4.4: *Strengthened partnership, coordination and implementation of the Joint programme on Population*

The JPP has established a range of mechanisms for managing the programme and reporting on programme progress. Oversight of the JPP is provided by the JPP Joint Steering Committee chaired by the GoU and with the following membership: DfID, ILO, IOM, MoES, MoH, MoLG, MoLHUD, PopSec, Uganda Registration Services Bureau (URSB), UN Resident Coordinators Office, UNAIDS, UNFPA, UN-Habitat, UNHCR, UNICEF, UN-Women, WFP and WHO. The Joint Steering Committee is co-chaired by the Director of PopSec and the UN Resident Coordinator. Since the programme began in January 2011, six meetings have been held (19 January and 21 September 2011, 19 January and 20 September 2012, 24 January and 03 July 2013).

The JPP is administered by UNFPA and a team of five staff were appointed in 2011: JPP Programme Manager, Senior Programme Officer, Monitoring and Evaluation Officer, Finance Officer and one driver. There has been one staff change - the first Senior Programme Officer resigned in August 2012 and up until July 2013 a staff member was seconded from PopSec to fulfil these duties. In July 2013 the post was filled by a Public Health doctor.

Figure 6: JPP Management and Coordination



Generally JPP coordination at national level was regarded as very good by key informants and was favourably compared with other UN Joint Programmes. As the WFP 2011 Annual Report states : Programme coordination is good but "there is need for synchronization and selection of the JPP target areas based on 'real needs' and level of vulnerability rather than convenience of implementation".

However at regional and district level it was observed that the JPP Focal Points were not always aware of the whole programme and were only familiar with the agency programme that they were responsible for. This needs strengthening and could be achieved through increased JPP team

monitoring visits to regions and districts and through strengthened government ownership of the programme.

10.1 Financing

The UKaid/DfID contributed $39,076,238 (62%) of the three years 2011, 2012 and 2013 of the programme to-date. The UN agencies have contributed $23,900,531 for the three years. UNFPA made the biggest contribution to the JPP (57%) followed by WFP (35%). UN-Habitat has not made any financial contribution to the JPP; UN-Women made US$ 5,000 over three years and WHO US$ 6,000 over the same period (Table 14).

Table 14: Annual contribution by DfID and UN agency

Agency	2011	2012	2013	Total
ILO	32,000	10,000	-	**42,000**
IOM	500,000	-	-	**500,000**
UNFPA	1,106,061	2,381,500	10,297,336	**13,784,897**
UN-Habitat	-	-	-	**0**
UNHCR	148,092	-	-	**148,092**
UNICEF	435,000	364,542	50,000	**849,542**
UN-Women	5,000	-	-	**5,000**
WFP	8,565,000	-	-	**8,565,000**
WHO	-	6000	-	**6,000**
TOTAL UN	**10,791,153**	**2,762,042**	**10,347,336**	**23,900,531**
DfID	11,919,576	12,529, 901	14,626,761	39,076,238
TOTAL	**22,710,729**	**15,291,943**	**24,974,097**	**62,976,769**

Source: JPP financial reports 2011 to 2013

The greatest amount of expenditure has been on Outcome 1 (over half), followed by Outcome 2 about one third of the total budget, Outcome 4 about 10 per cent, and Outcome 3 about 5 per cent of the budget. Precise programme management costs are not known and each UN agency takes 7 per cent overhead costs for programme activities that they support. The MTE team was not required to undertake a financial analysis of programme costs, but recognise that further analysis of costs are required to determine value for money by Outcome area.

Nearly all key informants from UN agencies, government and implementing agencies expressed concern about the late disbursement of funds. This was a major frustration for them and was impeding programme implementation. This was a major problem for those agencies that cannot carry over funds from one financial year to the next. An analysis of disbursements to UN agencies was undertaken during the MTE and found that initial disbursements to agencies in the first quarter of 2011 were slow due to initial systems set up. The second disbursement took an average of eight days from UNFPA headquarters to other UN agency headquarters and an average of 12 days from UN agency headquarters to country office accounts. In 2012 and 2013 the disbursement period from UNFPA headquarters to other UN agency headquarters was about one week (Annex 12 Table 1). However, it appears that delays are incurred in funds being transferred from UN agencies headquarters to country office accounts. It is recommended that the bottlenecks to receipt of funds from UN agency headquarters to county offices are identified so that implementation can be stepped up in the final period of the JPP.

11. Monitoring and evaluation

Good systems are in place for monitoring and evaluation with implementing partners (IP) responsible for submitting quarterly reports and all UN agencies preparing an Annual Report. Some of the reports from implementing partners were available for review and most of them were very comprehensive (especially Uganda Red Cross Society and Windle Trust reports). However, it is not clear that these reports were read thoroughly by the responsible agency as some of the recommendations were repeated in each report without any evidence of action being taken.

Increased attention should also be taken to the way in which data are presented so it is clear how many new and repeat clients are being referred to. For clients of YFCs, consideration should be given to the use of an unique identifier code so that records are more accurate and a clear distinction is made between new and repeat clients.

11.1 Annual reports and annual work plans

Annual reports are submitted by all UN agencies and vary in quality and comprehensiveness. Some reports provide a sound overview of progress made and any challenges encountered. However, a few reports were insufficiently detailed and it was difficult to use them to extract information from for this evaluation.

Annual Reports for 2011 and 2012 were submitted in May and April and respectively (**Annex 13 Table 1**). This is much too late and reports were submitted after Annual Work Plans had been approved. This delay was also regarded by some agencies as contributing to the late disbursement of funds. It is recommended that Annual Reports are submitted in January so that the findings can inform the Steering Committee meeting.

No reports of government implementation of JPP activities were available for review. These are important especially in the final year of JPP implementation when it is expected that the government will assume a greater role in taking forward programme activities, especially at district and regional level.

11.2 Joint monitoring missions

The JPP started out by conducting quarterly joint monitoring missions in 2011. However, this was reviewed and reduced to two missions a year for 2012 and 2013. There were mixed reports about the frequency of these visits. The donor considered that they need to be more frequent whilst some of the smaller agencies felt the reduced number was sufficient.

Out of the 15 JPP districts Arua had the greatest number of visits (four) in the first 2.5 years of programme implementation, this was followed by Gulu (three) and Abim, Katakwi, Kitgum, Kotido, Moroto, Mubende and Oyam (with two visits). Six districts (Amudat, Bundibugyo, Kaabong, Kanungu, Nakapiripirit and Yumbe only had one joint monitoring visit during two and a half years (**Annex 13 Table 2**). These districts are amongst the most vulnerable districts and justify more intensive monitoring. In addition, monitoring visits should be used to provide support and supervision to the districts. It is therefore recommended that measures are put in place to increase

JPP monitoring at district level, this could be increased through increased regional involvement and support to programme implementation.

One of the strengths of the JPP joint monitoring visits is their "joint-ness", but this only works properly if all key implementing partners participate. There has been good government representation, especially by PopSec who have participated in all missions and UBOS who participated in half the visits. However, the MoH only participated in one out of nine visits in May 2013 and the MoES has not participated to date (Table 15).

Table 15: List of joint monitoring visits conducted by coverage and participation

	Date of mission	Places visited	Government agencies	UN agencies	Donor
1.	20 to 21 June 2011	Arua, Gulu	PopSec	ILO UNFPA UN-Habitat	
2.	15 to 18 August 2011	Katakwi, Kotido, Moroto	PopSec	UNFPA UNICEF WFP WHO	
3.	14 to 17 November 2011	Arua, Gulu, Oyam	PopSec UBOS	UNFPA UNICEF WHO	DfID
4.	25 to 28 June 2012	Abim, Kaabong, Kitgum, Kotido	PopSec UBOS	IOM UNFPA UNICEF UN-Women	
5.	23 to 27 July 2012	Arua, Gulu, Mubende	PopSec	ILO IOM UNFPA	
6.	12 to 16 November 2012	Arua, Oyam, Yumbe	MGLSD PopSec	ILO UNFPA Un-Habitat WHO Windle Trust/UNHCR	
7.	13 to 15 November 2012	Amudat, Moroto, Nakapiripirit	PopSec UBOS	UNFPA WFP WHO	
8.	19 to 24 May 2013	Abim, Katakwi, Kitgum	?	UNFPA UNICEF	
9.	19 to 24 May 2013	Bundibugyo, Kanungu, Mubende	MoH PopSec UBOS	UNFPA UN-Habitat WHO	

Source: GoU/UNJPP Joint Monitoring Visit Reports 2011 to June 2013

In November 2012 the format of the missions changed with half the team going to three districts and the other half covering another three districts. This revised system appears to work well and reporting in May 2013 was considerably improved.

A shortcoming of the monitoring missions is that whilst implementation bottlenecks were identified in the reports, a system for follow-up by responsible agency does not appear to be in place. This

needs to be addressed in the future so that districts and implementing partners can see the benefits of the visits and feel that their concerns are being addressed. Several DHOs spoken to were frustrated that they have raised problems with JPP implementation but they have not yet seen evidence of these being addressed.

It is also recommended that the JPP team spend more time in the field outside of joint monitoring missions. This would enable them to have a finger on the pulse and be more responsive to district and programme needs.

In addition to the joint monitoring visits, UN agencies conduct their own monitoring visits, but reports of these were not made available to the MTE team. A JPP repository of all reports should be available to facilitate the speedy retrieval of all data and reports.

12. Conclusions and recommendations

It is proposed that re-programming takes place to focus on the challenges identified in the MTE and to reduce the complexity and fragmentation of the programme in the final year of implementation. Efforts should be made to increase GoU/MoH ownership of the programme so that it is fully sustainable and integrated into existing GoU systems and structures by the end of 2014.

Three main challenges facing the programme were identified: 1. Data adequacy, quality, availability and use for planning purposes, in particular availability of complete and timely quality data from routine information systems for monitoring progress in key indicators; 2. Capacity of the health services to deliver quality maternal, neo-natal, child and youth-friendly health services; and 3. Insufficient monitoring and supervision.

So meaningful comparisons can be made between districts and an analysis of the effectiveness of interventions can be conducted, it is proposed to provide the same health sector interventions in each district with attention paid to quality of care of family planning, maternal and neo-natal health care components and integrate these programmes more closely with youth-friendly services and HIV/STI services in the final year of JPP implementation. This should focus on synergies between the interventions and build on the lesson learnt from the example of good practice on the integration of nutrition interventions and male involvement into maternal and child health programmes which have resulted not only in improved nutritional status, but also in increased health care utilisation.

Under the reprogrammed JPP we proposed the four outcome areas are revised as follows:

Outcome 1: Integrate reproductive, maternal, neo-natal, child and adolescent/youth (RMNCHA) services

National level

Sexual and reproductive health information and services for young people

1. Provide Youth friendly corners with a standardised set of culturally appropriate sexual and reproductive health information (in local language), equipment and supplies that take into account the age and gender-specific needs of young girls.

2. Procure a new set of films on sexual and reproductive health and use monitoring visits to exchange films with other districts.

3. Establish a system for accrediting a health service as "youth-friendly" along the lines of Baby-friendly hospitals. The key criteria should include: staff and /or peer educators trained in youth-friendly approaches and in post; culturally appropriate information materials; confidentiality of information; privacy, especially for a private space(separate room) for counselling; accessibility with opening hours based on young people's needs. Only after being accredited should facilities be able to be called youth-friendly and signs can be erected.

4. Strengthen supervision by the MoH and DHO to ensure that services are fully functional and that records are being correctly maintained. Regular monitoring should be in place to ensure that standards are maintained and records are correct.

5. Strengthen Red Cross capacity to supervise more YFCs to ensure that a standard model of service delivery is provided.

6. The proposal for scale-up of YFHS to non-JPP districts should not proceed until data collection problems in the existing 15 districts have been resolved and there is a proper MoH system in place for monitoring YFHS quality, supervising services and ensuring continuity of care when trained staff leave.

7. Review the practice in some schools of repeat pregnancy testing and ensure that counselling is provided and informed consent obtained before any tests are performed on students.

Family planning, maternal, neo-natal and child health services

8. In consultation with district, regional and national partners agree an integrated national package of Reproductive, Maternal, Neo-natal, Child and Adolescent/Youth Health for the JPP and specify the evidence-based health interventions to be implemented in all 15 districts.

9. Strengthen human resource capacity at facility level with necessary skills and ensure key posts are filled for delivery of a quality package of RMNHCA. The JPP should continue to advocate with Population Champions, the Ministry of Finance, MoH and local governments to prioritise recruitment and retention of health workers as part of the government commitment to Family Planning 2020.

10. Revise the indicator for measuring the number of new users of FP to be based on the total number of women as a percentage of women aged 15 to 49 years.

11. Improve disaggregation of data by “new” FP clients and a distinction made between women who are using any form of modern contraception for the first time and those who are a using a method which is “new” to them.

12. HMIS data should indicate whether the contraceptive was provided from a government static facility, reproductive health camp or a private-not-for-profit provider. This would enable the MoH to see where capacity has been built in government health facilities and where further strengthening is required.

13. Pay more attention to the concept of “spacing” not “stopping” births, addressing cultural concerns about contraception and ensuring that adequate time is devoted to each client to explain the range of different methods available, their appropriateness and possible side effects.

14. Determine the reasons for the high level of removal of IUDs and fear of side effects and take remedial actions. This could be done through independent research commissioned to ascertain the reasons for removal and whether pressure from husbands and family members is a contributing factor.

15. Address challenges at identified facilities in terms of ensuring health facilities have essential maternal and neo-natal health care supplies in agreement with MoH recommended minimum package (or where it is available but outdated for example, delivery beds in Abim) and ensure that all health facilities in the 15 JPP districts, HC III and above have standardised equipment.

16. Support provision of running water and a power source to facilities providing delivery services.

17. Address problems with transportation of pregnant women to health facilities and develop sustainable solutions (possible use of motorbike ambulances).

18. Undertake a feasibility study on the appropriateness of waiting mother's shelters for when demand for maternal health care services increases.

19. The MoH should revert to using the basic Maama kits after the expanded kits have been distributed.

20. Strengthen policy reforms and strategies to address legal sociocultural barriers to women and youth's access to sexual and reproductive health services e.g. i. byelaws to facilitate pregnant women accessing antenatal care and delivery in a health facility; strengthening efforts to increase access to condoms and contraception by sexually active young people, including addressing the cultural context and locally appropriate messages.

Regional and district level

21. Establish regional meetings (in Karamoja, North, Central and South-west) of district officials responsible for implement the JPP to meet with the regional political leadership to discuss implementation and progress. Such a forum would also facilitate political commitment and identification of roles and responsibilities and would be tasked to discuss issues of health systems and sustainability.

22. Establish district and regional networks of health workers providing YFS. This will provide an incentive for the staff and also an opportunity to learn from examples of good practice identified in the MTE report and also to provide training updates.

Outcome 2: Strengthen role of the districts in community interventions being undertaken by VHTs, peer educators, MAGs and APADOC committees, Population Champions and through the local radio.

District level

23. Support community groups PEs, VHTs, MAGs and APADOC Committees to be self-sustaining through the integration of income generating activities into their operations to improve commitment from young people (PEs), VHTs and men, and their capacity to undertake outreach activities.

24. Establish district and regional networks of YFC peer educators (PEs). This will provide an opportunity for PEs and also an opportunity to learn from examples of good practice and to provide training updates.

25. Create and regularly maintain a district list (data base) of all peer educators trained in youth friendly services identify turnover in PEs and the need to identify and train new PEs. (Consider using innovative technology - Ureport/MTrac – for peer educators).

26. Train up more PEs and put mechanisms in place to increase their retention and motivation.

27. Involve District Community Development Officers (DCDOs) in the community component of the programme and designate them to work with the DHO to monitor progress of all community based JPP activities in the district.

28. Establish systems of supervision and monitoring of community interventions to be undertaken by DCDOs with records kept of all activities.

29. Support the roll-out of the sexual and reproductive health component of the secondary school life skills-based curriculum.

Bursaries for vulnerable girls

30. The JPP should pay for the already enrolled girls to complete O or A-Level and BTVET.

31. Develop a clear mechanism of referring students to schools to avoid the inconvenience of having to transfer students to other schools mid-way through their enrolment.

32. Repeat the Empowerment camp in 2014 to sensitise the girls in receipt of bursaries and encourage them to complete school.

33. Communicate mechanisms for funding to the schools to avoid any inconvenience and uncertainty that girls have faced as a result of delayed payment of fees to ensure that girls are not sent home for defaulting on any of the school requirements.

Outcome 3: Youth and vulnerable groups have competitive skills and opportunities to participate in the economy for sustainable livelihood

34. Integrate skills training and employment creation in the proposed National Youth Programme.

35. Prepare the *National Action Plan on Youth Employment* (NAPYE) to take into consideration lessons learnt from the MTE of Outcome 3, including offering financial and business management skills to students completing BTVET to enable them manage their businesses.

36. Support the completion of the LMIS framework, NAPYE, Labour Market Needs Assessment (LMNA) survey and the Labour Force Survey (LFS) report and use the recommendations from these four main reports to prepare and phase the activities for 2014.

37. Use the LMIS data to generate future training areas and youth employment creation projects.

38. Benchmark LMIS implementation with other countries, i.e. in Rwanda.

39. Add an output indicator on the LMIS intervention in the final JPP evaluation.

Outcome 4: Data availability and utilisation, monitoring and evaluation component

National level

40. Develop a system of monitoring progress of Population Champions and provide examples of good practice in advocacy to demonstrate their effectiveness as a strategy for behaviour change mobilization.

41. Standardize training, facilitation and mode of operation of Population Champions across JPP districts to make them more relevant and effective.

42. Provide champions with milestones to be achieved in the final year of the JPP and at the end of the 2014 evaluate the impact of this innovative strategy.

43. Provide continuing training to keep the users of the harmonized database system up to date and to ensure that all the departments are able to support the system needs. It is advisable that the improved 2nd edition of the software is installed into all user departments.

44. Use lessons learned from Yumbe district for benchmarking by other districts who are still struggling to use the system.

45. Strengthen timely follow-up of recommendations made in implementing partner's reports and the findings of joint JPP monitoring missions. This involves the design of tools to help assess follow up on actions recommended from the monitoring visits which can be reviewed in Steering Committee meetings.

46. Provide access to the electronic repository of documents so that JPP programme documents can be accessed by not only UN agencies but also government (national, district and local) and implementing partners.

47. Submit Annual Reports by all UN agencies at an agreed date in January so that the information in the reports underpins the Annual Work Plans for the following year.

48. Identify the bottlenecks contributing to late disbursement of funds to UN agencies and implementing partners and take appropriate remedial actions to address them.

49. Discuss JPP activities at the UN Programme Management Team meeting one month before the UN JPP Steering Committee to ensure that UN agencies are speaking as one in their formal interactions with government and the donor (DfID).

District level

50. Strengthen district JPP coordination and ownership of the programme through increased JPP joint team monitoring visits and build linkages so that UN agencies work integrated way rather than individual partners at district level.

51. Establish quarterly district JPP planning, coordination and M&E meetings to facilitate integration of JPP interventions, review data, implementation progress and follow up. To be chaired by the DHO and attended by all IPs. Progress should be fed back to the CAO to regularly brief the DEC and the Council on what is going on in the District.

Sustainability

52. Develop a sustainability strategy involving district level officials for the full hand-over of all health, education and community interventions to GoU by 2014.

Future programming (post 2014)

1. Make reproductive, maternal, neo-natal, child and adolescent/youth health more explicit in the next National Development Plan and UNDAF.

2. Integrate youth employment, youth skills building, and bursaries for vulnerable young women into the national Youth employment action plan.

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