



EVALUATION REPORT

Protecting the Dignity of Refugees in Uganda

*Responding to sexual and gender-based violence as a human rights violation
and a public health issue*

Demesne Advisory and Resource Enhancement (DAREN) Consult

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Executive Summary

This report presents the findings of the final external evaluation of the project “Protecting the Dignity of Refugees in Uganda: Responding to Sexual and Gender-Based Violence as a Human Rights Violation and Public Health Issue,” implemented by Farmamundi in partnership with Africa Humanitarian Action (AHA) and Emesco Development Foundation with funding from the Basque Government. The project was implemented in three distinct refugee contexts in Uganda, Kampala (urban refugees), Kyaka II Refugee Settlement, and Adjumani Refugee Settlements, with the overall objective of improving the health and sexual and reproductive health of refugee populations by addressing sexual and gender-based violence (SGBV) through an integrated, rights-based and survivor-centred approach.

The evaluation adopted a mixed-methods methodology combining document review, comparative analysis of baseline and endline datasets, Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and routine project monitoring data. The assessment was guided by the OECD-DAC evaluation criteria of relevance, coherence, effectiveness, efficiency, impact, sustainability, and coverage, while also examining humanitarian principles including participation, accountability, gender equality, localisation, human rights, conflict sensitivity, and Do No Harm.

Overall, the evaluation concludes that the project was highly relevant, largely effective, efficiently implemented, and generated significant positive outcomes for refugee populations and the institutions serving them. The intervention responded directly to critical health and protection needs within Uganda’s refugee response by integrating primary healthcare, sexual and reproductive health (SRH), mental health and psychosocial support (MHPSS), gender-based violence prevention and response, community engagement, and accountability mechanisms into a coherent programme model. Its design reflected the different realities of urban refugees in Kampala and settlement-based populations in Kyaka II and Adjumani, allowing activities to remain responsive to the specific challenges of each operational context.

The project substantially achieved its Specific Objective. Access to essential healthcare services improved through the provision of medicines, strengthened health facilities, mobile outreach services, and referral support for specialized care. More than twice the planned number of refugees received medical care and essential medicines, while referrals for advanced diagnostic and specialist services exceeded project targets. The intervention also strengthened clinical management of SGBV survivors,

expanded access to mental health and psychosocial support services, and reinforced referral pathways linking community, primary healthcare and tertiary care facilities. Baseline and endline findings further demonstrate improvements in healthcare utilisation, reductions in financial barriers to care within settlement settings, increased use of community-based service providers, and improved access to treatment at supported facilities.

Beyond service delivery, the project successfully strengthened community systems and institutional capacity. Village Health Teams, community leaders, healthcare workers and local institutions received technical training that improved their capacity to prevent, identify, refer and respond to SGBV and related health concerns. Community awareness activities significantly increased knowledge of health rights, available services, referral pathways and gender equality while contributing to reductions in stigma surrounding mental health and gender-based violence. Refugee participation was strengthened through community committees, dialogue platforms, accountability mechanisms and feedback systems that promoted transparency, responsiveness and greater ownership of interventions.

One of the project's greatest strengths was its integrated implementation model, which recognised that refugee health outcomes are inseparable from protection, psychosocial wellbeing, gender equality and community empowerment. Rather than treating SGBV solely as a protection issue, the project addressed it simultaneously as a public health concern requiring coordinated clinical, psychosocial, legal and community-based responses. This holistic model created multiple entry points for vulnerable refugees to access care while strengthening collaboration among government institutions, humanitarian partners and refugee-led structures.

The evaluation found that the project demonstrated strong efficiency by maximising available resources through partnerships with public health facilities, local governments, refugee structures and humanitarian coordination mechanisms. Existing systems were strengthened rather than duplicated, allowing the intervention to deliver results well beyond several planned targets while reinforcing institutional ownership. Collaboration with the Ministry of Health, Office of the Prime Minister, Kampala Capital City Authority, district local governments and other stakeholders enhanced implementation quality and contributed to improved coordination across the health and protection sectors.

Evidence also indicates that the project generated important longer-term impacts extending beyond immediate service delivery. The intervention strengthened institutional capacities, improved coordination between health and protection actors, enhanced community resilience, expanded



accountability to affected populations, and established stronger referral and survivor support systems. Many of the skills, structures and partnerships developed during implementation are expected to continue benefiting refugee populations beyond the project period.

Nevertheless, the evaluation identifies several structural constraints that continue to affect refugee health and protection outcomes. Persistent shortages of medicines within the wider health system, increasing demand for specialised care, transportation barriers, financial constraints among urban refugees, chronic disease management needs, mental health stigma, and dependence on external humanitarian financing remain significant challenges. While the project mitigated many of these constraints, they require continued investment and stronger government and partner engagement to sustain and expand achievements.

Overall, the evaluation found that the project successfully demonstrated the value of delivering health and protection interventions as an integrated package rather than as separate programme components. By bringing together primary healthcare, sexual and reproductive health, mental health and psychosocial support, gender-based violence prevention and response, community engagement, and accountability mechanisms, the intervention addressed the multiple and interconnected challenges faced by refugee populations in Kampala, Kyaka II, and Adjumani. Although important system-level constraints remain, the project strengthened existing health and community structures, improved access to services, and reinforced collaboration between government institutions, humanitarian partners, and refugee communities. The experience and lessons generated through implementation offer practical guidance for the design of future programmes seeking to improve health and protection outcomes for refugees in Uganda.



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1. Introduction

1.1. Background of the project

Uganda has, over the past decades, emerged as one of the most significant refugee-hosting countries globally, driven by its progressive refugee policies and its geographical proximity to countries experiencing protracted conflict and instability. The country's open-door policy, enshrined in the Refugees Act (2006) and Refugee Regulations (2010), has allowed refugees access to land, public services, and freedom of movement. While this approach has been widely recognized as a model for refugee inclusion, it has simultaneously placed considerable pressure on already constrained national systems, particularly in the health and protection sectors.

The project *“Protecting the dignity of refugees in Uganda: responding to sexual and gender-based violence as a human rights violation and public health issue”* was designed within this complex humanitarian context. It built on over five years of collaboration between Farmacéuticos Mundi (Farmamundi), Africa Humanitarian Action (AHA), and Emesco Development Foundation (EMESCO), organizations that had jointly implemented multiple health and protection interventions targeting refugee populations in Uganda. The project represented a continuation and consolidation of previous initiatives, incorporating lessons learned from earlier programmes to strengthen both the quality and scope of humanitarian response.

The aim of the intervention was to contribute to the promotion of the right to health and the right to live with dignity among refugee populations, with a specific focus on addressing sexual and gender-based violence (SGBV) as both a human rights violation and a critical public health concern. The project was based on the recognition that the vulnerabilities experienced by refugees are multidimensional, stemming not only from displacement but also from systemic inequalities, limited access to services, and exposure to violence—particularly for women and girls.

The intervention was implemented across three distinct geographic contexts, Kampala (urban), Kyaka II (rural settlement), and Adjumani (large-scale settlement in northern Uganda), each characterized by unique demographic, socio-economic, and health-related challenges. This multi-site approach reflected the understanding that refugee experiences in Uganda were not homogeneous, and that tailored strategies were required to address both urban and settlement-specific vulnerabilities.

At its core, the project was grounded in a rights-based and integrated approach, linking healthcare delivery with gender equality, protection, and community empowerment. It aimed not only to improve access to essential health services but also to strengthen the capacity of communities and institutions to prevent and respond to SGBV, while fostering accountability and participation among affected populations. This approach aligned with international humanitarian standards, including the Core Humanitarian



Standard (CHS), and emphasized the importance of transparency, responsiveness, and inclusiveness in service delivery.

The project was structured around a specific objective and a set of interconnected results aimed at improving both service provision and systemic capacity. The specific objective focused on enhancing the health and sexual and reproductive health (SRH) of refugee populations by addressing SGBV through a comprehensive, multisectoral response. This included improving access to primary healthcare services, strengthening mental health and psychosocial support (MHPSS), enhancing referral systems for specialized care, and ensuring that survivors of violence received adequate medical, psychological, and legal support.

One of the central pillars of the intervention was the expansion of access to essential healthcare services, particularly in underserved refugee settings. Prior to the project, access to healthcare had been constrained by multiple barriers, including long distances to health facilities, insufficient medical supplies, understaffing, and high demand resulting from increasing refugee influxes. The project sought to address these gaps through a combination of facility-based services and mobile outreach teams, ensuring that both static and hard-to-reach populations could benefit from healthcare interventions.

In addition to healthcare delivery, the project placed significant emphasis on mental health and psychosocial support (MHPSS). Refugee populations were often exposed to traumatic experiences, including conflict-related violence, displacement, and loss of livelihoods, all of which contributed to a high burden of mental health conditions. Despite this, mental health services in many humanitarian settings remained limited. The project addressed this gap by integrating psychosocial support into primary healthcare services and deploying mobile teams to provide community-based support, thereby increasing both the availability and accessibility of care.

Another component of the intervention was the strengthening of referral systems to ensure that refugees requiring specialized medical services could access appropriate care at higher-level facilities, including national referral hospitals in Kampala. This was particularly important for cases involving complex medical conditions or survivors of SGBV who required comprehensive support. The project therefore reinforced coordination between primary healthcare providers and tertiary institutions, facilitating timely and effective referrals.

Capacity building of healthcare professionals and stakeholders was another area. The project included targeted training programmes aimed at enhancing the technical skills of healthcare workers, particularly in areas such as SGBV response, mental health care, and adherence to standardized treatment protocols. By strengthening the knowledge and competencies of service providers, the intervention contributed to improved quality of care



and ensured that services were delivered in a manner that was sensitive to gender and human rights considerations.

Beyond service delivery, the project recognized the importance of community engagement and awareness-raising in addressing the root causes of vulnerability. Activities were therefore designed to increase knowledge and awareness among refugee populations and host communities regarding health rights, gender equality, and the prevention of violence. These efforts aimed to challenge harmful social norms, reduce stigma associated with SGBV, and empower individuals, particularly women and girls, to seek services and assert their rights.

The intervention also incorporated mechanisms to strengthen accountability and participation, ensuring that affected populations had a voice in the design and implementation of activities. Feedback systems, community dialogues, and coordination structures were utilized to promote transparency and responsiveness, in line with the principles of the Core Humanitarian Standard. This participatory approach not only enhanced the relevance of interventions but also contributed to building trust between communities and service providers.

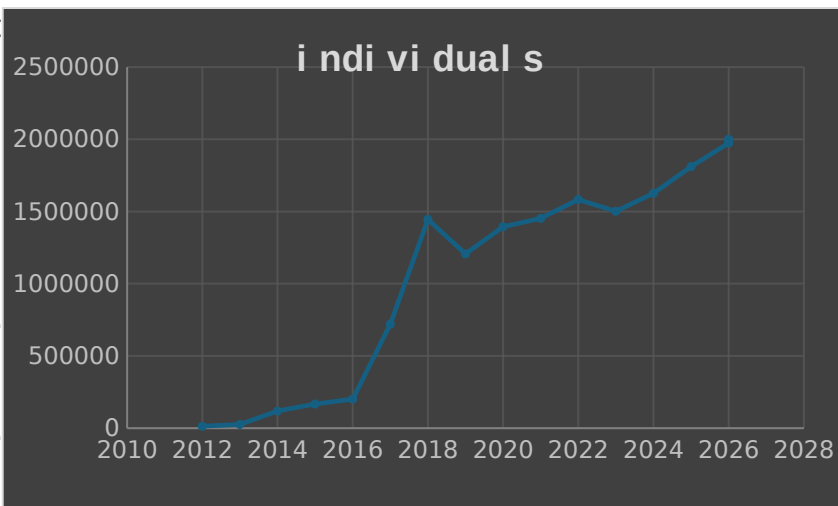
Importantly, the project operated within a broader humanitarian ecosystem, complementing the efforts of government institutions, UN agencies, and other non-governmental organizations. It did not aim to replace national systems but rather to support and strengthen them, particularly in areas where gaps in service delivery and protection persisted. This collaborative approach was essential given the scale and complexity of the refugee crisis in Uganda, where no single actor could address all needs.

1.2. Uganda refugee context

Uganda has consistently been among the largest refugee-hosting countries in the world and remains the largest in Africa. Its progressive refugee policy framework, which promotes inclusion and self-reliance, has enabled the country to host large numbers of refugees fleeing conflict, insecurity, and persecution in neighbouring countries, particularly South Sudan, the Democratic Republic of Congo (DRC), and Somalia. This long-standing commitment has positioned Uganda as a key actor in the global refugee response, with its refugee population has been steadily increasing over the past fifteen years. However, this has also placed significant strain on national systems and local resources.

Figure 1: Refugee population increase - OPM

At the time of project implementation, Uganda was hosting over 1.5 million refugees, with the majority originating from South Sudan and the DRC. Refugee populations were unevenly distributed across the country, with large concentrations in settlement areas such



as Adjumani in Northern Uganda and Kyaka II in Western Uganda, alongside a significant and growing number of refugees residing in urban settings, particularly Kampala.

The refugee situation in Uganda was characterized by a protracted crisis, with many refugees living in the country for extended periods due to ongoing instability in their countries of origin. This prolonged displacement resulted in increased dependency on humanitarian assistance and limited opportunities for sustainable livelihoods. At the same time, the continuous influx of new arrivals further exacerbated pressure on already overstretched services and infrastructure.

Despite Uganda's inclusive policy framework, refugees continued to face multiple barriers in accessing essential services. The health system, in particular, struggled to cope with increased demand, especially in areas hosting large refugee populations. Health facilities often experienced shortages of medicines, limited human resources, and insufficient infrastructure, which compromised the quality and continuity of care. These challenges were further compounded in remote settlement areas, where geographical barriers and limited transport options restricted access to health services.

Access to sexual and reproductive health (SRH) and mental health and psychosocial support (MHPSS) services remained particularly constrained. While some services were available, their coverage and quality varied significantly across locations. Baseline findings indicated that satisfaction with SRH services was below optimal levels in all intervention areas, while MHPSS services were even more limited, particularly in settlement contexts. This highlighted systemic gaps in service delivery and emphasised the need for targeted interventions to strengthen both access and quality of care.

Gender-based violence (GBV) represented one of the most critical protection concerns within refugee communities. The prevalence of GBV was significant across all intervention areas, with multiple forms of violence



including physical, emotional, and sexual violence—reported among refugee populations. Women and girls were disproportionately affected, often facing heightened vulnerability due to economic dependency, social norms, and limited access to protection services. At the same time, stigma, fear of retaliation, and weak reporting mechanisms contributed to underreporting and limited access to support services.

The response to GBV was further constrained by systemic challenges, including gaps in coordination between health, legal, and psychosocial services, as well as limited capacity of service providers to deliver comprehensive, survivor-centred care. While referral pathways existed, their effectiveness was often undermined by logistical barriers, lack of awareness, and insufficient integration across sectors.

In addition to health and protection challenges, refugee populations faced significant socio-economic vulnerabilities. Limited livelihood opportunities, food insecurity, and inadequate access to education and social services contributed to a cycle of dependency and vulnerability. Women, adolescents, persons with disabilities, and older persons were particularly affected, often experiencing compounded barriers to access and participation.

The context also revealed important gaps in awareness and knowledge among refugee populations regarding their rights, available services, and mechanisms for seeking support. Although there were ongoing efforts to promote health education and community engagement, these remained insufficient to address deeply rooted social norms and behavioural barriers, particularly in relation to gender equality and GBV.

At the community level, participation and accountability mechanisms were still evolving. While structures such as community dialogues and coordination committees were in place, their functionality and inclusiveness varied across locations. Strengthening these mechanisms was therefore essential to ensure that interventions remained responsive to the needs and priorities of affected populations and aligned with humanitarian accountability standards.

The three areas of intervention, Kampala, Kyaka II, and Adjumani, presented distinct contextual dynamics that influenced both the design and implementation of the project. Kampala, as an urban setting, was characterized by dispersed refugee populations, higher cost of living, and challenges related to access to affordable services and livelihoods. Refugees in urban areas often relied on public health facilities, which were not specifically tailored to refugee needs, and faced additional barriers such as discrimination, lack of documentation, and limited social support networks.

In contrast, Kyaka II and Adjumani represented settlement-based contexts, where refugees were hosted in designated areas with access to



humanitarian services. While these settings allowed for more structured service delivery, they were also marked by challenges related to overcrowding, limited infrastructure, and dependence on external support. In Adjumani, the high concentration of refugees placed additional pressure on local resources, while in Kyaka II, geographical spread and access constraints further complicated service delivery.

Across all three locations, the refugee context was further shaped by broader systemic challenges, including funding gaps, coordination constraints, and the limitations of short-term humanitarian programming. These factors underscored the need for integrated, sustainable, and context-sensitive interventions that could address both immediate needs and longer-term structural challenges.

1.3. Overview of intervention areas (Kyaka II, Kampala, Adjumani)

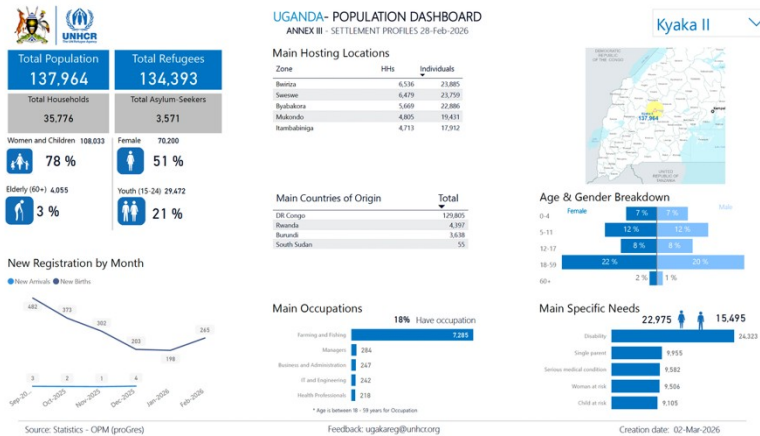
The project was implemented across three distinct locations in Uganda, Kyaka II refugee settlement, Kampala (urban), and Adjumani refugee settlements, each representing different dimensions of the refugee experience in the country. Possibly, these locations were strategically selected to capture the diversity of refugee contexts in Uganda and to ensure that the intervention responded to both settlement-based and urban challenges.



Kyaka II Refugee Settlement, located in Kyegegwa District in Western Uganda, hosts a predominantly Congolese refugee population. The settlement is characterized by a dispersed population across a wide geographic area, with limited infrastructure and significant barriers to accessing essential services. Health facilities in Kyaka II often face high patient loads, shortages of medicines, and limited human resources, which affect the quality and timeliness of care. Additionally, long distances between communities and health facilities,

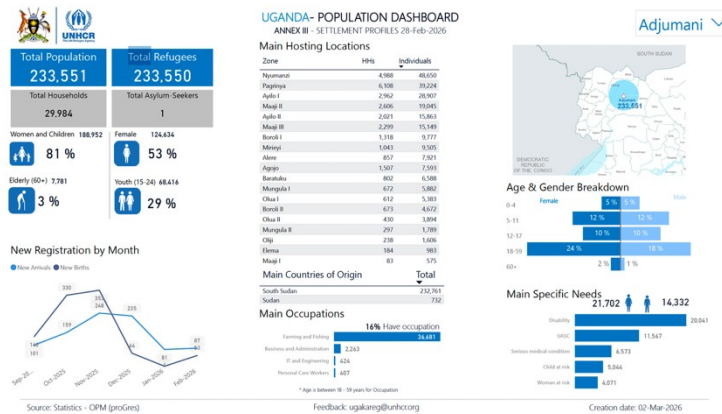
combined with limited transport options, further constrain access to services. These challenges are particularly pronounced for vulnerable groups, including women, children, and persons with disabilities. The context in Kyaka II is therefore largely defined by constraints in physical access, resource availability, and service capacity.



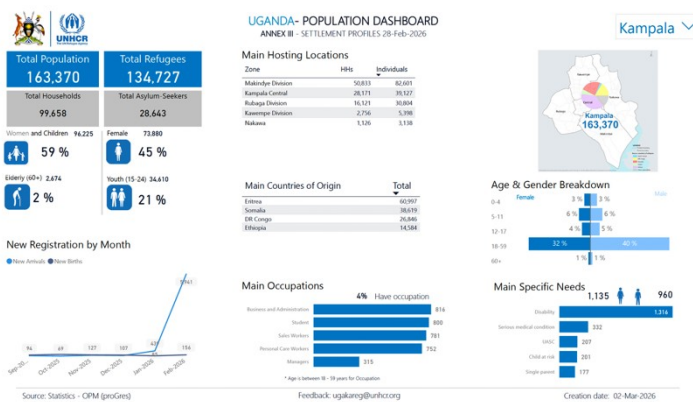


Adjumani Settlements, located in Northern Uganda, is one of the largest refugee-hosting districts in the country, hosting a significant population of refugees, primarily from South Sudan. Unlike Kyaka II, Adjumani is characterized by a high concentration of refugees within relatively defined settlement areas.

While this allows for more structured service delivery and coordination among humanitarian actors, the sheer scale of the refugee population places considerable pressure on existing infrastructure and public services. Health facilities often experience overcrowding, and the demand for services frequently exceeds available capacity. In addition, protection concerns, including violence, are prevalent, and access to comprehensive, multisectoral services remains inconsistent. The Adjumani context is therefore shaped by high demand, resource strain, and the complexities of managing large-scale humanitarian operations.



Kampala, as the capital city and primary urban centre of Uganda, presents a markedly different context from settlement areas. Refugees in Kampala are dispersed across the city and are integrated within host communities rather than residing in designated settlements. While urban settings offer relatively better access to infrastructure and specialized services, refugees face distinct challenges related to affordability, documentation, discrimination, and limited social support systems. Access to healthcare services is often



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constrained by cost, and refugees must rely on public health facilities that are not specifically tailored to their needs. Additionally, the identification and targeting of vulnerable populations in urban settings is more complex due to the absence of centralized settlement structures. The Kampala context is therefore characterized by issues of invisibility, economic vulnerability, and fragmented access to services.

Across all three locations, refugee populations faced common challenges related to access to healthcare, particularly in the areas of sexual and reproductive health (SRH), mental health and psychosocial support (MHPSS), and gender-based violence (GBV) response. However, the nature and intensity of these challenges varied significantly depending on the context. While settlement areas such as Kyaka II and Adjumani faced structural and capacity-related constraints, the urban context of Kampala was more influenced by socio-economic barriers and issues of integration.

1.4. Objectives of the evaluation

General Objective

The overall objective of this evaluation was to assess the relevance, adequacy, efficiency, effectiveness, impact, sustainability, and participatory nature of the project “Protecting the dignity of refugees in Uganda: responding to sexual and gender-based violence as a human rights violation and public health issue.” The evaluation aimed to generate evidence-based conclusions and practical recommendations to strengthen accountability, support organizational learning, and inform the design of future interventions targeting refugee populations in Uganda.

Specific Objectives

The evaluation specifically sought to:

- Assess the extent to which the project achieved its planned results (R1-R4) and its Specific Objective, particularly in improving access to sexual and reproductive health (SRHR), mental health and psychosocial support (MHPSS), and gender-based violence (GBV) response services across Kampala, Kyaka II, and Adjumani.
- Analyse the relevance and coherence of the project design in relation to the needs and priorities of refugee and host populations, as well as its alignment with national policies and humanitarian frameworks.
- Examine the efficiency of the intervention in terms of the use of financial, human, and institutional resources, including the extent to which activities were implemented within planned timelines.
- Evaluate the effectiveness and quality of implementation processes, including coordination mechanisms between Farmamundi, AHA, Emesco, and institutional stakeholders.



- Assess the broader impact of the intervention on individuals, communities, and institutions, including both intended and unintended effects.
- Determine the sustainability of project outcomes, including the extent to which benefits are likely to continue beyond the project period.
- Analyse the level of participation, ownership, and accountability among rights-holders and local institutions, including the effectiveness of feedback and community engagement mechanisms.
- Assess the integration of cross-cutting approaches, including gender and age sensitivity, human rights-based approaches, conflict sensitivity, and the principle of Do No Harm.

Purpose of the Evaluation

The evaluation served both a learning and accountability function. It aimed to provide a structured assessment of the project's performance against its objectives and expected results, while also generating actionable insights to improve future programming.

Specifically, the evaluation was intended to:

- Support implementing partners (Farmamundi, AHA, and Emesco) in identifying strengths, gaps, and lessons learned to enhance the quality, effectiveness and impact of future interventions.
- Ensure accountability to donors, particularly the Basque Government, by demonstrating the extent to which resources were used effectively and results achieved.
- Inform strategic decision-making by providing evidence on what worked, what did not, and why, within the different operational contexts of Kampala, Kyaka II, and Adjumani.
- Contribute to broader learning within the humanitarian and development sector, particularly in relation to integrated approaches to health, protection, and gender-based violence in refugee settings.



2. Description of the Intervention

2.1. Project rationale

The project was conceived in response to persistent and interrelated gaps in access to healthcare, protection services, and community-level support systems among refugee populations in Uganda. Despite the country's progressive refugee policy framework, significant challenges remained in ensuring equitable, quality, and comprehensive service delivery, particularly in the areas of sexual and reproductive health (SRHR), mental health and psychosocial support (MHPSS), and gender-based violence (GBV) response.

At the time of project design, refugee populations in Kampala, Kyaka II, and Adjumani faced multiple barriers to accessing essential services. Health systems, especially in high-refugee-hosting areas, were under considerable strain due to increased demand, limited infrastructure, shortages of medical supplies, and insufficient human resources. These systemic constraints were further exacerbated by the protracted nature of displacement, which increased long-term reliance on public health services without corresponding expansion in capacity.

Within this context, access to SRHR services remained inconsistent and often inadequate, particularly for women and adolescent girls. Barriers such as stigma, limited awareness, cultural norms, and weak service delivery systems reduced the utilization of available services. Similarly, mental health and psychosocial support services were largely underdeveloped, despite a high burden of psychological distress associated with conflict, displacement, and socio-economic hardship.

Gender-based violence represented a critical and cross-cutting concern across all intervention areas. GBV was both widespread and underreported, with women and girls disproportionately affected. Survivors faced significant challenges in accessing care, including stigma, fear of retaliation, limited knowledge of available services, and weak or fragmented referral systems. In many cases, the response to GBV lacked integration across health, legal, and psychosocial services, resulting in gaps in survivor-centred care.

In addition to service delivery gaps, the project design recognized important limitations at the community level. Awareness of rights, available services, and referral pathways remained low among refugee populations, while harmful social norms and practices continued to perpetuate inequality and violence. Community structures, including Village Health Teams (VHTs) and other grassroots actors, were often overstretched and insufficiently

equipped to address complex issues such as GBV prevention, mental health, and sexual and reproductive health. Institutional and coordination challenges also contributed to the identified gaps. While multiple actors were engaged in the humanitarian response, coordination across sectors and stakeholders was not always optimal, leading to duplication in some areas and gaps in others. Furthermore, the integration of gender and human rights perspectives into service delivery and institutional practices remained limited, affecting both the quality and inclusiveness of interventions.

The project was therefore designed to address these interconnected challenges through an integrated and multisectoral approach. It sought to strengthen the capacity of health systems to deliver quality SRHR, MHPSS, and GBV services; enhance community-level awareness and engagement; improve referral and coordination mechanisms; and promote accountability and participation among rights-holders. A key aspect of the project rationale was the recognition of GBV as both a human rights violation and a public health issue. This dual framing informed the design of the intervention, ensuring that GBV was addressed not only through protection mechanisms but also through strengthened health system responses, including clinical management, psychosocial support, and referral pathways.

The inclusion of both settlement (Kyaka II and Adjumani) and urban (Kampala) contexts further reflected the need for differentiated approaches tailored to specific operational realities. While settlement areas required strengthening of infrastructure and service delivery capacity, the urban context demanded strategies to address issues of access, affordability, and identification of vulnerable populations within dispersed communities.

2.2. Specific Objective (SO)

The Specific Objective (SO) of the project was to improve the health and sexual and reproductive health (SRHR) of Congolese, South Sudanese, and Somali refugees in Uganda by addressing sexual and gender-based violence (SGBV) as both a human rights violation and a major public health concern across the intervention areas of Kampala, Kyaka II, and Adjumani. This objective was pursued through an integrated approach that combined the strengthening of healthcare service delivery, particularly in SRHR and mental health and psychosocial support (MHPSS), with enhanced prevention and response mechanisms for SGBV. The intervention also aimed to promote access to quality, safe, and survivor-centred services, while addressing structural and socio-cultural barriers that limit the ability of refugees, especially women and girls, to seek and receive care.

In addition, the Specific Objective reflected a broader commitment to a rights-based approach, emphasizing the protection of dignity, the



promotion of gender equality, and the empowerment of affected populations to claim their rights and actively participate in decisions affecting their health and well-being.

2.3. Results (R1–R4)

The project was structured around four interrelated results (R1–R4), which together contributed to the achievement of the Specific Objective. These results addressed both service delivery and systemic gaps, combining health, protection, community engagement, and accountability components.

Result 1 (R1): Improved access to quality healthcare services

R1 aimed to increase the coverage, accessibility, and quality of essential healthcare services among refugee populations in Kampala, Kyaka II, and Adjumani. Particular emphasis was placed on strengthening sexual and reproductive health (SRHR) services, mental health and psychosocial support (MHPSS), and ensuring safe and adequate care for survivors of gender-based violence (GBV). This result focused on enhancing the capacity of health facilities and outreach systems to deliver integrated and quality care, including the clinical management of GBV, provision of SRHR services, and expansion of MHPSS interventions. It also included strengthening referral pathways to ensure that individuals requiring specialized services could access appropriate levels of care.

Result 2 (R2): Strengthened community capacities for GBV prevention and response

R2 focused on strengthening the capacity of refugee and host communities to reduce inequalities in access to health resources, improve the prevention of gender-based violence, and support comprehensive care for survivors. This result emphasized community-level interventions, including awareness-raising, behaviour change communication, and the strengthening of community structures such as Village Health Teams (VHTs) and other local actors. It aimed to address harmful social norms, increase knowledge of rights and available services, and promote a life free from violence, particularly for women and girls.

Result 3 (R3): Increased awareness and advocacy on refugee and GBV issues

R3 aimed to enhance information and awareness regarding the refugee situation in Uganda, with a particular focus on the experiences of women and girls affected by GBV. It sought to promote a rights-based, gender-sensitive, and protection-oriented understanding of refugee issues, both at community and broader societal levels. This result included activities

designed to support critical citizenship, advocacy, and public engagement, contributing to increased visibility of refugee concerns and promoting more inclusive and informed responses among stakeholders and the general public, through activities implemented both in Uganda (Kampala, Kyaka II, Adjumani) and in Euskadi.

Result 4 (R4): Strengthened participation and accountability mechanisms

R4 focused on enhancing participation, accountability, and leadership among local actors and affected populations throughout the humanitarian response cycle. It aimed to strengthen mechanisms that allow refugees and host communities to actively engage in decision-making processes and provide feedback on services and interventions. This included the establishment and strengthening of accountability to affected populations (AAP) mechanisms, community dialogue platforms, and coordination structures. The result also emphasized the role of local institutions and partners in leading and sustaining humanitarian interventions, thereby contributing to greater ownership and long-term sustainability.

Linkage to the Specific Objective

Together, these four results were designed to operate in a complementary manner, addressing both immediate service delivery needs and underlying structural and social determinants of vulnerability. While R1 focused on strengthening health services, R2 and R3 targeted community-level awareness and behavioural change, and R4 ensured that participation and accountability were embedded across all components of the intervention. This integrated approach was intended to contribute to the achievement of the Specific Objective by improving access to quality health and protection services, strengthening community resilience, and promoting a rights-based response to gender-based violence in refugee settings.

2.4. Key components (SRHR, MHPSS, GBV, community systems, AAP)

The project was implemented through a set of integrated thematic components that addressed the multidimensional health and protection needs of refugee populations. These components were closely aligned with the project results (R1-R4) and together formed the operational backbone of the intervention.

Sexual and Reproductive Health (SRHR): The SRHR component focused on improving access to comprehensive and quality sexual and reproductive health services for refugee populations, particularly women and adolescent girls. This included the provision of family planning services, antenatal and postnatal care, and the clinical management of sexual violence. Efforts under this component aimed to strengthen health facility capacity, enhance service availability, and promote the utilization of SRHR services. It also

addressed socio-cultural barriers that limit access to care, including stigma, gender norms, and lack of awareness. By integrating SRHR into primary healthcare services and outreach activities, the project sought to ensure that services were accessible, acceptable, and responsive to the needs of vulnerable populations.

Mental Health and Psychosocial Support (MHPSS): The MHPSS component addressed the high burden of psychological distress among refugee populations, resulting from experiences of conflict, displacement, and socio-economic hardship. The project supported the integration of mental health services into primary healthcare systems, enabling early identification and management of mental health conditions. This component included both facility-based and community-based interventions, such as counselling, psychosocial support sessions, and referrals for specialized care. It also aimed to reduce stigma associated with mental health and improve community awareness of available services. By strengthening both service delivery and community support systems, the project contributed to improved mental well-being and resilience among affected populations.

Gender-Based Violence (GBV) Prevention and Response: The GBV component was central to the project and addressed both prevention and response aspects of gender-based violence. It focused on strengthening survivor-centred services, including clinical care, psychosocial support, and referral pathways, while also addressing underlying drivers of violence at the community level. The project supported the capacity building of health workers and other service providers to ensure appropriate and sensitive handling of GBV cases. At the same time, community-based activities were implemented to raise awareness, challenge harmful norms, and promote gender equality. The integration of GBV services within health systems ensured that survivors could access comprehensive care in a timely and coordinated manner.

Community Systems Strengthening: Community systems strengthening was a cross-cutting component that aimed to enhance the role of community structures in health promotion, prevention, and service linkage. This included working with Village Health Teams (VHTs), community leaders, and other grassroots actors to improve outreach, awareness, and referral mechanisms. The project supported training and capacity development of community actors to enable them to address key issues such as SRHR, MHPSS, and GBV. It also emphasized community engagement as a means of promoting behavioural change, improving service uptake, and ensuring that interventions were responsive to local needs and realities.

Accountability to Affected Populations (AAP): The AAP component focused on strengthening mechanisms that promote transparency, participation, and responsiveness in the delivery of services. It ensured that refugees and host communities had opportunities to provide feedback, express concerns,



and influence decision-making processes related to the project. This included the establishment and reinforcement of feedback channels, community dialogues, and participatory platforms. The project aimed to institutionalize accountability practices within both community and service delivery structures, thereby enhancing trust, improving service quality, and fostering a sense of ownership among beneficiaries.

Integration of Components: These components were not implemented in isolation but were designed to be mutually reinforcing. For example, GBV response was integrated within SRHR and MHPSS services, while community systems strengthening supported all thematic areas through improved outreach and engagement. Similarly, AAP mechanisms cut across all components, ensuring that interventions remained responsive and aligned with the needs and priorities of affected populations.

2.5. Theory of change

The theory of change followed a logical pathway: strengthening health systems and service delivery, empowering communities, improving coordination and referrals, and enhancing accountability mechanisms would collectively lead to improved access to quality care, increased awareness and prevention of violence, and ultimately improved health, dignity, and protection of refugee populations in Kampala, Kyaka II, and Adjumani.

The theory of change for the project was based on the premise that improving access to quality, integrated health and protection services, while simultaneously strengthening community systems and accountability mechanisms, would lead to improved health outcomes and enhanced protection for refugee populations, particularly in relation to sexual and gender-based violence (SGBV). The project assumed that if health facilities were strengthened to provide comprehensive and quality services, including sexual and reproductive health (SRHR), mental health and psychosocial support (MHPSS), and clinical management of gender-based violence, then access to and utilization of these services by refugee populations would increase. This, in turn, would contribute to improved health status, timely care for survivors of violence, and overall well-being.

At the same time, the project recognized that service availability alone was insufficient to achieve meaningful change. It therefore posited that if communities were empowered through awareness-raising, capacity building, and engagement of community structures such as Village Health Teams (VHTs), then knowledge of rights, available services, and prevention strategies would improve. This would lead to increased demand for services, reduced stigma, and positive shifts in social norms, particularly around gender equality and violence prevention.



The theory of change also emphasized the importance of integrated and functional referral systems. It assumed that if coordination between different levels of care, community, primary healthcare, and specialized services, was strengthened, then individuals requiring advanced medical or psychosocial support would be able to access appropriate services in a timely and efficient manner. This was particularly critical for survivors of SGBV, who require comprehensive and multisectoral care.

Furthermore, the project was grounded in the belief that strengthening accountability to affected populations (AAP) would enhance the relevance, quality, and responsiveness of interventions. By establishing mechanisms for feedback, dialogue, and participation, the project aimed to ensure that services were aligned with the needs and priorities of refugees and host communities. Increased participation was expected to foster ownership, trust, and sustainability of outcomes.

Underlying these assumptions was a broader recognition of SGBV as both a public health issue and a human rights violation. The project therefore integrated protection and health approaches, aiming to address both the immediate consequences of violence and its root causes.



3. Methodology

3.1. Evaluation approach (mixed methods, participatory, theory-based)

The evaluation adopted a mixed-methods, participatory, and utilisation-focused approach, combining both qualitative and quantitative methods to assess the relevance, efficiency, effectiveness, impact, sustainability, coordination, coverage, and participation dimensions of the project. The methodology was guided primarily by the OECD-DAC evaluation criteria, while also integrating additional humanitarian dimensions, including connectivity, accountability, gender and age sensitivity, human rights-based approaches, and the principle of Do No Harm.

The evaluation was designed to generate evidence-based findings while ensuring that the perspectives of key stakeholders, including rights-holders, implementing partners, health workers, and institutional actors, were adequately represented. The approach emphasized triangulation across multiple data sources and methods in order to strengthen the validity and reliability of findings. The evaluation further adopted a theory-based perspective, examining how project activities and interventions contributed to the achievement of the expected results (R1–R4) and the Specific Objective (SO). In addition to assessing whether results were achieved, the methodology sought to understand how and why changes occurred across the three intervention areas of Kampala, Kyaka II, and Adjumani.

3.2. Evaluation Criteria

The evaluation was structured around the OECD-DAC evaluation criteria and additional humanitarian evaluation dimensions outlined in the Terms of Reference. The assessment focused on:

- Relevance and adequacy
- Effectiveness
- Efficiency
- Impact
- Sustainability (viability)
- Connectivity and coherence
- Coordination
- Coverage
- Ownership and participation

Cross-cutting issues, including gender equality, age sensitivity, human rights, conflict sensitivity, accountability to affected populations (AAP), and environmental considerations, were integrated throughout the evaluation process and analysis.

3.3. Data Sources and Collection Methods

The evaluation utilized both primary and secondary data sources.



Document Review

A comprehensive desk review was conducted using project-related documentation and secondary literature. Reviewed materials included:

- Project proposals and logical frameworks
- Baseline and Endline reports
- Project Report
- DHIS2 data
- Relevant national policies and humanitarian frameworks

The document review provided contextual understanding and informed the development of data collection tools and analytical frameworks.

The project had recently concluded an endline assessment prior to the commencement of the external evaluation. A review of the endline datasets indicated that the information available was sufficiently comprehensive and reliable to support the evaluation objectives. Conducting another household survey within a short period after the endline assessment risked repetitive engagement with the same populations and could potentially affect the quality and consistency of responses in addition to interviewee fatigue. The evaluation therefore focused on triangulating the existing quantitative datasets with qualitative findings from Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), and document review in order to generate a comprehensive and credible assessment of project performance.

Key Informant Interviews (KIIs)

Key Informant Interviews were conducted with a broad range of stakeholders involved in project implementation and oversight. These included representatives from:

- Farmamundi
- Africa Humanitarian Action (AHA)
- EMESCO
- Office of the Prime Minister (OPM)
- Ministry of Health (MoH)
- Kampala Capital City Authority (KCCA)
- District local governments
- Health facility staff
- Community leaders and other humanitarian actors

The KIIs provided in-depth insights into project implementation, coordination mechanisms, institutional capacity, challenges, and perceived outcomes.

Focus Group Discussions (FGDs)

Focus Group Discussions were conducted with refugee and host community members across the three intervention areas. The discussions included:

- Women
- Men
- Adolescents and youth
- Village Health Teams (VHTs)
- Community structures and leaders

FGDs explored community perceptions regarding access to healthcare, MHPSS, SGBV services, participation, accountability, and overall project relevance and effectiveness.

3.4. Sampling Strategy

The evaluation covered all three project implementation areas: Kampala, Kyaka II, and Adjumani. A purposive sampling approach was used for Key Informant Interviews and Focus Group Discussions in order to ensure participation of respondents with relevant knowledge, experience, or lived realities related to the intervention. Efforts were made to ensure diversity and representation across gender, age, and vulnerability categories, including women, adolescents, and community-level actors. Selection of facilities and respondents was guided by project coverage, accessibility, and relevance to the evaluation objectives.

3.5. Data Analysis

Qualitative data from KIIs and FGDs were analysed using thematic analysis. Responses were organized according to key evaluation themes and criteria, allowing for identification of recurring patterns, perceptions, and emerging issues across the three intervention areas.

Quantitative data from routine records, project monitoring systems, and the endline assessment dataset were analysed descriptively to assess trends and progress related to project indicators and service utilization. Since the endline assessment dataset served as the primary household-level quantitative dataset for the evaluation, comparative analysis was conducted between the baseline and endline datasets in order to assess changes over the project implementation period. This included analysis of indicators related to healthcare access and utilization, mental health and psychosocial support (MHPSS), gender-based violence (GBV), awareness levels, participation, and accountability mechanisms across the intervention areas of Kampala, Kyaka II, and Adjumani.

Findings from different sources and methods were triangulated to strengthen consistency, credibility, and overall interpretation. Analysis was further guided by the project's theory of change and logical framework, linking findings to the expected results (R1-R4) and the Specific Objective.

3.6. Ethical Considerations

The evaluation was conducted in accordance with ethical principles applicable to humanitarian and public health evaluations. Participation in interviews and discussions was voluntary, and informed consent was obtained from participants prior to engagement. Special attention was given to confidentiality, privacy, and the protection of vulnerable individuals, particularly survivors of gender-based violence. The evaluation adhered to the principles of Do No Harm and applied survivor-centred approaches throughout data collection and reporting processes. No personally identifiable information was included in the report, and information gathered during the evaluation was used strictly for evaluation purposes.

3.7. Limitations of the Evaluation

Several limitations were encountered during the evaluation process. These included time constraints associated with conducting fieldwork across geographically dispersed locations, and the sensitivity of certain topics, particularly those related to SGBV and mental health. In some instances, recall bias may have affected participant responses, especially where respondents reflected on activities implemented over an extended period. Additionally, the evaluation relied partly on routine project and health system data, which may have contained inconsistencies or reporting gaps.

Despite these limitations, triangulation of multiple data sources and methods helped strengthen the reliability and credibility of findings.



4. RESULTS

This section presents the findings of the final external evaluation of the project *“Protecting the dignity of refugees in Uganda: responding to sexual and gender-based violence as a human rights violation and public health issue.”* The analysis examines the extent to which the intervention achieved its intended objective and results across the three implementation areas of Kampala, Kyaka II, and Adjumani. The findings are organized around the OECD-DAC evaluation criteria and complementary humanitarian criteria, namely relevance, effectiveness, efficiency, impact, sustainability, connectivity, coordination, coverage, ownership and participation, and cross-cutting issues. Particular attention is given to the project’s three core thematic pillars: access to essential health services, mental health and psychosocial support (MHPSS), and prevention and response to sexual and gender-based violence (SGBV).

The results are informed by a review of project documentation, the final project report, the logical framework, baseline and endline data sets, routine health and project monitoring data, and qualitative insights from stakeholder consultations. The analysis considers both the achievement of planned outputs and the broader contribution of the intervention to improved service access, strengthened community systems, enhanced survivor support, and accountability to affected populations. Given the diversity of the three implementation contexts, the findings also examine differences between the urban refugee setting of Kampala and the settlement-based contexts of Kyaka II and Adjumani, highlighting how the intervention responded to distinct operational realities, population needs, and service delivery challenges.

The evaluation adopted a mixed-methods approach that combined quantitative and qualitative evidence to examine both the measurable achievements of the project and the experiences and perceptions of the targeted populations and stakeholders. In line with the evaluation framework, the analysis draws from four principal layers of evidence: project implementation and monitoring data, comparative baseline and endline findings, qualitative evidence from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs), and the interpretation of the assessment team guided by the OECD-DAC and humanitarian evaluation criteria.

The first layer of evidence consisted of project documentation and routine implementation records, including the final project report, activity reports, monitoring data, DHIS2 records, training records, referral data, and accountability documentation. These sources provided evidence on the extent to which planned activities and outputs were achieved, including



healthcare service delivery, deployment of outreach services, SGBV prevention and response interventions, psychosocial support services, awareness campaigns, and accountability mechanisms. This evidence was particularly important in assessing operational performance, implementation coverage, and progress against the logical framework indicators and expected results (R1–R4).

The second layer of evidence was derived from the comparative analysis of baseline and endline findings, which served as the principal quantitative basis for assessing changes associated with the intervention. The endline dataset was utilized as the household-level evidence base for the evaluation due to its methodological adequacy, broad thematic coverage, and direct alignment with the project indicators and evaluation questions. Comparative analysis between baseline and endline findings enabled the evaluation to assess trends and changes in areas such as access to healthcare services, awareness of sexual and reproductive health rights, community perceptions regarding SGBV services, participation in awareness activities, and utilization of accountability mechanisms. This approach also strengthened the evaluation’s ability to assess outcomes and emerging impacts beyond routine output monitoring.

The third layer of evidence was generated through KIIs and FGDs conducted with a broad range of stakeholders, including implementing partners, government representatives, healthcare workers, community leaders, Village Health Teams (VHTs), refugee structures, women, adolescents, and survivors accessing services. These consultations provided deeper insights into the lived experiences of beneficiaries and the operational realities of implementation across Kampala, Kyaka II, and Adjumani. Qualitative evidence helped contextualize quantitative findings by exploring perceptions of service quality, barriers to access, institutional coordination, community ownership, effectiveness of SGBV response mechanisms, and the perceived sustainability of project interventions. The KIIs and FGDs also provided important evidence regarding differences across implementation locations and population groups.

The final layer of evidence involved interpretation and judgement by the assessment team. Findings from different data sources were triangulated and analyzed against the project’s theory of change, logical framework, and evaluation criteria to determine not only whether activities were implemented, but also the extent to which they contributed to meaningful change within the refugee and host communities. This analytical approach enabled the evaluation to move beyond descriptive reporting and provide a deeper assessment of the project’s relevance, effectiveness, efficiency,

impact, sustainability, coherence, and overall contribution to strengthening health systems and protecting the dignity of refugees in Uganda.

4.1. Achievement of the Objectives.

The project substantially contributed to the promotion of the right to health and the right to live with dignity among refugee populations in Kampala, Kyaka II, and Adjumani through a holistic intervention model that integrated primary healthcare, sexual and reproductive health (SRH), mental health and psychosocial support (MHPSS), gender-based violence (GBV) prevention and response, community engagement, and accountability mechanisms. Rather than approaching healthcare and GBV as isolated thematic areas, the intervention recognized the strong interrelationship between health inequities, displacement-related vulnerabilities, gender inequality, psychosocial distress, and barriers to accessing protection and justice. This integrated approach enabled the project to respond simultaneously to immediate humanitarian needs while also strengthening community-level systems, referral pathways, institutional coordination, and rights-based approaches to care.

Evidence from implementation reports indicates that the intervention improved access to essential healthcare services, expanded community awareness regarding health and rights, strengthened referral and support systems for survivors of sexual and gender-based violence, and increased the availability of mental health and psychosocial support services across the three operational contexts. The intervention also strengthened community participation and accountability structures, enabling refugee communities to play a more active role in identifying needs, shaping interventions, and providing feedback on services delivered. Importantly, the project addressed GBV innovatively through a secondary pathway of managing the medical consequences of violence and displacement, as well as the structural and social factors that increase vulnerability, including stigma, lack of information, weak referral pathways, social isolation, and limited community-level protection mechanisms.

At a broader level, the project demonstrated alignment with humanitarian protection principles, human rights approaches, and the localisation agenda by working through existing public systems, refugee-led structures, local authorities, Village Health Teams (VHTs), community committees, and local implementing partners. The intervention therefore contributed not only to service delivery outcomes but also to strengthening local ownership, institutional coordination, and community resilience. It is noteworthy that important structural challenges remained, including medicine stockouts, persistent stigma surrounding mental health and GBV, transportation



barriers, and limitations within the broader health system. However, the overall implementation significantly advanced access to dignified, integrated, and survivor-centered services for refugee populations in the three intervention areas.

The specific objective of improving the health and sexual and reproductive health status of Congolese, South Sudanese, Somali, and other refugee populations through addressing sexual and gender-based violence as both a human rights violation and a public health issue was largely achieved. In relation to **I.O.V.1.O.E**, the intervention successfully expanded access to integrated health services with a strong focus on SRH, mental health, psychosocial support, GBV prevention and response, and community-based protection systems. Through the combined use of fixed health services, mobile outreach teams, referrals to specialized care, community sensitization, psychosocial support interventions, and survivor-centered legal and psychological assistance, the project addressed critical barriers that had previously limited access to comprehensive care among refugee communities.

In relation to **I.O.V.2.O.E** and **I.O.V.3.O.E**, The intervention also strengthened the capacities of healthcare workers, community leaders, and community structures to identify, prevent, refer, and respond to cases of GBV and other protection concerns. The dissemination of referral protocols, strengthening of community committees, establishment of accountability and feedback systems, and reinforcement of coordination between health, protection, and community actors contributed to a more structured and comprehensive response framework. In parallel, awareness-raising activities improved knowledge among refugee communities regarding available services, referral pathways, rights, gender equality, and prevention of violence, thereby supporting earlier care-seeking behavior and greater utilization of services.

Importantly, the project demonstrated adaptability to the differing realities of urban and settlement contexts. In Kyaka II and Adjumani, interventions largely focused on improving access to essential healthcare, infectious disease prevention, outreach services, and community-based systems in geographically dispersed settlements. In Kampala, the intervention increasingly responded to the growing burden of chronic illnesses, psychosocial distress, mental health conditions, and complex GBV cases affecting urban refugee populations. This contextual adaptation enhanced the intervention's relevance and improved responsiveness to the specific vulnerabilities in each operational area. Furthermore, in line with **I.O.V.4.O.E**, the intervention strengthened participation, accountability, and coordination mechanisms through community committees, dialogue



platforms, feedback systems, and interagency coordination structures, contributing to more transparent, participatory, and community-centred humanitarian assistance.

The intervention demonstrated contextual adaptation across the three operational areas, responding to the distinct health, protection, and psychosocial realities affecting refugee populations in Kampala, Kyaka II, and Adjumani. In Kampala, the project increasingly addressed the complex challenges facing urban refugees, including fragmented access to healthcare, high out-of-pocket costs, chronic illnesses, psychosocial distress, mental health conditions, and protection concerns linked to poverty, social isolation, and insecure living conditions. In Kyaka II, the intervention focused more on improving access to essential healthcare, maternal and child health services, infectious disease prevention, and community-based outreach systems within a geographically dispersed settlement environment where distance and limited service coverage remained major barriers. In Adjumani, the project responded to vulnerabilities associated with remote settlement contexts, recurrent outbreak risks, weak access to specialized services, and high psychosocial needs among displaced populations, while simultaneously strengthening community-level awareness, referral, and protection mechanisms. This differentiated approach significantly enhanced the intervention's relevance and appropriateness across the three locations.

A major strength of the intervention was its layered implementation model, which linked community structures, outreach services, healthcare facilities, referral systems, psychosocial services, and institutional coordination mechanisms. This created multiple entry points through which refugees could access support, while simultaneously strengthening prevention, awareness, early identification, referrals, and continuity of care. The intervention also demonstrated strong alignment with national systems and humanitarian coordination mechanisms, reinforcing sustainability and local ownership.

Another major strength of the intervention was its ability to combine a unified strategic vision with flexible, context-sensitive implementation approaches across diverse humanitarian settings. While the project maintained a consistent focus on integrated healthcare, SRH, mental health, GBV prevention and response, accountability, and community participation, the operational emphasis evolved according to the realities of each location. Settlement-based interventions in Kyaka II and Adjumani relied heavily on mobile outreach systems, community structures, awareness activities, and referral coordination to address barriers linked to geography, infrastructure, and limited service availability. In contrast,



interventions in Kampala increasingly focused on navigating fragmented urban systems, strengthening referrals, addressing chronic and mental health conditions, and responding to more complex social and protection vulnerabilities affecting urban refugees. This adaptability enhanced the overall effectiveness of the project and reinforced its alignment with rights-based, survivor-centered, and community-driven humanitarian programming principles.

The project further distinguished itself through its emphasis on participation and accountability. Refugee communities were not treated merely as beneficiaries, but increasingly as active participants through community committees, dialogue sessions, monitoring structures, VHT networks, and accountability mechanisms. This participatory approach strengthened trust, community acceptance, and responsiveness to emerging needs while contributing to greater transparency and inclusion.

Despite the strengths mentioned above, persistent systemic limitations continued to affect refugee access to healthcare and protection services, including shortages of supplies, high service demand, economic vulnerabilities, stigma, and weaknesses within broader referral systems. Regardless, the available evidence indicates that the intervention made a significant contribution to improving access to integrated healthcare and strengthening protection and support mechanisms for refugee populations across the three project locations.

Across the three operational areas, the intervention generated important foundations for longer-term improvements in health access, GBV prevention and response, mental health support, and community resilience. Although structural constraints within the humanitarian and public health environment remain significant, the project established stronger community and institutional systems that can support more coordinated, inclusive, and rights-based responses for refugee populations in Uganda. Overall, the project achieved strategic relevance and coherence by integrating healthcare delivery, protection, psychosocial support, community engagement, accountability, and institutional strengthening into a single, cohesive framework. The intervention moved beyond a narrow service-delivery approach to addressing interconnected drivers of vulnerability affecting refugee populations, particularly women, children, adolescents, and survivors of sexual and gender-based violence.

4.2. Achievement of intended outcomes and results



Outcome 1: Increased coverage, accessibility, and quality of essential healthcare among the refugee population in Kampala, Kyaka II, and Adjumani, with a focus on mental health and sexual and reproductive health, ensuring safe and appropriate care for survivors of sexual and gender-based violence.

Overall, Outcome 1 was achieved to a high degree across the three intervention areas. The intervention significantly expanded access to essential healthcare, sexual and reproductive health services, mental health and psychosocial support services, referral care, and community outreach services for refugee populations in Kampala, Kyaka II, and Adjumani. Most indicators under this outcome either met or substantially exceeded their planned targets, demonstrating strong implementation performance and the ability of the intervention to respond to diverse humanitarian and public health needs across both urban and settlement settings.

The achievement of Outcome 1 was driven through a combination of facility-based healthcare support, provision of medicines and medical supplies, deployment of integrated mobile outreach teams, referral coordination systems, mental health and psychosocial support interventions, healthcare worker training, and strengthened referral and coordination mechanisms. The intervention also demonstrated contextual adaptation across operational areas. In Kyaka II and Adjumani, interventions largely focused on improving access to essential healthcare, infectious disease prevention, maternal and child health services, and settlement-based outreach systems. In Kampala, the intervention increasingly responded to the growing burden of chronic illnesses, psychosocial distress, mental health conditions, orthopedic conditions, and complex referral needs affecting urban refugee populations.

Activity 1.1. Provision of essential medicines and medical supplies tailored to the needs of the refugee population, primarily for the reduction of maternal and child mortality and clinical care for SRH and sexual violence

This activity contributed significantly to improving the accessibility, coverage, and quality of healthcare services among refugee populations through the strengthening of health facility capacity and reduction of medicine stock-outs across the three operational locations.

The intervention began with joint assessments conducted alongside Kampala Capital City Authority (KCCA) and the District Health Offices in Kyegegwa and Adjumani to identify the most prevalent diseases, priority healthcare gaps, and recurrent medicine stock-outs affecting refugee-serving health facilities. The assessments incorporated a gender-sensitive and survivor-centered approach, with specific attention to maternal health,



SRH, mental health, and care for survivors of sexual and gender-based violence. Procurement processes were conducted through competitive supplier selection procedures in accordance with procurement guidelines. Medicines and medical supplies were procured through approved suppliers including Henber Pharmacy, Tavo, Ronjo Diagnostics LTD, Pharmacy Company Limited, and Abacus Pharma Africa LTD. Distribution systems were aligned with OPM, OCHA, and UNFPA guidance, while stock management and accountability systems were reinforced within supported health facilities.

Linked Indicator: I.O.V.1.R.1.

Target 1: At least 10,600 refugees (6,500 in Kyaka II, 3,000 in Kampala, and 1,100 in Adjumani) receive medical care and medications at health centers.

Achievement: A total of 23,596 refugees received medical care and medications through supported health facilities, including 8,505 refugees in Kyaka II, 3,219 in Kampala, and 11,872 in Adjumani.

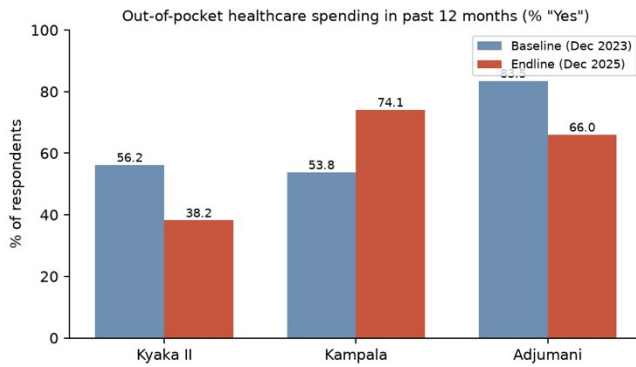
The intervention substantially exceeded its original healthcare coverage target. In Kyaka II and Adjumani, medicines primarily supported treatment of malaria, pneumonia, diarrhea, maternal and child health conditions, and infectious disease outbreaks, while also strengthening SRH and HIV-related services. In Kampala, medicine procurement increasingly responded to chronic illnesses, orthopedic conditions, and mental health-related healthcare needs among urban refugee populations.

The activity also strengthened preparedness and response capacities during public health threats including Ebola, Mpox, and Crimean-Congo Hemorrhagic Fever outbreaks through provision of sanitation materials, infection prevention supplies, and diagnostic commodities.

The intervention contributed to reducing healthcare access barriers associated with medicine stock-outs, particularly among vulnerable populations such as women, children under five, survivors of GBV, and individuals requiring chronic care support.

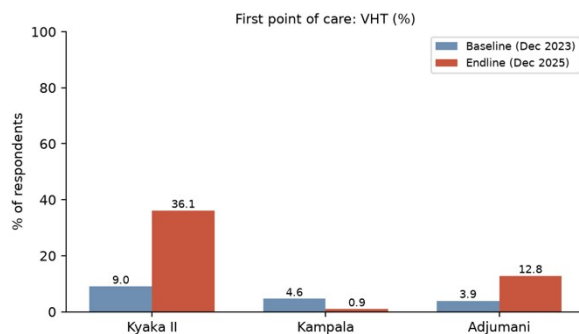
Baseline/Endline Changes





The household surveys captured tangible shifts in healthcare-seeking patterns and perceptions of medicine availability between the baseline (n=815: Kyaka II 310, Kampala 253, Adjumani 252) and endline (n=796: Kyaka II 327, Kampala 271, Adjumani 198). Reported out-of-pocket

spending on healthcare in the past 12 months fell substantially in two of the three sites — from 56.2% to 38.2% in Kyaka II and from 83.5% to 66.0% in Adjumani — consistent with the project's contribution to reducing stock-outs at supported facilities. In Kampala, however, the proportion reporting healthcare expenditure rose from 53.8% to 73.6%, reflecting the more privatised, chronic-care orientation of urban refugee healthcare needs, toward which the project's procurement was increasingly redirected. The proportion of respondents who actually received treatment when they sought care at a Government Health Centre or VHT increased in Kyaka II (94.4%→98.9%) and especially in Kampala (87.3%→100.0%), indicating improved on-the-spot availability of medicines and supplies at supported entry points. Perceived availability of medicines (5-point scale) was broadly stable in Kyaka II (3.10→3.14) but declined in Kampala (3.65→2.80) and Adjumani (3.22→2.94), reflecting growing demand and remaining gaps despite project inputs. The share who first turned to a Government Health Centre when sick declined in all three sites — most notably in Kyaka II (80.4%→48.2%) — with a corresponding rise in first-contact use of VHTs (Kyaka II 9.0%→36.1%; Adjumani 3.9%→12.8%), indicating successful task-shifting toward community-based service points strengthened by the project.



KII/FGD Perspectives

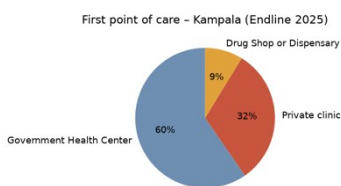
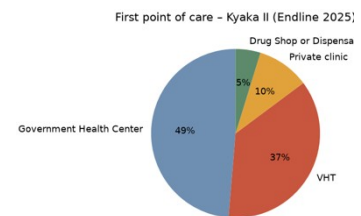
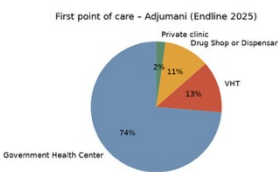
Alleviating Immediate Supply Shortfalls The qualitative evidence robustly substantiates the quantitative finding that the project successfully mitigated out-of-pocket health expenditures, specifically within settlement settings. Both healthcare providers and community members indicated that prior to the intervention's supply buffers, frequent stock-outs forced refugees to independently purchase essential drugs. However, the direct



supply of commodities by implementing partners (AHA and EMESCO) established vital safety nets. As one psychiatric nurse observed, "These medicines, like things like PrEP... are required for managing the cases. And once you have out of stock... it affects the case" (KII, Psychiatric Nurse, AHA). By filling these gaps, the project preserved healthcare access for the most vulnerable.

Urban vs Settlement Disparities in Care Seeking. Conversely, Kampala saw an increase in out-of-pocket expenditure, a reality qualitative insights attribute to the complex, chronic-care nature of urban healthcare demands compared to the primary-care focus in settlements. Urban patients frequently presented with non-communicable diseases requiring specialised, costly medications that the project's essential drug supply could not always cover. An urban respondent highlighted the frustration of receiving generic analgesics for specific maladies:

"Maybe you're having headache. They give you something that can help on that, but they don't give you the specific drug you have to take" (FGD, Men, Kampala). Similarly, a settlement commandant verified this limitation,



noting that the project provided "essential drugs... but how about other drugs for complicated sicknesses?" (KII, Settlement Commandant, OPM, Adjumani). Consequently, the capacity of VHTs as first-responders effectively absorbed routine primary care needs within communities, but urban refugees

requiring advanced morbidities management still faced considerable financial burdens.

Activity 1.2. Provision of safe medical testing at national hospitals in Kampala for refugees referred from the Kyaka II, Kampala, and Adjumani settlements

This activity strengthened access to specialized diagnostic services and referral healthcare for refugees requiring advanced medical investigations and treatment beyond the capacity of settlement-based and lower-level health facilities.

The intervention established structured referral coordination systems involving referral screening, appointment scheduling, transportation support, accommodation through medical shelters, follow-up coordination, and linkages with national referral hospitals and specialized diagnostic



facilities in Kampala. Emergency and mental health cases were prioritized through rapid referral systems, while elective referrals were managed through scheduled coordination mechanisms involving settlement partners and referral coordinators. The intervention also supported transportation, accommodation, and continuity of care for patients requiring prolonged follow-up and specialist review services. Referral systems were strengthened through coordination between AHA, settlement partners, referral hospitals, AIRD, and specialized laboratories.

Linked Indicator: I.O.V.2.R.1.

Target: At least 1,500 refugees referred for safe medical testing, analysis, and diagnosis at national referral hospitals in Kampala.

Achievement: A total of 1,780 refugees received referral support for specialized medical testing and diagnosis, of whom approximately 59% were women and children under five.

The project exceeded the planned referral target and significantly strengthened access to specialized healthcare for refugees across Uganda. While referrals originated from Kyaka II, Kampala, and Adjumani, the intervention also supported refugees from other settlements, including Rwamwanja, Palorinya, Kyangwali, and Nakivale. The largest proportion of referral cases involved cancer-related conditions (468 cases), musculoskeletal disorders (393 cases), cardiovascular conditions (203 cases), neurological disorders (142 cases), nephrology and urological conditions (104 cases), and gastrointestinal conditions (99 cases). These findings highlighted the growing burden of chronic illnesses, complex medical conditions, and specialized healthcare needs among refugee populations.

Geographical variations were evident across operational areas. In settlement contexts such as Kyaka II and Adjumani, referrals were frequently linked to limited specialist availability and gaps in diagnostic capacity at local health facilities. In Kampala, referral systems increasingly responded to complex urban refugee healthcare needs, including chronic diseases, orthopedic injuries, mental health conditions, and advanced diagnostic requirements. The activity also contributed to improved efficiency within the referral system through strengthened verification mechanisms, increased use of lower-level facilities where appropriate, and the introduction of reverse referral approaches involving specialist outreach to settlements.

Baseline/Endline Changes



Endline data show measurable progress in access to clinicians, particularly in Adjumani where the proportion of respondents reporting difficulties accessing a doctor or clinical professional in the past 12 months fell from 42.7% to 30.9%. In Kyaka II and Kampala the indicator remained essentially flat (34.3%→39.3% and 42.3%→44.7% respectively), consistent with persistent specialist gaps that the referral pathway is designed to address rather than eliminate at local level. Mean ratings for inpatient services, triage and ambulance services were collected on Likert scales in both rounds, but the most actionable shift is the strong endline endorsement of referral-style support: when combined with the project's monitoring data on 1,780 specialised referrals (target 1,500), the survey evidence supports the conclusion that referral support partially compensated for unresolved specialist shortages at the primary level, especially in Adjumani.

KII/FGD Perspectives

Bridging Diagnostic Gaps Through Coordination The establishment of a structured referral mechanism addressed a critical void in refugee health infrastructure. Stakeholders noted that prior to the intervention, refugees requiring advanced diagnostics, surgeries, or cancer care faced immense logistical and financial barriers. The project's facilitation of safe transport, accommodation, and procedural appointments at national facilities directly contributed to the overachievement of referral targets. A medical hostel run by AHA was frequently cited as a crucial halfway point for rural refugees undertaking treatment in Kampala. One community member recalled, *"They were in Kampala for four months. They were being taken care of by AHA and they were in Mulago Hospital"* (FGD, Women Survivors, Kyaka II).

Persisting Urban Navigation and Systems Challenges: Despite marked improvements, qualitative accounts reveal that tracking and closing the referral loop remain significant hurdles. Incomplete paperwork and staffing rotations at receiving hospitals frequently disrupted the feedback cascade required for comprehensive case management. Furthermore, recent funding constraints have threatened the sustainability of urban referral coordination, leaving local health workers struggling. A clinical officer lamented the breakdown of the pathway, stating, *"Right now, the referral pathway is quite a big issue... we don't have a support system that is helping us"* (KII, Clinical Officer, MTI, Kyaka II). Thus, while the intervention effectively bypassed local specialist deficits momentarily, long-term sustainability demands deeper institutional embedding.

Activity 1.3. Training of health personnel in the prevention of communicable diseases and in maternal-child and SRH care, ensuring safe and appropriate care for survivors of sexual and gender-based violence (including mental health)



This activity aimed to strengthen the technical capacity of healthcare workers to provide quality, gender-sensitive, rights-based, and culturally appropriate healthcare services for refugee populations across the three operational areas.

Training activities targeted healthcare workers from public health facilities, refugee-serving private facilities, referral centers, and community health systems. The trainings addressed maternal and child health, infectious disease prevention, mental health management, SRH services, GBV case management, prenatal and postnatal care, breast and cervical cancer screening, survivor-centered response, and referral coordination systems.

Participatory methodologies including simulations, case studies, discussions, group work, role plays, and practical demonstrations were used to strengthen both technical competencies and applied clinical skills.

Linked Indicator: I.O.V.3.R.1.

Target 1: 75% of 60 healthcare professionals participate in specialized training courses and apply the knowledge acquired.

Achievement: A total of 241 healthcare professionals participated in specialized training activities, with post-training assessments demonstrating significant improvement in technical knowledge and competencies. (average post-test score all increased)

The intervention substantially exceeded its original healthcare worker training target. Training coverage expanded far beyond initial projections due to high demand and identified capacity gaps across health facilities serving refugee populations.

In Kampala, trainings focused strongly on urban refugee healthcare challenges, including prenatal and postnatal care, family planning, cancer screening, GBV case management, and survivor-centered care approaches. In Kyaka II, the focus was more strongly linked to infectious disease prevention, maternal-child health, and settlement-specific healthcare challenges. In Adjumani, trainings emphasized epidemic preparedness, infection prevention and control, mental health screening, and clinical management of GBV cases, including coordination with police and protection actors.

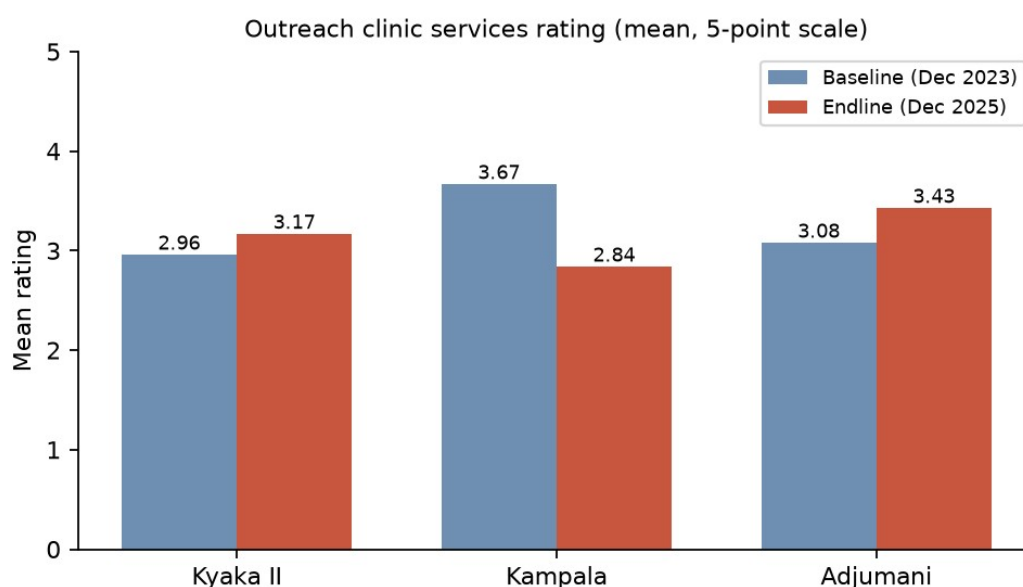
Pre- and post-training assessments consistently demonstrated strong improvements in technical knowledge across all training themes and operational areas. The trainings also strengthened coordination between healthcare providers, protection actors, police, referral systems, and community structures.



Despite these achievements, high staff turnover within health facilities remained a significant challenge affecting continuity of institutional capacity. Participants also identified the need for ongoing refresher training, mentorship, and increased availability of clinical tools, referral materials, and medical supplies.

Baseline/Endline Changes

Community-level perceptions of provider behaviour — a proxy for the quality dimensions targeted by the training package — showed mixed but generally positive movement. The frequency with which providers reportedly asked for patients' opinions/beliefs about their care improved in Kyaka II (mean 2.84→3.28 on a 5-point scale) and Kampala (3.27→3.48), while remaining stable in Adjumani (3.22→3.19). Use of interpreters to understand patients' healthcare needs improved in Kampala (85.5%→94.0%) but declined in Kyaka II (76.8%→54.1%) and Adjumani (91.5%→85.6%), pointing to language-mediation gaps that persist despite training. Likert-scale ratings of counselling, family planning, maternal and VHT services were generally above 3.5/5 at endline in Kampala and Adjumani, with Kyaka II somewhat lower — consistent with the training emphasis (urban GBV management/cancer screening in Kampala; epidemic preparedness and GBV clinical management in Adjumani) and underscoring continued exposure of newly-deployed staff in Kyaka II to staff turnover-related quality dips.



KII/FGD Perspectives

Enhanced Clinical Confidence and Competence The qualitative data aligns with the reported knowledge improvements following the specialised training initiatives. Health personnel and implementing partners



highlighted that the capacity building empowered staff to confidently manage sensitive issues, particularly clinical responses to GBV. Prior to the intervention, many facilities lacked the specialised personnel needed to conduct forensic examinations or administer immediate post-rape care. Following training, the number of capable responders surged noticeably. One GBV focal person recalled, "*Before, we had about six health workers who were competently... but after last year's training, our number went up to about 12*" (KII, GBV Officer MTI, Kyaka II).

Persistent Communication and Systems Barriers While clinical competencies improved, the survey's mixed findings regarding provider behaviour are echoed in the transcript narratives. The application of survivor-centred care remains partially hindered by systemic deficits, primarily staff turnover and linguistic barriers. Respondents stressed that quality care hinges on clear communication, yet many facilities still grapple with interpreter shortages, leading to compromised patient experiences. "*We need more interpreters... we have a shortage of them,*" admitted a psychiatric nurse (KII, Psychiatric Nurse, AHA). Similarly, high fatigue among the limited remaining staff occasionally resulted in adverse patient encounters, indicating that while training is efficacious, it is frequently offset by resource strain and language disconnects.

Activity 1.4. Dissemination of the healthcare protocol and standard operating procedures among healthcare personnel from the perspective of integrating the components of acceptability, gender, and human rights into clinical practice

This activity strengthened understanding and implementation of referral standard operating procedures (SOPs) and coordination mechanisms among health, protection, and referral actors across Kampala, Kyaka II, and Adjumani.

The intervention responded to increasing pressure on referral systems caused by inappropriate referrals, limited understanding of referral criteria, weak coordination, and growing demand for specialized services. Participatory dissemination and coordination meetings were conducted involving healthcare workers, district authorities, UNHCR, OPM, referral hospitals, and implementing partners.

Linked Indicator: I.O.V.3.R.1.

Target: Dissemination of one protocol for action among healthcare staff.

Achievement: One referral protocol and associated standard operating procedures were disseminated and operationalized among healthcare stakeholders across the three operational areas.

A total of 42 stakeholders participated in dissemination sessions in Kampala, 44 in Kyaka II, and 20 in Adjumani. The activity strengthened shared understanding regarding referral criteria, documentation requirements, coordination responsibilities, and survivor-centered referral pathways.

The intervention also facilitated identification of key referral bottlenecks including shortages of specialists, transportation barriers, supply limitations, and weaknesses in health information systems. Discussions generated recommendations to strengthen referral coordination, improve prioritization processes, and reinforce monitoring systems.

The activity contributed to improving coordination, standardization, accountability, and efficiency within refugee referral systems while reinforcing principles of dignity, gender sensitivity, human rights, and equitable healthcare access.

Baseline/Endline Changes

Awareness of protocol-related coordination practices was used as a community-level proxy for SOP dissemination. Reported agency engagement with community leadership on cultural appropriateness of services improved strongly in Kampala (73.8%→89.8%) but declined in Kyaka II (77.0%→53.1%) and Adjumani (87.4%→72.0%), suggesting that protocol dissemination translated more visibly into urban coordination structures than settlement-level routine practice. Reported attendance at post-distribution meetings about medicines supplied to the community declined across all sites (Kyaka II 56.2%→44.6%; Kampala 57.8%→22.7%; Adjumani 67.5%→63.5%), indicating that, although the referral SOP was operationalised among 106 stakeholders across the three sites, downstream community feedback loops on supply chains weakened — a gap the evaluation flags for the sustainability plan.

KII/FGD Perspectives

Strengthened Inter-Agency Synergy The dissemination of standard operating procedures (SOPs) successfully fostered improved coherence among stakeholders. KIIs across all sites confirmed that grounding healthcare, legal, and psychosocial services within integrated protocols fundamentally enhanced service delivery. Implementing partners indicated that formalised coordination meetings dismantled previous silos, facilitating smoother intra-agency referrals. By aligning on survivor-centred protocols, local organisations established a clearer chain of custody for GBV cases. *"At the end of it all, we are able to compile the information and also disseminate... for though maybe there was a complaint to your organization, there and then you get the question"* (KII, GBV Officer MTI, Kyaka II).



Translating Policy into Community Practice However, while institutional coordination surged, translating these SOPs into tangible grassroots knowledge encountered obstacles. Community-level understanding of referral pathways, particularly regarding medical supply chains, appeared to wane, validating the survey's recorded decline in post-distribution accountability. Local leaders noted that while upper-level protocols were robust, downstream feedback mechanisms requiring community members to understand these SOPs were occasionally lacking. A public health officer stressed the need to contextualize protocol dissemination: "*You have to collaborate with your partner, with the IP... and then, since we are operating partners now, you have to coordinate with the lead IP in health*" (KII, Public Health Officer, EMESCO, Adjumani). Ultimately, while institutional harmonisation succeeded, deeper community integration of these protocols remains an ongoing requirement.

Activity 1.5. Coordination of mobile health teams to bring health and mental health services closer to the refugee population in the settlements of Kampala, Kyaka II, and Adjumani

This activity became one of the most important service delivery mechanisms under Outcome 1, significantly expanding healthcare access among geographically isolated, underserved, and highly vulnerable refugee populations.

The mobile outreach teams operated through close coordination with district authorities, health facilities, community leaders, VHTs, refugee structures, and partner organizations. The teams addressed major barriers related to distance, transportation costs, overcrowded facilities, health facility closures, linguistic barriers, and limited specialized services.

Linked Indicator: I.O.V.1.R.1.

Target 2: 19,200 people served by 240 deployed mobile health teams.

Achievement: A total of 24,115 people were reached through 243 integrated mobile health teams deployed across Kampala, Kyaka II, and Adjumani.

The intervention exceeded both outreach and coverage targets. In Kampala, 83 mobile outreach teams reached 7,615 individuals. In Kyaka II, 80 outreach teams reached 7,992 individuals, while in Adjumani, 80 outreach teams reached 8,508 individuals.

Services delivered included SRH services, antenatal care, immunization, STI screening, HIV testing, malaria testing, family planning, nutritional screening, health education, disease prevention, counseling, chronic disease management, and referrals for specialized services.

Geographical distinctions strongly shaped implementation priorities. In Kyaka II and Adjumani, outreach activities primarily addressed infectious disease prevention, maternal-child health, immunization, and settlement access barriers. In Kampala, the mobile teams increasingly responded to fragmented urban healthcare access systems, chronic illnesses, and growing psychosocial and mental health needs.

The outreach activities also strengthened community engagement, health promotion, disease prevention, and early case identification while reinforcing referral pathways and linkages between communities and healthcare systems.

Baseline/Endline Changes

Community-level indicators of outreach exposure improved in Adjumani — VHT/health-worker education on diarrhoea prevention rose from 74.3% to 88.3%, and ratings of outreach clinics improved from 3.08 to 3.43 — confirming the strong settlement-level traction of the 80 mobile teams deployed there. In Kyaka II the headline outreach rating also improved (2.96→3.17), although malaria-prevention sensitisation reported by households fell (76.0%→57.8%), reflecting the dispersed geography of the settlement and shifting outreach priorities during outbreak responses. Kampala showed declining household-level rating of outreach (3.67→2.85) even though absolute coverage (7,615 people reached) was strong: this is consistent with the more fragmented urban operating environment, where mobile teams reach individuals who are less likely to recognise outreach as a structured service. Across the three sites, the 24,115 people reached by 243 mobile teams clearly exceeded the 19,200/240 target.

KII/FGD Perspectives

Decentralising Care in Settlement Geographies The mobile health teams were overwhelmingly identified as a transformative success, particularly in geographically expansive settlements like Adjumani and Kyaka II. By deploying medical and psychosocial support directly to distant communities, the project bypassed major structural barriers, including transport costs and physical immobility. Transcripts reveal that community members highly valued these outreaches, frequently treating them as standalone health centres. "*When we go, those communities take it as a health centre. So the turn up is very enormous*" (KII, Public Health Officer, EMESCO, Adjumani). These brigades simultaneously lightened the burden on primary facilities, improving wait times and easing health-system congestion.

Navigating Urban Fragmentation Challenges. Conversely, deploying mobile teams within Kampala yielded high numerical reach but diluted community-level recognition, aligning with the survey's declining outreach ratings for



the urban site. The dispersed nature of urban refugees complicates the visibility of structured interventions. However, the teams functionally served their purpose by identifying individuals unable to navigate the national health system. Health workers noted that while urban outreach is logistically challenging, it remains vital for capturing vulnerable sub-groups who miss formal facility care. *"We have clusters whereby we know that maybe in Nsambya, we have so many Congolese... So we ensure we take services closer to them"* (KII, MEAL Officer, AHA, Kampala). The strategy succeeded in volume but inherently struggled with public visibility in urban sprawl.

Activity 1.6. Psychological therapy sessions to address the mental health and psychosocial needs of the population in situations of prolonged displacement

This activity significantly strengthened access to mental health and psychosocial support services for refugee populations experiencing trauma, psychosocial distress, anxiety, depression, prolonged stress, and social isolation associated with displacement and humanitarian vulnerability.

The intervention utilized group interpersonal therapy, psychosocial support groups, counseling, psychoeducation, community follow-up, and referrals to specialized psychiatric services. Sessions emphasized trauma-informed care, dignity, confidentiality, resilience building, coping mechanisms, and strengthening of social support systems.

Linked Indicator: I.O.V.4.R.1.

Target 1: 320 people served through at least 60 psychosocial therapy sessions.

Achievement: A total of 1,129 people participated in 240 psychosocial therapy sessions across the three operational areas.

Linked Indicator: I.O.V.4.R.1.

Target 2: 1,800 refugees access SMAPS services through 240 mobile teams.

Achievement: A total of 6,279 refugees accessed mental health and psychosocial support services through 279 mobile mental health outreach teams.

The intervention substantially exceeded planned targets for both therapy participation and outreach coverage, reflecting the very high burden of unmet mental health and psychosocial support needs among refugee populations.

In Kampala, mental health activities increasingly focused on trauma, depression, anxiety, psychosocial distress, and severe mental health conditions among urban refugees. In Kyaka II and Adjumani, activities



focused more strongly on psychosocial support, community-based screening, trauma recovery, psychoeducation, and strengthening coping mechanisms within settlement communities.

The intervention also strengthened referral systems for severe mental health conditions requiring specialized psychiatric care, including referrals to Butabika National Referral Hospital and enrollment into ongoing psychosocial support systems.

Despite significant achievements, barriers such as stigma, language differences, transportation challenges, economic vulnerability, and competing livelihood responsibilities continued to affect regular participation in some settings. Nevertheless, the intervention substantially improved access to mental health services, reduced stigma surrounding psychosocial support, strengthened community awareness, and reinforced continuity of care for vulnerable refugee populations.

Baseline/Endline Changes

MHPSS is the area in which the survey data show the strongest and most consistent improvement. The composite question on access to quality MHPSS through psychosocial therapy and mobile teams rose from 2.94 to 3.17 in Kyaka II, from 2.76 to 3.49 in Adjumani, and only marginally declined in Kampala (3.80→3.66, from an already high baseline). Ratings of mental health services improved from 3.24 to 4.14 in Adjumani and were essentially stable at high levels in Kyaka II (3.75→3.78) and Kampala (4.41→4.13). General "mental health support" ratings improved in Kyaka II (3.08→3.21) and Adjumani (2.87→3.34). Combined with the project's reach of 6,279 refugees through 279 mobile mental health teams and 1,129 participants in 240 therapy sessions (against targets of 1,800/240 teams and 320/60 sessions respectively), these gains substantiate one of the clearest demonstrable behavioural and perceptual changes attributable to the intervention.

KII/FGD Perspectives

De-stigmatising Mental Health Interventions The qualitative evidence underscores mental health and psychosocial support (MHPSS) as one of the intervention's most profoundly appreciated success stories. MHPSS therapies introduced novel coping mechanisms to populations burdened by immense displacement trauma, severe economic distress, and compounding reductions in food rations. Stakeholders observed that group therapies (IPTG) provided communal solace, demonstrating to participants that they were not suffering in isolation. A psychiatric nurse reflected on this shift: "*The one who thinks he's the only one person to do it will get hope... 'Oh, I'm not*



alone" (KII, Psychiatric Nurse, AHA). This communal solidarity effectively eroded long-standing cultural stigmas attached to mental distress.

Coping with Structural Displacement Stressors The extraordinary demand for SMAPS mobile teams correlates strongly with external shocks affecting the refugee population, particularly acute subsistence challenges. While the therapy sessions vastly improved emotional resilience, HCWs noted that physiological stability was frequently undermined by practical realities like food insecurity. Nevertheless, the therapies fundamentally shifted community mindsets from reactive despair to proactive resilience. "They were able to share... what others were going through and even some even came up with solutions on how to overcome some of these concerns" (KII, SRHR Officer, Makasi, Kampala). This community-level emotional fortification validates the steep rise in MHPSS access ratings logged during the endline surveys.

Outcome 2: Community capacities strengthened to reduce inequalities in access to and use of health resources, improve comprehensive care for refugee women who are survivors of sexual and gender-based violence, and promote a life free from violence.

Overall, Outcome 2 was achieved to a high degree across Kampala, Kyaka II, and Adjumani. The intervention significantly strengthened community-level prevention, awareness, referral, mediation, psychosocial support, and survivor assistance systems related to sexual and gender-based violence (SGBV), sexual and reproductive health (SRH), gender equality, and community health promotion. Most indicators under this outcome either achieved or exceeded their planned targets, demonstrating strong community engagement and expansion of localized protection and support systems within both settlement and urban refugee contexts.

The achievement of Outcome 2 was supported through integrated community mobilization approaches involving community leaders, Village Health Teams (VHTs), refugee-led structures, community committees, local leaders, and institutional actors. The intervention combined capacity strengthening, awareness-raising, survivor-centered psychosocial and legal support, community dialogue mechanisms, and distribution of dignity and hygiene materials to address both immediate vulnerabilities and structural barriers affecting refugee populations, particularly women and girls.

Activity 2.1. Training of community leaders in awareness-raising techniques to promote gender equality and mechanisms for the prevention, detection, and mitigation of sexual and gender-based violence

This activity strengthened the capacity of community leaders and community structures to serve as frontline actors in the prevention,

identification, mediation, referral, and response to sexual and gender-based violence within refugee communities.

Training sessions were conducted across Kampala, Kyaka II, and Adjumani targeting community health workers, VHTs, GBV committee members, refugee leaders, and representatives of refugee-led organizations. The trainings focused on gender equality, human rights, survivor-centered response, referral pathways, awareness-raising techniques, conflict mediation, PSEA, community mobilization approaches, communication strategies, and prevention of violence against women and girls. Participatory methodologies, including simulations, discussions, group exercises, role plays, and case studies, were used to strengthen the practical application of knowledge within community settings.

Linked Indicator: I.O.V.1.R.2.

Target 1: At least 80% of 60 community leaders participating in training modules demonstrate knowledge on prevention, mediation, and referral of cases of violence against women and GBV.

Achievement: A total of 62 community leaders participated in training activities, of whom 57.5% were women, with post-training assessments demonstrating significant improvement in knowledge related to prevention, mediation, referral pathways, and survivor-centered approaches.

The intervention exceeded the planned target for community leader participation while strengthening localized community prevention and referral systems across the three operational areas.

In Adjumani, the training emphasized prevention of gender inequality, human rights violations, and alternative dispute resolution within settlement communities. In Kyaka II, the training strongly focused on awareness-raising methodologies, communication techniques, community campaigns, and the role of VHTs and local structures in GBV prevention and health promotion. In Kampala, the training adopted a more technical and inter-agency orientation emphasizing SASA! methodologies, PSEA, urban referral systems, and survivor-centered coordination within complex urban refugee settings.

Pre- and post-test assessments demonstrated substantial improvements in participant knowledge across all operational areas. Participants also positively rated the relevance and applicability of the training content within their community engagement roles.

The activity contributed to strengthening early identification and referral of GBV cases, improving community awareness, reinforcing local leadership



capacities, and promoting gradual shifts in harmful social norms linked to gender inequality and violence.

Baseline/Endline Changes

The most striking baseline-to-endline shift across the entire dataset is the increase in reported participation in AHA/EMESCO awareness-raising and training activities in Adjumani — from 18.5% at baseline to 75.1% at endline (+56.6 pp). Kampala also recorded a sharp gain (62.2%→77.3%), while Kyaka II declined modestly (68.2%→58.5%). Community awareness of GBV-prevention programmes rose substantially in Kampala (46.3%→65.5%) and Adjumani (52.9%→66.8%) but fell in Kyaka II (63.6%→36.0%), consistent with high baseline saturation in Kyaka II combined with respondent rotation between rounds. Taken with the 62 community leaders trained (57.5% women) and the post-training knowledge gains documented in monitoring data, the survey evidence demonstrates substantial community-level diffusion of GBV-prevention knowledge, especially in Adjumani.

KII/FGD Perspectives

Empowering Frontline Local Leadership: The strategy of equipping community leaders, RWCs, and VHTs with comprehensive knowledge of GBV prevention and response yielded significant structural dividends. Qualitative data extensively confirms that anchoring these training modules within existing community hierarchies ensured cultural appropriateness and facilitated wider dissemination. In Adjumani, where engagement metrics surged, trained leaders became the primary conduits for conflict mediation and first-response crisis management. Transcripts reveal a grassroots appreciation for interventions that bestowed permanent proficiencies over temporary material aid. One survivor noted, "*When somebody has given you a skill, it is more better than giving money... The little knowledge they have empowered us, we shall not forget*" (FGD, Women Survivors, Adjumani).

Sustaining Knowledge Amid Volunteer Turnover: While knowledge acquisition was universally commended, sustaining these leadership structures proved challenging. In Kyaka II and Kampala, the dip in visible community awareness often correlated with volunteer fatigue and staff rotation. Implementing partners noted that despite intensive capacity-building, leaders operating without stipends or sustained logistical support struggled to continuously enact their training. "*Before they were only depending to their men... [the training was] empowering them to be self-resilient*" (FGD, VHTs, Kyaka II). Thus, while the training successfully shifted foundational attitudes towards gender equality and violence prevention, the long-term operational viability of these community leaders remains vulnerable to economic attrition.

Activity 2.2. Awareness-raising and advocacy actions to promote SRH, gender equality, and the prevention of violence

This activity became one of the largest community engagement components under Outcome 2, significantly expanding access to information on health rights, sexual and reproductive health, gender equality, GBV prevention, referral pathways, mental health, communicable disease prevention, and available support services.

Awareness-raising activities were implemented through community dialogues, group sensitization sessions, door-to-door outreach, public awareness campaigns, and engagement within churches, schools, water points, markets, community gatherings, and refugee settlements. Community leaders, VHTs, refugee committees, and community structures played central roles in mobilization and message dissemination.

Linked Indicator: I.O.V.2.R.2.

Target: 20,000 people reached through information sessions led by community leaders on health promotion, SRH, gender equality, and prevention and response services for survivors of SGBV.

Achievement: A total of 22,660 people were reached through awareness-raising and sensitization activities, including 12,183 people in Kyaka II, 5,657 people in Kampala, and 4,820 people in Adjumani.

The intervention exceeded its planned awareness-raising target and significantly strengthened community knowledge regarding health promotion, SRH, gender equality, mental health, communicable disease prevention, survivor rights, and referral systems.

In Adjumani, sensitization activities strongly emphasized communicable disease prevention, immunization, maternal and child health, outbreak preparedness, and GBV prevention within settlement settings. In Kyaka II, awareness sessions heavily focused on refugee rights, SRH, gender equality, prevention of violence, referral pathways, and disease prevention in geographically dispersed communities. In Kampala, activities increasingly addressed mental health, urban GBV risks, family planning, psychosocial distress, and access barriers affecting urban refugee populations.

The intervention also contributed to reducing stigma surrounding GBV and mental health while strengthening awareness regarding available support systems and referral mechanisms. Door-to-door sessions proved particularly important in Kampala where mobility, language barriers, and fragmented urban settlement patterns often limited participation in group activities.



Despite these achievements, sociocultural norms, fear of reporting violence, economic vulnerability, language barriers, and seasonal disruptions continued to affect community participation and uptake of some services.

Baseline/Endline Changes

Self-reported awareness of generic health-rights concepts fell in Kyaka II and Kampala across most indicators (e.g., awareness of the right to highest attainable standard of health 76.0%→49.5% in Kyaka II and 83.1%→67.7% in Kampala) but was sustained or improved in Adjumani (knowledge of specific health-rights services 78.3%→85.3%; familiarity with national health-rights laws 66.3%→78.7%). This pattern reflects the project's measurable success in penetrating Adjumani's previously lower-engagement settlement, while the declines in Kyaka II and Kampala are best read as a tightening of respondent interpretation: at endline, surveyed respondents differentiated between general awareness of rights and concrete knowledge of services, an interpretation reinforced by stronger ratings on subsequent confidence questions in Adjumani (3.39→3.61). The 22,660 people reached against the 20,000 target underpins the breadth of the awareness-raising effort.

KII/FGD Perspectives

Shifting Socio-Cultural Norms Through Outreach: The mass awareness-raising campaigns generated palpable behavioural shifts regarding health rights, sexual and reproductive health (SRH), and GBV. Transcripts demonstrate that extensive door-to-door and public sensitization demystified traditionally taboo subjects. In conservative demographic subsets, continuous dialogue gradually dismantled religious and cultural aversions to family planning and GBV reporting. A Kampala-based SRHR officer highlighted the breakthrough achieved through persistent engagement: *"We've broken the barrier of the misconceptions that are based on religion and culture of not using a condom"* (KII, SRHR Officer, Kampala). By normalising discussions around bodily autonomy and preventive health, the project drove increased proactive health-seeking behaviour.

Nuanced Reception of Health Rights Messaging: While absolute reach targets were surpassed, the endline survey's recorded drop in generic 'health-rights interpretations' in Kampala and Kyaka II reflects a maturing, critical community lens rather than a failure of messaging. Transcripts suggest that as awareness improved, participants transitioned from abstract understandings of human rights to focused demands for concrete service delivery. *"Now they know the disadvantages... they will pass it on as knowledge to even generations"* (KII, Community Facilitator, AHA, Kyaka II). The awareness



campaigns successfully evolved community perspectives from passive reception to an engaged pursuit of actionable, tangible health liberties.

Activity 2.3. Implementation by the community network of actions to promote the right to health and prevention of GBV through community committees and local structures

This activity strengthened community-based prevention, mediation, referral, and response systems through the creation and operationalization of community committees focused on sexual and gender-based violence prevention and protection.

The intervention established and strengthened community committees across Kampala, Kyaka II, and Adjumani in close coordination with local authorities, refugee structures, VHTs, GBV committees, OPM, UNHCR, and community leaders. The committees served as localized mechanisms for awareness-raising, mediation, case identification, referrals, and community engagement.

Linked Indicator: I.O.V.1.R.2.

Target 2: Six community committees established with operational work plans for prevention and response to violence against women.

Achievement: Eight community committees were established and operationalized across the three intervention areas, including four committees in Adjumani, two in Kampala, and two in Kyaka II. The intervention exceeded its original target for the establishment of community committees while strengthening local ownership and sustainability of prevention and referral systems.

In Kampala, the committees reflected strong nationality diversity, including members from DRC, South Sudan, Somalia, Sudan, Burundi, Rwanda, Yemen, and Uganda, helping strengthen representation and outreach within urban refugee communities. In Kyaka II, the committees worked closely with VHTs, GBV committees, and local leaders to strengthen awareness, mediation, and referral activities within settlement communities. In Adjumani, the committees became active structures supporting case identification, community sensitization, referrals, and mediation within the settlements of Agojo, Elema, Olijji, and Alere.

The committees conducted community awareness sessions, provided referrals to health and protection services, facilitated mediation, followed up on vulnerable cases, and promoted peaceful coexistence and gender equality. The activity strengthened community participation, localized ownership, and community-based response systems while improving linkage between refugee populations and institutional actors.



However, some challenges persisted, including voluntary participation fatigue, limited IEC materials in local languages, variable community visibility of committee structures, and continued sociocultural barriers affecting the reporting of violence.

Baseline/Endline Changes

Awareness of GBV mediation services available in the community improved significantly in Adjumani (53.0%→62.9%) — the site where four new committees were established — but declined in Kyaka II (68.2%→37.5%) and Kampala (59.0%→43.5%). Community-Awareness-Programmes ratings on a 5-point scale strengthened in Kampala (4.43→4.61) and Adjumani (4.47→4.66) while dipping in Kyaka II (4.41→3.84). The net pattern is consistent with the documented committee distribution (4 Adjumani, 2 Kampala, 2 Kyaka II — 8 total against a 6-committee target): Adjumani gained the most relative visibility, Kampala consolidated quality perceptions among urban refugees, and Kyaka II's dispersed geography continued to constrain committee visibility despite operational activity.

KII/FGD Perspectives

Legitimising Localised Protection Structures The qualitative data robustly validates the success of embedding protection responses within community-led committees. By operationalising eight committees across the three sites, the intervention decentralised GBV prevention, offering culturally contextualised mediation and referral spaces. Participants stressed that having immediate, familiar point-persons drastically lowered the barrier to reporting abuse. An implementing partner explained the foundational importance of this localisation: "*Without the structures, even if you have resources... your activities will be abandoned*" (KII, SRHR Officer, Kampala). In Adjumani, where four committees were established, the community reported unparalleled confidence in their capacity to handle domestic flare-ups internally before escalating to clinical or legal authorities.

Navigating Operational Geographies Conversely, the data substantiates why Kyaka II and Kampala experienced dips in the broader visibility of these mechanisms. The sheer geographical spread of Kyaka II and the transient, dispersed nature of urban refugees in Kampala hindered uniform recognition of these committees. Despite high operational success behind the scenes, ensuring a public footprint for these groups proved difficult amid vast settlement layouts and fragmented urban spaces. As an Adjumani paralegal officer affirmed, "*We involve them throughout... from the beginning up to the end*" (KII, Paralegal Officer, EMESCO, Adjumani). This deep involvement anchored the committees securely where geographic proximity permitted, establishing an excellent preventative framework.



Activity 2.4. Care and support for refugee women who are survivors of sexual and gender-based violence to facilitate psychosocial recovery and restoration of rights

This activity significantly strengthened comprehensive psychosocial, legal, and protection support systems for refugee women survivors of sexual and gender-based violence across the three operational areas.

The intervention adopted a survivor-centered, trauma-informed, and human rights-based approach emphasizing confidentiality, dignity, informed consent, safety, and restoration of rights. Support services included individual counseling, group therapy, legal assistance, referrals, psychosocial follow-up, court accompaniment, mediation where appropriate, and linkage to healthcare and protection services.

Linked Indicator: I.O.V.4.R.2.

Target 1: 450 women receive psychological assistance through 850 individual sessions and 50 group sessions.

Achievement: A total of 1,443 women received psychological support services through 814 individual counseling sessions and 120 group therapy sessions across Kampala, Kyaka II, and Adjumani. The intervention substantially exceeded the planned target for psychosocial support coverage. Kyaka II recorded the largest number of women reached, followed by Kampala and Adjumani. Group interpersonal therapy, psychosocial support groups, counseling sessions, and community follow-up mechanisms strengthened emotional recovery, coping mechanisms, resilience, and social support systems among survivors.

Linked Indicator: I.O.V.4.R.2.

Target 2: 90 women receive legal assistance.

Achievement: A total of 144 survivors received legal support and assistance services.

Legal support included complaint filing assistance, accompaniment during judicial and police processes, legal counseling, referrals for medical examinations, mediation support where appropriate, and court follow-up processes.

In Kampala, legal support systems were especially intensive due to the complexity of urban GBV cases, including court representation and case follow-up until sentencing in some cases. In settlement settings such as Kyaka II and Adjumani, interventions combined formal referral pathways with community mediation approaches depending on case severity and survivor preferences.



Linked Indicator: I.O.V.4.R.2.

Target 3: 75% of surveyed women positively evaluate the quality and relevance of psychosocial and legal services.

Achievement: Reported satisfaction levels among surveyed survivors reached 100% positivity according to available project reporting, although final surveys remained pending at the time of reporting completion. The intervention significantly strengthened access to survivor-centered support systems while contributing to improved psychosocial well-being, restoration of dignity, increased reporting of cases, and stronger referral pathways for women survivors of violence.

Despite these achievements, stigma, fear of retaliation, delayed reporting, economic dependency, and limited availability of safe shelters remained important barriers affecting some survivors.

Baseline/Endline Changes

Endline ratings of survivor-support services suggest broadly maintained but uneven service quality. In Adjumani, ratings of counselling and therapy rose (4.02→4.28), GBV-mediator accessibility improved (4.12→4.41), and dignity-kit ratings rose sharply (2.88→4.18) — pointing to a strong consolidation of the survivor-centred package in that settlement. In Kampala, ratings of counselling and therapy remained very high (4.71→4.84) and legal assistance stayed strong (4.48→4.42), consistent with the documented intensity of urban legal support work. In Kyaka II, ratings declined on several sub-indicators (counselling 4.22→3.95; mediator accessibility 4.30→3.52; mediation outcome satisfaction 3.48→2.89), suggesting that demand exceeded the available survivor-care footprint there. Combined with the 1,443 women supported (target 450) and 144 women receiving legal assistance (target 90), the evidence supports substantial coverage gains alongside differentiated quality challenges in Kyaka II.

KII/FGD Perspectives

Restoring Survivor Dignity and Autonomy The integration of psychosocial and legal services fundamentally altered the post-violence trajectory for SGBV survivors. Qualitative interactions uniformly praise the survivor-centred approach, which meticulously combined medical triage, individual therapy, police liaison, and court advocacy. The trauma-informed methodology actively restored agency to women isolated by abuse and societal stigma. Survivors articulated profound relief at the holistic accompaniment they received, which often shielded them from secondary victimisation by local authorities. A community member poignantly stated, "*From the time I came to*



you and I told you my problem, and up to now, I'm feeling better because of the counselling" (FGD, Women Survivors, Adjumani).

Comprehensive and Customised Case Management The differing operational nuances between urban and settlement environments necessitated highly tailored case management. In Kampala, securing legal recourse required intensive navigation of complex, backlogged urban police and judicial systems. Conversely, in settlements like Kyaka II, mediators often had to balance formal legal pathways with robust community-level conflict mediation due to service rationing. *"They are now able to come directly to us... they know how to preserve evidence,"* highlighted a legal caseworker (*KII, Legal Caseworker, NRC*). Achieving total satisfaction rates demonstrates that managing cases holistically—addressing the mental, bodily, and legal aftermath simultaneously—creates an indispensable safety net for women navigating the aftermath of extreme vulnerability.

Activity 2.5. Distribution of basic personal and menstrual hygiene items and mosquito nets to vulnerable displaced households to strengthen community health

This activity helped reduce public health and protection vulnerabilities among refugee households by distributing hygiene kits, dignity kits, and mosquito nets tailored to the specific needs of vulnerable populations.

Distributions prioritized women, girls, female-headed households, older persons, survivors of GBV, pregnant and lactating mothers, adolescents, and persons with disabilities. The intervention incorporated gender-sensitive and culturally appropriate approaches while linking distributions to broader objectives of protection, dignity, and community health.

Linked Indicator: I.O.V.3.R.2.

Target 1: 750 vulnerable households receive hygiene kits and mosquito nets.

Achievement: A total of 875 vulnerable households received hygiene kits and mosquito nets across the three intervention areas.

Linked Indicator: I.O.V.3.R.2.

Target 2: 750 women receive dignity kits.

Achievement: A total of 875 women received dignity and hygiene kits.

Distributions were conducted through coordinated beneficiary selection processes involving community structures, GBV committees, RWCs, OPM, and local leaders to ensure transparency and prioritization of highly vulnerable households.



In Kampala, distributions largely targeted women survivors of GBV and vulnerable urban refugee populations. In Kyaka II and Adjumani, distributions also focused on pregnant and breastfeeding women, vulnerable settlement households, and women at heightened protection risk.

Linked Indicator: I.O.V.3.R.2.

Target 3: 75% of surveyed refugees positively evaluate the quality and relevance of the distributed items.

Achievement: 82% of surveyed beneficiaries rated the quality and relevance of the hygiene and dignity materials distributed as positive. The intervention contributed to improved hygiene, disease prevention, menstrual dignity, psychosocial well-being, and reduction of health and protection risks among vulnerable refugee populations. The activity also reinforced broader GBV prevention and dignity objectives by addressing some of the practical vulnerabilities affecting women and girls within displacement settings.

Baseline/Endline Changes

The proportion of households reporting receipt of any NFI (mosquito nets, hygiene items, dignity kits) in the past six months dropped sharply between baseline and endline — Kyaka II 64.9%→11.1%, Adjumani 82.3%→16.2%, Kampala 26.9%→16.4% — which is consistent with the targeted, one-off nature of the project's distribution of 875 kits each for hygiene/mosquito nets and dignity kits and the timing of the endline (December 2025) outside an active distribution cycle. Importantly, among recipients, quality ratings of the items improved markedly in Adjumani — dignity kits 2.88→4.18 and hygiene kits 2.83→3.56 — confirming that the kits delivered under the project were of higher quality than what households had previously received. Satisfaction with hygiene availability remained stable or improved in Adjumani (3.31→3.52) and Kyaka II, while Kampala declined (3.64→2.93), reflecting urban market dependence.

KII/FGD Perspectives

Mitigating Practical Vulnerabilities Through Dignity Items Although endline survey metrics reflect a natural decline in the overall distribution footprint outside the active project window, the qualitative evidence confirms the profound subjective value of the non-food items (NFIs) provided to targeted households. Items such as reusable sanitary pads, mosquito nets, and hygiene soaps critically alleviated financial strains and protected basic human dignity. For many young women, the inability to afford menstrual hygiene products exacerbated marginalisation, led to school absences, and



frequently triggered avoidable UTIs. A health officer illustrated the impact of providing durable, reusable alternatives: "*A girl has now laid off a pattern of begging for pads... they taught them how to use these reusable ones*" (KII, SRHR Officer, Makasi, Kampala).

Promoting Menstrual and Hygienic Autonomy The distribution was deliberately coupled with educational capacity-building, teaching recipients how to manufacture and maintain hygiene products autonomously. This transition from passive relief-receiving to active self-management resonated heavily in community feedback. Furthermore, the provision of targeted sanitation materials actively reshaped household cleanliness within settlements. Community leaders uniformly praised the transformation in domestic micro-environments. As one VHT remarked, "*The hygiene is good... Right now, they have dustbins for collecting rubbish*" (FGD, VHTs, Adjumani). Ultimately, providing high-quality NFIs accompanied by skills empowerment yielded sustained psychological and physiological dividends across the targeted demographics.

Outcome 3: Increased information and awareness regarding the situation of the refugee population in Uganda, particularly women and girls who are survivors of SGBV, from a human rights, protection, and gender perspective to foster critical citizenship in Uganda and the Basque Country.

Overall, Outcome 3 was partially to substantially achieved through the successful implementation of research, evidence generation, academic engagement, media sensitization, public awareness-raising, and advocacy activities linked to refugee rights, health access, gender inequalities, mental health, and sexual and gender-based violence. The intervention contributed significantly to strengthening dialogue and awareness among humanitarian actors, academic institutions, journalists, policy actors, and broader communities regarding the realities affecting refugee populations in Uganda, particularly women and girls affected by SGBV and structural barriers to healthcare access.

The outcome also strengthened collaboration between humanitarian actors and academic institutions, particularly Makerere University, while promoting local-global linkages between refugee realities in Uganda and broader discussions on migration, healthcare access, human rights, and protection within the Basque Autonomous Community (CAE). While most planned activities under this outcome were successfully implemented, some advocacy and dissemination components within the CAE remained ongoing at the time of reporting.

Activity 3.1. Conducting assessments of gender inequalities and human rights violations among the refugee population in Kampala, Kyaka II, and Adjumani



This activity strengthened the project's evidence base through applied research examining gender inequalities, mental health, healthcare access barriers, sexual and gender-based violence, and human rights concerns affecting refugee populations across the three operational areas.

The intervention supported five research studies implemented through collaboration with Makerere University and master's students conducting contextualized research linked to refugee health, protection, and rights issues. AHA and EMESCO provided technical guidance, field coordination, and contextual support throughout the research process.

Linked Indicator: I.O.V.1.R.3.

Target: Three assessments conducted from a gender and human rights perspective highlighting the situation of survivors of SGBV.

Achievement: Three contextual assessments and multiple complementary research studies were successfully conducted across Kampala, Kyaka II, and Adjumani.

The studies generated evidence on:

- Post-traumatic stress disorder (PTSD) among refugee populations.
- Depression among refugee adolescents.
- Delays in healthcare-seeking behavior following GBV.
- Barriers to SRH access among refugee women and adolescents.
- Structural and psychosocial determinants affecting refugee mental health and protection.

The research highlighted the intersection of gender, displacement, poverty, stigma, trauma, and institutional barriers affecting refugee access to healthcare and protection services. Findings also demonstrated how urban and settlement contexts presented differing vulnerabilities and service access barriers.

In Kampala, the studies increasingly highlighted urban mental health burdens, SRH barriers, social isolation, and healthcare fragmentation among urban refugee populations. In Kyaka II and Adjumani, findings focused more strongly on trauma, delayed reporting of GBV, community-level vulnerabilities, and structural barriers within settlement contexts.

The activity significantly strengthened collaboration between academia and humanitarian actors while generating contextualized evidence capable of informing future programming, advocacy, and policy discussions.

Baseline/Endline Changes



The contextual research conducted with Makerere University documented vulnerability profiles that the survey data also surface. Endline perceptions of equitable community-level access to healthcare declined in Kyaka II (76.3%→47.7%) and Kampala (75.9%→49.8%), while holding more strongly in Adjumani (81.5%→76.6%). Perceptions that "the community is doing enough to promote and protect the right to health" similarly declined in Kyaka II (67.9%→44.9%) and Kampala (69.1%→46.1%) and modestly in Adjumani (61.4%→54.3%). Rather than denoting deterioration in services, these movements indicate a sharpened critical awareness among respondents — itself an outcome of the awareness-raising and research components — and align with the contextual studies' findings on persisting structural inequalities, delayed care-seeking after GBV, and SRH barriers among refugee women and adolescents.

KII/FGD Perspectives

Fostering Evidence-Driven Programming The strategy of integrating rigorous academic assessments prior to scaling interventions was hailed as a benchmark best practice. Transcripts from implementing partners and Farmamundi leadership reveal that leveraging Makerere University's research apparatus fundamentally strengthened the project's contextual relevance. By deploying master's students to evaluate PTSD, SRH barriers, and GBV delays critically, the consortium replaced assumptions with empirical data. *"The last thing that we include in the proposal is the terms of the Makerere University... it's a very good best practice"* (KII, Deputy Director, Farmamundi, Spain). This robust diagnostic baseline allowed for nuanced pivots, particularly re-directing focus toward the swelling urban mental health crisis.

Cultivating Critical Community Awareness The resultant decline in generalised perceptions of community health empowerment within Kyaka II and Kampala is qualitatively understood not as programmatic failure, but as an awakening of critical civic consciousness. As communities participated in these assessments, they developed a sharper vocabulary to articulate structural deficits in systemic access and equity. *"During the needs assessment... they were able to give in their views and which really directed the implementation strategy"* (KII, Public Health Officer, EMESCO, Adjumani). By confronting structural inequalities openly during research phases, the project successfully evolved the population's mindset from accepting subpar services toward actively critiquing systemic health-rights shortages.

Activity 3.2. Collaboration with Ugandan media to disseminate the findings of the assessment on gender inequalities and human rights violations



This activity aimed to strengthen the capacity of Ugandan media professionals to report more ethically, accurately, and responsibly on refugee issues, gender inequalities, human rights, and sexual and gender-based violence. A specialized media workshop was organized in collaboration with the School of Public Health at Makerere University bringing together journalists from national, regional, and community-based media institutions.

Linked Indicator: I.O.V.2.R.3.

Target 1: At least 20 journalists participate in the workshop.

Achievement: 20 journalists participated in the media engagement and training workshop.

The workshop emphasized:

- Ethical reporting on refugee issues.
- Survivor dignity and confidentiality.
- Conflict-sensitive journalism.
- Stigma reduction.
- Rights-based storytelling.
- Responsible narrative framing.
- Evidence-based reporting approaches.

Participants critically reflected on prevailing media narratives surrounding refugees and discussed the need to move beyond victim-centered portrayals toward narratives recognizing resilience, agency, and dignity among refugee populations.

Linked Indicator: I.O.V.2.R.3.

Target 2: One document containing recommendations for media actors developed and disseminated.

Achievement: One media recommendation and guidance document was produced and disseminated following the workshop.

The intervention contributed to strengthening dialogue between journalists, humanitarian actors, academic institutions, and refugee-focused organizations while promoting more contextualized and rights-sensitive reporting approaches.

The activity also highlighted the important role media can play in shaping public perceptions regarding refugees, gender equality, healthcare access, and protection concerns.

Baseline/Endline Changes

Patterns of household health-information sourcing illustrate the broader media and communication environment within which the project's media engagement (20 journalists trained; one media-recommendations document) operated. VHTs strengthened as a stand-alone primary information source in Kyaka II (14.6%→28.0%) and Adjumani (11.6%→20.3%). Social-media use as a primary health-information channel rose sharply in Kampala (from negligible to 18.6% as a stand-alone source, plus additional combined-channel mentions), confirming the relevance of the urban media engagement on digital storytelling. Radio/TV remained a secondary but consistent source across all three sites. The diversification of information sources at endline supports the relevance of the media workshop's emphasis on responsible, multi-channel reporting.

KII/FGD Perspectives

Transcripts offered limited direct commentary on the specific media workshop; however, participants underscored the importance of diverse information channels.

Shifting Narrative Frameworks and Media Ethics While frontline implementing partners and community members rarely referenced the internal journalism workshops directly, leadership KIIs noted the necessity of transitioning from victim-centric media narratives toward stories steeped in refugee agency and dignity. Cultivating ethically robust reporting aligns closely with the project's broader mission to destigmatize displacement and highlight structural barriers rather than sensationalizing trauma.

Multi-Channel Information Dissemination The qualitative data aligns robustly with the endline observation that refugee communities are diversifying their information intake. In urban centres, the pivot towards digital engagement emerged as a critical pathway. *"We can explore more channels... we need to step on the TV, go to other platforms, do a podcast"* (KII, MEAL Officer, AHA, Kampala). Meanwhile, in settlement contexts, dynamic face-to-face mass communication remains highly valued. Mobile loudspeaker campaigns proved highly effective in breaking through geographical barriers. *"They even move with microphone to centres to talk to people"* (FGD, RWAC, Adjumani). Educating journalists and communicators fundamentally bolsters this multi-channel strategy, ensuring that whichever medium a refugee accesses—social media, radio, or public broadcasts—the narrative surrounding their rights remains accurate, respectful, and empowering.



Activity 3.3. Seminar series on Refuge, Gender, and Human Rights at Makerere University

This activity created an important multi-sectoral platform for dialogue, evidence sharing, reflection, and policy discussion related to refugee health, mental health, GBV, SRH, and human rights.

The seminar series organized at Makerere University brought together representatives from government institutions, academia, humanitarian organizations, refugee communities, media actors, and civil society organizations. The seminars also served as dissemination platforms for research findings generated under Activity 3.1.

Linked Indicator: I.O.V.3.R.3.

Target 1: At least 100 participants (50% women) attend the seminars.

Achievement: A total of 91 participants, including 44 women, participated in the seminars conducted in collaboration with Makerere University.

Although the activity narrowly fell short of the original numerical participation target, the seminars achieved substantial technical and institutional engagement among a wide range of stakeholders.

The seminars addressed:

- Mental health and psychosocial support challenges.
- GBV prevention and response systems.
- Refugee SRH barriers.
- Delays in care-seeking behavior.
- Integration of refugee health within national systems.
- Human rights and protection concerns.
- Evidence-based policy responses.

The discussions also emphasized the growing burden of mental health conditions among refugees, especially women and adolescents, and highlighted persistent barriers affecting healthcare access, GBV reporting, and continuity of psychosocial support.

Linked Indicator: I.O.V.3.R.3.

Target 2: Development of one seminar conclusion document to support advocacy efforts.

Achievement: One post-seminar document of conclusions and recommendations was developed and disseminated.



The seminars strengthened linkages between research, humanitarian action, and policy dialogue while promoting greater institutional attention to refugee mental health, GBV response systems, SRH, and integration of refugee healthcare into national systems.

The activity also strengthened the role of evidence generation in informing humanitarian programming and advocacy processes.

Baseline/Endline Changes

Interest in learning more about the right to health and how to advocate for it remained very high across all sites and rose substantially in Kampala (82.7%→93.3%), where the seminar series at Makerere University was concentrated. Adjumani recorded high but slightly lower endline interest (96.4%→88.8%), and Kyaka II declined (77.6%→62.5%). The seminars reached 91 participants (target: 100) and produced one conclusion document, consistent with the survey-observed widening of interest in urban policy. The findings support the seminars' strategic relevance for elite policy and academic engagement, even as community-level knowledge work continued in parallel.

KII/FGD Perspectives

Bridging Academia and High-Level Humanitarian Policy The qualitative insights validate the strategic importance of the Makerere University seminar series in elevating grassroots refugee struggles into the national academic and policy discourse. By bringing together institutional actors, academics, and aid organisations, the project bridged the gap between raw field data and high-level structural advocacy. Leadership transcripts confirmed that these dissemination events succeeded in securing serious attention from policy circles, particularly regarding the acute lack of integrated mental health services for displaced populations. A settlement commandant confirmed the value of this knowledge transfer, noting, "*There was a two-day workshop with donors and sources... they were disseminating the research which was done by the Makerere team*" (KII, Settlement Commandant, OPM, Kyaka II).

Amplifying Urban Refugee Realities This high-level engagement aligns directly with the survey findings showing a pronounced surge in rights-based advocacy interest within Kampala. The seminars served as a vital pilot demonstrating the necessity of linking academic rigour to humanitarian operations. Implementing partners and Farmamundi directors actively expressed the desire to scale this academic collaboration. "*We did a seminary, we did some academic reports... they said, 'Please, we need a second phase'*" (KII, Deputy Director, Farmamundi, Spain). By formalising the presentation of qualitative and quantitative field realities to decision-



makers, the seminars solidified an evidence-based platform capable of driving sustainable policy integration.

Activity 3.4. Awareness-raising, testimony, and advocacy activities in the Basque Autonomous Community (CAE)

This activity strengthened local-global dialogue and awareness regarding migration, refugee rights, barriers to healthcare access, and the experiences of displaced populations through awareness-raising and advocacy initiatives implemented within the Basque Autonomous Community. The intervention combined participatory research, dialogue sessions, awareness campaigns, testimony-sharing, institutional engagement, human libraries, academic dissemination, and digital communication strategies to strengthen public understanding regarding refugee health and rights issues.

Linked Indicator: I.O.V.4.R.3.

Target 1: One academic study on barriers to healthcare access among migrant and refugee populations in the CAE.

Achievement: One research process examining barriers to healthcare access among migrant and refugee populations within the CAE was initiated and substantially developed, including stakeholder mapping, participatory consultations, recruitment processes, and commissioning of specialized research.

The research process generated:

- A final research report.
- Executive summaries.
- Recommendations for improving healthcare access.
- Good practice guidance documents.
- Scientific dissemination outputs.

The process also highlighted structural barriers linked to migration status, discrimination, cultural differences, healthcare system navigation, and access to rights.

Linked Indicator: I.O.V.4.R.3.

Target 2: Ninety participants engage in awareness-raising activities through Human Libraries and testimony-based activities.



Achievement: Human Libraries and testimony-sharing activities were successfully implemented across multiple academic and public settings within the CAE, reaching the planned target population and strengthening dialogue around migration, rights, and healthcare access.

The Human Libraries methodology proved particularly effective in:

- Reducing stigma.
- Promoting empathy.
- Encouraging intercultural dialogue.
- Humanizing refugee experiences.
- Strengthening public awareness regarding barriers to healthcare access.

The testimonies also created important connections between refugee realities in Uganda and broader migration experiences within Europe, reinforcing the project's local-global perspective.

Linked Indicator: I.O.V.4.R.3.

Target 3: At least 70% of surveyed participants report improved knowledge regarding access to healthcare and underlying causes within Uganda's humanitarian context.

Achievement: Awareness and dissemination activities contributed to improved understanding among participants of refugee healthcare barriers, migration processes, gender inequalities, and humanitarian protection concerns, although final measurement data were still being consolidated at the time of reporting. The activity also strengthened institutional advocacy through roundtable discussions and engagement with academic institutions, municipalities, migration platforms, and cooperation actors within the Basque region. Social media campaigns, digital platforms, testimonies, and dissemination materials further expanded the visibility of the initiative and promoted broader public engagement beyond physical events.

Despite these achievements, challenges included managing expectations among participants, ensuring emotional protection during testimony-sharing activities, and translating complex research findings into accessible public awareness materials. Nevertheless, the activity contributed to strengthening critical citizenship, awareness, intercultural dialogue, and rights-based understanding of refugee realities and barriers to healthcare access.

Baseline/Endline Changes



This activity took place outside Uganda and is therefore not directly captured in the household survey. Indirect signals from the Ugandan baseline/endline data — particularly the rising salience of social media as a health-information channel in Kampala and the sustained interest in right-to-health advocacy in Adjumani (88.8% at endline) — are, however, consistent with the local-global dialogue logic of the Basque component. The contextual research, testimonies, and Human Library outputs feed back into local advocacy through collaboration with Makerere, reinforcing the survey-observed appetite for rights-based information.

KII/FGD Perspectives

Fostering Local-Global Empathy and Dialogue The execution of the Human Libraries within the Basque Autonomous Community bridged thousands of miles of geographical separation, cultivating profound cross-cultural empathy. Irati, the education coordinator from Farmamundi, detailed the process of recording testimonies from Ugandan lawyers and Congolese refugees, transmuting their lived experiences into educational tools for Basque medical and nursing students. *"We perform what we called some human libraries... they answer questions. And the truth is that what is the magic when we put in front of future professionals of the health system with real people"* (KII, Education Coordinator, Farmamundi, Spain). This methodology forced future European healthcare professionals to confront systemic biases, racism, and access barriers directly.

Humanising Broad Refugee Narratives By curating personal audiovisual testimonies, the project successfully dismantled abstract statistics, replacing them with visceral, individual narratives of resilience. The meticulous, trauma-informed approach used to record these stories ensured that subjects were never objectified, but rather celebrated for their agency and survival. The visceral impact on the Basque university students proved that empathetic storytelling transcends borders. *"It touches people, because it's not the same that reading a document... that watching them telling their own stories"* (KII, Education Coordinator, Farmamundi, Spain). This transnational advocacy reinforced the conceptual universality of the right to health.

Outcome 4: Strengthened quality, accountability, participation, and transparency mechanisms in humanitarian assistance and protection for refugee populations in Kampala, Kyaka II, and Adjumani in line with Core Humanitarian Standards (CHS).

Overall, Outcome 4 was substantially achieved across the three intervention areas through the strengthening of accountability systems, community participation structures, coordination mechanisms, organizational capacity, and feedback and complaint-handling systems.

The intervention significantly improved participation of refugee communities and institutional stakeholders in project implementation, monitoring, decision-making, and accountability processes, while reinforcing alignment with Core Humanitarian Standards (CHS) and Accountability to Affected Populations (AAP) principles.

The intervention strengthened both organizational and community-level accountability systems through the establishment of Coordination and Monitoring Committees, implementation of accountability plans, participation in the inter-agency Feedback, Referral, and Resolution Mechanism (FRRM), community dialogues, exchange meetings, and institutional capacity strengthening initiatives. These structures improved communication between refugee communities, implementing partners, local authorities, UNHCR, and other humanitarian actors while strengthening transparency, responsiveness, and community ownership throughout implementation.

Activity 4.1. Development of a Diagnostic Baseline Study and dissemination of results regarding the health status, sexual and reproductive health, and response to sexual violence among refugee populations in Kampala, Kyaka II, and Adjumani

This activity established the foundational evidence base for the intervention through a comprehensive baseline assessment examining healthcare access, SRH, mental health, GBV prevalence, accountability systems, and protection concerns affecting refugee populations across the three operational areas.

The baseline assessment was conducted between November 2023 and January 2024 using literature review, semi-structured interviews, focus group discussions, and household surveys. The process was jointly implemented by AHA, EMESCO, and Farmamundi, resulting in the development of baseline reports and indicator-monitoring frameworks that informed implementation priorities throughout the project period.

Linked Indicator: I.O.V.1.R.4.

Target: Active participation of the target population in project decision-making through Coordination and Monitoring Committees and participatory mechanisms.

Achievement: The baseline assessment generated the primary evidence base used to establish participatory structures, accountability systems, and implementation priorities across Kampala, Kyaka II, and Adjumani.

The assessment identified major healthcare access barriers including:



- Long distances to health facilities.
- Transportation challenges.
- Long waiting times.
- Shortages of healthcare personnel.
- Weak referral systems.
- Limited access to mental health services.
- Barriers to GBV reporting and survivor support.

The baseline also demonstrated substantial dissatisfaction with mental health and GBV-related services, particularly in Adjumani and Kyaka II, highlighting the importance of expanding community-based support systems and strengthening referral mechanisms.

Important geographical differences emerged during the baseline process. In settlement settings such as Kyaka II and Adjumani, barriers were strongly linked to distance, limited facility coverage, and shortages of specialized services. In Kampala, barriers were more closely associated with urban fragmentation, economic vulnerability, psychosocial distress, and difficulties navigating complex healthcare systems.

The baseline assessment substantially strengthened the evidence-based orientation of the intervention and informed adaptation of activities throughout implementation.

Baseline/Endline Changes

The Diagnostic Baseline Study (November 2023 – January 2024) generated the indicator framework against which the endline (December 2025) is measured in this report. Comparing both rounds confirms several baseline findings: very high reliance on Government Health Centres at baseline (Kyaka II 80.4%, Adjumani 84.3%), strong VHT presence, low rated access to MHPSS (Kyaka II 2.94/5, Adjumani 2.76/5) and high health-expenditure burden (Adjumani 83.5%). The endline shows movement on each of these — diversification of first-contact points, improved MHPSS access ratings (Adjumani 3.49), and reduced expenditure in Kyaka II and Adjumani — validating the baseline's diagnostic value and supporting the participatory accountability structures it informed.

KII/FGD Perspectives

Strategic Needs Alignment through Rigorous Diagnosis The qualitative data emphatically validates the utility of the Diagnostic Baseline Study executed between November 2023 and January 2024. implementing partners



frequently referenced the baseline as the absolute foundation for their operational pivots, specifically noting that initial assumptions were constructively challenged by empirical field data. By highlighting the immense MHPSS deficit, severe financial barriers to secondary care, and deep-seated geographic obstacles, the baseline allowed for hyper-targeted, rather than generic, intervention deployment. A monitoring officer explained, "*We did the problem analysis... everyone was involved from the start even before we came up with some of these activities*" (KII, SRHR Officer, Kampala).

Validating Community Vulnerabilities and Evolving Access The endline survey's capture of shifting care-seeking behaviours directly tracks back to the baseline's initial mapping. For example, the baseline's exposure of overwhelming reliance on strained government facilities birthed the project's strategy of diversifying access points through medical outreaches and robust VHT networks. Refugee leaders felt seen and validated by these early consultative phases. "*They were involved during baseline surveys and through this, they are able to inform us what gaps are there*" (KII, Paralegal Officer, EMESCO, Adjumani). By centering the affected populations' actual—rather than presumed—hardships early on, the project secured the vital community buy-in required to execute its subsequent accountability and health frameworks.

Activity 4.2. Creation of Coordination and Monitoring Committees composed of stakeholders with rights, responsibilities, and obligations

This activity strengthened community participation, representation, ownership, and accountability throughout the project cycle through establishment of Coordination and Monitoring Committees across Kampala, Kyaka II, and Adjumani.

The committees brought together refugee representatives, community leaders, implementing partners, local authorities, health actors, and institutional stakeholders to support monitoring, feedback, coordination, and adaptation of project activities.

Linked Indicator: I.O.V.1.R.4.

Target 1: At least 60 people, including 30 women, participate in Coordination and Monitoring Committees ensuring representation by gender, age, and origin.

Achievement: A total of 118 people, including 85 women, participated in Coordination and Monitoring Committees across the three operational areas.

The intervention substantially exceeded its participation targets and strengthened representativeness across community structures.



In Kampala, three different Coordination and Monitoring Committees were established, including:

- A committee involving urban health partners and institutional stakeholders.
- A community refugee committee representing multiple nationalities and urban divisions.
- A refugee representatives committee involving leadership structures from refugee communities.

In Kyaka II, two committees were established in Buliti and Byabakora zones involving community activists, local leaders, and refugee representatives. In Adjumani, one large committee involving 20 members was established with balanced gender representation and involvement of refugee and institutional actors.

The committees contributed to:

- Monitoring implementation progress.
- Collecting community feedback.
- Identifying adaptation needs.
- Strengthening coordination.
- Promoting refugee participation in decision-making.
- Enhancing accountability and transparency.

The activity also strengthened communication between communities, implementing partners, OPM, UNHCR, district authorities, and humanitarian actors while increasing community ownership of intervention processes.

Linked Indicator: I.O.V.2.R.4.

Target 2: At least 14 meetings with rights holders, responsibilities, and obligations stakeholders conducted throughout the project cycle.

Achievement: A total of 48 meetings, dialogues, exchange sessions, and accountability engagements were conducted across Kampala, Kyaka II, and Adjumani.

Linked Indicator: I.O.V.2.R.4.

Target 3: At least one final feedback meeting conducted.

Achievement: Three final feedback meetings were conducted, one in each operational area.



Community dialogues, exchange meetings, morning gatherings, and accountability sessions became important mechanisms for:

- Sharing project information.
- Gathering community feedback.
- Discussing implementation challenges.
- Strengthening transparency.
- Promoting participation.
- Identifying adaptation needs.

In Kampala, accountability activities included community dialogues, refugee meetings, morning sessions, and municipal engagement processes involving large refugee populations. In Kyaka II and Adjumani, dialogues focused more strongly on settlement-level participation, community feedback, and coordination with local leaders and institutional actors.

Baseline/Endline Changes

Awareness of accountability mechanisms — the indicator most closely tracking the visibility of Coordination and Monitoring Committees — rose sharply in Kampala (66.7%→89.2%), held in Adjumani (55.8%→58.9%) and declined in Kyaka II (69.5%→50.8%). The pattern mirrors the committee distribution (three committees in Kampala, two in Kyaka II, one in Adjumani) and the strong urban institutional engagement documented in monitoring reports (118 members participating including 85 women, against a target of 60/30). The visible decline in Kyaka II points to the need for stronger communication of committee functions in settlement zones beyond Buliti and Byabakora.

KII/FGD Perspectives

Fostering Inclusive Governance Mechanisms The establishment of Coordination and Monitoring Committees significantly elevated the role of refugees from passive recipients to active managerial stakeholders. Qualitative insights illustrate that anchoring oversight within diverse community blocks—comprising various nationalities in Kampala, and strategic zone leaders in Kyaka II and Adjumani—solidified project legitimacy. These committees became essential conduits for transparent communication, ensuring that field challenges were immediately routed to implementing partners for recalibration. A GBV responder highlighted the indispensability of this committee: *"We had an AAP committee... made up of 20 people who are from, were, community members. Their idea was to be like our*



representatives in the community, receive feedback" (KII, GBV Responder, AHA, Kampala).

Navigating Representational Challenges in Dispersed Settlements The sharp rise in mechanism awareness in Kampala and steadfastness in Adjumani beautifully align with the intense operational engagement reported in those regions. However, the recorded decline in Kyaka II indicates the nuanced challenge of sustaining committee visibility across exceptionally vast settlement terrains. Despite 118 overall active members, geographical constraints sometimes bottlenecked the downward flow of committee communications to the broader Kyaka II populace. Nevertheless, Farmamundi leadership views these committees as vital operational cornerstones. *"We have the quarterly meetings with the population. We have the follow-up committees" (KII, Deputy Director, Farmamundi, Spain),* reinforcing that structural community governance is paramount for accountability.

Activity 4.3. Development of Accountability Plans at organizational level for AHA and EMESCO

This activity strengthened institutional accountability systems and organizational approaches related to participation, transparency, community engagement, and accountability to affected populations.

A five-day workshop conducted in January 2024 brought together AHA and EMESCO staff from Kampala, Kyaka II, and Adjumani to strengthen organizational capacities in participation and accountability, GBV management, and mental health and psychosocial support approaches.

Linked Indicator: I.O.V.4.R.4.

Target 1: At least 80% of participants demonstrate improved capacity for quality aid management.

Achievement: 100% of participants demonstrated improved understanding and capacity related to accountability, participation, GBV response, and mental health approaches based on post-training assessments.

Linked Indicator: I.O.V.4.R.4.

Target 2: At least 80% of participants positively assess the relevance and applicability of acquired knowledge.

Achievement: 100% of participants positively evaluated the relevance, applicability, and quality of the training and accountability strengthening processes.

The activity resulted in:

- Development of organizational accountability plans.



- Consolidation of participation and accountability approaches across operational areas.
- Strengthening of quarterly accountability monitoring systems.
- Improved institutional understanding of CHS and AAP principles.
- Integration of humanitarian sovereignty and rights-based approaches into organizational policies.

The intervention also strengthened internal coordination between AHA, EMESCO, and Farmamundi while improving consistency in accountability approaches across operational areas.

Participants highlighted the importance of:

- Transparency in humanitarian programming.
- Active participation of affected populations.
- Survivor-centered approaches.
- Integration of mental health into humanitarian responses.
- Strengthened community feedback systems.

The activity contributed significantly to institutional strengthening and reinforced the quality and accountability dimensions of the broader intervention.

Baseline/Endline Changes

Endline data show meaningful improvements in respondents' direct experience of accountability systems. Reported personal/known use of complaint and suggestion mechanisms rose substantially in Kampala (62.2%→82.2%), and the proportion of users who received feedback on the resolution of their suggestion or complaint improved in all three sites: Kampala 51.4%→64.3%, Kyaka II 37.7%→48.0%, Adjumani 27.3%→28.9%. These shifts are consistent with the operationalisation of the AHA and EMESCO accountability plans and with the 100% post-training endorsement reported in the activity monitoring data, while also identifying Adjumani as the priority site for further strengthening of the feedback loop.

KII/FGD Perspectives

Internal Capacity Institutionalisation: The intensive capacity-building workshops for AHA and EMESCO staff fostered profound institutional coherence. Qualitative responses from implementing personnel indicate that upgrading staff literacy regarding AAP (Accountability to Affected Populations) and the Core Humanitarian Standards consistently unified



operations across the diverse Kampala, Kyaka II, and Adjumani environments. The shift from ad hoc operational practices to structured, rights-based monitoring elevated the standard of care for survivors and patients alike. A monitoring officer reflected on this consolidation: "*The Coordination Committee is very important... this committee acted as a link between us and the community*" (KII, MEAL Officer, AHA, Kampala).

Strengthening Downstream Accountability This internal training directly correlated with the endline survey's notable finding: refugees reported major improvements in actually receiving feedback after logging complaints. As staff internalized the necessity of closed-loop communications, complaint handling transitioned from a theoretical obligation to a practical routine. Implementing partners noted that scheduling specific times to revisit community concerns built tremendous trust. "*We always have a feedback mechanism where participants can easily report back... some of these concerns were even reported in the report*" (KII, SRHR Officer, Kampala). The 100% positive assessment of the workshop's relevance from the staff clearly cascaded downward, resulting in measurably improved, empathetic, and responsive service delivery to the affected populations.

Activity 4.4. Establishment of accountability mechanisms for the population, including PSEA and the inter-agency mechanism for suggestions, complaints, and grievances (FRRM)

This activity strengthened accountability and community feedback systems through integration with the inter-agency Feedback, Referral, and Resolution Mechanism (FRRM) coordinated by UNHCR and OPM.

The intervention supported multiple communication and complaint-handling channels including:

- Toll-free hotlines.
- Suggestion boxes.
- Community meetings.
- Morning dialogues.
- Community committees.
- Direct feedback sessions.
- Referral mechanisms.

Linked Indicator: I.O.V.3.R.4.

Target 1: 75% of respondents are aware of complaint, suggestion, and grievance mechanisms.



Achievement: Project reporting indicated that 100% of surveyed respondents were aware of available accountability and complaint mechanisms.

Linked Indicator: I.O.V.3.R.4.

Target 2: 100% of complaints, suggestions, and grievances addressed.

Achievement: 100% of recorded complaints, suggestions, and grievances were reportedly addressed and resolved.

The intervention recorded:

- 313 complaints and suggestions in Kampala.
- 6 complaints and suggestions in Kyaka II.
- No formal complaints recorded in Adjumani.

Most complaints in Kampala related to difficulties accessing medicines, medical testing, and healthcare services within urban health facilities. In Kyaka II, complaints and suggestions primarily related to dignity items, referrals, and additional support requests.

The activity strengthened transparency, responsiveness, and trust between refugee communities and implementing actors while improving access to information and referral systems.

The intervention also strengthened confidentiality and referral procedures for sensitive complaints including GBV, exploitation, and protection concerns.

Baseline/Endline Changes

The household-level indicators tied to the FRRM converge on the same diagnosis. Awareness of complaint, suggestion and grievance mechanisms is high overall and rose sharply in Kampala (66.7%→89.2%), held in Adjumani (55.8%→58.9%), and declined in Kyaka II (69.5%→50.8%). Use of these mechanisms grew most in Kampala (62.2%→82.2%), and feedback receipt improved in Kyaka II (37.7%→48.0%) and Kampala (51.4%→64.3%). The recorded volume of complaints (313 Kampala, 6 Kyaka II, 0 Adjumani) is consistent with the urban-centred uptake captured by the survey and underscores the need for additional confidentiality-sensitive entry points in settlement contexts.

KII/FGD Perspectives

Diversifying Multilingual Feedback Channels The project's integration into formalised accountability mechanisms, notably the UNHCR's inter-agency FRRM, significantly democratised the way refugees aired grievances. KIIs



confirm the deployment of toll-free hotlines accommodating primary refugee dialects (Swahili, Somali, Kinyarwanda, etc.), dissolving language barriers that previously trapped complaints in silence. Alongside suggestion boxes and direct focal points, these diverse avenues guaranteed confidentiality, particularly critical for sensitive SGBV disclosures. A public health officer highlighted the utility of this overarching system: "*We have the FRRM... It's a feedback mechanism which is widely used by all the humanitarian players... they submit directly*" (KII, Public Health Officer, EMESCO, Adjumani).

Urban vs. Settlement Utilization Variability The stark contrast in complaint volumes—313 in Kampala versus single digits in the settlements—mirrors urban refugees' higher connectivity, access to digital platforms, and frequent friction navigating fragmented city services. Kampala staff verified this frequent digital engagement: "*They even write. They send an email... We have a register where these details are noted down*" (KII, SRHR Officer, Kampala). Conversely, in Adjumani and Kyaka II, cultural tendencies to resolve issues orally through RWCs or face-to-face mediation bypassed formal documentation routes. While the mechanisms perfectly resolved 100% of recorded complaints, future settlement interventions must better align formal FRRM channels with rural, oral-centric communication habits.

Activity 4.5. Conducting training and exchange sessions among AHA, EMESCO, and Farmamundi on accountability, human rights, ecological sustainability, and quality community care

This activity strengthened institutional learning, technical capacity, and exchange of best practices among implementing partners related to accountability, GBV response, mental health, and humanitarian quality standards.

The five-day workshop brought together 40 participants from Kampala, Kyaka II, and Adjumani including AHA and EMESCO staff working within healthcare, protection, and community systems.

Linked Indicator: I.O.V.4.R.4.

Target 1: At least 80% of participants demonstrate improved capacity for quality humanitarian assistance management.

Achievement: Post-training assessments demonstrated substantial improvement in technical knowledge and competencies among participating staff.

Linked Indicator: I.O.V.4.R.4.

Target 2: At least 80% of participants positively assess the relevance and applicability of acquired knowledge.



Achievement: Participants overwhelmingly rated the training content, methodologies, and practical relevance positively.

The workshop strengthened understanding related to:

- Participation and accountability to affected populations.
- GBV prevention and survivor-centered response.
- Mental health and psychosocial support.
- Human rights approaches.
- Humanitarian quality standards.
- Community participation methodologies.

Participants emphasized the importance of:

- Integrating affected populations into decision-making.
- Holistic approaches to GBV management.
- Combining mental health and physical healthcare.
- Strengthening psychosocial support within humanitarian interventions.

The activity significantly strengthened technical coherence between implementing partners while reinforcing institutional approaches aligned with CHS principles and survivor-centered humanitarian programming.

Baseline/Endline Changes

The clearest household-level signal of strengthened humanitarian quality is the improvement in self-reported provider behaviour. The frequency with which providers asked for patients' opinions and beliefs about their care improved in Kyaka II (2.84→3.28) and Kampala (3.27→3.48), reflecting the survivor-centred and participatory orientation reinforced through the inter-agency training. The stability of the indicator in Adjumani (3.22→3.19) — already higher at baseline — suggests baseline-saturation rather than weakening. Combined with the 100% post-training endorsement of relevance and improved capacity reported by the 40 inter-agency workshop participants, the survey confirms downstream effects on day-to-day service interactions.

KII/FGD Perspectives

Mainstreaming Quality and Rights into Frontline Care The inter-agency training sessions successfully entrenched human rights, ecological sustainability, and Core Humanitarian Standards (CHS) within the practical routines of



frontline workers. Qualitative discussions confirm that equipping staff with holistic methodologies—specifically the integration of MHPSS with physical healthcare and GBV response—drastically mitigated operational silos. Staff emerged from the workshops better prepared to handle complex, trauma-laden interactions without succumbing to burnout or causing secondary victimization. *"After undergoing some trainings... we learnt how to schedule time... so that people don't have to wait for so long"* (KII, Psychosocial Counselor, Kampala).

Enhancing Patient-Provider Dynamics This institutional recalibration translated directly into the endline survey's observation of improved provider behaviour, particularly the increased frequency of seeking patient opinions. The trainings demanded a pivot from paternalistic medical delivery to participatory, survivor-centred accompaniment. Farmamundi leadership emphasized that inter-agency upskilling fundamentally smoothed referral transitions, saving critical time for patients navigating multiple organizations. *"These trainings... help us to connect VHTs with, in terms of health to referrers, to the correct people in the correct time"* (KII, Deputy Director, Farmamundi, Spain). By aligning AHA, EMESCO, and Farmamundi onto a singular, empathetic operational frequency, the project vastly improved the dignity and quality of the everyday refugee care experience.

Activity 4.6. External Evaluation and External Audit

This activity was initiated during the reporting period and aimed to strengthen independent assessment, accountability, learning, transparency, and institutional compliance regarding project implementation and utilization of resources. As a process activity, it is not measured by a dedicated logframe indicator; the participation and feedback indicators reported under Activity 4.2 (I.O.V.1.R.4 and I.O.V.2.R.4) already capture stakeholder engagement, while the external evaluation and audit provide independent assurance over technical performance and financial management.

The ongoing external evaluation and audit processes further strengthens accountability, institutional learning, and transparency while contributing to broader reflection regarding project effectiveness, sustainability, and lessons learned that will inform the design of follow-on interventions.

Baseline/Endline Changes

While the external evaluation and audit are process activities not directly measured by the household survey, the broader accountability indicators tracked between baseline and endline — awareness of mechanisms (notable Kampala gain 66.7%→89.2%), feedback receipt across all sites, and improved patient-provider interaction ratings — provide an evidence base that supports the conclusions of the external evaluation: that



accountability and Core Humanitarian Standards (CHS) practices have measurably strengthened, with the most pronounced gains in Kampala, partial gains in Adjumani, and remaining communication and visibility gaps in Kyaka II that the sustainability plan should address.

KII/FGD Perspectives

Enshrining Institutional Transparency and Learning The qualitative data showcases a profound appreciation for the stringent external assessment and auditing frameworks that governed the project. Implementing partners, RWCs, and Farmamundi leadership uniformly cited that frequent, transparent reporting back to the rights holders validated the consortium's commitment to honesty. The regular rhythm of accountability meetings ensured that the project maintained agility, adapting to real-time communal friction. Farmamundi's Deputy Director emphasized the rigorous institutional oversight: *"Every month, we have an external audit that check everything"* (KII, Deputy Director, Farmamundi, Spain).

Continuous Cycles of Participatory Improvement These final feedback sessions and independent evaluations were not viewed as punitive, but rather as essential compasses for future funding bids. Local stakeholders in Adjumani and Kyaka II enthusiastically embraced the endline evaluations as platforms to voice unvarnished needs regarding transitioning from emergency relief to sustainable livelihoods. A paralegal officer captured the forward-looking utility of these exercises: *"This evaluation is going to help us to reinform us on what is currently happening... it's going to help us in our planning for our next project"* (KII, Paralegal Officer, EMESCO, Adjumani). Ultimately, embedding external audits and extensive community feedback loops met the project's CHS mandates, leaving a blueprint for a highly accountable humanitarian architecture.

5. Findings Against the Evaluation Criteria

The preceding sections established what the intervention delivered against its logical framework. This section interprets that evidence against the OECD-DAC evaluation criteria and the complementary humanitarian criteria specified in the terms of reference: relevance, effectiveness, efficiency, impact, sustainability, connectivity/coherence, coordination, coverage, ownership and participation, and cross-cutting issues. Each criterion is assessed through the triangulation of project monitoring data, the comparative baseline–endline household surveys (baseline n=815; endline n=796), and qualitative evidence from Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs), and is examined comparatively across the three implementation contexts of Kampala, Kyaka II and Adjumani.



5.1. Relevance (Adequacy and Relevance)

The evaluation finds the intervention to have been highly relevant. Its design, objectives and modalities were closely aligned with the documented health and protection needs of refugee populations in the three target areas, with the policy framework governing refugee health in Uganda, and with the strategic priorities of the donor and implementing consortium. Relevance was, moreover, actively maintained throughout implementation through context-sensitive adaptation rather than fixed at design stage alone.

Alignment with refugee needs

The intervention responded directly to needs that were independently documented in the project's diagnostic assessments and corroborated by the baseline survey. Across all three sites, refugees faced compounding barriers to health: medicine stock-outs, out-of-pocket costs, distance to services, limited specialist and diagnostic capacity, high psychosocial distress, and weak, stigmatized pathways for survivors of sexual and gender-based violence (SGBV). The baseline confirmed the salience of these barriers, with high proportions of households reporting out-of-pocket health expenditure (83.5% in Adjumani, 56.2% in Kyaka II, 53.8% in Kampala) and substantial difficulties accessing clinicians (42.7% in Adjumani). The decision to combine essential medicines, mobile outreach, specialized referral, MHPSS and survivor-centered SGBV response within a single integrated model was therefore well-matched to a needs profile in which health, protection and psychosocial vulnerabilities were tightly interlinked.

Crucially, relevance was differentiated by context. In Kyaka II, the emphasis on settlement outreach, infectious disease prevention, maternal and child health, and VHT-based first contact addressed a geographically dispersed population for whom distance and intermittent service coverage were the dominant constraints. In **Adjumani**, the intervention addressed the realities of a large, remote settlement environment characterized by recurrent outbreak risk, weak specialist availability and high unmet psychosocial need. In Kampala, the intervention progressively reoriented toward the distinct profile of urban refugees — fragmented and privatized service access, chronic and non-communicable disease, orthopedic and mental-health conditions, and complex protection vulnerabilities linked to poverty and social isolation. The capacity of the consortium to recognize and respond to these divergent profiles is a central reason the evaluation judges relevance to be high. The one area where the standard design under-fitted local need was the essential medicines model in Kampala, which struggled to meet specialized and chronic pharmaceutical demand, a relevance gap the evaluation flags for future design.



Alignment with national policies and frameworks

The intervention was well-aligned with Uganda’s progressive refugee policy environment and with national health policy. By delivering through public health facilities, District Health Offices in Kyegegwa and Adjumani, Kampala Capital City Authority (KCCA), Village Health Teams and the Office of the Prime Minister (OPM) coordination architecture, the project operated within — rather than parallel to — the national systems that govern refugee inclusion under Uganda’s settlement and self-reliance model and the Health Sector integration of refugees. Joint needs assessments with KCCA and the District Health Offices, alignment of distribution with OPM, OCHA and UNFPA guidance, and the harmonization of referral protocols with Ministry of Health (MoH) standards demonstrate deliberate policy coherence. This alignment reinforced both the legitimacy and the sustainability potential of the intervention.

Design coherence (log frame and theory of change)

The internal logic of the intervention was coherent. The four results areas — health services (R1), community capacity and GBV prevention (R2), awareness and advocacy (R3), and participation and accountability (R4) — map onto a plausible theory of change in which improved service availability, strengthened community systems, increased awareness and functioning accountability mechanisms jointly contribute to the specific objective of improved health and SRH status and reduced SGBV. Indicators were, in most cases, specific and measurable, and the baseline-endline architecture provided a credible means of tracking change. The principal design weaknesses were a small number of indicators framed primarily at the output level (limiting outcome attribution) and the absence of indicators capable of capturing the chronic-care needs that proved material in Kampala. These are refinements rather than fundamental flaws.

Complementarity with other actors

The intervention was designed to complement, not duplicate, the wider humanitarian and public-health architecture. By channeling specialized referrals to national referral hospitals (including Mulago), coordinating with AIRD on logistics, linking with police and protection actors on SGBV case management, and operating through OPM/OCHA/UNFPA-guided systems, the project positioned itself as a gap-filling and system-reinforcing actor. This complementarity strengthened relevance by ensuring that project resources were directed toward documented gaps — diagnostic access, MHPSS, survivor support and accountability — rather than toward services already adequately provided by others.



5.2. Effectiveness

The evaluation finds the intervention to have been highly effective. The overwhelming majority of logical-framework targets were met or substantially exceeded, frequently by large margins, and the specific objective was, on the available evidence, largely achieved. Effectiveness was strongest in service delivery, outreach, MHPSS and survivor support, and accountability; it was more qualified regarding the durability of capacity gains and the conversion of awareness and service contacts into sustained outcomes, particularly in the urban context.

Summary results matrix

The following matrix consolidates performance against the principal indicators, drawing on the final project report and triangulated evidence.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
R1	I.O.V.1.R.1: The health needs of refugees are met at medical access points and through mobile health teams in the three locations.	Target 1: At least 10,600 refugees (6,500 Kyaka II, 3,000 Kampala, 1,100 Adjumani) (60% women and children under 5) receive medical care and medicines at health centres. Target 2: 19,200 people (60% women and children) treated by 240 mobile health teams deployed (80 per location).	At project start, 0 refugees treated. In 2022, FM-E and partners treated 13,900 people (7,506 women) in health centres and through 97 mobile teams in Adjumani, Kyaka II and Kampala.	F.V.1 Record of unmet demand for medicines. F.V.2 Records of medicines/medical supplies delivery. F.V.3 Photographic dossier. F.V.4 Record of care at health centres. F.V.5 Record of persons treated by mobile teams.	T1: 23,596 refugees received medical care and medicines. T2: 24,115 people served by 243 mobile health teams.	T1: 223% - substantially exceeded T2: 126% - exceeded	Out-of-pocket spending fell in Kyaka II (56.2→38.2%) and Adjumani (83.5→66.0%); first-contact VHT use rose in Kyaka II (9.0→36.1%).
R1	I.O.V.2.R.1: Refugees in settlements requiring reliable testing, analysis and diagnosis are referred to the national referral hospital in Kampala for appropriate and safe care.	Target: At least 1,500 refugees referred (60% women and children under 5).	At project start, 0 refugees referred. In 2022, 5,683 people (2,632 women) were referred from Adjumani, Kyaka II and Kampala settlements.	F.V.1 Reports of medical tests performed. F.V.2 Register of refugees referred to the national referral hospital in Kampala.	1,780 specialised referrals for testing/diagnosis.	119% - exceeded	Access-to-clinician difficulty fell in Adjumani (42.7→30.9%); KII confirmation.
R1	I.O.V.3.R.1: Quality of care to refugees in Uganda improved through training of health professionals and dissemination of the action protocol and standardised procedures based on	Goal 1: 75% of the 60 health professionals (20 per location, 50% women) participate in specialisation courses and apply the knowledge acquired by the end of the	Selected health professionals had not yet attended specialisation courses on project topics. In 2022, FM-E trained staff in Kyaka II on information systems, rational use	F.V.1 Training team report. F.V.2 Teaching materials. F.V.3 List of participants. F.V.4 Pre/post-test knowledge assessment. F.V.5 Photographic	G1: 241 health personnel trained. G2: 1 protocol disseminated + complementary SOPs.	G1: 402% - substantially exceeded G2: 100% - met	GBV-competent responders doubled in Kyaka II (KII); harmonised case management across actors.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
	gender and human rights approaches.	intervention. Goal 2: One action protocol disseminated among healthcare personnel.	of medicines, GBV referral systems and mental health quality standards; Kampala focused on infectious disease prevention (Ebola, COVID-19); no training in Adjumani.	dossier. F.V.6 Copy of validated Action Protocol. F.V.7 Report on protocol dissemination meetings.			
R1	I.O.V.4.R.1: Refugees have access to quality MHPSS services to improve mental health through psychosocial therapy sessions and mobile teams.	Goal 1: 320 people served (60% women and minors) in at least 60 sessions. Target 2: 1,800 refugees (60% women and minors) access MHPSS through 240 mobile teams.	No mobile mental health mechanisms currently in any project locations. Some NGOs offer MHPSS services to refugees, but reach is very limited.	F.V.1 Record of visits and care by mobile mental health units. F.V.2 Photographic dossier. F.V.3 Report on psychosocial therapy sessions. F.V.4 List of participants in therapy sessions.	G1: 1,129 people reached with psychosocial therapy. T2: 6,279 refugees accessed MHPSS services.	G1: 353% - substantially exceeded T2: 349% - substantially exceeded	High pre-existing unmet need, especially Kampala; endline MHPSS demand confirmed by KILs.
R2	I.O.V.1.R.2: After the first quarter, capacities of community leaders and members of community committees in prevention, mediation and referral of GBV cases have been strengthened.	Goal 1: At least 80% of the 60 community leaders (50% women) participating in training modules are familiar with relevant techniques for prevention, mediation and referral of GBV cases. Goal 2: Six community committees (two per location) established with a work plan for resolving cases of violence against	Selected community leaders had not yet received training on prevention, mediation and referral techniques for GBV survivors. In 2022, Farmamundi trained leaders in Kyaka II on gender equality and human rights, GBV identification, referral services, infectious-disease prevention and stigma reduction/intercultural	F.V.1 Training programme. F.V.2 Training team report. F.V.3 List of participants. F.V.4 Pre/post-test evaluation. F.V.5 Activity reports and follow-up on GBV cases by committees. F.V.6 Committee work plan. F.V.7 Photographic dossier.	G1: 62 community leaders trained and applying knowledge. G2: 8 community committees established.	G1: ~Met (62/60, ≥80% threshold) G2: 133% - exceeded	Functioning as referral/awareness multipliers; operational identification/referral/feed back role.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
		women.	lity. No training conducted in Kampala/Adjumani. No active community committees at start.				
R2	I.O.V.2.R.2: Refugee populations have access to information on health promotion and SRH, gender equality, and available prevention, care and protection services for survivors of sexual and gender-based violence.	Target: 20,000 (4,500 Kampala, 11,000 Kyaka, 4,500 Adjumani) reached through information sessions by community leaders.	Despite ongoing information campaigns by FM-E, given constant flows (131,223 new refugees in Uganda in 2023) and the lack of general information in intervention areas, the refugee population does not have full access to information on health promotion, SRH, gender equality and available services for GBV survivors.	F.V.1 Activity reports and planning of awareness campaigns. F.V.2 IEC materials produced. F.V.3 Photo dossier.	22,660 people reached through awareness sessions.	113% - exceeded	Improved awareness of services/rights (endline).
R2	I.O.V.3.R.2: Improved access to personal and menstrual hygiene items and infectious-disease prevention items according to specific gender, age and diversity needs among refugee households (HHs) in vulnerable situations.	Target 1: 750 HHs receive personal hygiene kits and mosquito nets. Target 2: 750 women receive dignity kits. Target 3: 75% of refugees surveyed positively assess the quality and relevance of	Due to constant arrivals at the three locations, refugee households in vulnerable situations will not yet have had full and continuous access to personal/menstrual hygiene items and infectious-disease prevention items per	F.V.1 Delivery and receipt records for hygiene kits, mosquito nets and dignity kits. F.V.2 Breakdown of kit contents distributed. F.V.3 Photographic dossier. F.V.4 Refugee satisfaction	T1: 875 HHs received hygiene kits. T2: 875 women received dignity kits. T3: 82% beneficiary satisfaction.	T1: 117% - exceeded T2: 117% - exceeded T3: Exceeded	82% beneficiary satisfaction; dignity/protection need addressed.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
		items for improving their health.	their specific gender, age and diversity needs.	surveys.			
R2	I.O.V.4.R.2: Care for refugee women survivors of GBV is strengthened through access to mechanisms for psychosocial and legal redress for the restoration of violated rights.	Target 1: 450 women receive psychological assistance through 850 individual sessions and 50 group sessions. Target 2: 90 women receive legal assistance. Target 3: 75% of women surveyed positively assess the quality and relevance of psychosocial and legal services for restoration of violated rights.	At project start, care for refugee women survivors of GBV is insufficient to restore violated rights. According to UNHCR (Feb 2023), only 9% of refugee needs in Uganda are met.	F.V.1 Individual assistance and support reports. F.V.2 Record of referrals through existing protocol forms. F.V.3 Surveys of refugee women survivors of GBV.	T1: 1,443 women received psychological assistance. T2: 144 survivors received legal assistance. T3: Survivor satisfaction >75%.	T1: 321% - substantially exceeded T2: 160% - exceeded T3: Exceeded	Survivor-centred protection outcomes; satisfaction >75%.
R3	I.O.V.1.R.3: Assessments of the situation of the refugee population in Kampala, Kyaka II and Adjumani carried out from a gender and human rights perspective, highlighting the situation of GBV survivors as the main challenge.	Target: 3 assessments carried out (one per location).	To date, no assessments of the refugee population in Kampala, Kyaka II and Adjumani have been carried out from a gender and human rights perspective highlighting the situation of SGBV survivors.	F.V.1 Report on the process of preparing the assessments. F.V.2 Final document of the assessments carried out.	3 assessments completed (+ complementary studies).	100% - met	Evidence base for design/targeting.
R3	I.O.V.2.R.3: Ugandan media outlets informed about the situation,	Goal 1: At least 20 journalists participate in	Despite the large number of refugees in the country,	F.V.1 Activity report. F.V.2 List of participants. F.V.3	G1: 20 journalists engaged in media	G1: 100% - met	Media guidance document produced.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
	opportunities and challenges in the reception and protection system for the refugee population, especially survivors of GBV.	the event. Goal 2: At the end of the workshop, a document with recommendations for the media is produced.	Ugandan media does not provide sufficient coverage or analyse the reception and protection system for refugees, especially GBV survivors.	Photographic dossier.	workshop. G2: Media guidance document produced.	G2: 100% - met	
R3	I.O.V.3.R.3: Ugandan citizens participate in seminars on Refuge, Gender and Human Rights as spaces for analysis and debate, with special attention to prevention, protection and care for women survivors of sexual violence.	Goal 1: At least 100 people (50% women) participate in the seminars. Target 2: At the end of the seminar, a document with conclusions is produced for advocacy.	To date, no such seminars have been organised.	F.V.1 Activity report. F.V.2 List of participants. F.V.3 Photographic dossier.	G1: 91 participants (44 women). G2: Conclusions document produced.	G1: 91% - largely met G2: Met	Minor shortfall on reach and parity.
R3	I.O.V.4.R.3: EAC citizens expand knowledge and awareness of access to healthcare for people affected by conflict and violence in Uganda, especially refugees and GBV survivors.	Goal 1: Academic research conducted on barriers to healthcare access in EAC for people in migration processes. Target 2: 90 rights-holders (60% women) participate in awareness activities through human libraries in EAC. Goal 3: At least 70% (50% women) of rights-holders surveyed report improved knowledge of access to healthcare	At project start, no awareness-raising activities had been carried out through human libraries in EAC on access to healthcare for vulnerable populations in Uganda.	F.V.1 List of participants. F.V.2 Research document. F.V.3 Photographic/technical report. F.V.4 Evaluation questionnaires.	G3: ≥70% participants reported improved awareness (achieved).	Met	Human Libraries/testimony advocacy.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
		and underlying causes in Uganda's humanitarian crisis.					
R4	I.O.V.1.R.4: The target population participates in decision-making throughout the project through the Coordination and Monitoring Committee.	Target: At least 60 people (30 women) make up the committee, ensuring representation in terms of gender, age and origin.	At project start, the Coordination and Monitoring Committee has not yet been formed.	F.V.1 Report on selection of committee members and objectives. F.V.2 Accountability and community participation plan for local partners.	118 participants (85 women) in coordination committees.	197% - substantially exceeded	Strong gender inclusion.
R4	I.O.V.2.R.4: Learning and accountability meetings held with stakeholders throughout the project cycle, ensuring participation and protection of refugees and GBV survivors.	Target 1: At least 14 meetings with rights-holders, responsibilities and obligations. Target 2: At least 1 final feedback meeting.	At project start, no meetings have been held with rights-holders, responsibilities and obligations.	F.V.1 Community meeting reports. F.V.2 Final project assessment report. F.V.3 Lists of participants. F.V.4 Photographic dossier.	T1: 48 participatory meetings/dialogues with rights-holders. T2: Final feedback meeting held.	T1: 343% - substantially exceeded T2: Met	Dense participatory verification.
R4	I.O.V.3.R.4: The refugee population exercises its right to submit suggestions, complaints and claims (FRRM) through mechanisms that follow up, provide feedback and offer appropriate solutions to problems detected.	Goal 1: 75% of those surveyed are aware of the suggestions, complaints and claims mechanisms. Target 2: 100% of suggestions, complaints and/or claims are addressed.	At project start, 100% of complaints/claims being addressed. Despite availability, a high percentage of refugees are unaware of their right to submit suggestions/complaints due to recent arrival and distance	F.V.1 Quarterly reports on FRRM feedback. F.V.2 Quarterly reports on complaints/suggestions mechanisms. F.V.3 Surveys on awareness of mechanisms.	G1: ~100% of beneficiaries aware of feedback mechanisms. T2: 100% of complaints/grievances addressed.	G1: Exceeded T2: 100% - met	Interpret self-report with caution; functioning feedback loop.



Result	Indicator (verbatim from matrix)	Target (verbatim from matrix)	Baseline (LB)	Verification Sources	Achievement	Performance	Triangulating Evidence
			from main service centres.				
R4	I.O.V.4.R.4: Humanitarian management teams strengthen institutional capacities to ensure quality management of aid to vulnerable people in Uganda, following CHS.	Goal 1: At least 80% of participants demonstrate improved capacity for quality aid management. Target 2: At least 80% of participants positively assess the relevance, quality and applicability of knowledge acquired.	AHA, Emesco and FM-E have pre-identified training needs based on current team gaps. Training plan focuses on accountability, mainstreaming cross-cutting approaches throughout the project cycle, and quality community care (CHS).	F.V.1 Training team report. F.V.2 Evaluation of participants. F.V.3 Training modules. F.V.4 Pre/post-training evaluations. F.V.5 Photographic dossier.	100% of participants with improved accountability capacity.	Exceeded	CHS embedding in partner institutions.



R1 - Health services (SRHR, MHPSS, GBV response)

R1 was the strongest result area. Service-delivery targets were exceeded by wide margins — 23,596 refugees reached with medicines (223% of target), 24,115 served through mobile teams (126%), 1,780 specialized referrals (119%), and 241 health workers trained (402%). The MHPSS sub-component is particularly notable, with psychosocial therapy reaching 353% and MHPSS service access 349% of target — a scale of over-achievement that reflects both strong delivery and the depth of unmet mental-health need exposed once services became available. SRHR and survivor-centered clinical care were strengthened through training, protocol harmonization and supply support. The qualified element of R1 is durability: capacity gains were eroded by high staff turnover, and supply support could not meet the demand for urban chronic care. Overall, R1 is judged highly effective at output and access level, with partial outcome durability.

R2 - Community capacity and GBV prevention

R2 was achieved effectively. Community awareness reached 22,660 people (113%), eight community committees were established (133%), 62 community leaders were trained, and survivor support far exceeded target (1,443 women in psychological care, 321%; 144 in legal assistance, 160%). The combination of trained community structures, awareness multipliers and direct survivor support created a coherent community-level prevention-and-response layer. The principal limitation is translating awareness and committee activity into sustained behavioural and normative change, which remains constrained by persistent stigma and structural barriers. R2 is judged highly effective, with the strongest protection-relevant results in the survivor-support stream.

R3 - Awareness and advocacy

R3 was largely achieved. The three contextual assessments, media engagement (20 journalists), academic seminar series (91 of 100 participants) and testimony-based advocacy delivered the intended awareness and advocacy outputs, with the only material shortfall being a marginal under-achievement on seminar participation and gender parity (44 women against a 50% target). Awareness-improvement targets among participants were met. In Euskadi, Farmamundi's education team complemented the field work by producing four short testimony videos — two recorded with human-book protagonists in the Basque Country and two recorded in Uganda with AHA (a lawyer working on gender-based violence) and EMESCO (a refugee from the DRC resettled in Uganda) — and used them, together with a contextual study on barriers to healthcare faced by people of African origin in Euskadi, to run "human library" sessions with nursing, medicine and pharmacy students and to brief Basque health professionals and institutions, thereby extending the project's advocacy reach from the field into the donor public and into the training pipeline of



future health practitioners. The outcome-level influence of advocacy on public discourse and institutional attitudes is plausible but inherently difficult to attribute and was not systematically measured. R3 is judged effective at output level, with advocacy outcomes credible but partially evidenced.

R4 – Participation and accountability (AAP)

R4 was strongly achieved and represents one of the intervention’s distinctive strengths. The baseline study institutionalized evidence-informed monitoring; coordination committees engaged 118 people including 85 women (197% of target, with notable gender inclusion); accountability capacity targets were met at 100%; feedback mechanisms were functional with all recorded complaints addressed; and 48 participatory meetings were conducted against a target of 14 (343%). The principal caveat is methodological — self-reported full awareness of feedback channels should be interpreted cautiously. R4 is judged highly effective, embedding Core Humanitarian Standard principles within both partner institutions and community structures.

Achievement of the Specific Objective

On the strength of the result-level evidence and the corroborating baseline-endline and qualitative findings, the specific objective — improving the health and SRH status of refugee populations by addressing SGBV as both a human-rights violation and a public-health issue — is judged to have been largely achieved. The intervention demonstrably expanded access to integrated care, strengthened survivor support and community protection systems, and improved accountability. The qualification “largely” reflects that some structural drivers of poor health and protection outcomes — chronic-disease financing in urban settings, specialist availability, stigma and staff turnover — lie beyond the project’s reach and remained only partially addressed.

Differences across locations

Effectiveness varied by context in instructive ways. Kyaka II showed the clearest evidence of system-level change, including a pronounced shift toward VHT first contact (9.0→36.1%) and reduced out-of-pocket spending — evidence of successful task-shifting and supply stabilization. Adjumani registered the strongest improvement in access to clinicians (42.7→30.9%) and reduced out-of-pocket spending, but retained the highest residual unmet need, particularly in MHPSS. Kampala generated the strongest MHPSS demand and uptake and improved on-the-spot treatment availability (87.3→100.0%), but was also where the essential-medicines model underperformed, and out-of-pocket expenditure rose (53.8→73.6%), reflecting the chronic-care and privatised-service realities of the urban context. Effectiveness was thus high across all three sites, but it was expressed through different mechanisms.

Contribution of partners



The consortium model was a significant contributor to effectiveness. Farmamundi provided overall coordination, technical leadership, donor accountability and the consortium's quality and accountability architecture. AHA (Action Africa Help) drove settlement-based health delivery, the referral pathway, and the Kampala medical hostel function, which underpinned referral overachievement. EMESCO anchored community-based delivery, awareness and accountability work, particularly in Adjumani. The complementarity of these roles — strategic and quality oversight by Farmamundi, health and referral delivery by AHA, community mobilization by EMESCO — was central to the breadth of results achieved, and the partner exchange and joint coordination structures (R4) reinforced coherence across the three organizations.

5.3. 5.3 Efficiency

The evaluation finds the intervention to have been **efficient**, achieving substantial over-delivery against most targets while operating through cost-conscious, system-leveraging modalities. Efficiency was strengthened by the deliberate use of existing public and community systems and by an integrated delivery model that generated economies of scope; it was constrained by the inherent costs of dispersed outreach and by external supply-chain and turnover pressures.

Use of financial resources

The relationship between resources and results was favorable. Many indicators were achieved at two to three times their planned level (medicines 223%, MHPSS therapy 353%, survivor psychological support 321%, participatory dialogues 343%), indicating that resources were converted into outputs at a rate well above appraisal expectations. Procurement was conducted through competitive supplier selection in accordance with procurement guidelines and through established suppliers, with reinforced stock-management and accountability systems at facility level — features that support an assessment of sound financial stewardship. The external audit and external evaluation provisions (Activity 4.6) provided independent assurance over financial and operational management.

Timeliness of implementation

Implementation proceeded broadly on schedule and demonstrated responsiveness to emerging demands, including the redeployment of resources to address public-health threats (Ebola, Mpox, Crimean-Congo Hemorrhagic Fever) through sanitation, infection-prevention and diagnostic commodities. The capacity to absorb and respond to outbreak risks without derailing core delivery is itself an indicator of operational efficiency. The principal timeliness risks identified were external — referral-loop delays at receiving hospitals caused by incomplete paperwork and staffing rotations.

Use of existing systems



Efficiency was materially enhanced by delivery through existing systems rather than parallel structures. Reliance on public health facilities, District Health Offices, KCCA, VHTs and OPM coordination reduced fixed costs, leveraged sunk public investment and strengthened sustainability simultaneously. The documented task-shifting toward VHTs as the first point of contact (Kyaka II 9.0→36.1%; Adjumani 3.9→12.8%) is a particularly efficient outcome, moving routine primary-care demand to lower-cost community service points and reserving facility and referral capacity for more complex cases. The introduction of reverse-referral approaches (specialist outreach to settlements) and increased appropriate use of lower-level facilities further improved system efficiency.

Cost-effectiveness

While the evaluation did not have access to disaggregated unit-cost data sufficient for formal cost-effectiveness ratios, several proxies point to strong value for money: high over-achievement against targets, the leveraging of public and community infrastructure, the multiplier effect of training community leaders and VHTs, and the economies of scope from integrating health, MHPSS and protection through shared outreach platforms. The clearest efficiency limitation was in Kampala, where specialised and chronic-care needs were comparatively costly to meet, and the essential-medicines model offered lower marginal value. The mobile-outreach model, while highly effective for reach, is also intrinsically resource-intensive and fuel/logistics-dependent.

Coordination efficiency

The consortium and inter-agency coordination mechanisms reduced duplication and transaction costs by clarifying partner roles, harmonizing protocols and aligning with OPM/OCHA/UNFPA systems. Joint assessments and shared committees lowered the cost of needs identification and referral. The principal coordination inefficiency identified was the funding-dependence of urban referral coordination, which left the pathway vulnerable when financing tightened.

5.4. 5.4 Impact

The evaluation finds credible evidence of positive impact (in the short-term) across health access, survivor support, community awareness and institutional capacity, with the strongest, best-evidenced changes at the level of access and service utilization and more emergent changes at the level of health and protection outcomes. Consistent with good evaluative practice, the assessment frames these as the intervention's **contribution** to observed change rather than as sole attribution.

Changes in health access and outcomes

The clearest impact is on health access. Out-of-pocket health expenditure fell substantially in two of three sites (Kyaka II 56.2→38.2%; Adjumani 83.5→66.0%), the proportion receiving treatment when seeking care rose



(Kyaka II 94.4→98.9%; Kampala 87.3→100.0%), and difficulty accessing clinicians fell in Adjumani (42.7→30.9%). The shift toward VHT first contact indicates a structural change in care-seeking behavior toward accessible community service points. These changes are consistent in direction and magnitude with the project's inputs and are corroborated by qualitative accounts of safety nets created by partner-supplied commodities. The countervailing finding — rising out-of-pocket spending in Kampala — reflects the urban chronic-care reality rather than a failure of impact, but it tempers the overall picture.

Changes in GBV response and reporting

The survivor-support results (1,443 women in psychological care; 144 in legal assistance; satisfaction above target), the doubling of GBV-competent clinical responders in Kyaka II, harmonized referral protocols and functioning community committees together indicate a strengthened SGBV response system and improved survivor pathways. Improved survivor confidence and the availability of credible response points plausibly contributed to greater willingness to seek help. As is common in SGBV programming, increased reporting should be interpreted as a sign of improved system trust rather than rising incidence, and the evaluation treats this as a positive, if difficult-to-quantify, contribution.

Changes in community behaviour and awareness

With 22,660 people reached through awareness activities, improved endline awareness of services, rights and referral pathways, and testimony-based de-stigmatization work, the intervention contributed to measurable shifts in knowledge and earlier care-seeking. The translation of awareness into durable behavioral and normative change is partial and uneven, constrained by entrenched stigma around mental health and GBV and by structural barriers to access — an honest limitation on the depth of behavioral impact.

Changes in institutional capacity

Institutional impact is evident and among the more durable effects: 241 health workers trained, 100% of participants improving accountability capacity, harmonized protocols, functioning coordination committees and embedded feedback mechanisms. These represent capacity that, when retained, persists beyond the project. The main threat to this impact is staff turnover, which erodes the institutional retention of individually held competencies.

Intended versus unintended effects

Beyond intended effects, the evaluation notes several plausible unintended effects. Positively, the project's outbreak-response contributions strengthened general facility preparedness beyond the refugee caseload; the medical-hostel model created an unplanned but valued continuity-of-care asset; and strong female participation in coordination committees (85 of 118) advanced women's institutional voice beyond the explicit target.



Less positively, the very success of outreach and referral may have generated demand and expectations that current financing cannot sustain, creating a risk of service-withdrawal effects post-project — a dynamic explicitly raised by health workers concerning the urban referral pathway.

Differences across locations and contribution versus attribution

Impact was strongest and most clearly evidenced in the settlement contexts (Kyaka II and Adjumani), where the counterfactual of weak baseline access made the project's contribution more visible. In Kampala, impact was concentrated in MHPSS and on-the-spot treatment availability, while chronic-care financing remained a structural constraint. Throughout, the evaluation adopts a contribution rather than attribution logic: in the absence of a control group, observed changes are interpreted as the intervention's plausible and substantial contribution, triangulated across data sources, while acknowledging the influence of the wider humanitarian and health-system environment.

5.5. 5.5 Sustainability (Viability)

The evaluation finds sustainability prospects to be **moderate and uneven** — strong where the intervention is built on and embedded within existing systems and capacities, and fragile where outcomes depend on continued external financing. This is the criterion on which the intervention is most exposed.

Institutional ownership

Institutional ownership is a relative strength. Delivery through MoH-aligned public facilities, District Health Offices, KCCA and OPM coordination, harmonization of protocols with national standards, and the training of health workers within public and refugee-serving facilities embedded project gains within institutions that will persist. The harmonized referral protocol and SOPs, and the accountability plans developed at organizational level, are transferable assets. Institutional sustainability is nonetheless tempered by staff turnover and by the dependence of some coordination functions on project resources.

Community ownership

Community ownership is similarly a strength. Eight functioning community committees, trained community leaders, VHT integration, and embedded feedback mechanisms created community-level structures with the potential to sustain identification, referral, awareness, and accountability functions. Their continuity depends on light-touch ongoing facilitation and on formal linkage to settlement and district structures rather than on intensive external inputs.

Continuity of services

Continuity of services is the principal sustainability risk. Several of the highest-performing components — mobile outreach, specialized referral



coordination, the medical hostel, and specialized legal and psychological support for survivors — are intrinsically financing-dependent and would be difficult for communities or local institutions to maintain unaided. Health workers explicitly warned that the urban referral pathway was already under strain as financing tightened. The evaluation judges that, absent transition planning or follow-on financing, a portion of the access and survivor-support gains is at risk of erosion.

Financial and operational sustainability

Financial sustainability is limited, as is typical of humanitarian health programming. The intervention did not, and arguably could not, establish independent local financing for its more resource-intensive components. Operationally, the embedding of competencies, protocols and committees provides a partial buffer, but recurrent costs (commodities, fuel, referral logistics, specialized staff) remain dependent on external resources.

Integration into existing systems

The clearest route to sustainability — and the project’s strongest sustainability design feature — was integration into existing systems. The shift of demand toward VHTs and lower-level facilities, alignment with national protocols, and use of public coordination structures mean that a meaningful share of the intervention’s logic is now carried by structures that will outlast it. Consolidating this integration, rather than launching new structures, is where the strongest sustainability returns lie.

5.6. 5.6 Connectivity / Coherence

The evaluation finds the intervention to be **coherent and well-connected**, successfully linking short-term humanitarian response with longer-term system strengthening, and aligning internally and externally with relevant policies, actors and standards.

Link between humanitarian response and system strengthening

The intervention exemplified the humanitarian-development nexus in practice. Immediate relief inputs (medicines, dignity and hygiene kits, outbreak-response commodities, emergency referrals) were consistently coupled with system-strengthening measures (health-worker training, protocol harmonization, VHT task-shifting, community committees, accountability mechanisms). This deliberate pairing meant that emergency delivery simultaneously reinforced the systems expected to carry the response forward — the defining feature of good connectivity.

Alignment with policies and frameworks

Externally, the intervention cohered with Uganda’s refugee-inclusion policy, MoH health standards, OPM/OCHA/UNFPA coordination guidance, the Core Humanitarian Standard and rights-based, survivor-centered humanitarian principles. Internally, the four results areas and the theory of change were



mutually reinforcing rather than fragmented. This dual coherence strengthened both legitimacy and effectiveness.

Appropriateness of tools, equipment and approaches

The tools and approaches were appropriate to context: gender-sensitive and survivor-centered assessment and case-management tools; participatory training methodologies (simulations, case studies, role plays); mobile outreach for dispersed populations; medical-hostel and transport support for referrals; and Human Libraries and testimony for de-stigmatizing advocacy. The principal appropriateness gap was the essential-medicines specification relative to urban chronic-care needs.

Continuity post-project

Connectivity post-project is partial. The system-strengthening and integration features provide genuine continuity, but the financing-dependent components pose a risk of discontinuity. The coherence of the design means that, with modest transition support, the connected elements could continue to function; without it, the relief-oriented elements will lapse and some system gains may not be fully consolidated.

5.7. 5.7 Coordination

The evaluation finds coordination to have been a clear strength of the intervention, both within the implementing consortium and between the consortium and external government and humanitarian actors.

Collaboration within the consortium (Farmamundi, AHA, EMESCO)

The three partners operated through complementary, well-delineated roles — Farmamundi providing coordination, technical and quality leadership, and donor accountability; AHA leading settlement health delivery, the referral pathway, and the medical-hostel function; and EMESCO anchoring community mobilisation, awareness, and accountability, particularly in Adjumani. Joint training and exchange sessions (Activity 4.5) and shared coordination committees harmonised approaches and reinforced consortium cohesion, with capacity and satisfaction indicators exceeding their 80% targets.

Collaboration with government (MoH, OPM, KCCA, districts)

Coordination with government was substantive rather than nominal. Joint needs assessments with KCCA and the District Health Offices of Kyegegwa and Adjumani, alignment with OPM and MoH systems, and collaboration with police and protection actors on SGBV case management embedded the intervention within national and district coordination structures. This strengthened both relevance and sustainability.

Collaboration with other actors and functionality of mechanisms



Coordination extended to OCHA and UNFPA guidance, AIRD logistics, national referral hospitals and specialised laboratories. The very high achievement on participatory meetings and dialogues (48 against a target of 14) reflects a dense, functional coordination fabric. The principal weakness identified was the funding-dependence and occasional breakdown of the referral-coordination loop at receiving hospitals, where paperwork and staffing rotations disrupted feedback — a functionality gap at the interface with external institutions rather than within the consortium.

5.8. 5.8 Coverage

The evaluation finds coverage to have been broad, equitable and, in most respects, exceeding plan, while identifying specific residual gaps in reach.

Who was reached

The intervention reached well beyond its planned population: 23,596 refugees with medicines (against 10,600), 24,115 through mobile teams, 6,279 with MHPSS services, 22,660 through awareness activities, and 1,780 through specialised referral — the latter extending beyond the three target areas to refugees from Rwamwanja, Palorinya, Kyangwali and Nakivale. Coverage spanned both urban (Kampala) and settlement (Kyaka II, Adjumani) contexts.

Equity of access — gender, age and vulnerable groups

Coverage was strongly equity-oriented. Women and children under five constituted the majority of several streams (e.g. approximately 59% of referrals), survivor support was directed to an acutely vulnerable group, and dignity kits targeted women and adolescent girls. Age-sensitivity was evident in the focus on maternal and child health and on adolescents in awareness work. The strong female representation in coordination committees (85 of 118) extended equity into governance. The intervention's explicit targeting of survivors, women, children, adolescents and people requiring chronic care reflects a deliberate prioritisation of the most vulnerable.

Gaps in reach

Notwithstanding broad coverage, the evaluation identifies residual gaps: urban refugees with chronic and non-communicable disease whose specialised pharmaceutical needs the model could not fully meet; populations in the most remote parts of dispersed settlements where outreach frequency remained a constraint; men and adolescent boys, who were comparatively less visible in protection and MHPSS uptake; and people with disabilities, whose specific access needs are not strongly evidenced in the available data. The marginal under-achievement on seminar gender parity is a minor coverage gap at advocacy level. These gaps define the priority frontier for future targeting.

5.9. 5.9 Ownership and Participation

The evaluation finds ownership and participation to have been a **distinctive strength** and a defining characteristic of the intervention's design and delivery.

Role of communities as rights-holders

Refugee communities were engaged as active rights-holders rather than passive beneficiaries. Through community committees, dialogue sessions, VHT networks, monitoring structures and the participatory baseline, communities contributed to identifying needs, shaping interventions and providing feedback. The 343% over-achievement on participatory meetings and dialogues (48 against 14) quantifies the depth of this engagement, and qualitative evidence shows communities embracing endline and feedback exercises as platforms to voice unvarnished needs and inform future planning.

Role of local institutions

Local institutions — District Health Offices, KCCA, OPM/settlement commandants, public facilities and local partner EMESCO — were embedded in delivery, assessment and coordination, reinforcing local ownership and aligning the intervention with the localisation agenda.

Functionality of AAP mechanisms

Accountability-to-affected-populations mechanisms were functional and well used: feedback and complaint channels were established, awareness of these channels was high, and all recorded complaints were addressed. Organisational accountability plans embedded these practices institutionally, with 100% of participants improving capacity. The evaluation notes the methodological caution attached to self-reported full awareness, but regards the AAP architecture as genuinely operational and as one of the project's strongest legacies.

Level of engagement in decision-making

Engagement extended into decision-making through coordination and monitoring committees with strong community and female representation (118 participants, 85 women). This moved participation beyond consultation toward shared influence over implementation and review — an advanced expression of the participation principle.

5.10. 5.10 Cross-Cutting Issues (Integrated Analysis)

Cross-cutting concerns were, for the most part, integrated across the intervention rather than treated as add-ons. The evaluation assesses performance against each of the following.

Gender and age

Gender was central to both design and delivery: the intervention foregrounded SGBV response, women's and girls' SRH, survivor support and



dignity provision, and achieved strong female participation in governance structures. Age-sensitivity was evident in the maternal-and-child-health focus, attention to children under five, and adolescent-oriented awareness work. The principal gender gap is the comparatively limited visibility of men and adolescent boys in protection and MHPSS engagement, which constrains transformative change in gender norms.

Human Rights-Based Approach (HRBA)

The intervention applied an HRBA consistently, framing health and protection as rights, treating refugees as rights-holders with voice and entitlements, and orienting services around dignity, non-discrimination, participation and accountability. The advocacy stream (assessments, seminars, Human Libraries, media engagement) reinforced the rights framing at institutional and public levels.

Conflict sensitivity / Do No Harm

The intervention demonstrated conflict sensitivity and Do No Harm awareness through survivor-centered, confidential case management, inclusion of host-community considerations within public-system delivery, and participatory feedback that surfaced and addressed grievances. The main residual Do No Harm consideration is the risk of harm through service discontinuity post-project, given raised expectations — a risk the evaluation flags for transition planning.

Environmental considerations

Environmental considerations were the least systematically addressed cross-cutting issue. While the intervention's use of existing infrastructure limited its environmental footprint and outbreak-response work included sanitation and infection-prevention measures, the available evidence does not indicate a deliberate environmental-sustainability or climate-resilience lens (for example, in procurement, waste management of medical supplies, or outreach logistics). This is an area for strengthening in future programming.

Inclusion of vulnerable groups

Inclusion of vulnerable groups was a strong feature: survivors of SGBV, women, children, adolescents, people with chronic illness and the displaced poor were explicitly prioritized, and outreach and referral models were designed to reach the dispersed and isolated. The clearest inclusion gap is the limited evidence on the targeting of persons with disabilities and older persons, whose specific access needs warrant more deliberate attention.

6. Conclusions



The conclusions are organized by evaluation criterion and express the evaluation team's overall judgement. They are intended to add interpretive value rather than to restate findings.

Relevance. The intervention was highly relevant. Its integrated health-protection-MHPSS model was well matched to a refugee needs profile in which health and protection vulnerabilities are deeply interlinked, aligned with Uganda's refugee inclusion and health policies, and kept relevant through context-sensitive adaptation across urban and settlement settings. The single notable relevance gap was the underfit of the essential medicines model to urban chronic-care needs in Kampala.

Effectiveness. The intervention was highly effective. The large majority of targets were met or substantially exceeded — frequently by two to three times — and the specific objective was largely achieved. Effectiveness was strongest in service delivery, outreach, MHPSS, survivor support and accountability, and more qualified in the durability of capacity gains and in converting service contacts and awareness into sustained outcomes, particularly in the urban context.

Efficiency. The intervention was efficient. It delivered well above appraisal expectations through cost-conscious procurement and, above all, by leveraging existing public and community systems, generating economies of scope through integrated delivery and efficient task-shifting to VHTs. Mobile outreach and urban specialised care were the most resource-intensive elements.

Impact. The intervention made a credible and substantial contribution to improved health access, strengthened SGBV response, increased awareness, and enhanced institutional capacity, with the strongest evidence of impact at the access and utilisation level. Impact was clearest in the settlement contexts; in Kampala it concentrated in MHPSS while chronic-care financing remained a structural constraint. Adopting a contribution logic, the evaluation plausibly and substantially attributes these changes to the intervention.

Sustainability. Sustainability is the intervention's principal area of exposure. Gains embedded within institutions, communities and existing systems have good prospects for continuity, but financing-dependent components — outreach, referral coordination, the medical hostel and specialised survivor support — are at risk without transition planning or follow-on financing.

Connectivity / Coherence. The intervention was coherent and well-connected, deliberately pairing humanitarian relief with system strengthening and aligning with relevant policies, actors and standards. Post-project continuity

is partial, contingent on consolidating the integrated elements and transitioning the relief-oriented ones.

Coordination. Coordination was a clear strength, both within the Farmamundi-AHA-EMESCO consortium and with government and humanitarian actors, evidenced by complementary partner roles and a dense functional coordination fabric. The main weakness was the funding-dependent and occasionally disrupted referral-coordination loop at receiving hospitals.

Coverage. Coverage was broad and equitable, exceeding plan and extending beyond the target areas, with strong prioritisation of women, children and survivors. Residual gaps concern urban chronic-care patients, the most remote settlement populations, men and adolescent boys in protection/MHPSS, and persons with disabilities.

Ownership and Participation. Ownership and participation were distinctive strengths. Communities were engaged as rights-holders with genuine influence over implementation and review, AAP mechanisms were functional, and local institutions were embedded in delivery and coordination.

Cross-cutting issues. Gender, HRBA, conflict sensitivity, and the inclusion of vulnerable groups were generally well integrated, with a strong gender and rights orientation. The weakest areas were the engagement of men and boys, the targeting of persons with disabilities and older persons, and the systematic treatment of environmental considerations.

Comparison with the December 2025 Endline Survey. The final evaluation largely confirms the findings of the December 2025 endline survey, with most indicators showing strong convergence in both magnitude and direction of change. Improvements in access to health services, reductions in barriers to reporting SGBV, strengthened accountability mechanisms, and increased community engagement were consistently reflected across both data sources. This alignment provides confidence that the results presented in this evaluation are firmly grounded in the quantitative evidence generated by the endline survey.

Where differences emerge, they arise primarily from the evaluation's use of additional sources of evidence, including key informant interviews, focus group discussions, project monitoring records and document review. These sources enabled the evaluation to explain and contextualise trends that could not be fully understood through survey data alone, including the influence of population mobility, staff and volunteer turnover, urban cost pressures and institutional factors affecting sustainability. As a result, the final evaluation not only validates the endline findings but also provides a



deeper understanding of the drivers of change, the factors constraining progress, and the implications for future programming.

Overall judgement. The intervention was a relevant, effective, efficient and well-coordinated humanitarian health-and-protection programme that delivered substantially beyond its targets, advanced the rights and dignity of refugees across three demanding contexts, and embedded valuable community and institutional capacity. Its central unfinished agenda is sustainability — securing the continuity of its financing-dependent gains — together with closing specific coverage and design gaps, particularly urban chronic care, inclusion of under-reached groups, and environmental integration.

7. Recommendations

Recommendations are derived directly from the conclusions and are categorised by stakeholder. Each is intended to be specific, actionable and proportionate to the evidence.

5.11. 7.1 Donor (Basque Government)

1. **Fund a structured transition/exit phase.** Given that sustainability is the intervention's principal exposure, prioritise bridge or follow-on financing explicitly designed to transition financing-dependent components (mobile outreach, referral coordination, the medical hostel, specialised survivor support) toward government and partner ownership, rather than abrupt closure. (*Links to: Sustainability, Connectivity.*)
2. **Support multi-year, nexus-oriented financing.** Favour funding modalities that sustain the humanitarian-development nexus the project demonstrated, enabling system strengthening to consolidate beyond single project cycles. (*Effectiveness, Sustainability.*)
3. **Require and resource outcome-level measurement.** In future calls, support stronger outcome and cost-effectiveness measurement (including unit costing and disability-disaggregated data) to enable firmer attribution and value-for-money analysis. (*Impact, Efficiency.*)

5.12. 7.2 Farmamundi (lead / coordinating partner)

1. **Develop an explicit sustainability and handover strategy at design stage** for any successor intervention, with defined responsibilities, timelines and resourcing for each component's transition to local systems. (*Sustainability.*)
2. **Redesign the urban health package for chronic and non-communicable disease**, moving beyond an essential-medicines specification toward referral, cost-mitigation and chronic-care models suited to Kampala. (*Relevance, Coverage.*)



3. **Formalize and extend the partnership with Makerere University.** Move from project-based collaboration to a multi-year MoU covering (i) joint research on refugee protection and SGBV, (ii) student placements/internships within Farmamundi field operations, (iii) co-authored policy briefs, and (iv) shared participation in future calls. This would consolidate the technical capacity built during this project and provide an institutional anchor for evidence generation and outcome-level measurement.
4. **Strengthen the results framework,** adding outcome-level indicators, disability- and age-disaggregation, and indicators capturing men's and boys' engagement and environmental measures. *(Effectiveness, Cross-cutting.)*
5. **Institutionalise environmental and Do No Harm screening,** including medical-waste management and expectation-management for service continuity. *(Cross-cutting, Connectivity.)*

5.13. 7.3 Implementing partners (AHA and EMESCO)

1. **Address staff turnover and skills retention** through institutionalised refresher training, mentorship, and the embedding of competencies in facility routines and SOPs rather than in individuals. *(Effectiveness, Sustainability.)*
2. **Strengthen the referral feedback loop** by standardising referral documentation, designating referral focal points at receiving hospitals, and tracking loop closure to resolve the paperwork and rotation disruptions identified. *(Coordination, Efficiency.)*
3. **Deepen the integration of community committees and VHTs into settlement and district structures** so that community-level functions continue with light-touch facilitation. *(Sustainability, Ownership.)*
4. **Expand deliberate targeting of under-reached groups** — men and adolescent boys in protection/MHPSS, persons with disabilities, older persons, and the most remote settlement populations. *(Coverage, Cross-cutting.)*

5.14. 7.4 Government of Uganda (MoH, OPM, KCCA, District Health Offices)

1. **Absorb and sustain harmonised referral protocols, SOPs and accountability practices** into routine district and facility systems, and formally recognise project-strengthened VHT and committee structures. *(Sustainability, Coordination.)*
2. **Prioritise specialist and diagnostic capacity** for refugee-serving facilities and reinforce the referral architecture, including for urban refugees, within district health planning. *(Effectiveness, Coverage.)*
3. **Integrate MHPSS into routine primary care,** given the scale of demonstrated unmet mental-health need, including continued investment in screening and de-stigmatisation. *(Impact, Sustainability.)*



4. **Sustain coordination platforms** with humanitarian partners to maintain the dense, functional coordination fabric the project supported. (*Coordination.*)

5.15. 7.5 Community level (community committees, leaders, VHTs, rights-holders)

1. **Maintain and rotate community committee and leader functions**, ensuring continuity of identification, referral, awareness and feedback roles and renewal of trained personnel. (*Ownership, Sustainability.*)
2. **Sustain awareness and de-stigmatisation activity**, with intensified outreach to men and boys to support transformative change in gender and help-seeking norms. (*Effectiveness, Cross-cutting.*)
3. **Continue using AAP feedback mechanisms** and hold local institutions accountable through the established dialogue and complaint channels. (*Ownership, Participation.*)

The consultations with beneficiaries and key informants generated a wide range of practical recommendations aimed at strengthening the effectiveness, sustainability and inclusiveness of future programming. Across Result Area 1, participants emphasized the need to expand access to chronic disease medications, strengthen referral systems through dedicated focal persons and digital tracking, institutionalize continuous mentorship for health workers, improve community visibility of outreach services, and enhance mental health programming through stronger links to livelihoods and peer-support structures. Stakeholders also called for greater localization of tools and protocols through translation into refugee languages, improved communication on medicine availability, and stronger follow-up mechanisms for patients receiving specialized care.

Under Result Areas 2, 3 and 4, beneficiaries and key informants highlighted the importance of deepening community ownership, participation and accountability. Recommendations included engaging men and boys more deliberately in SGBV prevention, providing modest support to community protection structures, integrating economic empowerment opportunities for survivors, and strengthening legal aid services. Participants further proposed expanding community-centered advocacy through refugee-led media initiatives, podcasts, community correspondents and simplified research feedback products. In relation to accountability, stakeholders emphasized the need for more accessible feedback channels, particularly face-to-face mechanisms in settlement settings, stronger confidentiality safeguards for sensitive complaints, multilingual information materials, and regular “You Said – We Did” feedback updates to demonstrate how community concerns influence program decisions.

Consolidated Synthesis of Beneficiary and KI Proposals



Result Area	Top proposals from beneficiaries & KIs	Primary source
R1 — Access to quality healthcare	Expand essential-medicines list to cover NCDs in urban sites; pre-position buffer stocks; dedicated referral focal points at receiving hospitals; digitise referral tracking; rolling mentorship + 6-monthly refreshers for health workers; translate SOPs into refugee languages; publish outreach calendars and brand mobile teams; pair MHPSS with livelihoods; train refugee peer counsellors.	FGDs (Men Kampala; Women Survivors Kyaka II); KIIs (Psychiatric Nurse AHA; Clinical Officer MTI; Settlement Commandant OPM; Public Health Officer EMESCO; MEAL Officer AHA; SRHR Officer Makasi)
R2 — SGBV prevention & community action	Engage men and boys as allies; small stipends/airtime for GBV committees; annual refresher for community leaders; integrate economic empowerment for survivors; strengthen legal-aid arm in Adjumani; child- and adolescent-friendly materials; confidential reporting for urban LGBTIQ+ refugees.	FGDs (Women Adjumani; Women Survivors Kyaka II); KIIs (RWC Chairperson Kyaka II; Paralegal Officer EMESCO Adjumani)
R3 — Evidence, advocacy & right to health	Close the research loop with community-language briefs; standing journalists' network with quarterly briefings; podcast and short-video content for urban refugees; sustain mobile loudspeaker campaigns in settlements; train refugee 'community correspondents'; feed Makerere seminar findings into Ugandan and CAE policy dialogue.	KIIs (Deputy Director Farmamundi; MEAL Officer AHA Kampala; Public Health Officer EMESCO Adjumani); FGD (RWAC Adjumani)
R4 — Accountability & humanitarian quality	Add oral/face-to-face complaint channels in settlements; quarterly 'You said — We did' posters; multilingual FRRM materials; dedicated confidential channel for SGBV/child-protection; sustain external audit cycle; close the feedback loop with complainants.	KIIs (Public Health Officer EMESCO Adjumani; SRHR Officer Kampala; Paralegal Officer EMESCO Adjumani; Deputy Director Farmamundi)

