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Group Photo of Role Model Men

END OF PROJECT EVALUATION REPORT

Sexual Reproductive Maternal Child Health Project

OCTOBER 2017

ACKNOWLEDGEMENT

The end of project evaluation for sexual reproductive maternal child health project was commissioned by Care International with funding from Austria Development Cooperation through Care Austria. The evaluation was conducted by an independent consultant who was identified through a competitive bidding process. The consultant would like to extend gratitude to those that participated in this evaluation in various capacities. We appreciate the support given to the process by GWED G the implementing partner who provided full support during sampling, trainings and eventually traversed various communities in Acholi sub region to guide the data collection exercise.

We also appreciate the participation of the Role Model Men who provided support to the team by introducing and guiding us to their communities. We are also greatly indebted to all categories of respondents; women and men household members, adolescent boys and girls, participating schools and health centers, opinion/elders, traditional leaders/chiefs, clan leaders, local council leaders, relevant district local government officials for granting us interviews, and enduring the back and forth communication that went on throughout the execution of this survey.

Last but not least, a big thank you to Care International team particularly Mr. Ronald Matanda Program Manager and Mr. Ronald Ogal the Initiative Manager for having coordinated with sufficient detail, particularly your input in the harmonization of the entire evaluation process, and more importantly, providing prompt feedback amidst competing priorities.

On the basis of this interaction with key stakeholders, we hope that this external end-of-project evaluation captures the major findings, lessons learned, and recommendations that will help guide future work carried out using the role model men approach.

Haam Rukundo

LEAD CONSULTANT

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LIST OF ACRONYMS

Acronyms	Acronyms in Full
ADA	Australian Development Agency
ASRH	Adolescents Sexual Reproductive Health
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
CAOs	Chief Administrative Officers
CEO	Chief Executive Officer
DAC	Development Assistance Committee
DCDO	District Community Development Officer
FGDs	Focus Group Discussions
GBV	Gender Based Violence
GWED G	Gulu Women's Economic Development and Globalization
GOU	Government of Uganda
HH	Household
IUD	Intrauterine Device
KIIs	Key Informant Interviews
LCS	Local Councils
M&E	Monitoring and evaluation
MCH	Maternal Child Health
MOH	Ministry of Health
NDP	National Development Plan
NGO	Non-governmental Organisation
OVIS	Objectively Verifiable Indicators
PNC	Post Natal Care
PTA	Parents Teachers Associations
RMM	Role model men (man)
SRH	Sexual Reproductive Health
SRMCH	Sexual Reproductive Maternal Child Health
STDs	Sexually transmitted diseases
SDGs	Sustainable Development Goals
SPSS	Statistical Package for Social Sciences
UNFPA	United Nations Population Fund
USAID	United States Agency for International Fund
USAID SAFE	Supporting an Aids Free Era project
VHTs	Village Health Teams

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EXECUTIVE SUMMARY

This report presents the findings of an end of project evaluation for "Sexual Reproductive Maternal Child Health" a project implemented by CARE International in Uganda through Gulu Women's Economic Development and Globalization-GWED-G a local Non-Governmental Organisation based in Gulu Northern Uganda. The goal of the project was: "Improving Access to Reproductive, Child and Maternal Health in Northern Uganda" in the three districts of Gulu, Amuru and Nwoya, covering 9 Sub Counties (Ongako, Bungatira, Bobi, Koro, Patiko, Awach, Lamogi, Koch Goma and Alero). The three expected results were:

1) All members of the participating households have the required, age appropriate knowledge about key Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services;

2) Men and adolescent boys demonstrate supportive behaviours with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services; and

3) Health and Education service providers are more aware of demand based obstacles and actively engage to mitigate deterrents

The overall objectives of the final evaluation was to ascertain the contribution made by SRMCH project towards improving access to Reproductive, Child and Maternal Health in Northern Uganda of 5,600 women, men, girls and boys from Gulu, Amuru and Nwoya districts. The major focus area for the final evaluation was to assess the appropriateness of the theory of change and the project intervention logic, the results achieved during implementation, and its potential sustainability.

Approaches and Methodology

The SRMCH End of Project evaluation was carried out in full compliance with the DAC Evaluation Quality Standards (206). The consultant collected quantitative and qualitative data from the direct and indirect beneficiary households and also selected an additional 48 respondents from the non-intervention areas to act as a comparison (control).

The evaluation reached all the 9 sub counties where the project was implemented. Qualitative approaches were used to triangulate the data obtained from the household and a total of 20 key informants were interviewed and included among others, health workers, village health teams, members of school management committees, project/partner staff, cultural leaders, local council officials, religious leaders, and other opinion leaders as was found feasible during the field work. Data management and analysis took the following steps: coding; cleaning, entry, filling and analysis. Data was entered in Epidata downloaded from the server and exported into SPSS. For ethical consideration, the data enumeration team was composed of both male and female members; interviewers were adequately trained to collect primary data.

Relevancy of the Role Model Men Approach

The consultant found the Role model men approach to be relevant in all the households that participated in this evaluation. All the stakeholders from local government, cultural leaders, health sector, schools, and religious leaders that were interviewed as key informants confirmed the relevance and benefits of the role model men in tackling sexual reproductive maternal child health in the beneficiary households and the general communities as a whole. In particular, the role model men contributed to;

(i) Addressing gender based violence in households. The interviews with key informants and Focus Group Discussions indicated that the role model men influenced the target men to take

responsibility for improved relationships between the household members. The FGD participants were very appreciative of the project and attested about the reduced gender based violence.

> *"Before the project, the beating was every day and people would intervene every day to stop my husband from beating me".* ***FGD Participant-Household Wife***
>
> *"We no longer fight over money. I did not have any power over resources but now when we sell anything my husband will give me the money to keep and if there is need for the money, he will come and discuss it with me too. He now trusts me with controlling the finances of the home. He now believes that I am faithful and less likely to misuse the finances.."* ***FGD Participant-Household Wife***

(ii) The involvement of beneficiary men in the planning and decision making for the health wellbeing of family members has improved the maternal health of the mothers of reproductive age through improved attendance of antenatal care, family planning, and safe delivery in health centers.

> *"On average, we get 4 women being escorted by their husbands for antenatal care for every 10 women that we review per day. In the past seeing a male person in this unit was a miracle"* **Charity Amono: Enrolled nurse at Pabwo Health Centre.**
>
> *I was missing my ANC visits because I had no support but now my husband supports me and I don't miss any.* **FGD participant household wife**
>
> *"At least men are now taking children for immunization. It was very difficult to get a man in Acholi to take a child for immunization they considered it a woman's work."* **Obong Richard RMM Bobi Sub County**

iii)The community is more aware of the sexual reproductive health and maternal child health needs of the household members

> *"Before the GWED-G intervention one would find only 15 women coming for antennal care but now it is over 60 women- this is the great shift that has resulted directly from the sensitization."* ***Village Health Team during an FGD at*** **Lamogi**

The records from the health centres sampled show a consistent positive trend for mothers attending Antenatal care and family planning services

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Koch Goma Health Centre III	738	1690	2494
Awach Health Centre IV	693	**2,179**	**1,016**
Ongako Health Centre III	553	1,085	870
Lapainat Health Centre III	537	1,129	1,019
Bobi Health Centre III	447	530	500
Coo Pee Health Centre II	121	351	429
Awee Health Centre II	78	198	333

Table: Trends of women who turned up for antenatal services

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Koch Goma Health Centre III	222	682	960
Lapainat Health Centre III	224	694	558
Bobi Health Centre III	99	564	1,171
Awee Health Centre II	62	267	176

Table: Trends of women who turned up for family planning services

(iv) The project complimented the local government efforts and all the local government leaders interviewed indicated that they are already using the role model men in mediating the domestic conflicts that arise in the communities. They further indicated that they are already discussing possibilities of supporting the role model men using local government resources.

> *We have used role model men on many occasions during mobilisation and their impact is felt in the whole sub county. They have made our work easy because they reach every part of the community. Our health centres in the sub county were struggling with low turn up of mothers but recently in our planning meeting, they were demanding for more workers due to an overwhelming large turn up of mothers coming for safe delivery and antenatal care and child immunization.* **Key informant interviewee: Christopher OdongKara Chairperson Local Council III, Awach Sub County.**

Effectiveness

There was consistency between the specific project objective and the 3 main result areas and this translated itself to the field, as most time and efforts were focused on attaining the main results. The role model training curriculum was reviewed; the purpose and target of the training is clearly spelt in the manual and specific focus was put at promoting dialogue between adolescents, adult men around SRH and MCH issues, promoting active fatherhood for adolescents and adult fathers.

Project Inputs are in line with the technical nature of the project: heavy on activities (development of training curriculum materials, training of male role models, household dialogue, awareness trainings with leaders (traditional, religious, political, etc.), leaders in action meeting, community feedback sessions and health service forums, training of health service providers and connecting teachers & parents); contract (for GWED G the implementing partner); travel, logistics (for monitoring, training events and workshops); technical support services and general operating expenses (GWED G and Care International).

The male engagement dialogue was the most effective activity in generating results according to the results obtained from the project area. This activity targeted adult men from participating households who met regularly as a group to share experiences and perspectives. The team discovered that this was the most important activity as it allowed the men to discuss their issues on a regular basis and share experiences without necessarily losing their ego in the presence of their women and children. The contributing factor to male engagement dialogue being effective is the fact that men were willing to open up to each other and share experiences and benefits of taking responsibility for the SRMCH of their families. This broke the cultural beliefs against men taking a lead.

Efficiency

At output level, -the project achieved 100% as planned;

Result 1) all members of the participating households have the required, age appropriate knowledge about key Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services.

- All the 100 RMM were trained on Sexual Reproductive and Maternal Child Health

Result2) Men and adolescent boys demonstrate supportive behaviors with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services;

- Monthly household dialogues conducted with 1,000 households and each Participating household was visited twice by the role model man
- 67 male engaged dialogue sessions conducted with the role model men and members of the participating households
- 98 local leaders (M=51, F=47) benefited from the awareness trainings

- 42 Leaders in Action Meetings conducted

Result3) Health and Education service providers are more aware of demand based obstacles and actively engage to mitigate deterrents

- Nine (9) Community Feedback Sessions and Health Service forum were conducted.
- 107 health service providers from different health facilities in the project area trained and 58 benefited from the refresher training
- 150 members of the PTA (27 teachers and 123 parents) reached
- Five (5) learning bazaars were conducted

At outcome/Result level, the project achieved and surpassed the targets. Qualitative findings indicate that the project raised awareness on the RMM as well as on SRMCH, contributing significantly to the collaboration between stakeholders in the sexual health and reproductive sector, accomplished to change behavior of men to support their household member's access reproductive health services in just a period of 3 years.

> *Our community is very aware of the sexual reproductive issues. Men in this community have changed their attitudes and behavior about access to reproductive health services. This project was a unique one and results are evident in the whole community. I thank GWED G who thought of Role model men.* **Latigo Santo A cultural leader in Kal Kwaro Bungatira sub county.**

The RMM received strong backing from the wider stakeholder's especially local government leaders, cultural leaders, local councils and community members.

> *We work directly with local council 1 leaders, cultural leaders and community members. We get their support in every meeting we engage our target households. Religious leaders also mention us and what we do during the Sunday services.* **Okot Jackson; a role model man in Onekydyel Village Paidwe Parish Bibi Sub County**

The responses from the focus group discussions indicated that the project has allowed a common understanding of what constitutes a model household. This was very much appreciated and common for all the FGDS and Key Informant Interviews.

> *We thank GWED G for showing us what a role model household looks like.* **An FGD Participant in Kalamu Omya Village Bobi Sub County**

Impact/Results

1.Result1, 50% increase in knowledge of Participating Household's Members on Key, Sexual, Reproductive, and Maternal and Child Health Issues

A) Antenatal Care

Forty percent (40%) of the respondents understood that attending antenatal care is good for the health of the baby, 17% understood that it is for the health of the mother and 12% understood that it helps the mother to get information about the pregnancy. A midterm review indicated that 20.3% understand that women get HIV testing, 15.3% counseling, 11.3% checking woman pregnancy and 17.5% distribution of mosquito nets. A comparison of the mid-term indicates a positive shift of knowledge from basic services attained from the Health units to reasons behind the services. That's a reason why most of the responses at the end of project evaluation points to the importance of Antenatal Care rather than the services provided. Focus group discussions conducted for men and women also indicated that antenatal care is good for the mother and the baby`s health.

> *It is guaranteed that the mother who attends all the antenatal care schedules will be healthy and also produce a healthy child.*
> ***An FGD female participant***

Other participants in the FGDs indicated that ANC helps to create rapport with the health workers who in turn would assist during delivery.

Health workers at the health unit prefer and give priority to mothers who have been getting their antenatal services from the health facility.
An FGD female participant

The key informant interviews with the health workers indicated that majority of the mothers come for antenatal care during the second and third trimester of the pregnancy.

Table: Knowledge about the importance of Antenatal Care

b) Family Planning

The respondents were asked to mention the various family planning methods in order to ascertain the extent of their knowledge in as far as family planning is concerned. The results indicate that 24% mentioned Injections, 22% implants, 17% pills, 15% condoms and 7% IUD. Only 1% mentioned breast feeding as a method of family planning. Further analyses indicate that 74% of the respondents understand that the Family planning methods are obtained from a health center or hospital, 8% from the NGO and 8% from the clinic. On a good note, very few respondents mentioned that family planning is against their culture 1%, too expensive 1%, fear side effects 1%, difficult to get the method 2%, and my faith does not allow 1%. According to FGDs and KIIs, this is attributed to the project implementation specifically community dialogue meetings and health outreaches organized by the health centers in conjunction with the role model men.

"After the training on SRH, together with RMM, we have been able to conduct health outreaches in 4 villages which were resistant to family planning. As a result, men started accepting their women to use family planning methods" **Akello Claire the senior mid wife of Patiko health center III**

"This community had a strong cultural background about family planning, we engaged them into a series of community dialogue meetings and the results speak for themselves. All our people know about family planning methods and are positive about them. **A role model man during an FGD composed of only role model men**

According to key informant interviews with cultural leaders, previously, women used to hide themselves while attending family planning services because of the negative perceptions that men had about family planning. This was discussed during focus group discussions and some of the previous perceptions that came through the discussions include the fact that family planning stops child bearing and reduces the sexual desire of women.

*I used to think that if my wife goes for family planning, she will never have a baby again***. Male participant in the focus group discussion**

Due to the continuous dialoging through male engagement meetings, the men`s attitudes have changed as depicted from the male focus group discussions and female focus group discussions.

Now I know that family planning is all about child spacing and producing the children that we can take care of well. **Male participant in the focus group discussion**

C. Adolescents Knowledge about Sexuality and STDs

From the findings, the adolescents have acquired sufficient knowledge about their sexual reproductive health and STIs. Fifty nine percent (59%) are knowledgeable about the dangers associated with adolescent sexual intercourse; fifty two percent (52%) are knowledgeable about STDs transmission and prevention methods. When asked about the source of information, majority of the adolescent boys and girls acquired the knowledge from school (30%) and Radio (26%). The findings are in line with the FGDs with the adolescents where majority of the participants indicated that they acquired the knowledge from school. An example is Lapainat Primary school: The school has a family program every Wednesday where teachers talk to pupils while in school. The School has also allocated some small budget out of the money that is generated from the Parents Teachers' Association (PTA) to support the girls in school. The school also reported using the assembly time to talk about Adolescent Sexual Reproductive Health (ASRH) issues.

Comparing these results from the control and treatment, the project achieved 42% contribution on knowledge on Key, Sexual, Reproductive, and Maternal and Child Health Issues.

Result 2 A– Primary Indicator - 20% increase in supportive behaviors of male household members, as reported by male household members

Result 2B – Primary Indicator - 20% increase in supportive behaviors of male households members, as reported by female household members

Men Supporting Women for Health services

The evaluation explored the supportive behaviors of male household members, as reported by female and male household members. The study was biased towards five issues; 1) Escorting the mother to attend to Antenatal Care, 2) Escorting the mother for child deliver, 3) Escorting the mother for Post Natal Care, and 4) Assist in taking the child for immunization 5) supportive behaviors at household chores.

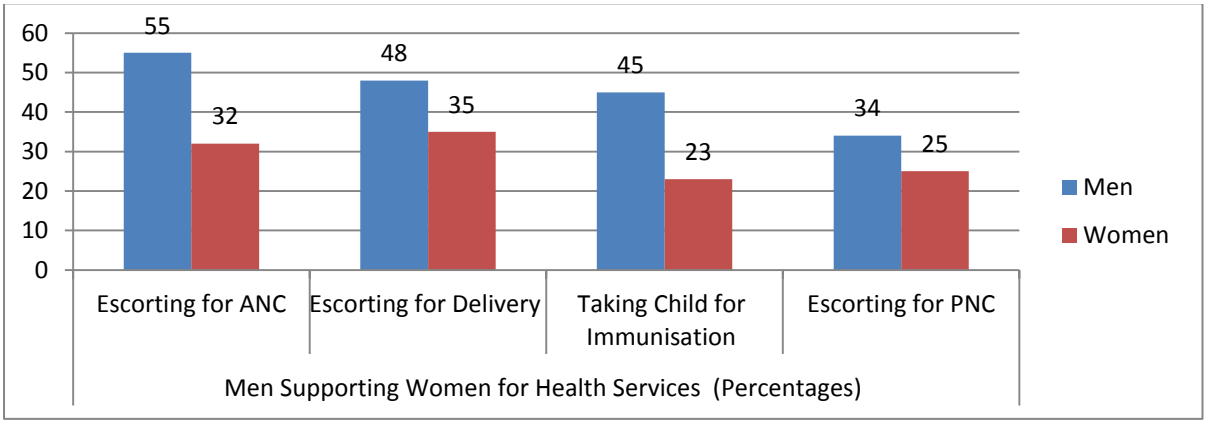

Fig: Men Supporting Women for Health Services

The consultant compiled a record of 7 health units using the Integrated Family Planning registers in the different facilities. The results indicate a sharp increase in number of men escorting their wives between 2014 and 2016. The results are presented as follows;

Table: Trends of men who turned up for antenatal services with their spouses

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Awach Health centre IV	188	637	953
Koch Goma Health Centre III	363	975	1,094
Ongako Health Centre III	71	218	471
Lapainat Health Centre III	249	541	362
Bobi Health Centre III	135	421	404
Coo Pee Health Centre II	20	70	32
Awee Health Centre II	24	65	122
Source: *Integrated Antenatal Register*			

The key informant interviews with the health centers where the communities go for maternal health services indicated that the situation has drastically improved. They indicated that in the last 2 years (2015 & 2016), the numbers of men observed escorting their wives for health services has increased from 0 to 3 for every ten mothers showing up at the health facility on a daily basis.

> *"For every 10 mothers we get, three are escorted by their partners"*
> ***A health worker at a health center***

Though this number was not easily verifiable through the register, the consultant too observed this for the health centers visited at each particular day through the period of data collection.

Men Supporting Women for Household Activities

The evaluation explored the supportive behaviors of male household members for household activities; these included; helping in activities related to child handling, and household chores such as cooking, washing clothes, fetching water and firewood. The results are presented as follows;

Role	Supportive Behavior of Men		
	Midterm Review	End term Review	Control Group
Feeding, Bathing or changing the child's clothes	24.10%	39.30%	9.9%
Taking the child to the Health centre	10.30%	43.40%	8.8%
Picking the child from School	24.10%	53.40%	11.5%
Playing with the child	48.30%	76.90%	7.1%
Teach the child Something	42.90%	70.00%	15.6%
Disciplining the Child	25.00%	53.60%	12.6%
Preparing food while partner is caring for the child	10.70%	30.70%	4.4%
Washing clothes	6.90%	26.90%	10.0%
Repairing the house	10.30%	38.40%	24.0%
cleaning the house	10.70%	44.30%	2.0%
Preparing Food	15.40%	43.80%	9.0%
Fetching Water	14.30%	40.70%	10.3%
Collecting Firewood	11.10%	38.50%	7.9%
Cutting wood	14.30%	40.70%	12.0%
Making Beds	17.90%	74.30%	9.9%

Table: Supportive behavior of men as reported by female household members

The data presented and further analysis indicate that the project indeed contributed an average of 26% in supportive behaviors of male household's members, as reported by female household members and 22% in supportive behaviors of male household's members, as reported by male household members. The project thus surpassed the target results

Result 3 – Primary Indicator - 20% of health service providers engaged in the project that demonstrates changes/ improvements in how services are offered.

This indicator was measured from two angles:

1.From the household responses; the consultant asked the respondents about the time taken to access the health services from the participating health centers, reasons for preference for the health facility as well as who attend to them when they access the services.

2. From the health centers themselves through key informant interviews with the nurses in charge of the specific units, focus group discussions with the Village Health Teams (VHTs), and an analysis of secondary data at the health centers particularly the registers.

Time Taken at the Health Center

The respondents were asked the time it takes them to get served at the health center and majority (44%) indicated that it takes 2 hours and 39% indicated that it takes one hour. Focus group discussions also indicated that the health workers have improved on speed at which they handle the mothers compared to previously when the health workers were not conscious about the time and speed of service delivery.

> *It now takes us 1 hour to finish the whole process of registering and getting the treatment. They have improved on this.* ***An FGD Participant***

The consultant probed from the health workers if they attribute this to any of the project interventions, they indicated that they were trained on how to remove the barriers to access and utilization of MCH services and long hours was one of them.

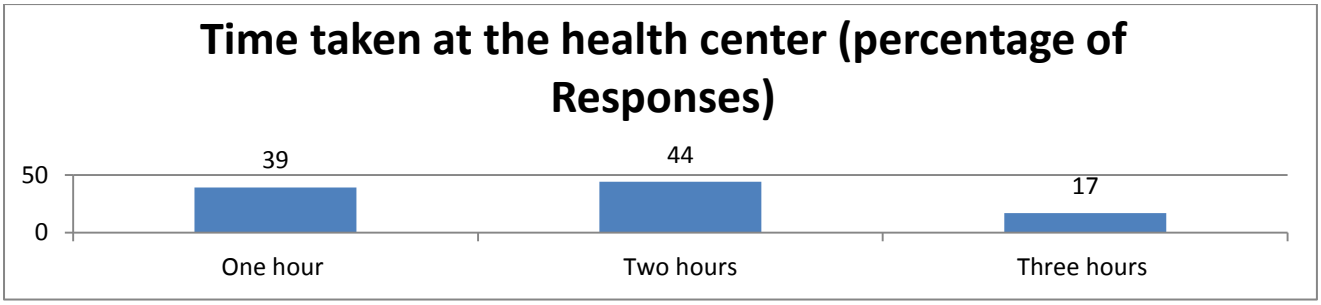

Table: Time Taken at the Health Centre

Further findings reveal that health center personnel are demonstrating better skills in handling adolescents and youth who visit the health center. Youth corners have been established and provide friendly services, such as HIV testing, counseling, hepatitis B, and treatment and management of STIs. According to Lakey Mily a nursing officer of Awach health center IV, she had this to say,

> ***"after the training in SRH, we established a youth corner and I attend to individual youth privately and as such the number of young people coming for RH services has increased and from 20 in quarter II of 2015 to 65 currently***".

Improvements in health services

The consultant through Key informant interviews explored the improvements in the service delivery of the health centers that the project reached using the following questions;

a) Does the health unit have critical specialist on staff at all times to attend to patients that need MCH services?

All the health unit staff interviewed indicated that there is a qualified government paid enrolled nurse at each unit of the health facility. For example there is a qualified staff at the ANC Unit, a qualified staff at Maternity unit and a qualified staff at the Immunization unit. Each unit has nursing assistants in addition to the enrolled nurse and student interns to assist in handling of the mothers. This is true for health center 4 and 3. The recruitment and retention of medical staff is not a project result but what evidently came out of the results is that the staff is more active and available all the time to attend to the mothers.

b) Do the health workers ensure that the mothers receive recommended services as per the conditions of their pregnancies and child immunization schedules?

The focus group discussions with VHTs indicated that their roles after the trainings from GWED G changed to also include follow up the patients in their respective villages to ensure they take their prescribed drugs and also comply with the recommendations of the health workers. This is also emphasized through health outreaches organized by the VHTs, health centers and role model men. For-example, mothers receive mosquito nets in the health units for malaria prevention. The health center s do not stop at giving the nets but go ahead and sensitize on how to place them properly on the bed and the dangers associated with non-compliancy. The biggest role of the project on this is using the role model men to further sensitize their households attached as well as mobilizing for the health outreaches in their respective villages

Lessons Learned

It is clear from the results that engaging men and boys is crucial to ending barriers against access and utilization of sexual reproductive maternal child health services.

Linking men's material interests with positive masculinities helps break the strong cultural orientation of men against supporting women for health services and household chores.

Mobilization efforts are effective when lead by community members. Perhaps one of the reasons why this project surpassed the intended results was due to the fact that the project established a strong network of role model men and community based facilitators. This ensured that the process

itself was owned and ultimately sustained by community members. GWED G and Care International just played a catalytic role of inspiring and supporting others to take action.

Promoting equitable relationships is the core of the role model men approach. Ultimately the work of promoting good relations is to influence the nature of relationships between women and men, the models of masculinity and femininity acceptable in the community, and increasing women's status in the community. The project addressed issues of gender, inequity, status, communication, were explored and this contributed to the success realized with the men and women

Recognize the importance of local leaders. Formal and non-formal leadership structures in the community carry great influence and power. The support and action of these leaders can greatly facilitate positive change as they did for the SRMCH project.

Sustainability

Given the outstanding achievements of the role model men on promoting Sexual reproductive maternal child health, the sustainability of the results and structures is equally important. On a good note, there was a consensus by all the relevant stakeholders in the program area that the structures built should be supported for their sustainability. The following commitments were made by the different stakeholders during a project closure meeting that was held on 11th August 2017.

Local Government Leaders and Health Workers

- Pledged to work with the role model men to monitor and report GBV cases in the community
- Look at the programs in the different sub counties where the RMM are working in and use the CDC programs to support the RMM.
- Leaders also promised that they are going to look at programs at the sub counties and engage them in those programs that they have capacity to do.
- Health workers committed to continue working closely with the role model men in conducting health service forums and outreaches in the community.
- Health workers and sub counties to continue working with the role model men and engage them as mobilisers for health programs.

Model men

- RMM confirmed that they will remain in groups so that it is easy for the districts to support them.
- Strengthen their groups through regular meetings and coordination so that they can continue working together
- Harmonize their work plan so that they can plan accordingly on how to continue reaching others in the community even without the project.
- Lobby with the radio stations so that they can allocate them some free air time.
- Use existing avenues to create linkages with local leaders.

The implementation of these commitments may go a long way in addressing concerns of sustainability of the project benefits. Other sustainability indicators discovered include; working with a local partner, alignment with the national and international policy frameworks, establishment of a network of local structures, social cohesion built among beneficiaries and taking care of cultural background.

Unintended Benefits

The consultant discovered that the project achieved positive results that were not intended at the initial design stages:

Reduction in gender based Violence (GBV) in the target communities. The project resulted in men and women working, planning and deciding together for the health education and livelihoods of the family members. In addition to this, the households indicated a great improvement in men

participation on household chores and supporting women for attending to their health and those of their children.

> *"My husband used to come home drunkard after selling the produce from our garden. After drinking we would be sure of the beatings me and the children. Now that is history. He even stopped drinking completely and we are happily living together"* ***A Wife of a Role Model Man during a Focus Group Discussion***

The FGDs indicated that these were the points of conflict and caused a big proportion of GBV cases that occurred in the households. As a result of the role model men intervention, there were no cases of GBV reported or observed in the communities.

Clean Homes: What was visible and evident in all the households visited is the fact that the general cleanliness around the homes was unique and good. All the households visited had toilets at home, the household members dressed differently, and there were no bushes and rubbish in the compounds. What was clear is the fact that the households live an exemplary life in all rounds of life. Though this was not part of the original design of the project, the role model men and the participating households were proud of having homes that are role models in the respective villages. The consultant indeed observed this and credits the project for finding a unique visible and differentiating feature of the households that participated in the project.

Reduced early marriages: Though the consultant could not get actual figures to support this finding, qualitative results indicate that there is a reduction in early marriages as reported during the focus group discussions. This was the same message the echoed by the senior men and senior women teachers in the schools that were interviewed. The same message also was given by the cultural and local opinion leaders.

> *We had a problem of early marriages which were initiated and geared by the parents in a bid to get exchange for money and gifts. This vice has reduced due to the sensitization of the role model men.* ***A senior woman teacher at Paibona Primary School***

The schools visited indeed ascended to the fact that the girl child education has greatly improved as more girls stay in school. The head teachers interviewed attributed this to the changed attitudes of the parents about the girl child and the risks associated with early marriages.

Conclusions and Recommendations

Relevance of RMM Approach

Conclusions

1. The RMM approach was found relevant in all 9 sub counties to differing degrees, all within the context of the Sexual reproductive maternal child health issues.

2. The RMM approach, its promotion among stakeholders at various levels is coherent with the local governments` mandates of using all available means to promote sexual reproductive maternal child health and enhance efficiency and effectiveness of service delivery as well as accountability of the development partners operating in the respective sub counties.

Recommendations for Replication and Scaling Up

1. Continue focus of RMM to SRMCH and all attention to the households` knowledge attitudes and behaviors towards SRMCH issues.

2. The RMM approach should remain just an approach and the scale up can incorporate other approaches to reach out to school adolescents. These other approaches should be able to supplement the great work done in the households by the role model men.

Efficiency and Effectiveness at Achieving Project Results

Conclusions

1. The project achieved 100% of the results at output level

2. The project achieved and surpassed the results at outcome level for all the 3 result areas as listed in the logical framework;

a) The project achieved 42% for age appropriate knowledge on sexual reproductive maternal child health. The project surpassed the target for result 1 as stated in the logical framework

b) On average the project contributed 26% in supportive behaviors of male household's members, as reported by female household members and 22% in supportive behaviors of male household's members, as reported by male household members. The project surpassed the target for result 1I as stated in the logical framework

c) The project achieved 100% of the health centers engaged in the project who demonstrated improvements in how services is offered and therefore have attracted the communities to utilize the services. The project surpassed the target for result 1II as stated in the logical framework

2. Expenditures have been found in line with their original allocations, although it is difficult to ascertain details of the project expenditures as this is out of the evaluation scope.

3. The team has found several examples of households as testimonies for the great work done by the role model men. This is proof that the RMM have successfully been accepted by the communities and community structures.

Recommendation for Replication and Scaling Up

The team recommends that CARE International continues using the role model approach for sexual reproductive maternal child health in communities that have the same context as the communities in Acholi Region in Northern Uganda.

Project Management/Coordination/Human Resources

Conclusions

1. The coordination structure put in place to support the RMM at community level has worked reasonably well.

2. The full-time Project officer housed at GWED G working closely with the community coordination structures has been a clear asset to the project.

3. The strong coordination and support by Care International Initiative Manager and Program Manager provided a leaning base for GWED G staff and was critical for the successful implementation of the project.

Recommendations for Replication and Scaling Up

The team recommends that GWED G should continuously lobby local governments to incorporate the role model men into service delivery structures. This will not come easily but advocacy and lobbying requires patience and if consistently pushed, results will come. On a good note, the project carried out activities purposely to create awareness about the role model men and there were already commitments from the District leaders to work with the role model men.

Communication/raising awareness

Conclusions

1. The RMM have played a major role with regards to raising awareness on SRMCH situation, including measures to better health service delivery, their efforts have remained within the communities which they serve.

2. Communication has not received enough attention by the project, especially at all levels, in part due to a weakness in the project design (lack of budget) itself. There was observed documentation of success stories but the stories were not widely shared on various media platforms.

Recommendations for Replication and Scaling Up

Communication and advocacy are integral part of information management and need to be appropriately budgeted for in future. The team feels that appropriate internal and external advocacy would go a long way into the successful adoption of the RMM at the local government service structures.

Capacity Development

Conclusions

1. The project's capacity development efforts for local partners have been key to galvanizing the collaboration and spearheading the main project outputs and outcomes. These included the development of the role model training manual, various training sessions of role model men, leaders and influencers training, community based facilitators, medical staff from the selected participating health centers, senior men and senior women of participating schools.

2. The role model men training materials, including curriculum and user guides, has been found to be of satisfactory quality and a major contributing factor to the successful adoption of knowledge and behaviours of the role model men.

3. The project has targeted most of the capacity activities on individuals rather than at an organizational level.

Recommendations for Replication and Scaling Up

The training materials should be simplified further and contextualized to be able to be used by the role model men at the household level.

Partnerships

Conclusions

1. The involvement of local governments and other local structures was strength of the project and contributed to the achievement of the results.

2. Cooperation between Care International and GWED G has good history and this project relied on the good relationship between the two parties.

Recommendations

1. There is an opportunity to market the RMM approach to other peer NGOs so that they can adopt the methodologies/tools and technical skills into their curricula for interventions targeting SRMCH issues in similar setting such as Northern Uganda.

1.0 INTRODUCTION

This report presents the findings of an end of project evaluation for "Sexual Reproductive Maternal Child Health" a project implemented by CARE International in Uganda through Gulu Women's Economic Development and Globalization-GWED-G a local Non-Governmental Organisation based in Gulu Municipality in Gulu District . CARE International in Uganda works with partners to address social injustices, defeat poverty and achieve a lasting change in the lives of the very poor, especially women and girls. CARE International in Uganda's current program focuses on women's and girls' economic rights, financial inclusion, governance of natural resources, and sexual and reproductive health rights, including a life free of violence. CARE International in Uganda's operations are guided by core values of excellence, accountability, respect, integrity and transparency. GWED-G works to strengthen the capacity of grassroots communities in Northern Uganda to become self-reliant agents of change for peace and development through training and education for them to make effective decisions concerning their rights, health, and development.

1.1 Brief Project Background

In September 2014, CARE International in Uganda in partnership with Gulu Women Economic Development and Globalization (GWED-G) with funding from Austrian development Agency (ADA) through CARE Austria initiated a three years Sexual reproductive, Maternal child health project with the goal of "Improving Access to Reproductive, Child and Maternal Health in Northern Uganda" in the three districts of Gulu, Amuru and Nwoya, covering 9 Sub Counties (Ongako, Bungatira, Bobi, Koro, Patiko, Awach, Lamogi, Koch Goma and Alero). The overall objective was to contribute to improved Reproductive, Maternal and Child Health amongst the target population. The project's purpose was to overcome the barriers arising from social constructs to accessing, Maternal and Child Health services. The three expected results were: 1) All members of the participating households have the required, age appropriate knowledge about key Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services; 2) Men and adolescent boys demonstrate supportive behaviours with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services; and 3) Health and Education service providers are more aware of demand based obstacles and actively engage to mitigate deterrents (see attached log frame with key indicators for each result). The direct beneficiaries of the project were 100 Role Model Men and their families, 10 households attached to each RRM (5100) and PTAs in 10 primary schools (Pagak, Awee, Lapainat, Paibona, Ajulu, Aleda, Bobi, Koch goma, Ongako and Koc koo P/7). In addition, the project worked with health and education service providers to address obstacles and actively engage communities to mitigate deterrents, thereby increasing access to services.

1.2 The End of Project Evaluation

CARE International in Uganda engaged an external consultant to conduct an end-of-project evaluation by systematically and objectively assessing the progress made towards the achievement of the intended goals of the project. The Project has been implemented since September 2014 and this end of project evaluation focused on the entire implementation period. The overall objective of this final evaluation was to ascertain the contribution made by SRMCH project towards improving access to Reproductive, Child and Maternal Health in Northern Uganda of 5,600 women, men, girls and boys from Gulu, Amuru and Nwoya districts. The major focus area for the final evaluation was to assess the appropriateness of the theory of change and the project intervention logic, the results

achieved during implementation, and its potential sustainability. The evaluation also presents key learning and recommendations that will help to ensure that the project's impact remains sustainable

1.2.1 Specific objectives of the evaluation

The final evaluation aimed to achieve the following specific objectives;

1.To establish impact made by the SRMCH project in relation to 3 outcome indicators;

Outcome 1 –Primary Indicator – 50% increase in knowledge of participating household's members on key, age appropriate, sexual, reproductive, and maternal and child health issues

Outcome 2 A) - primary Indicators - 20% increase in supportive behaviors of male household members, as reported by male household members

Outcome 2B) - Primary Indicator - 20% increase in supportive behaviors of male households members, as reported by female household members

Outcome 3–Primary Indicator - 20% of health service providers engaged in the project that demonstrate changes/ improvements in how services are offered

2. To identify best practices and lessons learned during the 3 years of implementation with regards to different interventions. Including, and in particular; Establish the extent to which targeted households have benefited from RMM approach in addressing Gender Based Violence (GBV) including improving girl child education and access to SRMCH services among women and girls of reproductive age; Establish the extent to which adolescents, both boys and girls, were reached with information on SRMCH using the RMM approach and Establish the level of involvement of local service providers during project implementation in addressing SRMCH and GBV issues

3.Summarize key findings from the project evaluation and provide recommendations for any potential future projects/ programs targeting the same vulnerable communities in Northern Uganda

2.0 DESCRIPTION OF THE EVALUATION METHODOLOGY

The SRMCH End of Project evaluation was carried out in full compliance with the DAC Evaluation Quality Standards (206). The end of project evaluation used both qualitative and quantitative methods to get the necessary data that was required to answer all the research questions.

2.1 Quantitative Data

The consultant collected quantitative data from 328 beneficiary households that were sampled from the 1000 households reached directly by the project through the role model men. This enabled the consultant to provide a numerical inference to project impact using statistical analysis to the evaluation results. The respondents included men, women, adolescent girls and adolescent boys.

2.2 Sample Size

The consultant used 3 parameters to determine the sample size

1. The margin of error:

The margin of error is the amount of error that the study design can tolerate. This study used 5% as the minimum error.

2. Confidence Level:

The confidence level is the amount of uncertainty the survey design can tolerate. For this study a confidence level of 95% was considered.

3. Population Size:

A total population of 5400 was considered for this evaluation

The consultant used a formula to substitute the above parameters to determine the sample size. The following statistical equation was used to determine the sample size for the end of project evaluation.

$$\textbf{Equation 1: } n = \frac{(Z^2\, pq)}{d^2}$$

Where;

n =refers to the desired sample size

Z =the standard normal deviate usually set at 1.96 which correspondents to the 95% confidence level.

p =Population of the target population estimated to have a particular characteristic, 50% was used due to lack of a reasonable estimate.

q =1.0 – p

d =degree of accuracy desired; in this context set at 0.05.(5%)

The sample size of 278 respondents (Rs) was obtained by substituting in the above formula as indicated below:

$$\textbf{Equation 1: } n = \frac{(Z^2\, pq)}{d^2} = \frac{(1.96)^2\,(0.5)(0.5)}{(0.05)^2} = 278 \text{ Respondents (Rs)}$$

From the Calculation, n = 287

In order to cater for non-responses and other unanticipated field challenges 10% was added on to the sample generated by the equation and this totaled to 316 respondents. On a good note,

the evaluation surpassed this number and reached a total of 328 respondents from the intervention areas. In order to attribute the impact to the SRMCH project, the study selected an additional 48 respondents from the non-intervention areas to act as a comparison (control)

2.3 Sampling for geographical coverage

The evaluation reached all the 9 sub counties where the project was implemented. A list of all the parishes and villages where role model men have reached was obtained from GWED G and together with consultation with Community based facilitators randomly sampled the parishes and villages that participated in the evaluation. Table shows the details of the actual districts, sub counties and parishes reached by this evaluation;

District	Sub counties Reached	Parishes Reached
Gulu	Awach	Gwengdiya
		Paduny
	Patiko	Kal
		Pawel
	Bungatiro	Punena
		Laliya
		Pabwo
Nwoya	Alero	Panyabono
Omoro	KochGoma	Orum
	Ongako	Onyona
		Kal
	Koro	Laipanat East
		Laipanat west
	Bobi	Palenga
		Paidwe
Amuru	Lamogi	Agwa Yugi
		Obbo

Table 1: Geographical coverage of the evaluation

Sampling of Households

The consultant used systematic sampling to arrive at households that were interviewed. At the start of each day, the research assistants identified a role Model man/household who provided the list of the 10 households that were reached. Using an interval of 3, the researcher sampled at least 4 households systematically. The role model man helped to guide the researchers through the villages to locate the sampled households.

2.4 Sampling of Respondents in the Household

The consultant used purposive sampling to arrive at the respondents that were interviewed. There was a deliberate effort to balance the sample where possible between the 4 categories of the respondents i.e. the husband, wife, female adolescent and male adolescent. However this was never achieved as per the category due to field challenges. On a good note, the number of respondents obtained per category was sufficient to make inferences for each target category of the respondents.

2.5 Qualitative Data

Qualitative approaches were used to triangulate the data obtained from the household. The data obtained provided more evidence of causality and different perspectives on changes that happened as a result of the project implementation.

1. Key Informant Interviews

Pamela Angwech Interviewing a Key Informant (Role Model Man)

The consultant purposively selected people who have particularly informed perspectives for their first-hand knowledge on the aspects of the SRMCH project for interviews as key informants. The interviews were loosely structured, relying on the broad themes of the evaluation. A key informant interview guide guided the key informant discussions and was specific for each category of the key informant. For example the local leaders had a separate guide that was different from that for health unit staff and senior women and men teachers in the target health centers and schools respectively. A total of 20 key informants were interviewed and included among others, health workers, village health teams, members of school management committees, project/partner staff, cultural leaders, local council officials, religious leaders, and other opinion leaders as was found feasible during the field work. A list is attached in appendix.

2. Focus Group Discussions

The consultant used focus group discussion methodology to capture key detailed information from the primary respondents as per the research questions. In order to allow free discussion of issues, the focus group discussions were disaggregated between gender and age categories where possible. Indeed 60% of the FGDs were single sex and same age bracket. The consultant ensured an optimum average number of 8 participants for each of the focus group discussion. The Focus Group Guide was the main tool for guiding the discussions of issues in the focus group discussions and was structured to include; probe questions, follow-up questions, as well as exit questions.

2.6 Data management and analysis

Data management and analysis took the following steps: coding; cleaning, entry, and filling. Data was entered in Epidata downloaded from the server and exported into SPSS.

Quantitative Data: Data was analyzed using Statistical Package for Social Scientists (SPSS version 18.0) in two stages: Firstly, a descriptive summary of characteristics of respondents and related aspects in the various themes was undertaken using frequency distributions and percentages. The data was disaggregated by various characteristics such as gender, education level, marital status etc.

Qualitative Data: Qualitative data collected through key inform ant interviews, FGDs, and in-depth interviews were analyzed thematically. Focus Group data was transcribed and later on analyzed using thematic procedures. Participants in a focus group discussion were assigned codes and captured verbatim. During the group discussions, individual responses were coded by each particular item and relate to the Subject matter and theme in the interview schedule. The major

issues of concern were analyzed in relation to the itemized Subjects and the corresponding answer categories classified by each item of a particular theme.

2.7 Ethical considerations

For ethical consideration, the data enumeration team was composed of both male and female members. Interviewers explained the purpose of the survey to respondents and sought informed consent of each and every respondent before starting new interview.

Interviewers were trained in interviewing skills and how to behave while in the field to avoid compromising the data quality. The interviewers were closely supervised to ensure they adhere to principles of; confidentiality, respect for the respondents, un-biasness, conflicting interest, honesty, privacy, convenience and clarity among others.

All authorities of local leaders at district, sub county and parish levels in the study areas were informed of the evaluation and its purpose prior to the start of the data collection process so as to obtain their permission as well.

Reproductive Health issues are very sensitive, so the interviews with the women might have touch such sensitive issues; this could have been distressful and might cause discomfort. Also women who have lost babies in childbirth they might find too distressing to discuss. These concerns were fully recognized by the consultant and all effort was done to minimize these effects

The participants were advised that they can withdraw from the interview process at any time without any negative consequences. The survey made sure that the respondent had fully understood the background and the objective of the research before starting the discussion.

Anonymity was maintained throughout this evaluation from the data collection up to the write-up of the report. All data collected: transcript, field notes and questionnaires were kept in a secure place and under lock and key in the care of the consultant. All data including the electronic copies of the data was stored in secured (locked) location during the field work. All other unwanted data was destroyed. Interviews were conducted in a private and suited the participant convenience and ensure confidentiality. The study did not pose any adverse effects on the public and did not place any demand on the local health services

2.8 Quality control and management strategies

Right from the planning stage, through hiring and training interviewers, sampling, data collection and analysis, quality control measures were considered. The Household Questionnaire was designed to ensure consistency with skip patterns embedded and checks to instruct and guide the interviewers.

Sampling strategy was strictly followed. Experienced research assistants who were eloquent in both English and Acholi language were identified, recruited and trained for two days

Upon completion of the training, the questionnaire was pre-tested by the team and necessary changes to the questionnaire were made depending on the feedbacks and comments from the pre-test.

The field team consisted of the consultant, GWED G staff and supervisors who guided the interviewers and provide instant quality assurance by checking for completeness and consistency of the questionnaire and accuracy and validity of the data before submission to the data management unit.

2.9 Challenges Encountered during the Study

Sampling Methodology: The consultant obtained a list of all the villages where role model men live and using simple random sampling method, selected the villages to participate in the

study. When it came to data collection, some villages that were randomly selected did not have participating households. The reason for this was the fact that the role model men were not geographically restricted during the selection of the households to enroll into the project. In order to counteract the challenge, the team obtained a list of households from the role model men and using systematic sampling selected the households to participate in the study and the team followed them to their respective locations.

3.0 KEY FINDINGS, INCLUDING BEST PRACTICES AND LESSONS LEARNED

The findings are organized in three sections, reflecting the study objectives. The first section is about the relevancy, efficiency and effectiveness of the project and Role Model Men Approach. Section two is focusing on the impact of the project to the beneficiaries in terms of knowledge, attitudes and practices towards sexual reproductive maternal child health issues. The last section is exploring the lessons learnt through the project, issues of sustainability as well as the recommendations for future programming.

3.1 Relevance of the Project

Identified Needs at the Initiation of the Project

At the initiation of the project, CARE International in Uganda carried out a needs assessment to determine the levels of knowledge, attitudes and practices in as far as SRMCH are concerned. Accordingly, the following problems motivated the initiation of the project;

Women and girls faced enormous challenges accessing public services including SRH, and MCH care. There was general lack of knowledge and understanding relating to the availability of SRH and MCH care services, compounded by a breakdown in the social fabric and the distortion of social norms that would otherwise regulate gender equality in the target communities. Men consciously and unconsciously impeded access of women, adolescents to basic SRH and MCH care services such as family planning services, HIV/AIDS prevention and testing, skilled attendance at childbirth, and support to infant feeding practices. Men were often uninvolved as fathers in the care of their infants. Adolescents suffered from societal taboos about discussions around sexuality, and the disintegration of traditional family structures had impeded youth's access to older relatives who might mentor them on these topics.

What the Project did to address the identified needs/problems

The approach of RMM Approach is from a model of engaging men and boys which is a key model for Care International that has been tried, tested and proved. The project worked with 100 role model men who were assigned 10 households each making a total of 1000 households reached. The Role Model Men were provided with in-depth training on sexual and reproductive health, including on issues specific to adolescents. They were also trained on maternal and child health, including the role of fathers in promoting MCH in the family and community. Topics that were covered included supporting mothers on breastfeeding, growth monitoring and weaning practices; men's role in childhood immunization, hygiene and proper diet for young children including cooking skills. They were then equipped to use the skills to engage in dialogues with household members in the homes, public spaces with other men, adolescent particularly out-of-school boys. Emphasis was also placed on service availability of SRH and MCH services. The Role Model Men then worked to sensitize the households comprising of men, women, adolescent boys and adolescent boys about access and utilization of SRMCH services.

Meanwhile, they received feedback from community members about their experiences accessing such services which was frequently shared in Community Feedback Sessions with health care workers. These fora then motivated and informed the training of health workers on making SRMCH services gender and age-sensitive so that men, adolescent boys, adolescent girls and men feel

comfortable accessing the services and or support each other access the services. Religious and traditional leaders, who also set community norms, were involved in trainings so that they may support the work of the role model men. Finally, teachers and parents were also engaged in adult and adolescent SRH topics through the PTA meetings.

3.1.1 Relevancy of the Role Model Men Approach

Role Model Man with his Wife engaging in Community Work

The consultant found the Role model men approach to be relevant in all the households that participated in this evaluation. All the stakeholders from local government, cultural leaders, health sector, schools and religious leaders that were interviewed as key informants all see the relevance and benefits of the role model men in tackling sexual reproductive maternal child health in the beneficiary households and the general communities as a whole.

The role model men approach was relevant in the context of northern Uganda especially in the area of women empowerment and sexual reproductive health situation, with much of the emphasis on breaking cultural barriers to men involvement in supporting their wives to access the services. This holds true for all the 9 sub counties under which the project was implemented with significant results spread across the sub counties. In particular, the role model men contributed to;

(i) Addressing gender based violence in households. The interviews with key informants and Focus Group Discussions indicated that the role model men influenced the target men to take responsibility for improved relationships between the household members. The interviews further indicated that beneficiary men involve their spouses in joint decision making and planning for health, economic welfare as well as the education of the household members a factor that addressed GBV in the participating HHs. This also came out very clearly during focus group discussions with women and men beneficiaries. The FGD participants were very appreciative of the project and testified about the reduced gender based violence.

> *"Before the project, the beating was every day and people would intervene every day to stop my husband from beating me.* **FGD Participant-Household Wife**

> *"I now value my wife. Previously before the project, i used to view my wife merely as property, as useless and as someone who cannot do anything and that I could do whatever pleases me as a man. This brought a lot of tension with her and we could engage in violence almost every day. Through male engagements with role model men, I learnt to value my wife and now I engage my wife and children-we have a meeting and come to a joint decision. When we make a decision it is a family decision and not an individual decision, we now live happily as a family. "* **FGD Participant-Male beneficiary Household head**

> *"My husband now trusts me with controlling the finances of the home. He now believes that I am faithful and less likely to misuse the finances. We now use nonviolent means to sort out any conflict that arises along the way. "* **FGD Participant-Household Wife**

(ii) The involvement of beneficiary men in the planning and decision making for the health wellbeing of family members has improved the maternal health of the mothers of reproductive age through improved attendance of antenatal care, family planning, and safe delivery in health centers. The interviews further indicated that Role model men and beneficiary household men are involved in taking their spouses to health centers for ANC, PNC, and Child immunization and incases of delivery. The consultant recorded voices of women and men that participated in focus group discussions and the voices indeed affirm to the fact that the role model men influenced the beneficiary household men to support their wives. This came from both the male and female participants.

> *"On average, we get 4women being escorted by their husbands for antenental care for every 10 women that we reveive perday. In the past seeing a male person in this unit was a miracle"* **Charity Amono: Enrolled nurse at Pabwo Health Centre**
>
> *"We have eight children if it was not for my husband finally accepting for me to be sterilized, I would not be alive. I am happy my husband accepted for me to get the permanent contraceptive."* **Household Mason Wife**
>
> *"At least men are now taking children for immunization. It is very difficult to get a man in Acholi to take children for immunization they consider it a woman's work."* **Obong Richard RMM Parish Paidwe Village Kulu Otit Bobi Sub County**
>
> *"Men are now taking responsibility for taking the women to health facilities before men used to say it is you who is pregnant and I am not needed. These men are taking children- virtually in Acholi it is women who take care of children but now men do not wait for wives."* **FDG participant**

(iii) The community is more aware of the sexual reproductive health and maternal child health needs of the household members. This according to the key informant interviews with community leaders was through the regular community dialogues and health outreaches that were organized by the role model men in conjunction with the Village Health Teams and health centers. The community dialogues indeed increased awareness which subsequently resulted into an increase in the number of community members coming for the services and most importantly increased the number of men escorting their wives according to the records obtained from the health centers.

> *"Before the GWED-G intervention one would find only 15 women coming for antennal care but now it is over 60 women- this is the great shift that has resulted directly from the sensitization."* **Focal person role model men Lamogi**
>
> *"Family planning has become real family planning in this community because the decision comes from both parties unlike in the past where there was chaos in families because women and men did not have knowledge about family planning.* **Odur Charles Klick Comprehensive Nurse, Bobi Health Centre"**

The records from the health centers sampled show a consistent positive trend for mothers attending Antenatal care and family planning services

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Koch Goma Health Centre III	738	1690	2494
Awach Health Centre IV	693	2,179	1,016
Ongako Health Centre III	553	1,085	870
Lapainat Health Centre III	537	1,129	1,019
Bobi Health Centre III	447	530	500
Coo Pee Health Centre II	121	351	429
Awee Health Centre II	78	198	333

Table2: Trends of women who turned up for antenatal services

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Koch Goma Health Centre III	222	682	960
Lapainat Health Centre III	224	694	558
Bobi Health Centre III	99	564	1,171
Awee Health Centre II	62	267	176

Table3: Trends of women who turned up for family planning services

(iv)The project complimented the local government efforts and all the local government leaders interviewed indicated that they are already using the role model men in mediating the domestic conflicts that arise in the communities. They further indicated that they are already discussing through the local councils how to incorporate the role model men in the local government service structures and provide them with incentives to reach to more households.

> *We have used role model men on many occasions during mobilisation and their impact is felt in the whole sub county. They have made our work easy because they reach every part of the community. Our health centers in the sub county were struggling with low turn up of mothers but recently in our planning meeting, they were demanding for more workers as the existing are overwhelmed by the large turn up of mothers coming for safe delivery and antenatal care as well as children for immunization.*
>
> **Key informant interviewee: Christopher OdongKara Chairperson Local Council III, Awach Sub County.**

It is worth noting that the RMM approach was found to be relevant in the context of households and more specifically for Maternal Child Health contexts where men had very strong and traditional cultural beliefs. The role model men have been able to break the barriers there by creating positive externalities of networking with other stakeholders and building awareness for the need for community bylaws for men involvement in maternal child health of their households.

The RMM Approach was evidently popular among many household groups, primarily for creating a common, user friendly, accessible and evidence based referral system that all stakeholders adhere to. The health system, the cultural leaders, religious leaders and local government leaders adhere to the referrals from the role model men. They liked the clarity and simplicity of the analysis of issues in the referrals; an indication of the technical knowledge in the subject matter that they deal in. Given the fact that the RMM are not technocrats but just community members, the users of the referrals were generally not so concerned with the quality of the data supporting the analysis as they did not have access to materials to use during the analysis of the cases. Their role was to refer the cases to relevant technical offices to take further investigation and action. What was unique also about the RMM referrals was the fact that the facts presented were a consensus between the RMM and the household member affected.

RMM have made a positive contribution by bringing data gaps related to men involvement in SRMCH to the fore, and by addressing some of those, mainly through changes in data recording registers. The health units utilize the registered that was centrally developed by the ministry of Health. The register has no provision for registering men that come to the health units supporting their spouses.

> *We draw a line at the margin of the register where we record the men that escort their wives. The ministry does not like it because they don't want us to tamper with the register.* **A health work in a health center III**

Due to the RMM involvement in the health services, the health units that participated in the project improvised and added an additional column for capturing whether the woman came with the partner or not. The column was drawn using a pen and the health units that were sampled had rough data about the number of men that visited the health centers with their spouses. This was not the case for the health units in the control that the consultant visited.

It was observed that the RMM were adopted from the previous Engaging Men Initiative a Project implemented by the partner institution GWED G and CARE International. The availability of their profiles in the communities that they reached enhanced their relevance and acceptance by the community members. Though this was seen as a time saving, economically viable, and technically feasible, setting a criteria and going through a selection process again specifically for this project would make them more relevant.

On the other hand however, the evaluation team did not observe evidence that the RMM approach led directly to measures addressing sexual reproductive issues in schools that were reached by the project or underlying problems at the school-level, despite the fact that Primary Teachers associations and senior women and men teachers were trained to reach out to adolescent girls and boys in schools

3.1.2 Consistency with Primary Stakeholders' Mandate, Local Government

The RMM and their promotion among stakeholders at village and sub county level were certainly coherent with Local government mandate to provide sexual reproductive maternal child health services to the communities and ensure stable nonviolent households. The enhanced relationship between the local government leaders and the RMM will result in allocating funds for RMM activities.

> *"We are already negotiating in our council and if we pass a vote, we shall provide them with facilitation to carry out their work"* **Christopher OdongKara Chairperson Local Council III, Awach Sub County.**

In very similar ways the RMM helped the Local Governments at village and sub county levels to lead in efforts to defeat SRMCH issues in the communities. The local government particularly the community development office provided technical advice and coordination of the RMM in the respective sub counties thereby optimizing their impact

> *"I provided charts and learning materials to the role model men in this sub county to use in the field. They were indirectly doing my work"* **Community development Officer Bobi Sub County**

This was done informally with no formal obligations but because they were supplementing their activities and in line with their mandate they supported them and this contributed further to the realization of the objectives.

3.2 Effectiveness and Efficiency

3.2.1 Project Design

There is consistency between the specific project objective and the 3 main result areas. The objective states under intervention logic: "Contribute to improved Reproductive, Maternal and Child Health amongst the target population" (Source: Project document, p.7). This is supported by the Objectively Verifiable Indicators (OVIs) listed: (1) 20% increase in reported service utilization in participating Households, (2) 50% increase in knowledge of participating household members on key, age appropriate, Health issues, (3) 20% increase in reported supportive behaviors of participating male household members by male household members, (4) 20% increase in reported supportive behaviours of male household members by female household members, (5) 20% of Health Service providers that demonstrate changes / improvements in how service is offered. These OVIs provide evidence of the overall project's success. The clarity in the OVIs translated itself to the field, as most time and efforts were focused on attaining the main results.

On the other hand, the team has identified a few weaknesses in the logic and internal coherence of the project design as reviewed through its logical framework and the project document. First of all, the project design of result I and II has been quite ambiguous. It assumes SRMCH as a single concept/indicator with no breakdown to indicate what issues the project will focus on. For example it is not clear whether the project designed to focus on PNC, ANC, Family planning, HIV AIDS,

Immunization, or adolescent sexual reproductive behavioral changes or all of them. Secondly, the logical framework and the project documents do not specify the period through which the results would be realized and thereafter the necessary modifications in the project design as a result of the achieved results.

The role model training curriculum was reviewed; the purpose and target of the training is clearly spelt in the manual which focused on the role model men as agents of change. Specific focus was put at promoting dialogue between adolescents, adult men around SRH and MCH issues, and promoting active fatherhood for adolescents as well as adult fathers. The manual at the same time promoted positive externalities through engagement of other stakeholders particularly the local leaders. Indeed as a result of the training, the existing capacity of local leaders in participating communities stands out as potential support vehicles at community level

On the other hand, the curriculum had some technical gaps. The manual focuses on men acquiring knowledge on sexual reproductive health and breaking the barriers that inhibit the men from supporting the households for health services. Issues of maternal and child health are not clearly spelt out in the manual and do not form as a core component of the curriculum. Though there was a clear effort to contextualize the manual to the Acholi Region, there is clearly no local examples of real situations that happened in the communities that the participants of the training could identify with. It also appears the ministry of health as key stakeholders in the maternal child health was not adequately involved in the development of the manual and this compromised the inclusion of key Maternal Child Health issues.

The project activities clearly support the attainment of the main result areas (1) Result 1 – All members of the participating households have the required, age appropriate knowledge about key Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services: (2) Result 2 – Men & adolescent boys demonstrate supportive behaviors with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services and (3) Result 3 – Health & Education Service providers are more aware of demand based obstacles and actively engage to mitigate deterrents – thereby increasing access to service

Inputs are in line with the technical nature of the project: heavy on activities (development of training curriculum & materials ,training of male role models, household dialogue, awareness trainings with leaders (traditional, religious, political, etc.), leaders in action meeting, community feedback sessions and health service forums, training of health service providers and connecting teachers & parents); contract (for GWED G the implementing partner); travel, logistics (for monitoring, training events and workshops); technical support services and general operating expenses (GWED G and Care International).

The main risk anticipated at the design stage was the political interference and unstable politics, weather conditions and unavailability of sexual reproductive maternal child health services. Though the risks are listed, there are no contingency measures described in the project design to mitigate against the risks for both the implementing agency (GWED G) and CARE International. While the risk assumption referred to above borders on the repetitious, other assumptions come to mind that should have been added that relate with the actual stakeholders of the project such as (1) stakeholders have indeed a strong interest in a RMM approach (2) stakeholders are willing and committed to engage in the project processes and (3) there is access to sufficient information necessary to enhance behavioral change of men

Perhaps the most important strength of the project design was the inherent assumption that IF – Men are supported to understand how elements of their behaviour negatively impact on the lives of family members; and if – men are exposed to alternative behaviours that they can see offer positive benefits; and if – men are supported to learn these behaviours; then – men will adapt these behaviours. The project design paid sufficient attention to the fact that decision-making is complex and information is just one input, among other socio-economic, cultural and political considerations that influence change in behaviour.

3.2.2 Effectiveness of Activities in generating Results

Activity1: Male Engagement Dialogues: This was the most effective activity in generating results according to the results obtained from the project area. This activity targeted adult men from participating households who met regularly as a group to share experiences and perspectives. The male engagement dialogues were facilitated by the role model men for their respective households. This probably was the most important activity as it allowed the men to discuss their issues on a regular basis and share experiences without necessarily losing their ego in the presence of their women and children. It should be noted here that the Acholi culture gives men a very strong feeling that they are the heads of families and this was previously understood that they are not supposed to participate in certain activities such as household chores.

The contributing factor to male engagement dialogue being effective is the fact that men were willing to open up to each other and share experiences and benefits of taking responsibility for the SRMCH of their families. This broke the cultural beliefs against men taking a lead. The other contributing factor is the regularity of these dialogue meetings. In some communities these meetings happened once in a month while in other communities the meetings happened two times in a month. This frequency gave the men a regular opportunity to address challenges as they arose in the different households. The other contributing factor was the fact that the role model men who facilitated these meetings were trained sufficiently and had adequate knowledge and changed their behaviours first so that the fellow men could see the benefits that they are enjoying in their respective households. The acquired knowledge during trainings also enabled them to discreetly facilitate the meetings and at the same time influence their fellow men to adopt good behaviour.

Activity2: Household Dialogue: This was the second most effective activity that contributed to realizing of results for the SRMCH project. This activity provided the Role Model Men with an opportunity to make monthly household visits to the 10 Households assigned. The visits engaged all household members, including men, women and adolescent boys and girls, to discuss important Sexual, Reproductive, Maternal and Child health issues within their households.

The main contributing factor to this activity is the fact that the household dialogue enabled the household members to build consensus around the issues that were discussed during the meeting. The consensus was action oriented and therefore issues were discussed and ways for resolving them discussed as well including attaching the responsibility center. The other contributing factor was the fact that the dialogue meetings were evidence based as they were held in the homes where GBV cases or neglect of duty happens. This gave no room for excuses or apportioning blame but rather focused on finding solutions for emerging issues. The role model man facilitated the meetings and was also engaged in counseling the household members where necessary.

Activity3: Awareness Trainings with Leaders (traditional, Religious, Political, etc.): The effectiveness of this activity varied from community to community. This activity mobilized key social influencers, sensitized and trained them to provide appropriate support to the Role Model Men. Their involvement in the project was to specifically provide mentoring support, encouragement and facilitating discussions and sensitization for out of school youth on topics of SRH and responsible fatherhood. What is key to note is that some leaders needed the support of the role model men as the role model men had more information and better behaviour than the leaders. The activity generated results in areas where the leaders had demonstrable behaviour to influence change in attitudes and that way provided better mentorship to the role model men. It would have been better if their role was to engage in mobilisation, monitoring and providing moral supportive to the role model men rather than mentorship.

Activity 4: Leaders in Action Meeting: At these meetings, Role Model men gathered together with traditional, religious and political leaders to discuss the progress of the program and to gather community feedback on the work of the Role Model Men around SRH and MCH. The consultant discovered that this activity basically contributed to monitoring and tracking the progress of the role model men work. The contradiction that came up at the design stage is that the role model men structurally did not report to the community leaders. They were also not mandated to share their reports with the local leaders but rather were answerable to the community based facilitators and the project officer at GWED G. Much as these meetings contributed to hold the RMM accountable for their work, it would have yielded more results if the project was designed that the local leaders endorses the RMM and their reports validated by the leaders. This would have created more ownership of the RMM at the local leadership level. According to interviews with role model men, these meetings were not frequent and regular and therefore it was even difficult to track progress, achievement, contribution, and contributing factors of this activity as there was no clear, regularly and structured circumstances under which the activity was performed.

Group Photo of community Leaders after an Action Meeting

Activity 5: Community Feedback Sessions and Health Service Forums: Community Feedback Sessions were hosted by role model men, together with various leaders and community members to discuss community access to SRH and MCH services in government health centers. These were also attended by the health workers and they shared their experiences and challenges they face as they provide the SRMC health services. This activity according to the discussions with health workers, role model men and local leaders contributed to harmonize the expectations of the health workers and the communities that they serve. The activity was highly effective at giving feedback to the health workers and therefore contributed to the improvement of the health services

Household Members during a Community Feedback Meeting

Activity 6: Training of Health Service Providers: This activity based upon issues that emerged from the Leaders in Action meetings and the Community Feedback Sessions to generate a training content for interested health care providers in making SRH and MCH services more accessible for the target population. This activity contributed to the improvement of health services to some extent but interactions with health workers indicated that the activity would have yielded more results if the design was basically on site coaching and mentorship of the health workers. The training would have been more practical and addressed the challenges faced by a specific and locality rather than organise a generic training to be attended by all health workers from different sub counties.

Activity 7: Connecting Teachers & Parents. Perhaps this is the activity that yielded the least results as depicted from the key informant interviews with senior women, men teachers and members of the PTAs in the participating schools. The design of this activity was that relevant feedback & observations from the Role Model Men would be discussed with teachers and parents at the regular PTA meetings to break the current silence around these issues and enable parents to engage with adolescents on issues important to SRH. The challenge with this activity was that the PTA meetings happen once in a year and therefor the interaction is limited to that time. This activity would have yielded better results if the role model men would discuss the observed adolescent issues in the households with the senior women and men teachers so that the adolescents get the message at teachers and the same message by the parents in the households.

3.2.3 Efficiency in Achieving Results

Overall, the consultant established that the project has accomplished the results listed in the log frame at output and outcome level.

At output level, -the project achieved 100% as planned:

Result (1) all members of the participating households have the required, age appropriate knowledge about key Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services.

- All the 100 RMM were trained on Sexual Reproductive and Maternal Child Health

Result (2) Men and adolescent boys demonstrate supportive behaviours with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services;

- Monthly household dialogues conducted with 1,000 households and each participating household was visited twice by the role model man
- male engaged dialogue sessions conducted with the role model men and members of the participating households
- 98 local leaders (M=51, F=47) benefited from the awareness trainings
- 42 Leaders in Action Meetings conducted

Result (3) Health and Education service providers are more aware of demand based obstacles and actively engage to mitigate deterrents

- Nine (9) Community Feedback Sessions and Health Service forum were conducted.
- 107 health service providers from different health facilities in the project area trained and 58 benefited from the refresher training
- 150 members of the PTA (27 teachers and 123 parents) reached
- Five (3) learning bazaars were conducted

At outcome/Result level, the qualitative findings indicate that the project raised awareness on the RMM as well as on SRMCH, contributing significantly to the collaboration between stakeholders in the sexual health and reproductive sector, accomplished to change behaviour of men to support their household member's access reproductive health services in just a period of 3 years.

> *Our community is very aware of the sexual reproductive issues. Men in this community have changed their attitudes and behaviour about access to reproductive health services. This project was a unique one and results are evident in the whole community. I thank GWED*

G who thought of Role model men. **Latigo Santo A cultural leader in Kal Kwaro Bungatira sub county**

The RMM have received strong backing from the wider stakeholder's especially local government leaders, cultural leaders, local councils and community members.

We work directly with local council 1 leaders, cultural leaders and community members. We get their backing in every meeting we engage our target households. Religious leaders also mention us and what we do during the Sunday services. **Okot Jackson; a role model man in Onekydyel Village Paidwe Parish Bibi Sub County**

The responses from the focus group discussions indicated that the project has allowed a common understanding of what constitutes a model household. This was very much appreciated and common for all the FGDS and Key Informant Interviews

We thank GWED G for showing us what a role model household looks like. **An FGD Participant in Kalamu Omya Village Bobi Sub County**

The team received evidence (at outcome/result level) from beneficiary households that the project was indeed very effective at changing men behaviour towards supporting their household members for sexual reproductive maternal child health and highly appraise the project for future interventions targeting women and adolescent boys and girls.

"He participates in household chores together with me something I never expected" A **woman from the participating household in Koch Goma Sub County**

"We sit together and plan for whatever we have and even crops that we have harvested from the garden" **A woman from the participating household**

Local leaders said because of the high efficiency in generating results, they will adopt the role model men for community dialogues that focus on solving gender based violence and influencing men involvement and taking responsibility for their household members in all the aspects of the household ranging from economic, health, education, and relationship dynamics. During the project closure meeting that was held on 11th August 2017, and attended by a total of 59 people who included LC V chairpersons, Chief Administrative Officers (CAOs), District Community Development Officers(DCDO), Gender Officers from the four districts of Gulu, Amuru, Nwoya and Omoro, the following commitments were made;

- District leaders committed to continue supporting the work of the RMM and requested for data of the role model men in their respective districts so that they can started planning on how to work closely with them.
- Chairperson LC V Omoro district during his closing remark assured the role model men that he will continue working closely with them like he did before when he was still the district speaker Gulu district local government. He requested other colleagues from the districts to take responsibility and integrate the component of the role model men in their plans.
- LC V Omoro districts also promised that to strengthen the role model men work, Omoro district this year 2017 will celebrate the International Men's Day in November 19th 2017. He went ahead to inform the CAO and DCDO Omoro to have it in mind.

3.2.4 Project's M&E mechanism

The project design contains an M&E plan with clear indicators, sources of verification, who and how frequently data will be collected. The M&E framework is composed of a plan and a log frame. However the plan is very shallow and does not specify the results at various levels. For instance there is no breakdown of immediate results, intermediate results and long term results. This also goes to the indicators and the rest of the M&E plan components. This probably explains why the project has no database of results constructed over a period of time and disaggregated between immediate, intermediate and long term results. The project did not carry out a baseline study and

results were being tracked during periodic quarterly, semi-annual and annual reports. Though this provided a solid measure means of tracking of indicators, there was no comparison with the baseline.

A baseline was necessary given the quantitative and unique nature of the Programme indicators and the innovative nature of the Programme design. On a good note however, there was no evidence that the lack of a baseline affected the achievement of results. The only effect is on the measuring of the progress and net contribution of the project according to the result indicators A mid-term review was conducted internally by Care and GWED G staff and recommendations were generated based on findings for improving efficiency.

3.2.5 Project Management and Coordination

The coordination structure put in place to support the project at community as well as at the sub national and national level worked reasonably well. A core group of community mobilisers (community based facilitators) were associated with the project. A larger audience of 100 role model men as the primary users and transmitters of the project message to the households was predominantly used and they were facilitated to form sub county coordination units for ease of coordination. GWED G was largely responsible for technical coordination services to the project activities as well as directly responsible for the achievement of the results. CARE International in Uganda had an operational office in Gulu with the initiative manager as the primary contact for the project. The national coordination was conducted by full-time Program Manager who was also based in the Gulu Office. These structures have been a clear asset to the project.

Regarding financial management of the project, the team was impressed to see the complex financial management structure in place, with a budget holder at the Gulu Office but working very closely with the Finance Office at CARE International office in Kampala following a robust finance management and procurement system. Though it is good to have a stringent financial and procurement system in place, it would be more beneficial if the system provided more flexibility to the initiative manager to handle key financial and procurement tasks. This would also enhance his/her responsibility for the successful implementation of the project. GWED G (implementing partner) on the other hand had a flexible finance management systems and this counteracted the likely negative effects of the long CARE International finance system.

3.2.6 Utilization of Funds

The expenditures by the project were largely in line with their original allocations per the total budget. The Team has found the financial management for the project at CARE level and partner level was necessarily appropriate. The initiative manager was the budget holder and accounting officer for the project, supported by the Program manager and head office finance and administrative staff. The Program manager is based in Gulu however the finance and procurement is based in Kampala at head office. Though this created some bureaucratic procedures that delayed some activities, their effects did not affect the delivery of the project. CARE `s system further requires that contracts and procurement of all items is done by procurement committee and this ensured efficient use of funds as it did not allow any loophole for misuse of funds or making inappropriate decisions.

The overall project budget according to the project documents was 333,333.88 Euro and reached an actual total of 1,000 households and an estimated total population of 5400 individuals over a 3 year period. On average, it costed 333.33388 euros to reach to each household and an estimated 61.73 euros to reach to each individual in each household. By any standards and through experience of projects with similar magnitudes, the consultant appraises this project was highly efficient in utilizing the resources.

3.3 Project Impact

The consultant used two methods to determine the impact

of the project

1. Contribution analysis

The consultant analyzed the theory of change to build up evidence that demonstrates the contribution made by the project 'beyond reasonable doubt', while also establishing the relative importance of other influences. The method draws on the idea that an intervention's theory of change can be used to infer causation by assessing whether the processes that it aims to initiate have in fact occurred. The consultant took the project intervention as the point of departure. The theory of change according to the project documents states that "IF – Men are supported to understand how elements of their behaviour negatively impact on the lives of family members; and if – men are exposed to alternative behaviours that they can see offer positive benefits; and if – men are supported to learn these behaviours; then – men will adapt these behaviours"

2. The Experimental Design

The consultant used an Experimental method to compare the results for a treatment group of beneficiaries, who participated in the project, and a control group who did not. The experiment helped to determine the net impact of the project. In additional to covering the 9 sub counties that the project intervened, the consultant selected a sub county where there was no intervention at all and the possibilities of spillover effects were very minimal. Respondents were selected randomly from then sub County, a health center and a school was selected where the intervention never happened. This sub county was used for comparison known as a control group. This method provided a causal relationship between intervention and outcomes.

3.3.1 Demographic Characteristics of the Respondents

The basic rule, the entire impact of the SRMCH project was traced from the households as they were end users of the intervention. In order to put the results into context, it is important to first understand the demographic characteristics of the population that was selected to participate in the project.

a) Sex, Category and Age distribution

There was an effort to balance the male and female respondents and amidst the field challenges the team managed to get 47% females and 53% males. In terms of age, 23.9% were adolescent of the age between 12 to 17 years. The study deliberately targeted more beneficiary household members to be part of the study and indeed 53% were beneficiary household members and formed the majority of the respondents. Adolescent boys and girls constituted 28%, role model men 10% and wives of role model men 7%. The consultant deliberately balanced the responses across all the categories of the respondents according to the project beneficiary category target.

Options of Response	Frequency	Percentage
Sex of the Respondent		
Female	154	47
Male	174	53
Category of the Respondents		
Role model Man	34	10.4
Wife of a role model man	21	7.4
Beneficiary of a role model HH	174	53
Adolescent Boys	46	14.05
Adolescent Girls	48	14.65
Age Distribution		
12– 17 Years (Adolescents)	78	23.8
18 – 34 Years (Youth)	120	36.6
35 Years and above (Elderly)	130	39.6

Table 4: Sex, Category and Age distribution

b) Household Size, Marital Status and Highest Level of Education

Majority of the households sampled had members between1 to 10 and surprisingly 12.5% were big households with 11 to 20 members and 0.9% (3 households) had 21 to 30 household members. Majority of the respondents 51% were married with one partner and also a good number 22.9% were single and never married. Majority 38.1% had dropped out of primary school and 17.4% were currently in primary school. Majority of the responses were engaged in subsistence farming and only 10% were engaged in commercial agriculture as their main source of income. It is good to note that these findings are in line with the UBOS 2014 statistics about household characteristics in the respective sub counties that participated in the study. This implies that the methodology used complied with the statistical standards and confirms the validity of the study.

Options of Response	Frequency	Percentage
Household Size		
1 – 10	277	84.5
11 – 20	41	12.5
21 – 30	3	.9
Marital Status		
Single	75	22.9
Married (Monogamy)	168	51.2
Married (Polygamy)	30	9.1
Co-Habiting	41	12.5
Widow (ed)	5	1.5
Separated	7	2.1
Level of Education		
No Formal Education	26	7.9
Currently in primary school	57	17.4
Currently in secondary school	13	4
Dropped out in primary school	125	38.1
Completed Primary Education	50	15.2
Completed secondary level	25	7
Tertiary education	10	3
Others	20	6.1
Main Source of Income		
Subsistence farming	230	70.1
Agribusiness	33	10.1
Small Business	9	2.7
Casual labor	4	1.2
Still a student	13	4
Don't have any source of Income	30	9.1

Table 5: Household Size, Marital Status and Highest Level of Education

3.3.2 Result1, Knowledge of Participating Household's Members on Key Sexual, Reproductive, and Maternal and Child Health Issues

a) Antenatal care

Knowledge about the importance of attending antenatal care was explored by the study. 40.8% understood that attending antenatal care is good for the health of the baby, 17% understood that it is for the health of the mother and 12% understood that it helps the mother to get information about the pregnancy.

Focus group discussions conducted for men and women also indicated that antenatal care is good for the mother and the baby`s health.

> *It is guaranteed that the mother who attends all the antenatal care schedules will be healthy and also produce a healthy child.* **An FGD female participant**

> *It is guaranteed that the mother who attends all the antenatal care schedules will be healthy and also produce a healthy child. An FGD female participant*

Health workers at the health unit prefer and give priority to mothers who have been getting their antenatal services from the health facility. **An FGD female participant**

The key informant interviews with the health workers indicated that majority of the mothers come for antenatal care during the second and third trimester of the pregnancy.

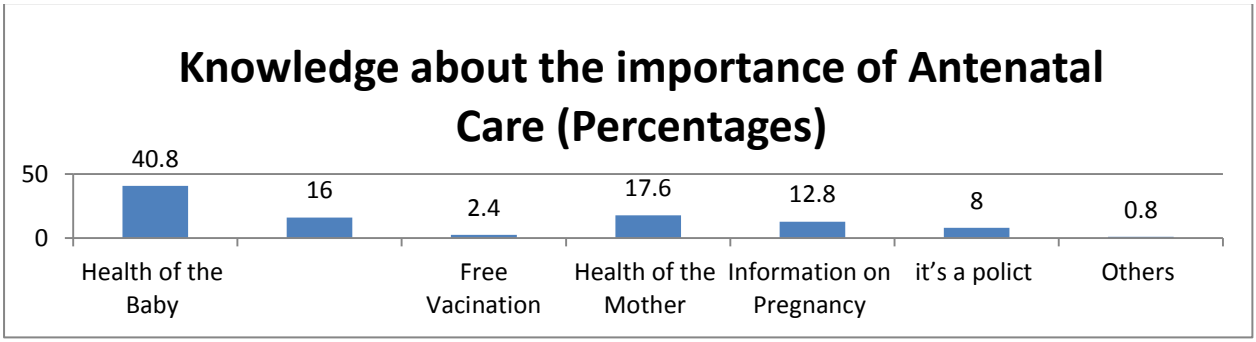

Figure1: Knowledge about the Importance of Antenatal Care

Further analysis of this indicator revealed the understanding of the specific services obtained from the health centers. The results indicate that 31% understand that mothers get HIV testing and counseling, 20% mentioned pregnancy test and mosquito nets for malaria prevention, and 11% mentioned pregnancy care drugs.

Happy Mother after Safe Delivery at Paibona Health Centre

B) Safe Delivery

Respondents were asked to mention the places they understand offers opportunities for safe mother delivery. Majority of the respondents (60%) indicated that it is safer to deliver from a health center followed by Hospital with 35% of the responses. Only 2% mentioned that it is safe to deliver from home, clinic and at the home of a traditional birth attendant. Focus group discussions with mothers indicated that they used to think that it is costly to deliver from a health facility and preferred delivering from home in the presence of a relative or traditional birth attendant and only went to the health in cases of complications.

My husband used to think that we cannot afford delivering from a health center until when the Role Model Man sensitized us about the requirements at the health center. We could not believe it is a free service. **An FGD female participant**

Due to the sensitizations through the family visits by the role model man, they have learnt about the danger of delivering at home. They cited all the benefits of safe delivery an indication that they have knowledge about safe delivery.

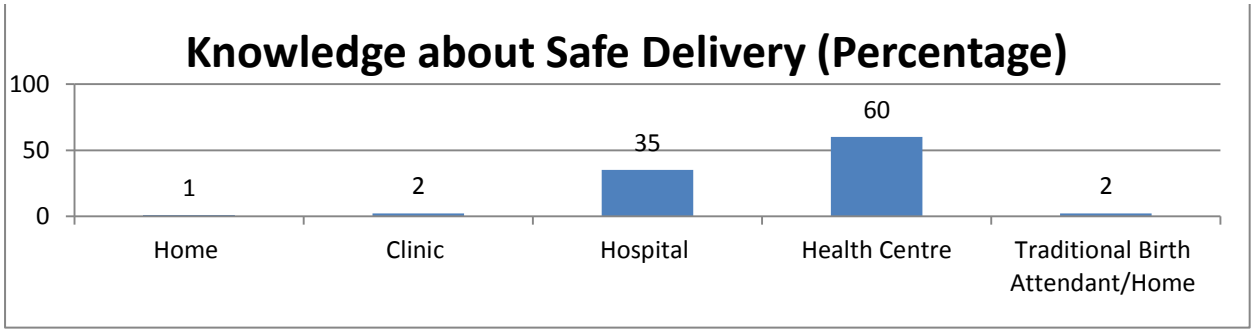

Figure2: Knowledge about Safe Delivery

The respondents were further asked to indicate the reasons why they prefer to deliver from a health center or hospital. This was intended to probe further if they have knowledge about the benefits of safe delivery in a medical facility. Majority of the respondents (18%) indicated that they get good services, 14% indicated that they are safer under the care of a trained personnel, 13% indicated that it is better to deliver from where they attend Antenatal Care and 11% indicated that it is cheaper to deliver in a health facility.

c) Child Health & Immunization

Knowledge about child health and immunization was also explored by this evaluation. The study explored knowledge about issues to do with immunization, breastfeeding of the child and proper feeding for the breast feeding mother. 93% had knowledge about the need and importance of child health and immunization.

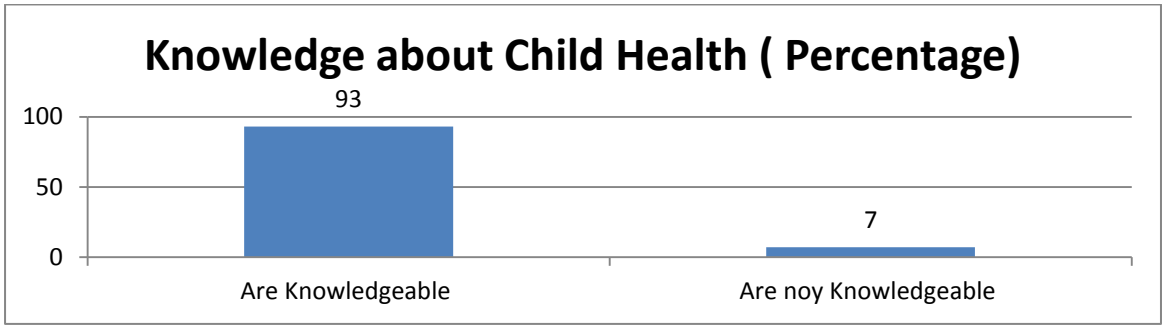

Fig3: Knowledge about Child Health and Immunisation

This was further probed from the household respondents on the specific vaccines they are aware of what is given to children when they go for immunization and indeed 23% were aware of Polio Vaccine, 18% were aware of measles vaccine, 16% BCG vaccine, 14% tetanus, and 12% Pneumonia. During focus group discussions with women, they were knowledgeable about the specific vaccines but the men could hardly cite at least two vaccines and the commonly mentioned was Polio. Key informants mentioned other partners promoting immunization and child health to include USAID SAFE, AMREF and Save the Children.

d) Family Planning

The respondents were asked to mention the various family planning methods in order to ascertain the extent of their knowledge in as far as family planning is concerned. The results indicate that 24% mentioned Injections, 22% implants, 17% pills, 15% condoms and 7% IUD. Only 1% mentioned breast feeding as a method of family planning.

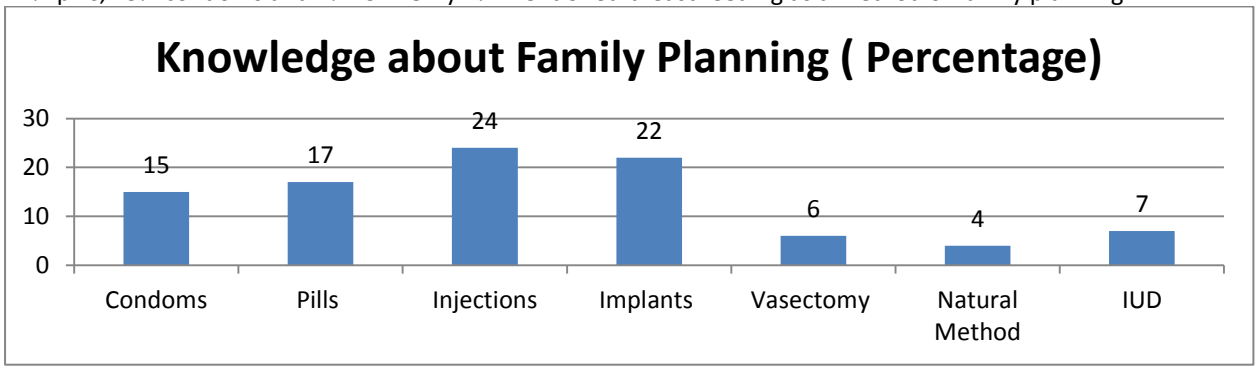

Fig4. Knowledge about Family Planning

Further analysis indicates that 74% of the respondents understand that the Family planning methods are obtained from a health center or hospital, 8% from the NGO and 8% from the clinic. On a good note, very few respondents mentioned that family planning is against their culture 1%, too expensive 1%, fear side effects 1%, hard to get the method 2%, and my faith does not allow 1%. These were negative perceptions that existed in the communities before the project implementation but after the project, the figures for the perceptions drastically dropped as per the findings. According to FGDs and KIIs, this is attributed to the project implementation specifically community dialogue meetings and health outreaches organized by the health centers in conjunction with the role model men.

"After the training on SRH, together with RMM, we have been able to conduct health outreaches in 4 villages which were resistant to family planning. As a result, men started accepting their women to use family planning methods" **Akello Claire the senior mid wife of Patiko health center III**

"This community had a strong cultural background about family planning, we engaged them into a series of community dialogue meetings and the results speak for themselves. All our people know about family planning methods and are positive about them? **A role model man during an FGD composed of only role model men**

A health Worker at Awach Health Centre attending to a couple seeking family planning services

According to key informant interviews with cultural leaders, previously, women used to hide themselves while attending family planning services because of the negative perceptions that men had about family planning. This was discussed during focus group discussions and some of the previous perceptions that came through the discussions include the fact that family planning stops child bearing and reduces the sexual desire of women.

> *I used to think that if my wife goes for family planning, she will never have a baby again.* **Male participant in the focus group discussion**

Due to the continuous dialoging through male engagement meetings, the men`s attitudes have changed as depicted from the male focus group discussions and female focus group discussions.

> *Now I Know that family planning is all about child spacing and producing the children that we can take care of well.* **Male participant in the focus group discussion**

e) HIV/AIDS Transmission & Prevention

All the means through which HIV/AIDS is transmitted were mentioned with the majority 29% mentioning that the infection is transmitted through sex without a condom, and 22% through sharing sharp objects. The consultant probed further to understand if the respondents know about the various ways one could prevent the infection. Indeed all the possible means of protection were

mentioned with using a condom top on the list (35%), avoiding sharing sharp objects (23%), faithfulness to one partner, (20%) and abstinence (18%). On a good note, some myths about HIV/AIDS that existed before the project intervention such as transmission through mosquito nets dropped with minor mentions at 1% and seeking protection from witch doctors at 0.5%. The key informant interview with the GWED G project officer indicated that the project intervention emphasized faithfulness between couples, use of a condom and abstinence for the unmarried adolescents. This explains the trend of the results from the areas that the project intervened.

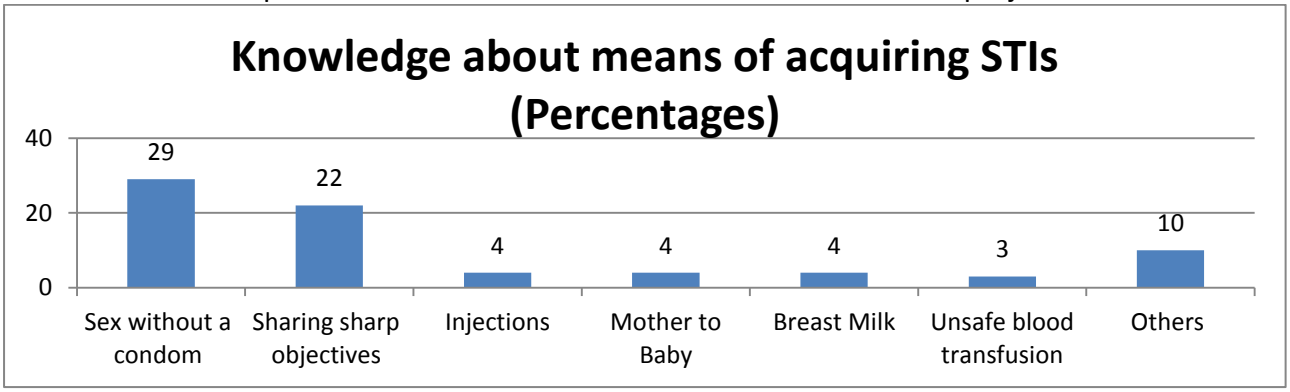

Fig5: Knowledge about the means of Acquiring STIs

f. Source of Information about ANC, PNC, Safe Delivery, Family Planning & Immunization

In order to verify the results attribution, to the SRMCH project, the consultant asked the respondents where they got the information about ANC, PNC, Family Planning, Immunization and Safe delivery, and indeed majority acquired the knowledge from the health workers during the community outreaches organized in conjunction with the Role model men. Others heard the message on Radio (20%) and others from GWED G staff (14%), role model men (12%) and community based facilitators. It is important to note that all these are the various means through which the message was channeled.

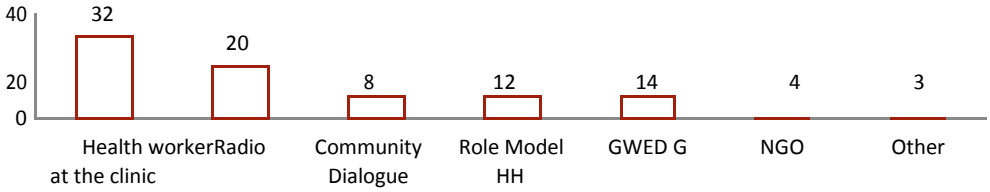

Figure 6: Source of Information about ANC, PNC, Safe Delivery, Family Planning & Immunization

g. Adolescents Knowledge about Sexuality and STDs

From the findings, the adolescents have sufficient knowledge about their sexual reproductive health and STIs. Fifty nine percent (59%) are knowledgeable about the dangers associated with adolescent sexual intercourse; fifty two percent (52%) are knowledgeable about STDs transmission and prevention methods. When asked about the source of information, majority of the adolescent boys and girls acquired the knowledge from school (30%) and Radio (26%). A very small fraction acquired the knowledge from the role model man (3.8%) parents (6.6%) and community dialogue (7.5%). The findings are in line with the FGDs with the adolescents where majority of the participants indicated that they acquired the knowledge from school. An example is Lapainat Primary school: The school has a family program every Wednesday where teachers talk to pupils while in school. The School has also allocated some small budget out of the money that is generated from the Parents Teachers' Association (PTA) to support the girls in school. The school also reported using the assembly time to talk about Adolescent Sexual Reproductive Health (ASRH) issues. The findings are presented in the table as follows;

Options of response (answers)	%
Is it possible that a girl gets pregnant with the first sexual intercourse?	
Yes	58.9
No	25.0
I DON'T KNOW	16.1
Girls: What could you do to avoid getting pregnant	
Have no sex	52.9
Jump several times after sex	3.9
Use of family planning methods	27.5
Wash intimate parts immediately after sex	2.0
Chose safe days for having sex	5.9
Do not know	3.9
Others	3.9
Boys: What could a boy do to avoid impregnating a girl?	
Have no sex	38.9
Use a condom	51.9
Make sure that the girl takes the pill	1.9
Respect the girl's safe days for having sex	5.6
Others	1.9
How can one get the Virus of HIV/AIDS?	
Drink from same bottle with a diseased	1.2
Having sex	47.0
Sharp objects	28.9
Having Unprotected Sex	18.1
Girls/Boys: What can you do to protect yourself from getting HIV	
Use condoms	63.0
No sex with elder men	2.2
Abstinence	13.0
Having no sex	8.7
Others	13.0
From where do you get all this information?	
At school	30.2
Radio	26.4
Friends	6.6
Community Dialogue	7.5
Role Model HH	3.8
My Father	6.6
My Mother	6.6
GWED-G	2.8
Other	7.5

Table 4: Adolescents Knowledge about Sexuality and STDs

g. Conclusion on Result 1

Using the contribution analysis to trace the SRMCH project impact, the results of the assessment are directly linked and traced throughout the project implementation as given by the household responses, FGDs and Key Informant Interviews. Since there is no baseline data to compare this, it is difficult to attribute the knowledge changes with precision. Therefore this method cannot tell us whether the project achieved 50% increase in knowledge of participating households in age appropriate SRMCH issues as targeted by the project.

Using the Experimental design, the data obtained from the control can provide a comparison to provide the net contribution of the project intervention. The selected parameters for knowledge about SRMCH include; knowledge about the importance of ANC, where to get safe child delivery, importance of immunization, family planning and Sexual transmitted infections. The two main reasons given by the control as to why they need to attend antenatal care: is to get medical treatment (36%) and for the health of the baby (19%) and to get information about the state of pregnancy. When asked about where to get safe delivery, majority mentioned Hospital as their preference for health services. All the participants in the control were knowledgeable about immunization and they attributed this to the mass mobilization of communities by a local NGO supported by USAID SAFE, save the Children and UNFPA.

What is clear from the comparison of the results from the control and the experiment is that the project contributed 42% to knowledge on Key, Sexual, Reproductive, Maternal and Child Health Issues

3.3.3 Result 2 A– Primary Indicator - 20% increase in supportive behaviors of male household members, as reported by male household members. Result 2B – Primary Indicator - 20% increase in supportive behaviors of male households members, as reported by female household members

a) Joint Planning

The consultant explored from the participating households if they plan together in three main dimensions: 1. Utilization of household resources, 2. Education of the children, 3. Health of the family members including family planning, antenatal care, child immunization and safe mother delivery. The responses were captured for both male and female respondents. Overall, the responses for males are higher than the responses for females across the three parameters as indicated in the figure. However, the difference in male and female responses do not justify the differences in supportive behaviour but rather a perception on what supportive behaviour means to each of them.

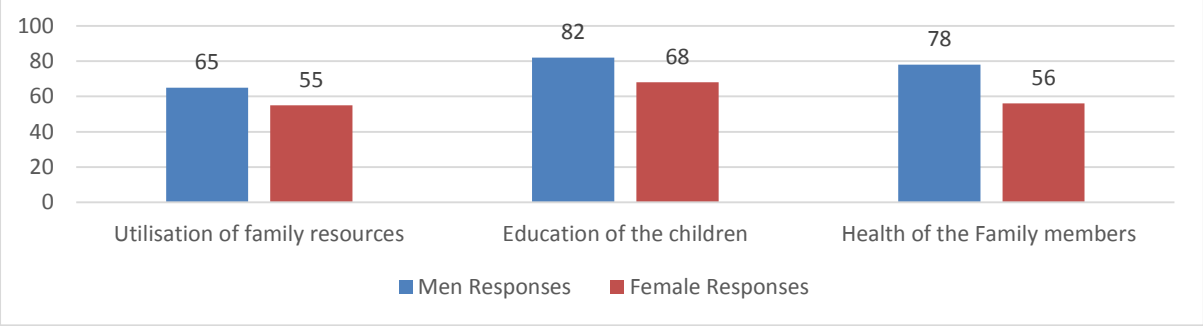

Figure 7: Resources about Joint Planning

Focus Group Discussions indicated that men previously used to deny female children going to school but as a result of the sensitization from the role model men, they now jointly plan and agree to take all the children to school including the girl children.

> *My first born who was a girl did not go to school because my husband denied her money school fees. Currently all my 2 young girls are in school and this is due to the sensitization we got from the Role Model Man.* **A female FGD Participant.**

The FGDs further indicated that previously men used to utilize the resources from the proceeds of the produce sales in drinking alcohol and marrying other women but when the role model men talked to them about planning together for utilization of resources, the men changed and the proceeds from the sale of produce is planned together between the men and women together with their old children.

> *"We sit together and plan for whatever we have and even crops that we have harvested from the garden"* **A woman from the participating household during an FGD**

The consultant also discovered through FGDs in KochGoma and Lapainak sub counties that most couples from the participating 10 household have come up with an initiative called the **"Birth Preparedness"** plan. Upon realizing that there is a pregnancy, they develop a plan and a budget for things that are needed for the baby and start saving money to buy them so that when it is time for delivery they just go to the health facility when they are very ready with all the required items.

> *We save money slowly so that by the time of child delivery, we are prepared with all the requirements.* **A woman from the participating household during an FGD**

b) Joint Decision Making

It is important to note here that, much as it might seem easy to plan jointly, this does not directly translate the plans into implementation. A household makes decisions on a daily basis and the

consultant explored to determine where and who makes the final decision in as far as the three parameters of utilization for household resources, education of the children and health of the family members. Engaging men alone in FGDs indicated that men`s behaviour on involving women in joint decision making has greatly improved and indicated that this is as a result of engaging men in male engagement meetings. Also due to the examples they see with the role model men, they have discovered that the family cannot grow when the parties involved do not make joint mutual decisions. The key informant interviews with the role model men also confirmed the fact that households now appreciate the concept of working together as the only means to household wellbeing.

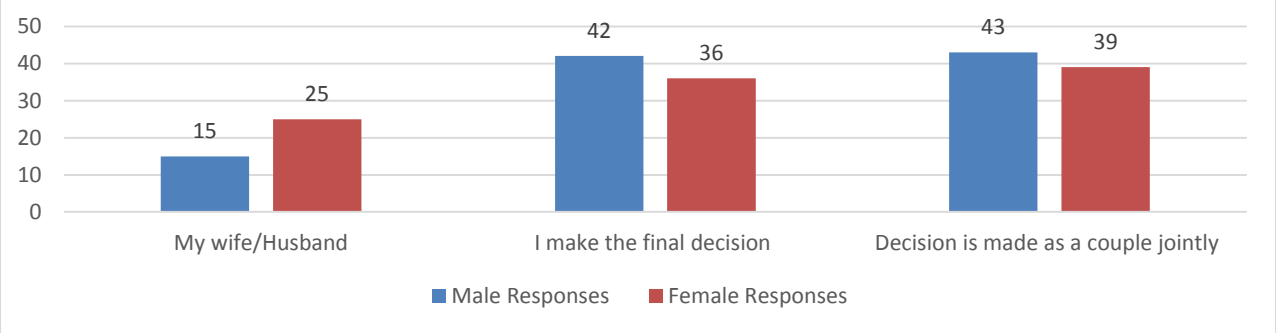

Figure 8: Responses about Joint Decision Making

d) Men Supporting Women for Health services (ANC, Delivery, PNC, Immunization)

The evaluation explored the supportive behaviors of male household members, as reported by female and male household members. The study was biased towards five issues; 1) Escorting the mother to attend to Antenatal Care, 2) Escorting the mother for child deliver, 3) Escorting the mother for Post Natal Care, and 4) Assist in taking the child for immunization 5) supportive behaviors at household chores.

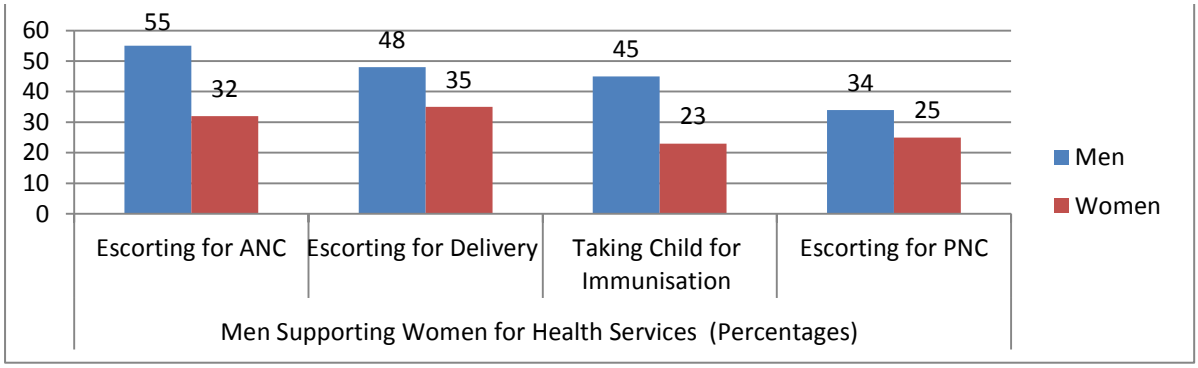

Figure 9: Men Supporting Women for Health services (ANC, Delivery, PNC, and Immunization)

When this was discussed during FGDs, it came out clearly that; men supportive behaviour for women is still low in all the communities but at the same time tremendous improvements have been achieved basing on the previous situation before the project intervention. The key informant interviews with the health centers where the communities go for maternal health services indicated that the situation has drastically improved. They indicated that in the last 2 years, the numbers of men observed escorting their wives for health services has increased from 0 to 3 for every ten mothers showing up at the health facility.

> *"For every 10 mothers we get, three are escorted by their partners"* **A health worker at a health center**

Though this number was not easily verifiable through the register, the consultant too observed this for the health centers visited at each particular day through the period of data collection.

The consultant compiled a record of 7 health units using the Integrated Family Planning registers in the different facilities. Though the number was not easily clearly verifiable through the register, the consultant too observed this for the health centers visited at each particular day through the period

of data collection. The results indicate a sharp increase in number of men escorting their wives between 2014 and 2016. The results are presented as follows;

Health Centre	Sept-Dec 2014	Jan-Dec 2015	Jan-Dec 2016
Awach Health centre IV	188	637	953
Koch Goma Health Centre III	363	975	1,094
Ongako Health Centre III	71	218	471
Lapainat Health Centre III	249	541	362
Bobi Health Centre III	135	421	404
Coo Pee Health Centre II	20	70	32
Awee Health Centre II	24	65	122
Source: *Integrated Antenatal Register*			

Table 7: Trends of men who turned up for antenatal services with their spouses

Men Supporting Women for Household Activities

The evaluation explored the supportive behaviors of male household members for household activities; these included; helping in activities related to child handling, and household chores such as cooking, washing clothes, fetching water and firewood. The results are presented as follows;

Role	**Supportive Behavior of Men**		
	Midterm Review	**End term Review**	**Control Group**
Feeding, Bathing or changing the child's clothes	24.10%	39.30%	9.9%
Taking the child to the Health center	10.30%	43.40%	8.8%
Picking the child from School	24.10%	53.40%	11.5%
Playing with the child	48.30%	76.90%	7.1%
Teach the child Something	42.90%	70.00%	15.6%
Disciplining the Child	25.00%	53.60%	12.6%
Preparing food while partner is caring for the child	10.70%	30.70%	4.4%
Washing clothes	6.90%	26.90%	10.0%
Repairing the house	10.30%	38.40%	24.0%
cleaning the house	10.70%	44.30%	2.0%
Preparing Food	15.40%	43.80%	9.0%
Fetching Water	14.30%	40.70%	10.3%
Collecting Firewood	11.10%	38.50%	7.9%
Cutting wood	14.30%	40.70%	12.0%
Making Beds	17.90%	74.30%	9.9%

Table 8: Supportive behavior of men as reported by female household members

Conclusion on Result 2

Using the contribution analysis method, there is clear evidence that the project made significant achievements with the biggest contribution to joint planning for all aspects of the household wellbeing i.e. health, education, livelihoods and utilization of resources. Though the number drops by half when it comes to implementing the plans, the FGDs indicated that the situation was far bad before the project implementation. This result is therefore attributed to the project implementation as it can be directly linked to the project implementation of activities and the theory of change.

Using the Experimental Design, the consultant decided to use 3 parameters to compare the results for the control and treatment i.e. joint planning, Joint decision making, and men escorting women for attending to Antenatal Care, Post Natal Care and taking children for immunization. The results for the control for the three parameters are presented as follows; NB: the percentages do not add up to 100. Each question captures only those who mentioned yes for all the responses and those who said no are not important for this analysis.

Category of Responses		Percentage of Responses
Joint Planning for ANC, PNC, Family Health, Education, Livelihoods and Utilisation of Resources		
One of the Spouse makes the plan	Female Responses	65
	Male Responses	69
Joint Planning	Female Responses	35
	Male Responses	31
Who makes the final decision on where your wife should attend ANC?		
Man makes the decision	Female Responses	72
	Male Responses	80
Woman makes the decision	Female Responses	11
	Male Responses	9
Decision is made as a couple jointly	Female Responses	17
	Male Responses	11
Man Escorting the Partner for ANC & PNC		
Yes	Female Responses	40
	Male Responses	45
No	Female Response	60
	Male Responses	55

Table 9: Control data for men supporting women for Health Services

The data presented and further analysis indicate that the project indeed contributed an average of 26% in supportive behaviors of male household's members, as reported by female household members and 22% in supportive behaviors of male household's members, as reported by male household members. This is the difference between the control and the treatment groups of respondents. This implies that the project achieved above the set target result at the initiation of the project.

3.3.4 Result 3 –Primary Indicator - 20% of health service providers engaged in the project that demonstrate changes/improvements in how services is offered

This indicator was measured from two angles:

1. From the household responses; the consultant asked the respondents about the time taken to access the health services from the participating health centers, reasons for preference for the health facility as well as who attend to them when they access the services.

2. From the health centers themselves through key informant interviews with the nurses in charge of the specific units, focus group discussions with the Village Health Teams (VHTs), and an analysis of secondary data at the health centers particularly the registers.

1. Households perceptions about how Health services are offered

a) Time Taken at the Health Center

One of the challenges/ reasons that men gave in FGDS as to why they do not escort their wives is the fact that they do not have time because they are engaged in other activities that benefit the household. This implies that to them time is key for an improved service delivery at the health center. The respondents were asked the time it takes them to get served at the health center and majority (44%) indicated that it takes 2 hours and 39% indicated that it takes one hour. The key informant interviews with medical staff indicated that the time varies depending on the number of clients they have. However on average they indicated that it takes about 15 minutes to receive a client, register, and then give the service sought. So depending on how many people the client finds determines the time it takes to get the services. Focus group discussions also indicated that the health workers have improved on speed at which they handle the mothers compared to previously when the health workers were not conscious about the time and speed of service delivery.

It now takes us 1 hour to finish the whole process of registering and getting the treatment. They have improved on this. **An FGD Participant**

The consultant probed from the health workers if they attribute this to any of the project interventions, they indicated that they were trained on how to remove the barriers to access and utilization of MCH services and long hours was one of them.

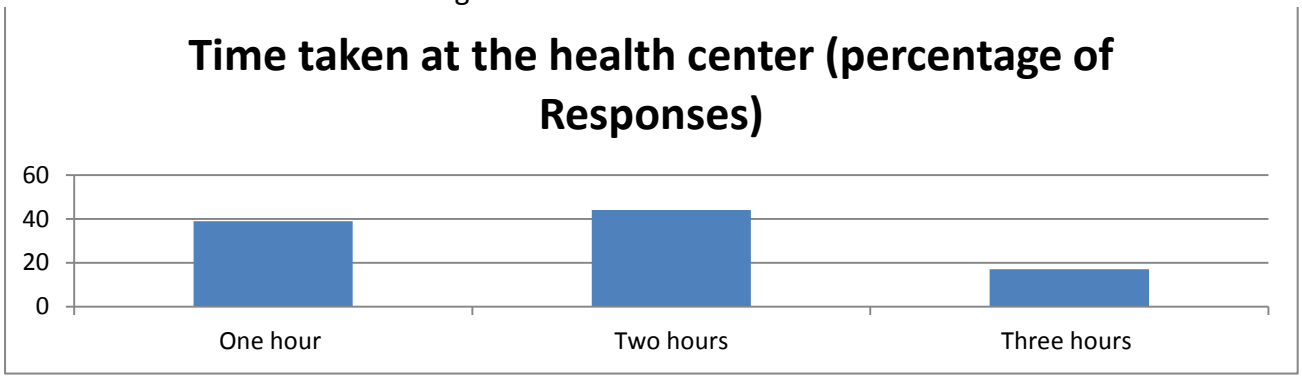

Figure 10: Time taken at the health center

b) Reasons for preference of health center

Respondents who indicated that they visit health centers for ANC, PNC, Child Delivery & Immunization were asked to indicate reasons why they prefer the health center instead of other places. Majority indicated that it is cheaper (85%) to get the services at the health center followed by access to trained personnel (60%), emergencies can be handled (54%), the place can be trusted (40%) and there is good service (34%). The responses given are an indication that the services at the health center are good and they have gained the trust and confidence of their clients in the community. The FGDs indicated: previously the health centers had lost the confidence of the people due to poor services particularly absence of health workers at the facility, absence of drugs and long lines of patients.

*"In the past the health centers had no drugs and we were treated in a harsh way whenever we go for the services. The situation has changed. They treat us as customers with a smile. "***An FGD participant**

Key informant interviews with the health centers also indicated that the trainings they received in addition to regular visits and monitoring by the VHTs and Role model men has compelled them to improve in the way they handle the clients which includes motivating staff to attend to patients all the time, having student nurses to assist in handling preliminary activities such as filling the register, taking the weight, blood pressure, and temperature of the mothers before they can see the medical assistant. Other actions taken is to prepare their requisitions for drugs and other items like Family planning kits in time so that they have a stock of drugs at every particular point in time.

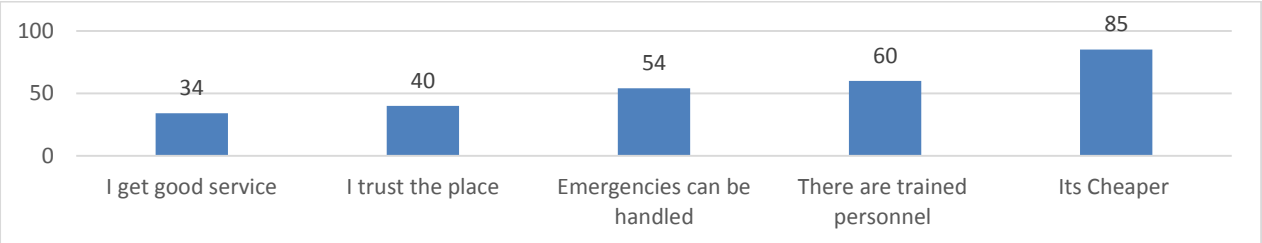

Figure 11: Reasons for preference of health center

c) Who attends to them at the Health Facility?

In order to probe further the improvements in health service delivery, the consultant asked the respondents to indicate who attends to them when they visit the health center and 80% of the respondents mentioned that they are attended to by a trained medical assistant/Nurse. This

confirms the fact that the issue of absentee medical workers has been squarely dealt with by the health units. Though it may be difficult to singly attribute this to the SRMCH project, the KIIs with the key staff indicated that the trainings that were organized by GWED G helped to open their eyes about the barriers to access and utilization of medical services and improvements were effected across the health facilities.

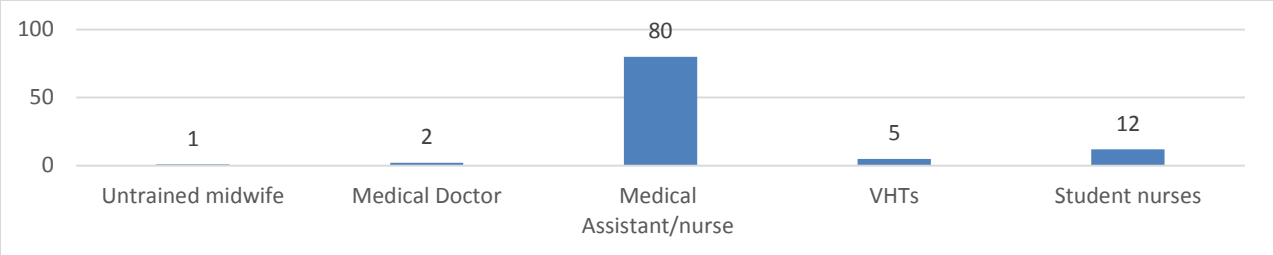

Figure 12: Who attends to them at the Health Facility?

2. Improvements in health services

The consultant through Key informant interviews explored the improvements in the service delivery of the health centers that the project reached using the following questions;

a) Does the health unit have critical specialist on staff at all times to attend to patients that need MCH services?

All the health unit staff interviewed indicated that there is a qualified government paid enrolled nurse at each unit of the health facility. For example there is a qualified staff at the ANC Unit, a qualified staff at Maternity unit and a qualified staff at the Immunization unit. Each unit has nursing assistants in addition to the enrolled nurse and student interns to assist in handling of the mothers. This is true for health center 4 and 3. The recruitment and retention of medical staff is not a project result but what evidently came out of the results is that the staffs are more active and available all the time to attend to the mothers.

b) Do the health workers ensure that the mothers receive recommended services as per the conditions of their pregnancies and child immunization schedules?

The focus group discussions with VHTs indicated that their roles after the trainings from GWED G changed to also include follow up the patients in their respective villages to ensure they take their prescribed drugs and also comply with the recommendations of the health workers. This is also emphasized through health outreaches organized by the VHTs, health centers and role model men. For-example, mothers receive mosquito nets in the health units for malaria prevention. The health center s do not stop at giving the nets but go ahead and sensitize on how to place them properly on the bed and the dangers associated with non-compliancy. The biggest role of the project on this is using the role model men to further sensitize their households attached as well as mobilizing for the health outreaches in their respective villages.

Conclusion on Result 3

Using the contribution analysis, the consultant was able to verify results and trace them through the project cycle from the beneficiaries of the health Centre, key informant interviews with staff and village health teams attached to the health facilities.

Using the experimental design, given the fact that the majority of the respondents get their medical attention from the village midwives, it is not proper to compare the numerical results. However what is clear is that the results for the control group indicate that the health centers in the control sub county are detached from the beneficiaries and the majority prefers the traditional birth attendants where they get quick services and they are not bothered about the quality or safety of the patients. This confirms the fact that the project all the health service providers (100%) engaged in the project demonstrated improvements in how services is offered and therefore have attracted the communities to utilize the services.

Options of response (answers)	Percentage of Responses
	Time Taken at the Health Facility
1 hour	84
2 hours	10
3 hours	5
	Reasons for Place of Delivery
It is near	37.5
I get good service	10
I trust the place	7.5
Emergencies can be handled	10
There are trained personnel	5
It's cheaper	10
Its where I have been attending ANC from	7.5
Others	12.5
	Who attends to you
No one	35.3
Untrained traditional mid wife Village Midwife	41.2
Medical Doctor	5.9
Medical Assistant or Nurse	11.8
Other	5.9

Table 10: Control Group; Perceptions about Health Services

The consultant was able to interview the health service providers at Pabbo health Centre, for instance, Evelyn Amenya confirmed that the uptake of health services in the area are very low. She also confirmed further that staff at the health Centre is not very keen about the quality of the service provided. Evelyn further attributed this to the fact that there is lack of a strict community monitoring and accountability system in place to hold the staff accountable for their actions.

3.3.5: Lessons Learnt and Best Practices

Lessons Learned

It is clear from the results that engaging men and boys is crucial to ending barriers against access and utilization of sexual reproductive maternal child health services.

Linking men's material interests with positive masculinities helps break the strong cultural orientation of men against supporting women for health services and household chores.

Mobilization efforts are effective when lead by community members: Perhaps one of the reasons why this project surpassed the intended results was due to the fact that the project established a strong network of role model men and community based facilitators. This ensured that the process itself was owned and ultimately sustained by community members. GWED G and Care International just played a catalytic role of inspiring and supporting others to take action.

Promoting equitable relationships is the core of the role model men approach: Ultimately the work of promoting good relations is to influence the nature of relationships between women and men, the models of masculinity and femininity acceptable in the community, and increasing women's status in the community. The project addressed issues of gender, inequity, status, communication, were explored and this contributed to the success realized with the men and women

Recognize the importance of local leaders: Formal and non-formal leadership structures in the community carry great influence and power. The support and action of these leaders can greatly facilitate positive change as they did for the SRMCH project.

4.0 ANALYSIS OF OPPORTUNITIES FOR FUTURE PROGRAMMING

4.1 Overlap and Duplication of other similar activities

The evaluation team qualitatively reviewed if there was duplication or overlap with other similar activities: The key informant interviews together with all the focus group discussions indicated that the Role Model Men Approach was used in the same target area by GWED G and Care on a GBV project before the SRMCH project. The role model men confirmed the fact that they were involved in another projects before the SRMCH project. The evaluation further discovered that there was no alternative approach that would have yielded results that are comparative to the results achieved by the role model men in promoting SRMCH among the communities reached. The interviews mentioned AMREF, USAID Safe, Save the Children, who had interventions in Gulu and Amuru supporting health centers for better service delivery.

> *"AMREF and USAID Safe supported us to get some of the materials we use here at the health center. We have not heard another NGO supporting the communities to increase their knowledge on sexual reproductive maternal child health".* **A midwife at Awach Health Centre**

The focus of AMREF and USAID Safe was on providing the mother kits, family planning kits, and other logistical support to the health units. There was no intervention with similar activities as the SRMCH project and also targeting the same geographical areas and the same beneficiaries and or using the role model approach. The consultant therefore affirms to the fact that there was no overlap or duplication of similar activities in the project area.

4.2 Opportunities for Scaling Up and Replication

In addition to the current project design and the RMM approach, the replication and scaling up would yield more benefits if the following are considered;

Using the multimedia approach; it was discovered by the evaluation team that the participants in the project took keen interest on matters that are discussed using various media channels. For instance 100% of the respondents in Pabbo Sub County had full knowledge about immunization and the source of this information was on radio, signposts and health outreaches organized by the health centers.

> *"We hear announcements and adverts on Radio about the benefits of immunization and we follow the advice and take our children to Pabbo Health center for immunization".* **A female participant in an FGD at in Pabbo sub county (A control sub county)**

The interviews with GWED G project staff indicated that the project did not have any component of radio messages or program sponsorship packages. This would have created more awareness for the role model men

Avoid parallel work with the VHTs; Discussions with the VHTs indicated that the role model men also do referrals to the health center yet they are not technically competent to do that. It appeared as if they were encroaching on the roles that are for the VHTs.

We work well with the Role Model Men but they do not have referral forms from the health centers. **A VHT in Kalamu Omya Village Bobi Sub County.**

Though the two structures expressed that they work together, there is a high potential for conflict. It is also important to note that VHTs get some structural support through the health centers and therefor they consider it as a privilege and would fight to defend their positions.

Local government adoption for GBV and family life; The local governments adoption of the project and role model approach largely depends on the perceived and real value added to the service delivery and if that is the best and only valuable alternative for such an improvement. Continuous marketing of the approach to the local governments during any of the available opportunities will ensure adoption of the approach across the sub counties.

SASA Methodology; the project document mentions using SASA methodology during implementation of the project but the consultant could not trace elements of the SASA methodology across the project period. Due to the evidence based approach fronted by SASA methodology, it would have yielded more results if this was put into consideration especially monitoring the beneficiaries across the stages of behaviour changes.

4.3 Unintended Benefits from the Project

The consultant discovered that the project achieved positive results that were not intended at the initial design stages:

Reduction in gender based Violence (GBV) in the target communities: The project resulted in men and women working, planning and deciding together for the health education and livelihoods of the family members. In addition to this, the households indicated a great improvement in men participation on household chores and supporting women for attending to their health and those of their children.

"My husband used to come home drunkard after selling the produce from our garden. After drinking we would be sure of the beatings me and the children. Now that is history. He even stopped drinking completely and we are happily living together" **A Wife of a Role Model Man during a Focus Group Discussion**

The FGDs indicated that these were the points of conflict and caused a big proportion of GBV cases that occurred in the households. As a result of the role model men intervention, there no cases of GBV reported or observed in the communities.

Clean Homes: What was visible and evident in all the households visited is the fact that the general cleanliness around the homes was unique and good. All the households visited had toilets at home, the household members dressed differently, and there were no bushes and rubbish in the compounds. What was clear is the fact that the households live an exemplary life in all rounds of life.

"My home is a role model home. I have a toilet, my compound is clean, my children go to school, I have a kitchen and an iron sheet roofed house. I learnt all this from my friend who is a role model man". **Male beneficiary of role model men during an FGD**

Though this was not part of the original design of the project, the role model men and the participating households were proud of having homes that are role models in the respective villages. The consultant indeed observed this and credits the project for finding a unique visible and differentiating feature of the households that participated in the project.

Reduction in early marriages: Though the consultant could not get actual figures to support this finding, qualitative results indicate that there is a reduction in early marriages as reported during the focus group discussions. This was the same message the echoed by the senior men and senior women teachers in the schools that were interviewed. The same message also was given by the cultural and local opinion leaders.

We had a problem of early marriages which were initiated and geared by the parents in a bid to get exchange for money and gifts. This vice has reduced due to the sensitization of the role model men. **A senior woman teacher at Paibona Primary School**

The schools visited indeed ascended to the fact that the girl child education has greatly improved as more girls stay in school. The head teachers interviewed attributed this to the change in attitudes of the parents about the girl child and the risks associated with early marriages

4.4 Sustainability

4.4.1 Buy In By Key Stakeholders

Given the outstanding achievements of the role model men on promoting Sexual reproductive maternal child health, the sustainability of the results and structures is equally important. On a good note, there was a consensus by all the relevant stakeholders in the program area that the structures built should be supported for their sustainability. The following commitments were made by the different stakeholders during a project closure meeting that was held on 11th August 2017.

1. **Local Government Leaders and Health Workers**
   - Pledged to work with the role model men to monitor and report GBV cases in the community
   - Pledged to look at the programs in the different sub counties where the RMM are working in and use the CDC programs to support the RMM
   - Leaders also promised that they are going to look at programs at the sub counties and engage them in those programs that they have capacity to do.
   - Health workers committed to continue working closely with the role model men in conducting health service forums and outreaches in the community.
   - Health workers and sub counties to continue working with the role model men and engage them as mobilisers for health programs.
2. **Role Model men**
   - RMM confirmed that they will remain in groups so that it is easy for the districts to support them.
   - Strengthen their groups through regular meetings and coordination so that they can continue working together
   - Harmonize their work plan so that they can plan accordingly on how to continue reaching others in the community even without the project.
   - Lobby with the radio stations so that they can allocate them some free air time.
   - Use existing avenues to create linkages with local leaders.

The implementation of these commitments may go a long way in addressing concerns of sustainability of the project benefits.

4.4.2 Project Design

Working with a Local Partner

CARE's work with GWED G a local partner was a strategic approach that built a residual capacity for the long term sustainability of the intervention as already seen in incorporating the RMM in other projects structures. The project rightly fit into GWED G strategic direction and this is reflected on the organizations' strategic plan. The Key informant interviews with the project officer GWED G indicated that GWED G will continue working on SRMCH issues even when the project closed as already reflected in the current work of GWED G with other development partners such as DIAKONIA. This too was echoed during the validation meeting by the Executive Director GWED G

where she made commitments that the organisation is committed to using the role model men on all the projects that focus on GBV and SRMCH.

> *"The transition on sustainability has already started with GWED G. We have decided to utilize the role model men for interventions targeting gender relations and sexual reproductive health"* **Pamella CEO GWED G**

Alignment with the national and International Policy Frameworks

At the national level, the project was aligned with The National Policy Guidelines and Service Standards for Reproductive Health Services, National Adolescents Health Policy for Uganda, the District Development Plans for Gulu, Amuru, Omoro and Nwoya. The evaluation team also found the project conforming to the development strategies contained in the Local Government Act (1997). The implication of this on sustainability is that the government has already prioritized SRMCH for support by government. When triangulated with the local government leader's commitments on the sustainability of the project, a clear direction is mirrored towards sustainability. Uganda is party to the UN convention for Sustainable development Goals (SDGs) and the project contributes to Goal number 3 Good Health Wellbeing, 4 Quality Education, 5 Gender Equality and 10 Reduced Inequalities. This implies that the local and central governments will support the project structures as they were convinced that the RMM bring about quick results for GBV and SRMCH

Establishment of a network of local structures

The establishment of a sustainable network of role model men and their cohort of households was an integral aspect of the project. The support of traditional, religious and political leaders, health care workers, PTAs were reviewed as will contribute to the sustainability of the project. The mentor relationship that was developed by the project for the role model men created a visible social bond that needs to be nurtured to continue to grow using minimal effort for them to take-off without external support. The project used an experiential learning and sharing approach where government institutions such as health clinics, ultimately bear responsibility for the target groups' ability to access information and services were part of the learning and experience sharing throughout the project cycle. This was clear from all the interviews with key informants' interviews that the learning that took place will be utilized to further improve the sustainability of the project interventions.

Social Cohesion Built among Beneficiaries

Perhaps what came out very clearly was the fact that social cohesion among the role model men as well as the respective 10 households was very prominent and pronounced as the factor that will contribute to the sustainability of the project results. The communities have informally established a self-monitoring and accountability system where members have come up with additional initiatives that include working together in groups, and saving together through formation of VSLAs.

> *"We know each other, we work together, we eat together some times, we share joys and sorrows. We have become a family. We will remain a family even when the role model man does not follow on us"* **A beneficiary woman during an FGD**

Taking Care of Cultural Background

Culture is a fundamental domain of social life and the SRMCH project recognized the prevailing cultural orientations of the target beneficiaries at the initiation of the project. During implementation, the cultural leaders were part and parcel to the project and this meant that they endorse the project and the message that the project carried. Also the facilitators of the project were sensitive on cultural dynamics of the area and therefore were careful not to harm the good cultural practices. Though some of the issues promoted such as family planning, and men involvement in HH chores were perceived by many as against the Acholi culture, there was a deliberate effort to clarify that actually the concept are in line with the cultural principles in Acholi Region. The concepts were thus made part of the culture and therefore will be practiced for generations.

In my community you could not talk about family planning and immunization. Men knew that some work is purely for women. A lot of men were drunkards and a liability to their households. At my chiefdom, we have passed a resolution that all men should be there to support their household members for health, education, and livelihoods. **Latigo Santo A cultural leader at Kal Kwaro Bungatira**

4.4.3 Opportunities to Further Enhance Sustainability

From the evaluation, it has become clear that the RMM have built strong knowledge base and social assets to survive without external support in all the communities that participated in the study. However, further support would help them move beyond the existing constraints towards a more sustainable phase. The following opportunities might enhance the sustainability of the results and structures

1. **Infrastructural support;** Interviews with the role model men indicated that the households that they work in a distant a part and this consumes their considerable time to traverse the long distance to reach each household every months. This was a point also pointed out by the households that the role model men are constrained by limited opportunities to move around the households easily using simple means like a bicycle. This constraint might limit the sustainability of the role model men`s services to the households and even limit them from expanding.
2. **Coordination and mobilization:** The interviews with the role model men and focus group discussions indicated that they have sub county committees which coordinate their activities in the respective sub counties. It is important to note that these committees work on a voluntary basis and they have been supported in some cases by the project to coordinate together with the community based facilitators who also work on a voluntary basis. Though they expressed interest to continue the coordination role, the consultant assesses that they need morale booster for them to keep on track. Their role has been very vital as their support motivates the role model men to work beyond their limits because they are accountable to an established structure.
3. **Learning and sharing;** the role model men were selected conscious of the fact that they will be facilitating acquisition of knowledge and change in behaviour. Though they were trained with sufficient materials, they still require more opportunities for learning and sharing of information between themselves and from an expert point of view.
4. **Learning materials:** perhaps one other constraint that might limit the sustainability of the project is the fact that the project did not provide adequate learning and sharing materials to equip the RMM with innovative materials of transmitting knowledge. Such would include illustrations, manuals translated in local language and monitoring templates localized in the context.

5.0 RECOMMENDATIONS FOR FUTURE ACTION AND CONCLUSION

The following conclusions and recommendations have been generated and reflect the most important findings and observations of the evaluation mission. The structure follows mostly well-established themes from the project management cycle and main thematic areas of the evaluation.

5.1 Relevance of RMM Approach

Conclusions

3. The RMM approach was found relevant in all 9 sub counties to differing degrees, all within the context of the Sexual reproductive maternal child health issues.

4. The RMM approach, its promotion among stakeholders at various levels is coherent with the local governments` mandates of using all available means to promote sexual reproductive maternal child health and enhance efficiency and effectiveness of service delivery as well as accountability of the development partners operating in the respective sub counties.

Recommendations for Replication and Scaling Up

3. Continue focus of RMM to SRMCH and all attention to the households` knowledge attitudes and behaviors towards SRMCH issues.

4. The RMM approach should remain just an approach and the scale up can incorporate other approaches to reach out to school adolescents. These other approaches should be able to supplement the great work done in the households by the role model men.

5.2 Efficiency and Effectiveness at Achieving Project Results

Conclusions

3. The project achieved 100% of the results at output level

4. The project achieved and surpassed the results at outcome level for all the 3 result areas as listed in the logical framework;

c) The project achieved 42% for age appropriate knowledge on sexual reproductive maternal child health. The project surpassed the target for result 1 as stated in the logical framework

d) On average the project contributed 26% in supportive behaviors of male household's members, as reported by female household members and 22% in supportive behaviors of male household's members, as reported by male household members. The project surpassed the target for result 1I as stated in the logical framework

d)The project achieved 100% of the health centers engaged in the project who demonstrated improvements in how services is offered and therefore have attracted the communities to

utilize the services. The project surpassed the target for result 1II as stated in the logical framework

4. Expenditures have been found in line with their original allocations, although it is difficult to ascertain details of the project expenditures as this is out of the evaluation scope.

5. The team has found several examples of households as testimonies for the great work done by the role model men. This is proof that the RMM have successfully been accepted by the communities and community structures.

Recommendation for Replication and Scaling Up

The team recommends that CARE International continues using the role model approach for sexual reproductive maternal child health in communities that have the same context as the communities in Acholi Region in Northern Uganda.

5.3 Project Management/Coordination/Human Resources

Conclusions

4. The coordination structure put in place to support the RMM at community level has worked reasonably well.

5. The full-time Project officer housed at GWED G working closely with the community coordination structures has been a clear asset to the project.

6. The strong coordination and support by Care International Initiative Manager and Program Manager provided a leaning base for GWED G staff and was critical for the successful implementation of the project.

Recommendations for Replication and Scaling Up

The team recommends that GWED G should continuously lobby local governments to incorporate the role model men into service delivery structures. This will not come easily but advocacy and lobbying requires patience and if consistently pushed, results will come. On a good note, the project carried out activities purposely to create awareness about the role model men and there were already commitments from the District leaders to work with the role model men.

5.4 Communication/awareness raising

Conclusions

3. The RMM have played a major role with regards to raising awareness on SRMCH situation, including measures to better health service delivery, their efforts have remained within the communities which they serve.

4. Communication has not received enough attention by the project, especially at all levels, in part due to a weakness in the project design (lack of budget) itself. There was observed documentation of success stories but the stories were not widely shared on various media platforms.

Recommendations for Replication and Scaling Up

Communication and advocacy are integral part of information management and need to be appropriately budgeted for in future. The team feels that appropriate internal and external advocacy would go a long way into the successful adoption of the RMM at the local government service structures.

5.5 Capacity Development / Lessons Learning

Conclusions

4. The project's capacity development efforts for local partners have been key to galvanizing the collaboration and spearheading the main project outputs and outcomes. These included the development of the role model training manual, various training sessions of role model men, leaders and influencers training, community based facilitators, medical staff from the selected participating health centers, senior men and senior women of participating schools.

5. The role model men training materials, including curriculum and user guides, has been found to be of satisfactory quality and a major contributing factor to the successful adoption of knowledge and behaviours of the role model men.

6. The project has targeted most of the capacity activities on individuals rather than at an organizational level.

Recommendations for Replication and Scaling Up

The training materials should be simplified further and contextualized to be able to be used by the role model men at the household level.

5.6 Partnerships

Conclusions

3. The involvement of local governments and other local structures was strength of the project and contributed to the achievement of the results.

4. Cooperation between Care International and GWED G has good history and this project relied on the good relationship between the two parties.

Recommendations

2. There is an opportunity to market the RMM approach to other peer NGOs so that they can adopt the methodologies/tools and technical skills into their curricula for interventions targeting SRMCH issues in similar setting such as Northern Uganda.

ANNEX 1: DETAILS OF THE EVALUATION METHODOLOGY

The SRMCH End of Project evaluation was carried out in full compliance with the DAC Evaluation Quality Standards (206). The end of project evaluation used both qualitative and quantitative methods to get the necessary data that was required to answer all the research questions.

Quantitative Data

The consultant collected quantitative data from 328 beneficiary households that were sampled from the 1000 households reached directly by the project through the role model men. This enabled the consultant to provide a numerical inference to project impact using statistical analysis to the evaluation results. The respondents included men, women, adolescent girls and adolescent boys.

Sample Size

The consultant used 3 parameters to determine the sample size

1. The margin of error:

The margin of error is the amount of error that the study design can tolerate. This study used 5% as the minimum error.

2. Confidence Level:

The confidence level is the amount of uncertainty the survey design can tolerate. For this study a confidence level of 95% was considered.

3. Population Size:

A total population of 5400 was considered for this evaluation

The consultant used a formula to substitute the above parameters to determine the sample size. The following statistical equation was used to determine the sample size for the end of project evaluation.

Equation 1: $n = \frac{Z^2 pq}{d^2}$

Where;

n =refers to the desired sample size

Z =the standard normal deviate usually set at 1.96 which correspondents to the 95% confidence level.

p =Population of the target population estimated to have a particular characteristic, 50% was used due to lack of a reasonable estimate.

q =1.0 – p

d =degree of accuracy desired; in this context set at 0.05.(5%)

The sample size of 278 respondents (Rs) was obtained by substituting in the above formula as indicated below:

Equation 1: $n = \frac{Z^2 pq}{d^2} = \frac{(1.96)^2(0.5)(0.5)}{(0.05)^2}$ = 278 Respondents (Rs)

From the Calculation, n=287.

In order to cater for non-responses and other unanticipated field challenges 10% was added on to the sample generated by the equation and this totaled to 316 respondents. On a good note, the evaluation surpassed this number and reached a total of 328 respondents from the intervention areas. In order to attribute the impact to the SRMCH project, the study selected an additional 48 respondents from the non-intervention areas to act as a comparison (control)

Sampling for geographical coverage

The evaluation reached all the 9 sub counties where the project was implemented. A list of all the parishes and villages where role model men have reached was obtained from GWED G and together with consultation with Community based facilitators randomly sampled the parishes and villages that participated in the evaluation. Table shows the details of the actual districts, sub counties and parishes reached by this evaluation;

District	Sub counties Reached	Parishes Reached
Gulu	Awach	Gwengdiya
		Paduny
	Patiko	Kal
		Pawel
	Bungatiro	Punena
		Laliya
		Pabwo
Nwoya	Alero	Panyabono
	KochGoma	Orum
Omoro	Ongako	Onyona
		Kal
	Koro	Laipanat East
		Laipanat west
	Bobi	Palenga
		Paidwe
Amuru	Lamogi	Agwa Yugi
		Obbo

Table 1: Geographical coverage of the Evaluation

Sampling of Households

The consultant used systematic sampling to arrive at households that were interviewed. At the start of each day, the research assistants identified a role Model man/household who provided the list of the 10 households that were reached. Using an interval of 3, the researcher sampled at least 4 households systematically. The role model man helped to guide the researchers through the villages to locate the sampled households.

Sampling of Respondents in the Household

The consultant used purposive sampling to arrive at the respondents that were interviewed. There was a deliberate effort to balance the sample amongst the 4 categories of the respondents i.e. the husband, wife, female adolescent and male adolescent and this enabled the consultant to make inferences for each target category of the respondents.

Qualitative Data

Qualitative approaches were used to triangulate the data obtained from the household. The data obtained provided more evidence of causality and different perspectives on changes that happened as a result of the project implementation.

1. Key Informant Interviews

The consultant purposively selected people who have particularly informed perspectives for their first-hand knowledge on the aspects of the SRMCH project for interviews as key

informants. The interviews were loosely structured, relying on the broad themes of the evaluation. A key informant interview guide guided the key informant discussions and was specific for each category of the key informant. For example the local leaders had a separate guide that was different from that for health unit staff and senior women and men teachers in the target health centers and schools respectively. A total of 20 key informants were interviewed and included among others, health workers, village health teams, members of school management committees, project/partner staff, cultural leaders, local council officials, religious leaders, and other opinion leaders as was found feasible during the field work. A list is attached in appendix.

2. Focus Group Discussions

The consultant used focus group discussion methodology to capture key detailed information from the primary respondents as per the research questions. In order to allow free discussion of issues, the focus group discussions were disaggregated between gender and age categories where possible. Indeed 60% of the FGDs were single sex and same age bracket. The consultant ensured an optimum average number of 8 participants for each of the focus group discussion. The Focus Group Guide was the main tool for guiding the discussions of issues in the focus group discussions and was structured to include; probe questions, follow-up questions, as well as exit questions.

Data management and analysis

1. Data management and analysis took the following steps: coding; cleaning, entry, and filling. Data was entered in Epidata downloaded from the server and exported into SPSS.
2. Quantitative Data: Data was analysed using Statistical Package for Social Scientists (SPSS version 18.0) in two stages: Firstly, a descriptive summary of characteristics of respondents and related aspects in the various themes was undertaken using frequency distributions and percentages. The data was disaggregated by various characteristics such as gender, education level, marital status etc.
3. Qualitative Data: Qualitative data collected through key informant interviews, FGDs, and in-depth interviews was analysed thematically. Focus Group data was transcribed and later on analysed using thematic procedures. Participants in a focus group discussion were assigned codes and captured verbatim. During the group discussions, individual responses were coded by each particular item and relate to the Subject matter and theme in the interview schedule. The major issues of concern were analysed in relation to the itemized Subjects and the corresponding answer categories classified by each item of a particular theme.

Ethical considerations

1. For ethical consideration, the data enumeration team was composed of both male and female members. Interviewers explained the purpose of the survey to respondents and sought informed consent of each and every respondent before starting new interview.
2. Interviewers were trained in interviewing skills and how to behave while in the field to avoid compromising the data quality. The interviewers were closely supervised to ensure they adhere to principles of; confidentiality, respect for the respondents, un-biasness, conflicting interest, honesty, privacy, convenience and clarity among others.
3. All authorities of local leaders at district, sub county and parish levels in the study areas were informed of the evaluation and its purpose prior to the start of the data collection process so as to obtain their permission as well.
4. Reproductive Health issues are very sensitive, so the interviews with the women might have touch such sensitive issues; this could have been distressful and might cause discomfort. Also women who have lost babies in childbirth they might find too distressing to discuss. These concerns were fully recognized by the consultant and all effort was done to minimize these effects

5. The participants were advised that they can withdraw from the interview process at any time without any negative consequences. The survey made sure that the respondent had fully understood the background and the objective of the research before starting the discussion.
6. Anonymity was maintained throughout this evaluation from the data collection up to the write-up of the report. All data collected: transcript, field notes and questionnaires were kept in a secure place and under lock and key in the care of the consultant. All data including the electronic copies of the data was stored in secured (locked) location during the field work. All other unwanted data was destroyed. Interviews were conducted in a private and suited the participant convenience and ensure confidentiality.
7. The study did not pose any adverse effects on the public and did not place any demand on the local health services

Quality control and management strategies

1. Right from the planning stage, through hiring and training interviewers, sampling, data collection and analysis, quality control measures were considered. The Household Questionnaire was designed to ensure consistency with skip patterns embedded and checks to instruct and guide the interviewers.
2. Sampling strategy was strictly followed. Experienced research assistants who were eloquent in both English and Acholi language were identified, recruited and trained for two days
3. Upon completion of the training, the questionnaire was pre-tested by the team and necessary changes to the questionnaire were made depending on the feedbacks and comments from the pre-test.
4. The field team consisted of the consultant, GWED G staff and supervisors who guided the interviewers and provide instant quality assurance by checking for completeness and consistency of the questionnaire and accuracy and validity of the data before submission to the data management unit.

Challenges Encountered during the Study

Sampling Methodology: The consultant obtained a list of all the villages where role model men live and used simple random sampling method to select the villages to participate in the study. When it came to data collection, some villages that were randomly selected did not have participating households. The reason for this was the fact that the role model men were not geographically restricted during the selection of the households to enroll into the project. The team obtained a list of households from the role model men and using systematic sampling selected the households to participate in the study and the team followed them to their respective locations.

ANNEX11: HOUSEHOLD QUESTIONNARE

IDENTIFICATION INFORMATION:

1	RESPONDENTS IDENTIFICATION NUMBER [ENTER 3 DIGIT CODE]									
2	DISTRICT NAME_____									
3	SUB COUNTY NAME_____									
4	PARISH NAME _____									
5	VILLAGE NAME _____									
6	INTERVIEW DATE						2	0	1	7
7										
8	NAME OF THE INTERVIEWER_____									
9	NAME OF THE SUPERVISOR_____									
10	STATUS OF INTERVIEW: COMPLETE ☐ INCOMPLETE…☐									

INTRODUCTION/CONSENT

Hello, my name is _____*(your full names)*_____ and I am an independent researcher working for GWED-G and Care International and i would like to ask you a few questions about you and your family as regards to sexual reproductive and martenal health. This should not take much of your time, and you can choose to stop the interview at any time, or to skip any questions if you like. There are no benefits for anyone who takes part, and no negative consequences for anything that is said in the discussion.Your responses are confidential, and your name will not be written down. We will use the information that you provide to learn about sexual reproductive health in your community.

In relation to what I have talked, is there any question so far?

Are you happy to proceed with the interview? Yes ☐ No ☐

(**IF NO**, THANK AND SAMPLE SOMEONE ELSE

SECTION 100: DEMOGRAPHIC CHARACTERISTICS

I will begin with some questions about your background.

No.	QUESTIONS AND FILTERS	CODING CATEGORIES
101	Record the respondent's sex	Female ……..…… 1 Male ……2
102	Respondent Category	Role model Man……1 Wife of a role model man……2 Child of a role model man……3 Beneficiary of a role model household ……4 Adolescent Boys ……5 Adolescent Girls……6 Others ……99

103	How old are you? In case the respondent does not know actual age, ask for an estimate of when the respondent was born and calculate complete years	**Complete years** ☐☐
104	How many people live in this household?	Indicate the number…….
105	What is your marital status?	Single……1 Married (Monogamy) ……2 Married (Polygamy) ……3 Co-Habiting ……4 Widow (ed)……5 Separated …… 6 Refuse To Answer……88
106	What is the highest level of education you attained?	No Formal Education……1 Currently in primary school ……2 Currently in secondary school ……3 Dropped out in primary school……4 Completed Primary Education……5 Completed secondary level……6 Tertiary education……8 **Others (specify)……99**
107	What is your religious affiliation?	Catholic ……1 Anglican ……2 Islam ……3 Born Again Faith……4 SDA ……5 **Others (Specify)……**99
108	What is your **MAIN SOURCE** of income **Single Response**	Subsistence farming ……1 Agribusiness ……2 Formal Employment……3 Small Business ….……4 Casual labor ……5 Still a student ……6 Art & Craft ……7 Don't have any source of Income ……8 **Others (Specify)…….** ……99

SECTION 200: REPRODUCTIVE HEALTH

Thank you, the rest of my questions are specifically about the health of you and your family. First, I'd like to ask you about your health as a woman (if a man) for your wife. In other words, these next questions are about reproductive health.

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	
	FOR WOMEN ONLY →		**Men Skip to 234**
201	Have you ever given birth?	Yes……1 No ……2 →	**SKIP TO 205**
202	How old were you when you first gave birth	Record the number	
203	How many children in total		

	have you given birth to?	Record the number	
204	How many of the children you gave birth to are currently living?	Record the number	
205	Have you been pregnant in the last three years	Yes……1 No……2 →	**SKIP TO 252**
206	During your last pregnancy, how many times did you go for Antenatal Care (ANC) check-up?	Record the number ……	
207	What services did you receive when you went for Antenatal Care (ANC)	HIV Testing ……1 Counselling……..2 Pregnancy test…..……...3 Got mosquito nets……..….4 Pregnancy care drugs……..……5 Food Supplements ……..…6 Others (Specify)…….99	
208	Why did you go for Antenatal Care (ANC)?	Health of my baby ….. ……1 Medical treatment for myself ……..2 Free vaccination ……..3 My health ….. ……..4 Information on pregnancy……..5 Free medical supplements ……6 It's a policy ……7 Other (Specify)……..99	
209	During your last pregnancy, did you have an injection in your arm against tetanus?	Yes……1 No ……2 → Not sure……99	**SKIP TO 212**
210	How many injections against tetanus (TT) did you receive?	Put the actual Number……	
211	How many injections should you have in total?	Put the actual Number…… Not sure ……88	
212	During your last delivery, where did you deliver from?	Home……1 Clinic ……2 Hospital ……...3 Health centre ……4 Traditional Birth Attendant Home ……....5 Other location (Specify:_____)……99	
213	Ask for reasons for the place of delivery	It is near……1 I get good service……..2 I trust the place……..3 Emergencies can be handled……4 There are trained personnel ……..5 Its cheaper ……6 Its where I have been attending ANC from…….7 Others……99	
214	Where do you prefer to deliver?	Home……1 Clinic ……2 Hospital ……...3 Health centre ……4	

		Traditional Birth Attendant Home ……....5 Other location (Specify:_____)……99	
215	Who assisted you with your last delivery? (PROBE: Anybody else?)	No One……1 Untrained Traditional Midwife ……..2 Medical Doctor ……...3 Medical assistant or Nurse …….,4 Village Midwife (trained health worker) …….5 Spouse……6 House Hold/Relatives ……7 Other (Specify___)……99 DK:……..88	
216	After your last delivery, did you receive any medical care within the first six weeks	Yes ……1 No ……2 ⟹ Not Sure ……88	SKIP TO 218
217	From whom did you seek care? (PROBE: Anybody else?)	No one ……1 Untrained traditional mid wife Village Midwife (trained health worker) ..……2 Medical Doctor……..3 Medical Assistant or Nurse ……..4 Other (Specify) _____.....99	

218	After delivery, did you(do you) attend all immunisation schedules for your child	Yes……1 No……2 ⟹	**SKIP TO 221**
219	What vaccines did your child receive and completed?(Ask for the immunisation card)	Polio Vaccine ……1 BCG……2 Measles Vaccine……3 Pneumonia……4 Tetanus…….....5 DPT……6 NONE……7 DK……..88	
220	Who helped you (is helping you) to take the child for immunisation?	Husband……..1 Children……..2 Neighbour ……..3 Friend ……....4 Relative ……5 I do not receive any help……6 Others (specify) ……..99	
221	How frequently does he/she help you to take the child for immunisation?	All the times…….. 1 Once in a while……..2 Not being helped at all……3 Others Specify ……..99	
MALE INVOLVEMENT IN ANC SERVICES			

222	Did you discuss and make a joint plan with your Spouse on where to attend ANC during the most recent pregnancy?	Yes……1 No…….……2	
223	Who makes the final decision on where you should attend ANC?	I make the final decision……..1 My Husband…….....2 Decision is made as a couple jointly…..3 Others:…….9 9	
224	Did you attend ANC at least once with your husband during the last pregnancy?	Yes……1 ⟹ No……2	**SKIP TO 225**
225	If no Why didn't he attend?	He was busy ……1 We didn't have transport for two people…2 He refused……..3 He's not interested ……4 Cultural Stigma……...5 I don't know……88 Others Specify……99	
226	As a couple, did you have a fixed arrangement on where you should deliver from?	Yes……1 No……2	
227	Did your husband escort you to the health unit during labour for the most recent delivery?	Yes……1 ⟹ No……2	**SKIP TO 229**
228	If no; why didn't he escort you?	He was busy ……1 We didn't have transport for two people…2 He refused……..3 He's not interested ……4 Cultural Stigma……...5 I don't know……88 Others Specify……99	
229	Was your husband present in the labour room during your delivery?	Yes……1 ⟹ No……2	**SKIP TO 231**
230	What could have prevented him from being with you in the labour room?	Social Stigma……1 Cultural taboo…….……2 Health workers did not allow you in the delivery room……3 Fear of the mother's and baby's outcome..4 The wife refused ……5 Others:……..99	
231	Did your husband discuss and make a joint decision on postnatal care services with you during the last pregnancy?	Yes……1 No……2	
232	Did your husband accompany you to seek care in a health unit	Yes……1	

	within the last six weeks after the delivery of your youngest child?	No……2	
233	What challenges did/do your husband face in escorting you to the health facility for ANC, delivery or PNC?	Lack of transport……..1 Long waiting time at the health facility.2 Concurrent job demand……..3 Long distance to health facility……4 Cultural taboos……..5 Social stigma……6 Others: ……99	
234	What do you recommend health managers should do in order to encourage men to be more involved in maternal health services? (Only three 3 Answers)	……..… ……..…… ……..…… ……..……	
FOR MEN ONLY		**→Women skip to 252**	
235	Do you have a child who is 1 Day to 7 years?	Yes……..1 No……2 →	**SKIP TP 300**
236	Are you, as a man, involved in maternal health care services?	Yes……1 No……2	
237	Are you, as a man, supposed to be involved in maternal health care services?	Yes……1 No……2	
238	How do you find the health workers' attitudes towards men accompanying their wives to hospitals?	They attend to us very well and friendly1 They are unfriendly to men ……2 Others specify ……99	
239	How much time does the woman spend on average in the health facility when going for ANC or PNC?	1 hour……..1 2 hours……2 3 hours……3 More than 3 hours……4	
240	Did you discuss and make a joint plan with your wife on where she attended ANC during the most recent pregnancy?	Yes……1 No……2	
241	Who makes the final decision on where your wife should attend ANC?	My wife……1 I make the final decision ……..2 Decision is made as a couple jointly…….3 Others:……9 9	
242	Did you attend ANC at least once with your wife during the last pregnancy?	Yes……1 → No……..2	**SKIP TO 243**
243	Why did you not attend?	I was busy ……1 She refused to go with me……2	

		We didn't have transport for two peop.l3 Others specify ……99	
244	As a couple, did you have a fixed arrangement on where your wife should deliver?	Yes……1 No……2	
245	Who makes the final decision on where your wife is to deliver?	My wife……1 I make the final decision……..2 Decision is made as a couple jointly…3 Others:……99	
246	Did you escort your wife to the health unit during labour for the most recent delivery?	Yes……1 No……2	**SKIP TO 247**
247	If no why?	I was busy ……1 She refused to go with me……2 We didn't have transport for two people.3 Others specify ……99	
248	Were you present in the labour room during your wife's delivery?	Yes……1 No……2	**SKIP TO 249**
249	What could have prevented you from being with her in the labour room?	Social Stigma……1 Cultural taboo……2 Health workers did not allow me in the delivery room ……..……3 Fear of the mother's and baby's outcome……. 4 Respect to my wife……5 Others:……..…99	
250	Did you accompany your wife to seek care in a health unit within the last six weeks after the delivery of your youngest child?	Yes……1 No……2	**SKIP TO 251**
251	What challenges did/do you face in escorting your wife to the health facility for ANC, delivery or PNC?	Lack of transport……1 Long waiting time at the health facility..2 Concurrent job demand……..3 Long distance to health facility……..4 Cultural taboos……5 Others specify ……...99	
252	What do you recommend health managers should do in order to encourage men to be more involved in maternal health services?	…… …… …… …… ……	

253. How often have did you do (your husband do) the following activities with your youngest child in the last 10 months?

	Rarely /	Once a	A few	Ever	Not

	Never	week	times a week	y Day	Appli cable
253A. Feeding, bathing or changing the child's dress					
253B. Soothing the child if he or she is crying or upset					
253C. Taking the child to the health centre if sick or for immunisation					
253D. Taking and picking up the child from school					
253E. Playing with the child					
253F. Teach the child something					
253G. Disciplining the child					
253H. Preparing food for your partner while she is caring for the child					

254. How often have you done (has your husband done) the following activities in the last 10 months?

	Rarely / Never	Once a week	A few times a week	Every Day	Not Applicable
254A. Washing Clothes					
254B. Repairing the house					
254C. Buying Food					
254D. Cleaning the house					
254E. Preparing Food					
254F. Fetching water					
254G. Collecting Firewood					
254H. Cutting wood					
254I. Making beds					
254 J. Others……					

SECTION 300: FAMILY PLANNING

In the next few questions, I'll be asking about family planning. When I say family planning I'm referring to techniques Couples can use to space pregnancies for the better health and development of their families or the ways or methods that a couple can use to delay or avoid a pregnancy

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	
301	From what you've seen or heard, what are some methods of family planning you are aware of? (PROBE: Can you think of any other methods?) (DO NOT READ LIST –MORE THAN ONE ANSWER POSSIBLE.)	Condoms ……...1 Pill……...2 Injections …….3 Implants……...4 Vasectomy/Tubaligation……..…..5 Breastfeeding ……....5 Abstinence ……....7 Natural Methods(sex during safe period or withdrawal before ejaculation) ……....8 IUD……9 Other (Specify: _____)….99	
302	Where can you purchase/receive these methods? (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE)	Clinic……1 Pharmacy/ Drug Shop …….2 Health Center /Hospital …….3 NGO……..4 Village health team……..5 From a friend……6 Other (Specify)…….……99	
303	How old is your youngest baby?		
304	Are you (Wife) currently pregnant?	Yes……1 No ……2 →	**SKIP TO 306**
305	Was this pregnancy intended	Did not want to get pregnant at all……1 it has happened before the planned date…2	
306	Have you ever used any family planning methods to prevent or to space pregnancy?	Yes ……..1 No ……2	
307	Are you currently using any family planning method to space pregnancy?	Yes……1 No……2 →	**SKIP TO 310**
308	Which family planning method or methods do you currently use? You can say more than one. (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.) Go to 312	Condoms ……...1 Pill……...2 Injections …….3 Implants……...4 Vasectomy/Tubaligation……..…..5 Breastfeeding ……....6 Abstinence ……....7	

		Natural Methods(sex during safe period or withdrawal before ejaculation) ……....8 IUD……9 Other (Specify: _____)….99	
309	Do you want to use a birth spacing method in the future?	Yes ……..1 ⟶ No ……2	**SKIP TO 311**
310	What is the main reason you do not want to use a method?	a) Wants children……1 b) Lack of knowledge……..2 c) Husband opposed……....3 d) Too expensive……4 e) Fear side effects……5 f) Health concerns……6 g) Hard to get method……7 h) Opposes birth spacing……8 i) Leave it to nature……9 j) My Faith Doesn't allow …….10 k) Against my culture……11 l) Others (Specify)……99	
311	Have you ever (your wife) got pregnant while you are using a family planning method?	Yes ……..1 No ……2	
312	Now that you know so many things about family planning; from where do you get all this information? You could PROBE like where else; IEC	Health worker at the clinic …….……1 Midwife at home.....2 Sign post, poster or band flit……..…3. Radio……..4 TV……..5 Friends……...6 Community Dialogue……..……7 Role Model HH……..8 My Father…...……...9 My Mother ……....10 GWED G……11 NGO……12 News Paper……13 Other (specify)……..…99	
313	What recommendations do you have to health managers on how best to provide family planning services ?(Put three (2) Answers)	…… …… ……	

SECTION 400: HIV/AIDS/STI (MEN, WOMEN, ADOLESCENT BOYS & GIRLS)

I'll be asking you specifically about HIV/AIDS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	
400	Have you heard of a disease called HIV/AIDS?	Yes ……..1 No ……2 ⟶	**SKIP TO 403**
401	From what you've seen and heard, how is HIV/AIDS	Sex without a condom ……1	

	passed from one person to another~~,~~ ? (PROBE: Any other ways?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)	Illegal sex without a condom ("Illegal sex" refers to sex outside of marriage)……..2 Sharing needles ……3 Injections……..4 Mother to baby during pregnancy/childbirth ……5 Breast milk……..6 Sharing razors…….7 Unsafe Blood Transfusions …..8 Kissing……..9 Holding Hands……10 Mosquitoes……..11 Others specify……..99	
402	From what you've seen and heard, what are some of the ways you can use to protect yourself from getting HIV/AIDS? (PROBE: Any other ways?) (DO NOT READ LIST – MORE THAN ONE ANSWER POSSIBLE.)	Abstinence ……..1 Using a condom …….2 Faithfulness of both partners …..3 Not having sex with people at high risk (ie - sex workers, drug addicts, etc)……4 Avoiding sharing Sharp Instruments ….5 Avoiding unsafe blood transfusions …..6 Avoiding mosquitoes bites ……7 Seeking protection by traditional healers……..8 Other (Specify) _____.....99	
403	Apart from HIV/AIDS, have you heard of any other sexually transmitted infections or diseases that one can get through sex? I mean the ones, such as gonorrhoea and syphilis.	Yes ……..1 No ……2	
404	Are there things that happen in the community that harm women/girls? Please give examples (DON'T READ LIST- can be more than one answer)	Early Pregnancies……1 Forced marriage……..2 Domestic violence ……..3 Forced sex/rape…….4 Sexual abuse…….5 Girls not sent to school at all……6 Girls stopped attending schools before completing schooling years…….7 Biased feeding in favour of boys/men...10 Biased medical care in favour of boys/men……1	**SKIP TO 406**

		1 None……...7 7 Others: specify……...99	
405	If women/girls face any of the problems you have just mentioned, where do they look for help?	Family member ……..……1 Friend……..2 Community leader……...3 Role model men……..4 Member of the role model HH……5 Health clinic…….6 School teachers ……7 Government service……..8 NGO……..9 GWED.G……..10 Others:……..99	
406	If a woman experiences forced sex, what services or treatments against HIV & pregnancy can she receive?	Emergency contraception……1 HIV PEP ……2 STI prevention ……...3 Injury treatment ……4 Psychosocial support……..5 Testing ……6 Other:……99	
407	Do you know where you can receive these services?	Clinic……1 Pharmacy/ Drug Shop …….……2 Health Centre / hospital ……...….3 NGO……..4 Village health team…….…..5 From a friend……6 Other (Specify)…….……99	
408	Excellent, you know so many things about sexual transmitted diseases; from where do you get all this information? You could PROBE like where else; IEC	At school ……..……1 Sign post, poster or band flit…..…2 Radio……..3 TV……..4 Friends……...5 Community Dialogue……6 Role Model man……...7 My Father…….....8 My Mother …….....9 NGO……10 GWED.G……11 News Paper……12 Other (specify)……99	

FOR ADOLESCENT BOYS AND GIRLS ONLY 12 -17 YEARS

No.	QUESTIONS AND FILTERS	CODING CATEGORIES	
409	Have you ever had sex in your life	Yes……1 No……2	**SKIP TO 418**
410	If yes have you had sex in the last 1 year	Yes……1 No……2	
411	The last time you had sex, What were the circumstances that led you to have sex?	By force……1 Willingly……2 No sex yet……3	

412	Is it possible that a girl gets pregnant with the first sexual intercourse?	Yes……1 No……2 I DON'T KNOW……88	
413	Girls: What could you do to avoid getting pregnant	Have no sex……1 Jump several times after sex……2 Use of family planning methods ……3 The man withdraws before ejaculation…4 Wash intimate parts immediately after sex……5 Chose safe days for having sex……7 Do not know……88 Others ……99	
414	Boys: What could a boy do to avoid impregnating a girl?	Have no sex……1 Use a condom……2 Withdraws the penis before ejaculation.3 Wash intimate parts immediately after sex……4 Make sure that the girl takes the pill…….5 Respect the girl's safe days for having sex……6 Others ……99	
415	Do you presently have a girl Lover/boy Lover?	Yes……1 No……2	**SKIP TO 427**
416	How many girl Lover/boy Lover do you have?	Record number ……	
417	How old is your girl Lover/boy Lover?	Record number ……	
418	Girls & Boys: What is your girl-lover/boy-lover profession (activity)?	Pupil/Student……1 Apprentice ……2 Driver ……3 Teacher……4 Business man/woman……5 Policeman/Military……6 Farmer ……7 Office worker ……8 Doctor/nurse ……9 Craftsman ……10 Boda-Boda……11 No profession……12 Other……99	
419	Have you ever had sex with your boy lover/girl-Lover?	Yes……1 No……2	**SKIP TO 427**
420	**Girls:** Did your partner ever use a condom with you? **Boys:** Did you ever use a condom?	Yes……1 No……2 Never had sex……88	
421	Girls: Did your partner use a condom when you had last sex? Boys: Did you use a condom when you had last sex?	Yes……1 No……2 Never had sex……88	
422	How can one get the Virus of HIV/AIDS?	Drink from same bottle with a diseased ……1	

		Having sex……2 Shake hands with a diseased……3 Wash oneself in the same river as a diseased……4 Sharp objects……5 Deep Kissing……6 Mosquito bites……7 Having Unprotected Sex……8 Do not know……88	
423	Can you be infected with HIV/AIDS by a healthy looking person?	Yes……1 No……2 Don't know……88	
424	Girls/Boys: What can you do to protect yourself from getting AIDS	Use condoms……1 No sex with elder men……2 Abstinence……3 Having no sex……4 Stop Living in the same house with people having AIDS……5 No sex with bar girls/Boys……6 Others(Specify)……99	
425	Excellent, you know so many things about this topic; from where do you get all this information? You could PROBE like where else; IEC	At school ……..……1 Sign post, poster or band flit…..…2 Radio……..3 TV……..4 Friends……...5 Community Dialogue……6 Role Model HH……...7 My Father…….....8 My Mother …….....9 NGO……10 GWED.G……11 News Paper……12 Other (specify)……99	

Now I would like to get your opinion. Do you agree or disagree with the following statements?

		agree	disagree	Don't Know
426	Nowadays it is not possible for girls to remain a virgin till marriage			
427	Boys put girls under pressure to have sex			
428	The pill is not for adult women only but for girls also.			
429	Condoms are not good for youth because it encourages them to have sex			
430	Girls accept sex only because they look for gift or money			
431	It is right that girls are expelled from school if they get pregnant			
432	If a boy impregnates a girls he should be expelled from school			
433	Girls should avoid being together with the boys after classes			
434	It is normal for boys to have sex before marriage			

435	People with AIDS should not be allowed to eat together with the others			
436	It is not possible to talk to the parents about sex, love and disease			
437	Condoms should be given to young people to help them avoid pregnancy and disease			

500: INTERRACTION WITH THE PROJECT (FOR ALL RESPONDENTS)

501	Have you heard about a role model man/role model household?	Yes……1 No……2 I am the role Model Man……3	SKIP TO 504
502	Have you gotten any advice from the role model man/House hold?	Yes……1 No……2	SKIP TO 502
503	How often have you gotten any advice from the role model man/ House hold?	Rarely / Never ……1 Once in 3 months……2 Once a month……3 Once a week……4 A few times a week……5 Every Day……6 Others ……88	
504	What services have you gotten from the Role model man/ House hold? **IF ASKING A ROLE MODEL MAN**: what services do you provide to other households	Counselling……1 Referral ……2 Mediation/dialogue on issues….3 Encouraging other Men on Escorting their women for ANC/PNC ……4 Encouraging other Men to assist their spouses on House hold chores……5 Others (specify) ……99	
505	From the behaviors of the role model man / household, what have you learnt from them? **IF ASKING A ROLE MODEL MAN**: What Makes you arole model man (Behaviour)?	Joint decision making……1 Men supporting women……2 Attending ANC &PNC……3 Taking Children to School……4 Jointly Working Hard……5 Avoiding premarital/extramarital sex…6 Others Specify ……99	
506	What advice do you give us in as far as using the role model approach?	Write the answers	
507	What challenges did you face to access the role model man/household? **IF ASKING A ROLE MODEL MAN**: What challenges do you face in reaching out to other house-holds?	Write the answers	
508	Was the role model man well equipped and technically competent to give you advice? **IF ASKING A ROLE MODEL MAN**: Did you receive adequate training & Support to give advice to other House-Holds	Yes……1 No……2	
509	If we stop supporting the role model man, will you keep getting services from the role model man/household? **IF ASKING A ROLE MODEL MAN**: If we stop Supporting you, Will you	Yes……1 No……2	

	keep giving services to the HH's		
510	How best can we support the role model man so that he keeps giving you the services even when we leave this place? **IF ASKING A ROLE MODEL MAN**: How best can we support you?	Write the answers	

I have asked all the questions I had. Thank you very much for your time

ANNEXIII: LIST OF MEETINGS ATTENDED

A)	INCEPTION MEETING
B)	TRAINING OF RESEARCH ASSISTANTS
C)	FEEDBACKMEETING AFTER PRTEST
D)	DAILY REVIEW MEETINGS WITH DATA COLLECTION TEAM
E)	WEEKLY REVIEW MEETINGS WITH CARE/GWED G STAFF
F)	VALIDATION MEETING
G)	FGD MEETINGS
H)	STAKEHOLDERS MEETINGS FOR EACH SUB COUNTY
I)	PROJECT CLOSURE MEETING

ANNEX IV: LIST OF PEOPLE INTERVIEWED

NAME	LOCATION	POSITION	TELEPHONE.
EVELYN AMENYA	PABBO HEALTH CENTRE	NURSING ASST.	0772192315
LAMUNU ALICE	PABBO H/CIII	NURSING ASST.	0788202470
OTIKA SANON AKENA	AWACH SUBCOUNTY	S/C LC III CHAIRPERSON	0774756699
RONALD OGAL	GULU	INITIATIVE MANAGER B	0782860729
ADONG LUCY	PABBO	HEAD TEACHER	0775080010
POLIN ACIRO	PABBO PRI SCHOOL	SENIOR WOMAN TEACHER	0774502072
ROBERT OJOK	PABBO PRI. SCHOOL	SENIOR MAN TEACHER	0774848653
OKOT JACKSON	ONEKDYEL VILLAGE(OMORO DISTRICT)	RMM	0777649164
MUHAMOOD OKELLO	KALAMU OMYA PAIDWE PAR-ISH ,BOBI SUBCOUNTY	RMM	0775014826
ODYA OSBORN	PAYUTA PARISH PADUNNY	RMM	0784590931
OBWOYA DENIS	AWACH SUB-CPUNTY	CBF	0784771992
CHARITY AMONO	PABWO SUB/COUNTY H/C III	NURSE	0782323800
ALANYO AMONO SLYVIAN	PABWO H/C III BUGATIIRA S/C	NURSING ASSISTANT	0773170124
ACAYE JULIUS PETER	KULUKENO P/S	HEAD TEACHER	0782302489
DAVLA AYO	KULUKENO P/S	SENIOR WOMAN	0782624749
ODONG WALTER OYET	KULUKENO P/S	SENIOR MAN	0772184220
CHRISTOPHER ODONGKARA		CHAIRPERSON LC III	077183789
MICHEAL ONENCAN	PABO S/C	SUBCOUNTY CHIEF	0782331511
LATIGO SANTO	KAL KWARO BUNGATIRA	CULTURAL LEADER	0778899520
OMONY SAMUEL.	GULU	SENIOR PROJECT OFFICER SRHM	0782013688

Lamogi Sub-county, Agwayugi: Parish, Jimo, Amuru district.

1	ATOO ALICE	F	
2	LHUMUNU ROSE	F	0793306928
3	ACAA TAMALI OJERA	F	
4	LAMWAKA M	F	
5	LALAM ROSE	F	
6	AUMA EVELI	F	
7	ANGEYO	F	
8	ONEK CHRISTINE	F	
9	ANGOM JENNIFER	F	
10	ATIM FLORENCE	F	
11	ALOBO ROSE	F	

1	TORACH JUSTINE	M	VHT	0779877985	PADUNY

2	AKONY DENIS	M	VHT	0784767972	PAYUTA
3	AKENA GEOFREY	M	VHT	0781038349	ACUTOMED
4	ODYA OSBORN	M	VHT	0784590931	PAYUTA
5	ONEN BOSCO	M	VHT	0771861087	BOLIPPI
6	AGZU MARYF	F	HW	0777985542	AWACH H/C

Pita village, KAL PARISH , ONGAKO SUBCOUNTY,OMORO DISTRICT.

1	LAGUM EVALIN	F	0793579910
2	AJOK JOYCE	F	
3	AKELLO JOYCE	F	
4	AMONO BEATRICE	F	
5	ACEN SHARON	F	
6	ADONG VICKY	F	0705393958
7	APIYO JENNETH	F	0774440782
8	ALANYO MARY	F	
9	AGENO FLAVIA	F	
10	ATIM FLORENCE	F	
11	AKELLO CHRISTINE	F	

PALENGA PARISH BOBI SUBCOUNTY, OMORO DISTRICT

1	LUGANJA VITO	M	RMM	BOBI
2	LATIGO JOSEPH	M	RMM	BOBI
3	ONEN JOHN BOSCO	M	RMM	BOBI
4	OKEMA GEORGE WILLIAM	M	RMM	BOBI

PALENGA PARISH BOBI SUBCOUNTY, OMORO DISTRICT

1	ADONG SUNDAY	F	PUPIL	BOBI
2	ALIMOGUM PROSSY	F	PUPIL	BOBI
3	LOUM OSCAR	M	PUPIL	BOBI
4	APIYO MERCY	F	PUPIL	BOBI
5	OLOYA TONNY	M	PUPIL	BOBI

VILLAGE KAL OKARA, NWOYA DISTRICT

1	OYELLA MARGRET	0782780144	F	WHH
2	ACIRO IRENE		F	
3	AKOTH MARY		F	WRM
4	APIO CONCY		F	WHH
5	AKWERO PASKA		F	WHH
6	LAKER JANET		F	WHH
7	APIO SCOVIA		F	WHH
8	ACAN CONCY		F	WHH
9	ACAN ROSE		F	WHH
10	APIO NANCY		F	WHH
11	AKULU MARGRET		F	WHH
12	ADONG KEVIN	0790041377	F	WHH
13	ACAYO EUNICE		F	WHH
14	ACEN PAMELLA		F	WHH
15	AKELLO STELLAH		F	WHH
16	ANYEKO JENNIFER		F	WRM

PAIBONWA PRIMARY SCHOOL

1	OPIRO MARK	M	PAIBONWA
2	OKIA THOMAS	M	PAIBONWA
3	PYBANGAKENE MAXWEL	M	PAIBONWA
4	AYELLA IVAN	M	PAIBONWA
5	AJOK MERCY	F	PAIBONWA
6	LUKICA MARY	F	PAIBONWA
7	ADOND SHARON	F	PAIBONWA
8	AMONO MONICA	F	PAIBONWA
9	ANENO PATRICIA PRECIOUS	F	PAIBONWA
10	AKWERO FIONA LAKWER	F	PAIBONWA
11	TORACH MICHAT	F	PAIBONWA
12	OPIO SAM	M	PAIBONWA

ANNEX V: SCHEDULE OF ACTIVITIES

		Start Date	Completion Date
1	Signing of Contract	27th	27th July
2	Inception Meeting	27TH July	27TH July
3	Inception report	21st July	24th July
4	Draft Evaluation Tools	21st July	25th July
5	Training of Research Assistants	3rd August	4TH AUG
6	Field Data Collection	5th August	14TH Aug
7	Data analysis and report writing	15th August	20th August
8	Draft report	29TH August	29th August
9	Validation	30th August	30th Aug.
11	Final report	**20th Sept.**	**20th Sept**

ANNEX V1: SUMMARY OF FOCUS GROUP DISCUSSION

11/08/2017

Men Beneficiary Of Role Model Men Held At Li-Subcounty Orum Parish Goro Village.

Yes we have been attending various training with our role-model men who were being trained by GWED-G about sexual reproductive health maternal care, gender based and child health care to us who are living in house as a couple.

The facilitators however have some strength and weaknesses as per the respondent.

The following are the strength of the facilitator they came up with:-+

The discussant said the facilitators are well informed and enrich with knowledge pertaining the aspect of sexual reproductive health, maternal care health care, family planning, child care and gender based violence.

They also said that the facilitators also exercise and execute their work systematically to the house hold under their administration and that have benefited us the men of Goro village a lot.

However, the weaknesses that we have seen in the facilitators are:-

Many beneficiaries miss out their good services since they are incapacitated in terms of transport means to reach their client that is the house hold attached to them.

The facilitators also lack something to identify them or differentiate them in the community like tags.

Due to vases of the area of jurisdiction, this has hampered their outreach programme in case of settling of emergency at their client home such as arbitrating domestic violence, therefore they / facilitator should be increased in numbers to ease their work.

They work very hard and they are not given any token to motivate them beside refresher course to be administered to them frequently.

Yes indeed the training has added value to us, men the beneficiary for instance created awareness ***domestic violence. Gender roles and responsibilities, sexual reproductive health, maternal health and child care.

The kind of health services we as men of Goro under this project receive are HIV counselling and testing, family planning services such as ANC &PNC among others .These services are normally got from Koch Goma health centre III and the situation for the last two years has been good

In this village our wives go for ANC the day they discover that they're pregnant. They go for these services at Koch Goma health centre III where they are able to receive pregnant test,HIV test and counselling ,Vaccination ,immunization ,baby check, sanitation and hygiene teaching , mosquito net mama kits.

Child health care services and for mother, they normally receive 4 injection for T.T and for the last two years, the services have been goo.(ANC & PNC).

Most house hold in this community especially those under this project respect wives and normally come up-joint decision on where and when to go for medical services. This has been remarkable for this last two years.

In our community men under the services of RMM have been supportive of wives when it comes to ANC, maternal health,PNC,they escort their wives and provide transport such as boda or bicycle and for the last two years men have not left their wives to suffer.

Most men who benefited from RMM have been able to change and perform these roles such as taking children to get treatment when they are sick, feeding bathing, soothing the child if he/she is crying escorting women for. ANC and PNC, fetching water, making beds, teaching and disciplining the child alongside their wives, Something that never used to happen in the past

Yes, since the intervention of this project most us men beneficiary , have started performing different in house chores such as washing clothes, preparing food collecting fire wood, buying food from the market, water fetching ,sweeping the house, and making meds/ironing clothes among others.

Most of the beneficiary of this project know about family planning and its methods such as condom use,pill plant,injecta plant,. IUD TUBULATION and vasectomy injection and moon beads

In the past there was no joint discussion between husband and wives about family planning method. Unlike in the past

were it was opposed therefore it has given its relevance importance and they now came up with joint decision to go for the services and for the last two years it has proven such successful and reduce on the number of children and child spacing one is having

Thank you this project has done well in our community and it should be continued to reach all the households in the village

Secondly the project funder should increase on the number of RMM, provide them with means of transport for outreach activities, give them identification tags, refresher workshops frequently and some small token to motivate them in their work.

6/08/2017

Role Model Men In Palenga Parish, Bobi Subcounty, Omoro District

Responses from Role Model Men

Roles and responsibilities

32) Shared experience with other men in house-holds (Joint decisions).

33) Trained on family planning aspects and GBV cases reduction at house-holds.

34) Shared responsibilities on resource ownership, access and control.

35) Men involvement in ANC, PNC and other maternal care services such as immunisation, good and balanced diet for pregnant mothers.

36) Improved nutrition for the newly born baby such as exclusive breast feeding for six months.

Approach and methods used:-

37) Community dialogues

38) Befriending men through sharing ideas and experiences.

39) Home visits and church announcements.

40) Participatory approach .Not dictating on their decision on their decisions.

41) Support received

42) Attained training on GBV issues, Gender, Sexual Reproductive health & maternal care.

43) Attained training on child rights, cancer screening etc.

Did you attend all the trainings?

34) Yes

How often did you attend the training --- Regularly?

Rate of quantity of the training. 8/10(80%).

Tools were given

Tools needed

35) Record books

36) Training manuals.

37) Neoplastic materials

38) IEC

Efficiency of the strategies used

36) Previously before the training, some of the households had serious GBV cases but after the training , the couples are staying freely and have been wedded in church.

37) Another change as a result of the training was on family planning.

38) Some households have taken to themselves to have joint decisions when using household resources.

39) Girls and boys are taken equally in terms of paying school-fees.

- Reduction in alcoholism

Achievements

- Freedom at households (peace).
- Reduction in GBV cases which has reduced
- Encouraged family planning and child spacing.
- Reduced on maternal deaths and mortality rates as a result of reduced diseases.
- Majority of the children are now at school

- Reduced alcoholism.
- Majority of the households have now acquired livestock.

Obstacles / challenges

- Social stigma and discrimination.
- Urge for sitting allowances by trainees
- Some men during the training sessions may either be drunk or give negative about the project.
- Negative sentiments of under minding the role-model men.

Support given

- Taking women for ANC.
- Helping the household chores.
- Providing money and materials in preparation for delivery.
- Cooking fetching water and buying food.
- Taking for PNC services such as check-ups for health conditions

Response of the husbands to their households.

In their view a role model men, they at least see a drastic change and positive response.

Women also give a positive response to men How was the situation in the last two years?

- There has been a remarkable change in the behaviours of men in relation to women responsibilities. Therefore the project was timely and result oriented though more engagements are still needed to cover over vast areas.

Recommendations

- The organisation once in a while should get back to the communities to engage them in shared decisions.
- Need to provide IEC materials eg.t-shirt to households trained by role model men and changed households for visibility.
- Need for refresher training and motivations towards good work done.
- Empowerment of wives of RMM to effect outreaches and information dissemination.

Project sustainability:

They will continue and also encourage their changed households to empower other unreached households(Multiplier effect) **Strategies to support households.**

- Being exemplary (hiring example) for others to copy from.
- Continued training and sharing decisions together for positivity.
- Improvement in reproductive health.

Level of capacity strengthening

- Had refresher training / courses
- Continuous follow ups and support/ monitoring
- Participation in training organised at the sub-county level.

7/082017

Adolescents (Girls And Boys) In Paibona P/S, Awach Sub-County How Is Hiv/Aids Spread?

- Sharing sharp objects
- Having sexual intercourse with an infected person.
- Blood contact with an infected.
- Mother to child transmission

How to control HIV/AIDS?

- Not having sex with an infected person?

Other STDs

- Hepatitis B
- Gonorrhea

Where did you acquire the training from ?

- GWED-G

What trainings were conducted?

- Life skills
- Pregnancies.
- Early marriages.

Challenges and obstacles encountered

- Early pregnancies.
- Over dependence on material support such as money.

Where do girls /women get services or help from?

- Health centre
- NGO such as GWED-g
- Parents
- School administration e.g. senior women/man teacher.
- Neighbours.

Assistance given to the woman / girl who has been forced to have sex.

- Testing for STIs
- Use of emergency contraception.
- Report the rape case to police for disciplinary prosecution.
- Counselling.

Where do they get services or help from

Health centres.

Friends

At what age do girls consent to have sex.

18 years and above.

Are there young girls who have relationships with elder persons.

- No

Are there any dangers one can encounter when young

- Early pregnancies
- Acquire HIV/AIDS and other STDs

Ways of protecting against STDs (HIV/AIDs)

- Use of condoms while having sex.
- Desist from moving /travelling at night
- Abstinence.

Aware of PTA and Role Model Men.

- Admitted they were aware of them.

Meeting schedules with pupils-

- Once in a month.

Advice given

- Encouraging pupils to take their studies very seriously
- Taking caution of HIV/AIDS.
- Observe good morals.
- Being obedient to elderly people like parents, teachers.

Are there changes as a result of this engagements/advice? Yes to a great extent .

Who/which people have been giving these training ?

- GWED-G
- Save the children.
- Health workers and teachers.

Sustainability of the project after closure.

- Will continue with the programme

Recommendations

- GWED-G together with other partners should continue supporting .
- Need for sensitization of the entire fraternity.
- Taking pupils for exceptional learning to the role.

- Provision of sanitary pads for girls.
- Need for writing materials like pens and books.

9/08/2017

Household Men Beneficiaries

Attended training such as

- Caring for the children
- Preparations for pregnancies.
- Escorting women and children to health centres.
- Sanitation and hygiene eg.Rubbish , pit latrine.
- Maternal health care.
- Helping in domestic chore and field work.
- Skills on livestock.
- Training on sexually transmitted diseases. (STDs)
- Child Education.

Strength of facilitators

- Have skills and knowledge (understand the content)
- Have a friendly approach.
- Good time managers.
- They are committed and sacrifice themselves.

Weaknesses of facilitators

- Problem of transport (distant areas and therefore can't cover a large scope).
- Hostility of some communities .
- Inadequate knowledge.
- Facilitation in terms of money.
- Conflict as a result of drunkard-ness by some facilitators.
- Limited numbers of facilitators to cover vast areas.
- Absence of working material/ protective wears in case they are offering their services at health centres.

Value added

- Reduced /minimised and GBV issues at households as a result of information dissemination.
- Minimised levels of drunkardness.
- Reduced on the level of promiscuity
- Theft of agricultural products and sale without joint decision (Decisions are done jointly currently).
- Family planning services have been promoted.
- Shares income and disclose the amount of income realised freely.
- Enable acquisition of livestock.

Training content able to address the beneficiary needs

- All the beneficiaries agreed that there was a remarkable change between the house-holds(men and women)

Services offered (at Pabwo Health centre III)

- Family planning
- Testing for STS such as HIV/AIDS , HEP B

Kind of workers.

- Nurses
- Nursing officers .
- Midwives
- Doctors

Access can be done at any time

Services obtained

- Refferals
- Health talks
- Provision of ARVS .
- Providing mama kits, mosquito nets
- Testing for pregnancy.

Situation in the last two years

- Previously the solar system was effective but currently they use torches and lamps for lighting due to the problem.

- Increase in population
- Absence and delays of the nursing officers /Doctors to attend to patients on emergencies .

Other commitments of the health workers.

No good relationship between the health workers and the patients No potential ethics of the health workers at the work place.

What do men do when their women have labour pains.

- Share the decision jointly
- Take them for testing on presentation of the foetus (position)
- Provision of foods that the doctors have recommended.

Preparations after 6months

- Introduction of solid food(weaning).
- Regular observation of health status of the body.
- Maintain hygiene and sanitation of the baby's environment.(Clothes)

Situation in the last 2years.

In the last two years decision making was individually but currently it's done jointly.

Services women get from their husbands

- Bathing the children.
- Escorting their women and children to health centres.
- Helping them in cooking and other domestic chores such as fetching water.

Testing

Previously testing was only left to women but currently they move for testing jointly.

Family planning services

Previously because there was limited knowledge but later after receiving this knowledge , they have engaged fully in the farming.

Ways of family planning (Methods)

- Vasectomy and tubulisation.
- Implants.
- Injection.
- Pills.

Benefits of family planning

- Enables producing whom one can manage (Manageable number) in terms of feeding and paying school fees.
- Makes the women healthy and reduces complications .
- One can develop since money is well appropriated and utilized.
- Peace of mind and stress free.
- Reduced GBV aspects.
- Improved hygiene and sanitation. (Clothes Environment).

RECOMMENDATIONS TO BETTER PROJECT IMPLEMENTATION

- Conditional training of the beneficiaries and follow-ups.
- RMM should be transferred to train else were in other community.
- Reduce and mitigate negative aspects on family planning.
- More training still needed
- More extension workers such as RMM needed.
- Improve on mobilisation skills.
- Exchange /study tours/visits to other communities (Share experiences, ideas for household beneficiaries & RMM)
- Provide tangible products such as livestock/oxen& ox-ploughs (Demonstration project /programme that can shoe case the work of the RMM & beneficiary HHS at the community level)
- Provision of soft loans to enable purchase of livestock, agricultural products e.g produce.
- Market linkages of agricultural products e.g Rice,gorghurm,soyabeans.

10/05/2017

Pupils Of Pabbo Primary School Hiv/Aids

They know.

Ways of HIV transmission

- Having sex with an infected person
- Sharing sharp objects.
- Mother to child transmission.(blood contact)

How the community protects them-selves against HIV/AIDS.

- Avoid sharing sharp objects.
- Having one partner.
- Abstaining from sex
- Avoiding gifts from strangers.

OTHER STIs

- Gonorrhoea.
- Syphilis
- Candida
- Hepatitis B.

SOURCE OF INFORMATION

- Health centres / clinics.
- School.
- Parents.

Challenges faced by the girls.

- Poverty
- Unwanted pregnancies.
- Early marriages.
- Divorce.
- School dropouts.

Where do the girls get help from?

- Hospital
- Friends.
- Teachers.
- Parents.
- Senior woman teacher.

In a situation where girls/women are forced in to sex, what services should be given.

- Taken to the police
- Report the case to police.

Boy/ Girl Relationship.

- Its quite not common though

At what age do Boys and girls have sex.

- 12 and above.

Boys and girls having sex with elderly people

- They are there.

How can we help girls and boys to stay in school.

- Abstaining from sex.
- Staying away from bad peer.
- Avoid walking at night.
- Provision of basic needs
- Paying their school fees.
- Provide advice.
- Reading hard

Do you know about PTA?

- Yes

How many times have they advised you?

- 3 times per term
- Both parents and teachers give.

ANNEXVII: TERMS OF REFERENCE (TOR)

End of Project Evaluation

FOR SEXUAL REPRODUCTIVE AND MEATERNAL CHILD HEALTH PROJECT - SRMCH

Submitted by:	Ronald Ogal – Initiative Manager SRMCH Project
Reviewed by:	Ronald Matanda – PM NUWEP
Approved by:	Delphine Mugisha – Program Director
Date:	1st June 2017

1.0 Introduction:

In September 2014, CARE International in Uganda in partnership with Gulu Women Economic Development and Globalization (GWED-G) with funding from Austrian development Agency (ADA) through CARE Austria initiated a three years Sexual reproductive, Maternal child health project with the goal of "Improving Access to Reproductive, Child and Maternal Health in Northern Uganda" in the three districts of Gulu, Amuru and Nwoya, covering 9 Sub Counties (Ongako, Bungatira, Bobi, Koro, Patiko, Awach, Lamogi, Koch Goma and Alero).

The project engages men using Role Model Men approach to overcome barriers limiting the access to Reproductive, Maternal and Child Health services that arise from social constructs with a focus on gender norms. It also addresses gaps in knowledge, attitudes and practices related to male involvement and their support to their spouses.

The project is implemented in partnership with GEWD-G who is the implementing partner and taking lead in community engagements, dialogues, beneficiary identification, monitoring, reviews, and documentation of best practices. While CARE has been ensuring efficiency and effectiveness of the project implementation while working closely with GWED-G, it also took the lead in monitoring and evaluation of the project. GWED-D implements this project by working with 100 role model men who reach out to other men in the 10 households attached to them in promoting supporting behavior of men and adolescents towards their family members in access to sexual, reproductive and maternal child health services. In addition, the project works with health and education service providers to address obstacles and actively engage communities to mitigate deterrents, thereby increasing access to services.

Currently, the project is in its final year of implementation. Therefore CARE international in Uganda plans to conduct an end-of-project evaluation with the support of an external consultant to systematically and objectively assess the progress made towards the achievement of the intended goals of the project. The evaluation will combine both qualitative and quantitative approaches. The results of this evaluation will provide recommendations for the replication and future planning of similar projects/programmes.

2.0 Overall objective of the end-of-project evaluation

The Project has been implemented since September 2014 and this end of project evaluation focuses on the entire implementation period.

The overall objectives of this final evaluation is to ascertain the contribution made by SRMCH project towards improving access to Reproductive, Child and Maternal Health in Northern Uganda of 5,600 women, men, girls and boys from Gulu, Amuru and Nwoya districts. The major focus area for the final evaluation is to assess the appropriateness of the theory of change and the project intervention logic, the results achieved during implementation, and its potential sustainability.

Based on the assessment of the project's success and failures, the evaluation shall present key learnings and provide recommendations that will help to ensure that the project's impact remains sustainable. It will collate and analyze lessons learnt, challenges faced and best practices obtained during implementation.

2.1 Specific objectives of the end-of-project evaluation

The final evaluation aims to achieve the following specific objectives;

1. To establish impact made by the SRMCH project in relation to outcome indicators outlined in the project document (refer to the attached logframe in the annex). Result Indicators are elaborated below:

Result 1 –Primary Indicator – 50% increase in knowledge of participating households members on key, age appropriate, sexual, reproductive, maternal and child health issues

This indicator is to assess and determine the extent to which the project interventions have enabled participating household members acquire age appropriate knowledge about Sexual, Reproductive, Maternal and Child Health issues to support family members in accessing services.

Result 2 – Primary Indicator - 20% increase in supportive behaviors of male household members, as reported by male household members

Primary Indicator - 20% increase in supportive behaviors of male households members, as reported by female household members

These 2 indicators are to be assessed as a whole to determine the extent to which project interventions have transformed men & adolescent boys to demonstrate supportive behaviours with regard to their family members accessing Sexual, Reproductive, Maternal and Child Health services

Result 3 –Primary Indicator - 20% of health service providers engaged in the project that demonstrate changes/improvements in how services is offered

This indicator is to assess the extent to which the project interventions have enabled Health & Education service providers to be more aware of demand based obstacles and actively engage with communities to mitigate deterrents, thereby increasing access to service.

2. To identify best practices and lessons learned during the 3 years of implementation with regards to different interventions. Including, and in particular;

- Establish the extent to which targeted households have benefited from RMM approach in addressing Gender Based Violence (GBV) including improving girl child education and access to SRMCH services among women and girls of reproductive age
- Establish the extent to which adolescents, both boys and girls, were reached with information on SRMCH using the RMM approach
- Establish the level of involvement of local service providers during project implementation in addressing SRMCH and GBV issues

3. Summarize key findings from the project evaluation and provide recommendations for any potential future projects/ programs targeting the same vulnerable communities in Northern Uganda

2.2 The Evaluation Questions

The following key questions will guide the end of project evaluation:

1. Relevance – (Access, design and focus of the project)

- Was the project relevant to the identified needs and priorities of the target beneficiaries?
- How relevant was the project to the priorities of the local governments in Northern Uganda?
- What challenges were faced due to changes in the context of the 3 districts? How did the project react to them and take them into account?

ii).Effectiveness- (Describe the management processes and their appropriateness in supporting delivery)

- To what extent were the expected results (impacts, outcomes and outputs) achieved? Was the project effective in delivering desired/planned results?
- Were the strategies used realistic, appropriate and adequate to achieve the results?
- To what extent did the Project's M&E mechanism contribute in meeting project results?
- How effective were the strategies and tools used in the implementation of the project?
- How effective has the project been in responding to the needs of the beneficiaries, and what results were achieved?

iii). Efficiency – (of Project Implementation)

- Was the process of achieving results efficient? Specifically, did the actual or expected results (outputs and outcomes) justify the costs incurred? Were the resources effectively utilized?
- What factors contributed to implementation efficiency?
- Did project activities overlap and duplicate other similar interventions (funded by other donors within the region? Are there more efficient ways and means of delivering more and better results (outputs and outcomes) with the available inputs?
- Could a different approach have produced better results?
- How efficient was the project's collaboration with the health and education service providers in making services more appropriate for male and female adolescents and on involving men in SRH and MCH?
- How efficient were the management and accountability structures of the project?
- How did the project financial management processes and procedures affect project implementation?

iv) Impact

- Is there improvement in reproductive, child and maternal health amongst the target group? If so, for how many? (overall programme objective)
- What unintended (negative and positive) effects of the project can be observed? Which measures were taken to ensure that negative impact is minimized?

v). Sustainability

- To what extent are the benefits of the project likely to be sustained after the completion of this project?
- To what extent will women and girls of reproductive age
- How effective were the exit strategies, and approaches to phase out assistance provided by the project including contributing factors and constraints
- What are the key factors that will require attention by whom in order to improve prospects of sustainability of project outcomes and the potential for replication of the approach?
- How were capacities strengthened at the individual and organizational level (including contributing factors and constraints)? To what extent will this contribute to continuation and scaling-up of activities and best practices after completion of the project?

(NB: The recommendations should provide comprehensive proposals for future interventions based on the current evaluation findings).

3.0 Scope and focus of the Evaluation

3.1 Scope of work

The consultant will undertake but not limited to the following scope of work:

- Assess the efficiency, effectiveness and impact made by the project to date looking at its strength (achievements), weaknesses, opportunities and threats (challenges) in terms of

Activities that have been implemented and financial expenditures incurred to determine ways of improving CARE's future programming

- Asses the overall relevance of the project considering the changing context in the 3 districts and interventions by local governments, health and education service providers and other development partners. Highlight any challenges faced that could have been the result of project design failure and the changing context on the ground
- Assess the sustainability of the project with regards to community ownership and stakeholder's involvement
- Make clear recommendations for the replication, future programs /projects, consolidation and sustainability of the project impact

4.0 Methodology for Evaluation

The SRMCH End of Project evaluation will be carried out in full compliance with the DAC Evaluation Quality Standards (206). This is a summative evaluation involving qualitative and quantitative methods to evaluate the support to SRMCH implementation and performance and to make recommendations for future programming.

4.1: Review of project documentation: Review of archived material related to the project.

This could include, but is not restricted to: annual and quarterly narrative and financial reports, the original project pro-posal document CARE and NUWEP program strategy documents.

4.2: Development of an evaluation approach and data collection tools / methods by the consul-tant and this should include;

- Detailed timeline and work plan
- Outline of any proposed changes to the scope of the evaluation
- Key interview questions
- Proposed sampling framework
- List of stakeholders to be interviewed, and
- Development of associated data collection and evaluation tools

4.3: Data Collection

SRMCH End of Project Evaluation will be carried out through a wide participation of all relevant stakeholders including CARE and GWED-G staff. Field visits to selected project sites; briefing and debriefing sessions with CARE and GWED-G staff is envisaged. Data collected should be disaggregated (by sex, age and location), where possible.

In order to use existing information and avoid duplication, data will be mainly collected from various information sources through a desk review that will include the comprehensive desk review and analysis of relevant documents, information, data/statistics, triangulation of different studies, etc. Data will also be collected from stakeholders' key informants through interviews, discussions, consultative processes, and observations in field missions by consultant.

5.0: Schedule

Activity	Deliverable	Time allocated
Evaluation design, methodology and detailed work plan		4 days
Inception Meeting initial briefing	Inception report	
Documents review and stakeholder consultations		20 days
Field interviews		
Data analysis, debriefing and presentation of draft Evaluation Report	Draft report	
Validation Workshop (to be organised by CARE International)		
Finalization of Evaluation report incorporating additions and comments provided by CARE and GWED-G staff Submission of Final report to CARE	Final evaluation Report	3 days

6.0: Expected Deliverables:

The following deliverables are expected.

6.1: Inception report: The consultant will prepare an inception report which details the evaluators understanding of the evaluation and how the evaluation questions will be addressed. This is to ensure that evaluator and CARE have a shared understanding of the evaluation.

The inception report will include the evaluation matrix summarizing the evaluation design, methodology, evaluation questions, data sources and collection analysis tool for each data source and the measure by which each question will be evaluated. The report will include the scope of work, work plan, time frame and analysis. The inception report should include a proposed schedule of tasks; activities and deliverables, with clear responsibilities for each task or product. The inception report will be discussed and agreed upon with all stakeholders.

6.2: Draft Evaluation report- The Evaluator will prepare a draft SRMCH Evaluation Report, cognizant of the pro-posed format of the report and checklist used for the assessment of valuation report and the report will be submitted to CARE for review and comments. CARE International in Uganda will share it with CARE Austria focal person for this project and also will share it with GWED-G staff working on this project for review and comments.

Comments from the different people will be provided within 10 days after the reception of the Draft Report. The report will be reviewed to ensure that the evaluation meets the required quality criteria and also to ensure that the evaluation meets the required quality standards. The report will be produced in English. The report should provide options for strategy and policy as well as recommendations.

CARE International in Uganda will be responsible for ensuring timely arrangement for a meeting for the review and validation of the evaluation report. CARE International in Uganda will provide comments within the time allocated by the ToR.

6. 3: The final report: This will be submitted 10 days after the validation workshop and will include comments from all the relevant people. The content and the structure of the final analytical report with findings, recommendations and lessons learnt should include the following:

- Executive summary
- Introduction
- Brief project background
- Description of the evaluation methodology
- Key findings, including best practices and lessons learned
- Analysis of opportunities to provide guidance for future programming
- Recommendations for future action and Conclusion

In addition, the final report should contain at least the following annexes:

- Terms of Reference for final evaluation
- Schedule
- List of meetings attended
- List of persons interviewed
- Details of evaluation methodology
- Summary of field interviews
- List of documents reviewed
- Any other relevant material, including data collection tools
- Results assessment form

7.0: Duty Station

The duty station of the work is Gulu, northern Uganda. However, the consultant will be required to travel to project sites within the three districts of Gulu, Amuru and Nwoya, covering 9 Sub Counties (Ongako, Bungatira, Bobi, Koro, Patiko, Awach, Lamogi, Koch Goma and Alero).

8.0: Required expertise and qualification

The Evaluator(s) must have the following expertise and qualifications:

At least a master's degree in Public Health, International Development, Development

Economics/Planning, Economic, Public Administration, and Management, social sciences and in any other related university degree.

- Extensive expertise, knowledge, and experience in the field of evaluation of development programmes
- At least 10 years of experience in working with international organizations and donors;
- Experience of programme formulation, monitoring and evaluation;
- Experience in participatory methods and excellent facilitation skills
- Fluency in English and knowledge of luo/Acholi will be an added advantage.
- Excellent written and verbal communication skills in English.

NOTE: If it is an individual consultant, s/he must exhibit expertise in gender, Maternal Child Health, Sexual Reproductive Health and Family Planning as well as demonstrable experience in conducting Participatory Action Research, baseline, mid-term or end term evaluation and use of scorecards.

9.0: Management Arrangements

The selected consultant will report to the Initiative Manager for this project and he will be the focal person for the evaluation with support from the Programme Manager Northern Uganda Women Empowerment Programme (NUWEP) and technical guidance from the Programme Quality and Learning (PQL) team in Kampala.

10.0: Time-Frame for the Evaluation Process

The evaluation will be conducted end of July 2017 for an estimated 27 working days.

11.0: How to apply

The Expression of Interest (EoI) should contain:

CV of the lead consultant and 2 other co-consultants with at least three (3) professional references each

A brief write-up (max 7 pages, font 12, Times New Roman and Double Space) on the understanding and interpretation of the ToR and how the assignment would be executed including a work plan with clear timelines and a proposed methodology

Financial Proposal that indicates the all-inclusive fixed total contract price in Uganda Shillings. The financial proposal shall specify a total lump sum amount, inclusive of the specific and measurable (qualitative and quantitative) deliverables. Payments are based upon output, i.e. upon satisfactory delivery of the services specified in the ToR

At least 2 reports of concluded assignments of a similar nature accompanied with

references Application Procedures

All Expressions of Interest should be delivered before 16th June 2017 marked with the reference “Improving Access to Reproductive, Child and Maternal Health in Northern Uganda”