UNESO

NETWORK OF KEY POPULATION SERVICE ORGANISATIONS LTD (UNESO)

END-OF-PROJECT EVALUATION REPORT

Advocacy to Improve Sexual Reproductive Health Rights of Sex Workers in Uganda.

Commonwealth Foundation-supported project

Evaluation period: September 2024 – July 2026

Report date: July 2026

Prepared for UNESO and the Commonwealth Foundation

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Acronyms

Acronym	Meaning
ACIHEWE	Action for improved health and Wealth
BYMI	Bundibungyo Young Mothers Initiative
CLM	Community-Led Monitoring
COPTEC	Come out Post Test club
CSMMUA	Coalition to Stop Maternal Mortality Due to Unsafe Abortion
CSO	Civil Society Organization
DHO	District Health Officer
DIC	Drop-In Centre
EDWA	Empowered at Dusk Women's Association
FP	Family Planning
GTA	Gender-Transformative Approach
GAHF	Give A hand Foundation
IEC	Information, Education and Communication
JEEWAG	Justice and Empowerment for Women & Girls Foundation
KWHSI	Kabarole Women's Health Support Initiative
KWHSI	Kasese Women's Health Support Initiative
KP	Key Population
LMEC	Lady Mermaid Empowerment Center
Malaba	Malaba Outfits
MAHIPSO	Masaka KP HIV Prevention & Support Organization
MONU	Men Of the Night Uganda
OGERA	Organization for Gender Empowerment and Rights Advocacy
OWEC	Organization For Women Empowerment Center
PLVYA	Platform for vulnerable youth and adults
PAC	Post-Abortion Care
PrEP	Pre-Exposure Prophylaxis
RUTI	RUTI neekos group
SRHR	Sexual and Reproductive Health and Rights
SIU	Scarlet Initiative Uganda
SLUM	Serving Live under Marginalization
SWING	
TAI	Trans Advocacy Initiative
VOICE	Voice for Community Empowerment Gulu
WOPEIN	Women Positive Empowerment Initiative Uganda
WONETHA	Women's Organization Network for Human Rights Advocacy
WWM	Women with a Mission
UNESO	Uganda Network of Sex Worker-Led Organizations

Acknowledgements

UNESO acknowledges the sex worker leaders, advocates, peer educators, human rights defenders, data collectors and member organizations who contributed evidence to this evaluation. Their practical examples from policy engagement and community-led monitoring to escorted referrals and district-level dialogue made it possible to assess not only what the project delivered, but how participating organizations used the learning and relationships created.

Appreciation is extended to district officials, health workers, law-enforcement representatives, civil society partners and facilitators who participated in project activities and supported the evaluation. The evaluation followed UNESO's commitments to participation, confidentiality, safeguarding and sex worker leadership.

Executive Summary

Overall, all approved output areas and deliverable in the Logic Model were completed.

The project made a strong contribution to organizational capacity, advocacy, stakeholder engagement and referral readiness. Long-term service uptake and population-level change were not consistently measured and therefore cannot be attributed to the project alone.

Criterion	Judgement	Headline evidence
Relevance	High	All 21 organizational responses described activities as relevant or very relevant to priority SRHR, rights, stigma, advocacy and coordination needs.
Coherence	High	Capacity building, policy analysis, gender transformation, dialogue, media, mapping and peer learning formed a logical pathway.
Effectiveness	High	All planned output areas were delivered; organizational-strengthening ratings averaged 4.31/5 and participating organizations provided concrete examples of applying the learning.
Efficiency	Reasonable	Regional delivery, peer approaches and partnerships extended reach of the project.
Impact / contribution	Promising	Organizations reported stronger advocacy confidence, district recognition, CLM, referrals and provider engagement.
Sustainability	Moderate–high	Knowledge, trained peers, partnerships and referral contacts are durable, but funding, turnover, stock-outs and laws threaten continuity.

This end-of-project evaluation assessed the performance and results of UNESO's two-year Commonwealth Foundation-supported project, Strengthening Sex Worker-Led Organisations to Advance Sexual and Reproductive Health and Rights and Gender Justice Advocacy in Uganda. The evaluation examined progress against the approved Logic Model and Monitoring Plan, with attention to relevance, coherence, effectiveness, efficiency, emerging impact, sustainability and learning.

Evaluation approach

The evaluation reviewed project reports, activity records, monitoring data, completed organizational feedback questionnaires collected from participating member organizations. Quantitative results were analyses descriptively, while qualitative responses were coded thematically and used to explain the meaning, application and limits of reported change.

Overall performance

The project was successfully implemented, and all approved activities were completed. These included policy-analysis workshops; SRHR advocacy and human-rights training; gender-transformative training; eight regional radio talk shows; advocacy and visibility materials; four regional health and human-rights dialogues; mapping of SRH service providers and development of a provider database in three regions; four biannual review meetings; and the end-of-project evaluation. On top of that project records confirm that the planned deliverables and output targets were achieved.

Training participation was strong. Policy analysis training reached 60 participants, meeting the planned target. SRHR advocacy and human-rights training reached 57 participants, while gender-transformative training reached 59 participants. The small attendance differences did not prevent completion of the approved training outputs or the wider capacity-building objective. Radio programmes across the four regions generated over 70 follow-up calls, which shows that there were audience interest and engagement despite Uganda's legal environment.

Key findings

- High relevance: All 21 participating organisations described the project activities as relevant or very relevant to the challenges faced by sex workers and sex worker-led organisations. The project responded to gaps in SRHR information, advocacy skills, organisational systems, stakeholder relationships, referral pathways and stigma-free service access.
- Stronger organisational capacity: Of the 13 respondents who provided clear ratings, 12 reported that the project made a significant or very significant contribution to organisational strengthening. The average rating was 4.31 out of 5. There was some practical evidence of policy development, improved documentation, stronger peer systems, a functional drop-in centre, community-led monitoring and greater confidence to engage district structures.
- Improved advocacy and leadership: Member organisations reported greater confidence to analyse policies, develop audience-specific messages, document community concerns and engage health workers, district officials, police, civil society organisations and the media. Some organisations also gained greater recognition in district structures and coalitions.
- Stronger partnerships: All organizations assessed described positive collaboration or partnership gains for instance, BYMI participated in district health, human-rights monitoring and HIV committees; LMEC and WOPEIN used provider networks to sustain referrals; VOICE participated in district health planning and the District AIDS Committee; and PVYA strengthened coordination with health facilities, community leaders and civil-society partners.
- Better referral readiness and service navigation: Of the 14 respondents with clear ratings, 13 reported a significant or very significant improvement in access to friendly services and referrals. The average rating was 4.57 out of 5. Organizations had identified a focal person at health centers with functional referral lists, partner-to-partner referrals during commodity shortages, community outreach, a drop-in centre and community-led monitoring of service gaps.
- Progress toward outcomes: The evidence strongly supports increased knowledge, organizational capacity, advocacy participation, stakeholder engagement and referral readiness. These changes contributed to the intermediate outcome of stronger and more effective SRHR and gender-justice advocacy by sex worker-led organisations. However, completed referrals, service uptake, changes in public attitudes and longer-term health outcomes were not consistently measured.

Sustainability and remaining challenges

The project's strongest sustainability assets are the skills retained by leaders and peer educators, stronger member networks, community-led monitoring practices, advocacy confidence and relationships with service providers and district actors. Participating organisations are already integrating the learning into their programmes and engagement activities. Sustainability may nevertheless be affected by restrictive laws, stigma, commodity stock-outs, limited funding, staff transfers, transport costs and the workload and well-being needs of peer leaders and frontline staff.

Conclusion

The evaluation concludes that the project was relevant, coherent and effective. All planned output areas were delivered, and the project made a clear contribution to stronger sex worker-led organisations, more informed advocacy, improved stakeholder relationships and better referral readiness. Its most important achievement was turning training and dialogue into practical organisational action. The project provided a strong foundation for continued advocacy and improved access to respectful, confidential and non-discriminatory SRHR services.

Priority recommendations

1. Strengthen the monitoring system by using consistent baseline, post-training and follow-up tools and by tracking referrals from initiation to completion.
2. Provide member organisations with small grants, mentorship and technical support to implement district action plans, community-led monitoring, peer education and advocacy.
3. Formalise referral pathways through an updated provider directory, clear referral procedures, confidentiality safeguards and quarterly review meetings with service providers.
4. Convert relationships with districts, health facilities, police and other institutions into formal arrangements with documented responsibilities and more than one focal person.
5. Strengthen legal literacy, safe case documentation, evidence-based advocacy and coalition action among member organizations and peer leaders.
6. Expand safeguarding, wellness, psychosocial support and supportive supervision for peer leaders, staff and volunteers.

1. Introduction and Project Background

UNESO, with support from the Commonwealth Foundation, implemented a two-year project designed to improve access to SRHR for sex workers in Uganda by strengthening sex worker-led organizations' capacity, coordination and advocacy effectiveness. Its theory of change linked knowledge of SRHR, human rights, gender justice and policy analysis to stronger organizational action, collective advocacy, stakeholder support and navigation of friendly services.

The project operated in a difficult environment characterized by criminalization, stigma, uneven availability of key-population-sensitive services, commodity stock-outs, staff turnover and funding disruption. The activity reports show that these barriers directly affected whether new knowledge and referral connections could translate into continuous access.

1.1 Intended results pathway

Results level	Intended change
Ultimate outcome	Improved access to SRHR for sex workers in Uganda.
Intermediate outcome	Sex worker-led organizations engage, participate and implement effective SRHR and gender-justice advocacy.
Short-term outcome 1	Increased SRHR, gender-justice and advocacy knowledge.
Short-term outcome 2	Increased public and stakeholder support for sex workers' SRHR.
Short-term outcome 3	Improved access to friendly SRHR services through mapping, referrals and engagement.

1.2 Main intervention package

- Policy analysis and advocacy workshops
- SRHR advocacy and human-rights training
- Gender-transformative approach training
- Regional health and human-rights stakeholder dialogues
- Provider mapping and referral strengthening
- Radio talk shows and IEC materials
- Biannual review, peer learning and movement coordination
- Mapping

2. Evaluation Purpose and Methodology

The evaluation examined what was achieved, what changed, why changes mattered, what contribution the project plausibly made, what is likely to continue and what UNESO should improve.

2.1 Evidence reviewed

Evidence stream	Coverage and use
Organizational feedback	21 unique completed tools collected 6–10 July 2026
Evaluation framework	UNESO protocol, criteria, results chain and analysis plan.
Narrative reporting	Year 1 and 2 reports.
Activity documentation	Activity reports and library search
Embedded monitoring	Participation, radio feedback, gender pre/post results and qualitative examples.

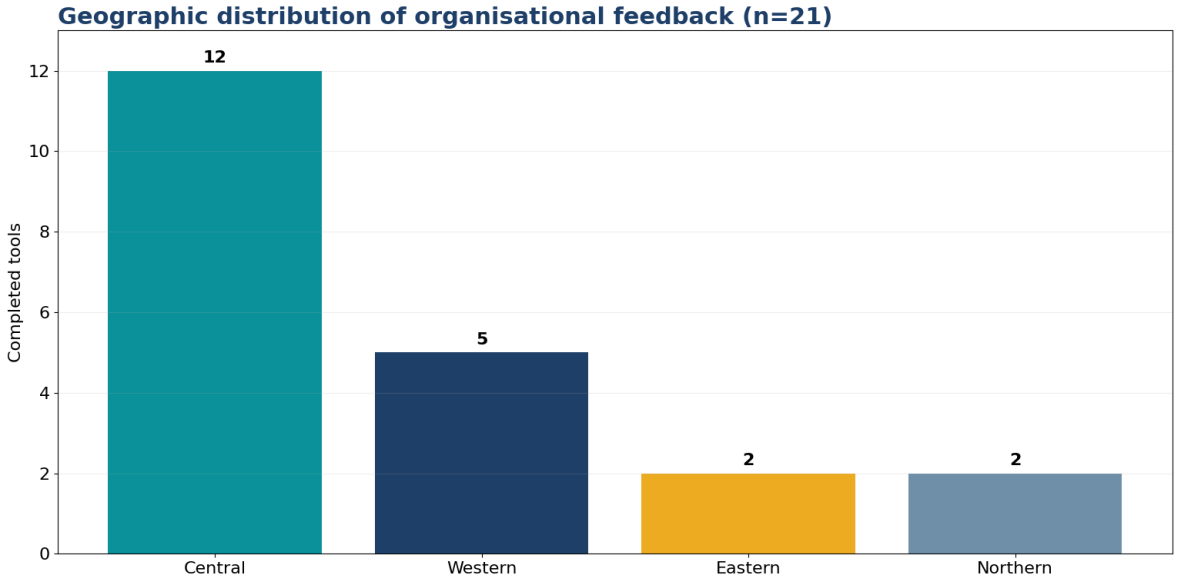


Figure 1. Geographic distribution of completed organizational feedback tools.

2.2 Analysis approach

Closed and semi-closed responses were coded descriptively. The score was valid only where a number or corresponding label was clearly stated. Open responses were coded under relevance, capacity, application, collaboration, referrals, public support, sustainability, gaps and recommendations. Evidence was triangulated with reports. Contribution language is used because plausible links can be established, but attribution to the project alone cannot.

2.3 Limitations and ethics

- UNESO due to funds assessed 21organisations which were purposive sampled out of all members or individual sex workers led organizations.
- Most outcome evidence was subjective.
- Sensitive experiences were paraphrased

3. Performance Against the Approved M&E Plan

This section aligns the evaluation directly with the approved Logic Model and Monitoring Plan. It assesses progress at output, short-term outcome and intermediate outcome levels using the indicators and data sources specified in those documents. The ultimate outcome, improved access to SRHR for sex workers in Uganda, is a long-term contribution goal and is not treated as wholly attributable or fully measurable within the project period.

3.1 Logic-model alignment

Results level	Approved result	Evaluation assessment
Ultimate outcome	Improved access to SRHR for sex workers in Uganda.	Contribution is positive but not fully measurable: referral readiness improved, while completed uptake and health outcomes could not objectively and systematically recorded.
Intermediate outcome	Sex worker organizations engage, participate and implement effective SRHR and gender-justice advocacy.	Substantial progress: organizations reported advocacy, CLM, dialogue, coalition participation, district recognition and program adaptation.
Short-term outcome 1	Increased knowledge on SRHR, gender justice and advocacy capacity.	Substantially achieved: near-target Year 1 training delivery, practical application examples and a 4.31/5 mean organisational-strengthening rating (n=13 valid ratings).
Short-term outcome 2	Increased public support for the SRHR of sex workers.	Partially achieved/evidenced: radio and stakeholder engagement generated response, but standardized attitude and social-media data were incomplete.
Short-term outcome 3	Improved access and uptake of available friendly SRH services.	Partially achieved: strong evidence of knowledge and referral improvements (4.57/5; n=14 valid ratings), but insufficient consolidated completed-referral and service-uptake records.

3.2 Output performance matrix

Performance status reflects the evidence supplied for this evaluation. “Partially evidenced” means that implementation or progress is documented, but the full target cannot be verified from consolidated records.

Logic-model output / target	Evidence available	Status
Output 1.1: Two policy-analysis workshops for 60 members	Two two-day sessions; 60 participants reported.	Achieved
Output 1.2: Two SRHR advocacy and human rights trainings for 60 members	Two sessions; 57 participants from 18 districts.	Substantially achieved (95%)
Output 1.3: Two GTA workshops for 60 members	Two workshop dates; 59 participants reported.	Substantially achieved (98%)
Output 2.1a: Eight regional radio talk shows over two years	Eight radio shows documented across two years: four Year 1 shows and four Year 2 shows listed for Kabale, Malaba, Fort Portal and Lira.	Achieved (100%)
Output 2.1b: Two pull-up banners, one commemoration banner and 385 T-shirts	Year 2 listing records 385 T-shirts (70 + 315) and one banner; report evidence also records pull-up/event banners.	Achieved (100%)
Output 2.2: Four regional dialogues reaching 120 stakeholders	Four Year 2 regional stakeholder dialogues in Fort Portal, Kabale, Gulu and Malaba, each listing 31 participants (124 participant attendances).	Achieved (100%)
Output 3: I Mapping report and health Provider database in three regions.	Year 2 listing records mapping inception (35), data-collector orientation (15 over five days), fieldwork, a six-person technical working group, validation (41) and dissemination (46).	Achieved (100%)
Biannual reviews and final evaluation	Year 2 listing records two update meetings (45 and 37 participants) plus evaluation inception (26) and close-out (21).	Achieved (100%)

3.3 Outcome indicator scorecard

Approved indicator	Evaluation evidence	Assessment / data gap
Number/type of engagements with district and national stakeholders	Regional dialogues and engagement with health, district, police, CSO and media actors. BYMI joined district health, HIV and human-rights committees; VOICE joined the District AIDS Committee and district health planning; WOPEIN engaged town councils and eight facilities.	Clear progress and varied engagement types; a consolidated engagement register is still required.
Inclusion in district/national policy processes	BYMI gained committee representation; VOICE participated in district health planning; JEWAG reported district recognition/CBO certification; LMEC joined KCCA/division platforms; OWEC reported stronger district influence.	Strong qualitative examples; no standard measure of the depth or regularity of participation.
Platforms where organizations advocate and issues addressed	Radio shows, district forums, coalitions and CLM spaces addressed stigma, rights, referrals, commodities and violence. PVYA and VOICE used radio; SLUM and WOPEIN used CLM; WONETHA used evidence in advocacy.	Platforms and issues are provided; a complete platform and advocacy-action tracker is still needed.
Representatives reporting increased SRHR, gender-justice and advocacy capacity	All 21 tools report positive application; 12/13 valid ratings were significant or very significant. Examples include LMEC’s draft gender policy, BYMI’s policy development, OGERA’s strategic-plan alignment and PVYA’s community dialogue.	Strong organizational evidence; individual participant totals and matched follow-up results are unavailable.

Radio, social-media and IEC engagement/positive response	Eight radio shows were documented. PVYA and VOICE reported using radio to discuss rights, stigma and service access; Year 1 monitoring recorded 76 follow-up calls, including supportive and stigmatizing responses.	Radio response is evidenced; social-media reach, IEC distribution and sentiment totals remain incomplete.
Knowledge of friendly services and case stories on improved access	Mean referral/access rating was 4.57/5; 13/14 valid ratings were significant or very significant. LMEC used the referral database during stock-outs; BYMI used an SRHR focal person; VOICE used a DIC; WOPEIN linked with eight facilities; WONETHA used escorted referrals.	Strong navigation and case evidence; consolidated completed-referral and service-uptake data are unavailable.

3.4 Gender and intersectionality performance

The Monitoring Plan required gender and intersectionality to be integrated into participation and outcome evidence. Implementation records show participation of female, male and transgender sex workers, young mothers, people living with HIV, people who use injecting drugs, migrants and one participant with a disability. Feedback also includes practical examples concerning trans women sex workers and male sex workers.
The evaluation can therefore confirm inclusive participation and diverse application examples, but it cannot determine whether knowledge, access or influence improved equally across groups.

M&E priority Future reporting should link each unique participant and beneficiary record to agreed, consent-based disaggregation variables, then compare reach, knowledge change, referral completion and client experience across groups without collecting unnecessary identifying information.

4. Findings by Evaluation Criterion

4.1 Relevance

The project was highly relevant. All 21 responses characterised activities as relevant or very relevant, including forms where the box itself was not marked but the narrative clearly affirmed relevance. Respondents described interconnected barriers: inadequate SRHR information; stigma and discrimination; weak referral pathways; limited organisational capacity; restrictive laws; poor coordination; commodity shortages; transport constraints; and inadequate reach of friendly services.

The design responded at several levels. Training addressed knowledge and skill, mapping and dialogue addressed practical navigation and relationships, media addressed awareness, and biannual meetings supported coordination. This was appropriate because respondents understood service access as a combined problem of information, power, stigma, relationships, supplies and law.

Need	Project response	Example

Limited knowledge	SRHR, rights and GTA training	TAI Uganda applied tailored information for trans women sex workers.
Weak advocacy	Policy analysis	WONETHA shifted toward evidence-based, audience-specific messages and case documentation.
Provider stigma	Dialogue and engagement	Malaba Outfits reported improved health-worker and DHO relationships.
Unclear referrals	Mapping and peer navigation	KWSHI Kasese gained health-worker contacts for referral.
Weak coordination	Reviews and coalitions	Women With a Mission described regional collaboration and coalition participation.

Table showing how the Project Responded to Identified Needs

Relevance conclusion: the interventions matched priorities before and after implementation, and its combined capacity, stakeholder and referral strategy fitted the multi-dimensional barriers described.

4.2 Coherence

Internal coherence was strong. Leaders developed shared concepts and policy knowledge, practiced advocacy and audience mapping, engaged stakeholders, mapped providers and applied learning through peer education, CLM, outreach, proposals and district engagement. For example, OGERA in Wakiso District aligned its strategic plan with SRHR priorities; SLUM in Wakiso applied CLM in four facilities; WONETHA in Wakiso strengthened peer navigation and escorted referrals; LMEC in Kampala developed a draft gender policy and used the referral database; and PVYA in Lira applied learning through community dialogue and outreach. These activities complemented members' existing HIV, SRHR, human-rights, gender and community-mobilization mandates.

External coherence was shown through work with facilities, DHOs, community development structures, police, CSOs, media and coalitions. BYMI in Bundibugyo reported engagement with the DHO, DCDO, police and district health, HIV and human-rights committees. VOICE in Gulu City participated in the District AIDS Committee and district health planning; WOPEIN in Kampala/Wakiso worked with town councils and eight government facilities; Malaba Outfits in Tororo strengthened relationships with the DHO and providers; and KWSHI in Kasese gained referral contacts. The Gulu dialogue linked community priorities with commodities, provider workload, key-population sensitivity and CLM, while the Year 1 report records UNESO and three members joining CSMMUA.

The main coherence risk is dependence on individual allies. Organizations across districts noted that trusted health workers, police officers and district officials may transfer, weakening referral and advocacy relationships. UNESO should convert these collaborations into formal institutional arrangements, designate at least two focal persons per institution and maintain documented action and referral plans.

4.3 Effectiveness: output delivery

As shown in the graph below, UNESO delivered the main activities planned across the two project years. In Year 1, capacity-strengthening activities reached 60 participants through policy-analysis training, 59 through gender-transformative training and 57 through SRHR and human-rights advocacy training. The biannual review meeting reached 32 participants. The small difference in participation across the three training areas shows that the project maintained broad and consistent coverage, while the review meeting involved a smaller group focused on assessing progress and learning.

In addition to the activities presented in the graph, the project conducted radio programmes, regional stakeholder dialogues, service-provider mapping, referral strengthening, production of information, education and communication materials, review and update meetings, and the final evaluation. Over the two years, eight radio talk shows were documented, meeting the overall project target. Together, the graph and activity records show that UNESO delivered a broad package combining organizational capacity building, public engagement, stakeholder collaboration and improved referral systems.

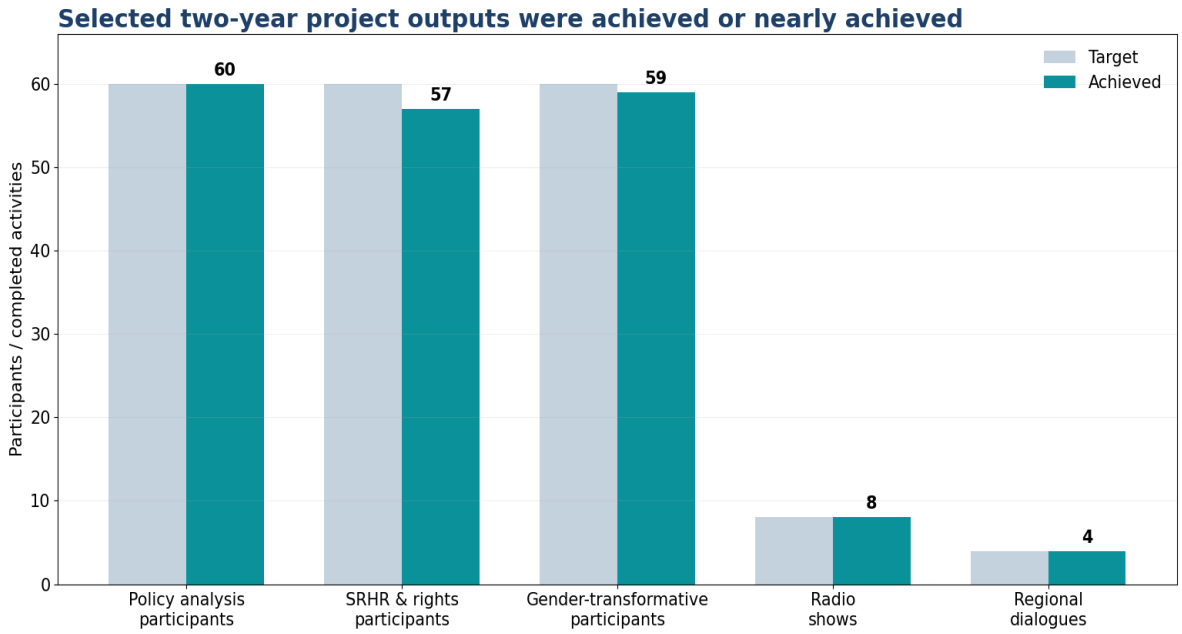


Figure 2. Target and achievement for selected two-year project outputs.

4.4 Organizational capacity and application

Among 13 interpretable scores, organisational strengthening averaged 4.31/5: five “very significant,” seven “significant” and one “moderate.” Twelve of 13 valid ratings were therefore significant or very significant. The additional Lira rating was 4/5 and described stronger advocacy, leadership, planning and documentation. BYMI reported stronger policies and committee participation; LMEC reported a draft gender policy and stronger district engagement; VOICE linked project learning to improved visibility, a functional drop-in centre and resource mobilisation; and WOPEIN described stronger referral and CLM systems.

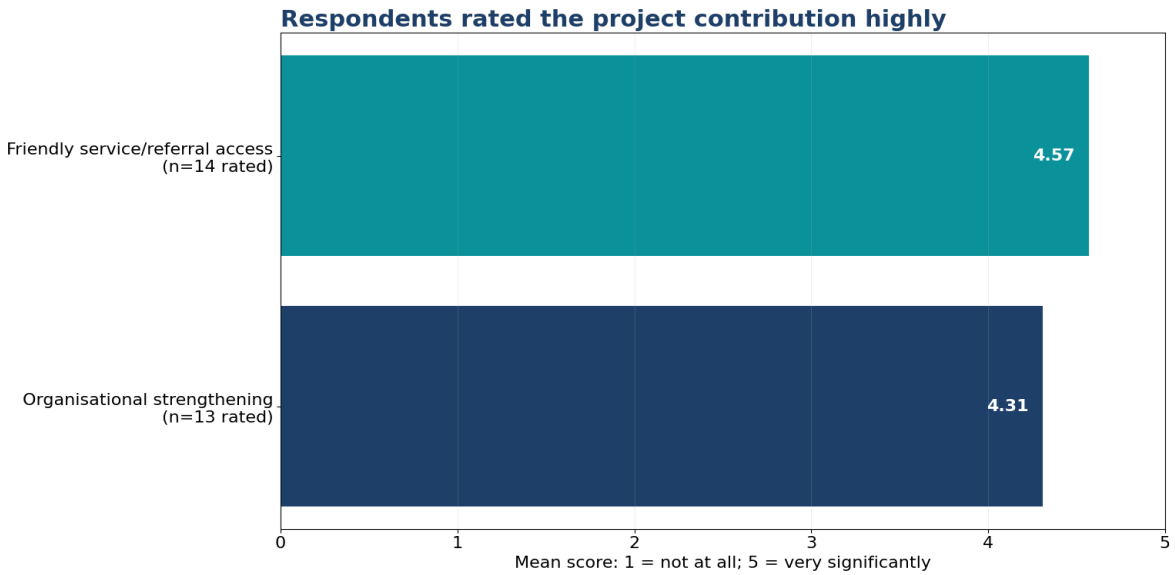


Figure 3. Mean contribution ratings.

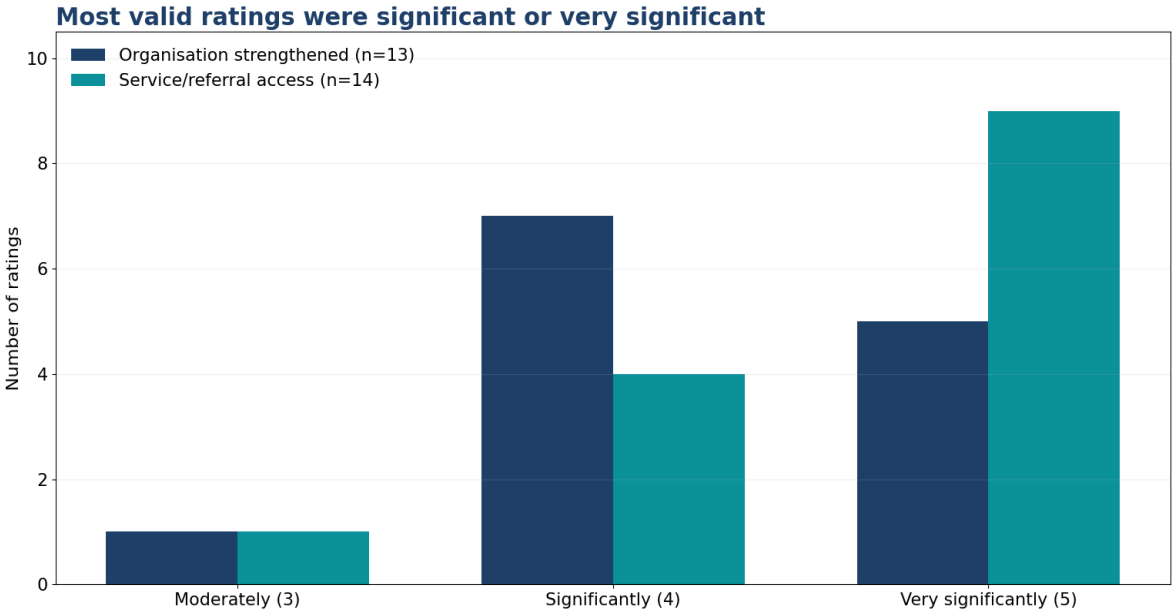


Figure 4. Distribution of valid contribution ratings.

How learning was applied

Pathway	Examples
Evidence-based advocacy	WONETHA tailored messages and used cases/testimony.
Programme integration	MON integrated SRHR for men in outreach; OGERA aligned its strategic plan.
CLM	SLUM conducted CLM in four facilities and used findings in advocacy.
Peer navigation	WONETHA trained navigators; GAHF trained five community champions; ACHEWE cascaded learning.

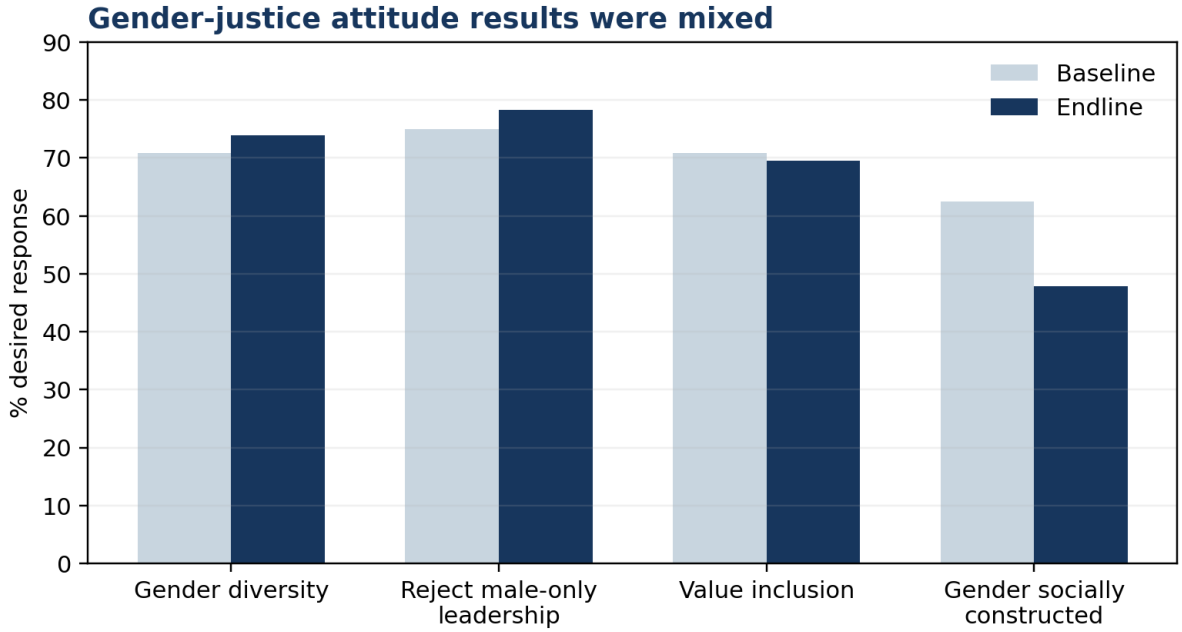
Institutional recognition	JEWAG reported district recognition/CBO certification; OWEC reported stronger Isingiro influence.
Resource mobilization	Kasese used updated SRHR/legal context in proposals; members proposed joint fundraising.

Contribution finding The strongest evidence is the repeated sequence training → organizational adaptation → advocacy or service-navigation action across different districts.

4.5 Knowledge and gender-justice learning

The Year 1 report states that participants improved their ability to define SRHR concepts, distinguish advocacy, activism and lobbying, identify policy audiences and articulate rights. Endline feedback supports practical use: respondents reported confidence to demand services, engage decision-makers, distinguish case types, develop messages and cascade information.

Gender-attitude results were mixed. Desired responses improved modestly for gender diversity (+3.1 percentage points) and rejection of male-only leadership (+3.3). Inclusion was broadly stable (−1.3), while understanding gender as socially constructed declined 14.7 points. The training reinforced some norms but did not consolidate a more complex concept.



Learning implication Use simpler definitions, locally grounded cases, teach-back practice and delayed follow-up assessment in future GTA sessions.

4.6 Partnerships and public/stakeholder support

Collaboration was one of the project's most consistent achievements. All 21 organizations reported at least one positive partnership with stakeholders such as health workers, health facilities, District Health Officers, community development officials, police, KCCA, MARPI, TASO, Marie Stopes, civil society organizations, coalitions, town councils and cultural institutions.

Examples of improved collaboration included:

- BYMI was consulted by district structures in Bundibugyo.
- LMEC participated in division-level and KCCA platforms.
- VOICE gained representation on the District AIDS Committee and participated in district planning.
- WOPEIN worked with eight government health facilities.
- PVYA coordinated community outreach and referrals with local leaders and partner organizations.

However, stakeholders and public support did not improve equally everywhere. Radio programmes generated 76 follow-up calls, showing increased public interest, but some callers still expressed stigmatizing views. Evidence from Gulu also showed increased recognition by district authorities, although stigma, arrests and barriers to services continued.

Overall, the project strengthened collaboration and engagement among participating organizations and stakeholders. However, it did not lead to a complete change in public attitudes or remove all barriers

4.7 Friendly services and referrals

Among 14 interpretable scores, improvement in friendly services and referrals averaged 4.57 out of 5: nine respondents rated the contribution as very significant, four as significant and one as moderate. Overall, 13 of the 14 valid ratings were significant or very significant. The completed tools explain how this change occurred. Bundibugyo Young Mothers Initiative (BYMI) used an SRHR focal person to connect members to friendly services; Lady Mermaid Empowerment Centre (LMEC) used the provider database to refer clients when particular services or commodities were unavailable; Women Positive Empowerment Initiative (WOPEIN) used mapped facilities and named contacts; Voice for Community Empowerment (VOICE) coordinated referrals through its drop-in center; and Platform for Vulnerable Youth and Adults (PVYA) combined community outreach with direct referrals to friendly clinics.

Provider mapping produced the greatest value when organizations converted information into active relationships and practical referral arrangements. Kasese Women's Health Support Initiative (KWSHI) obtained direct contacts at health facilities; Women With a Mission (WWM) identified where to refer clients for specific services; and the Women's Organization Network for Human Rights Advocacy (WONETHA) used peer navigators linked to facilities to refer and accompany clients. Masaka Key Populations HIV Prevention and Support Organization (Masaka KP) reported more respectful and less biased services, stronger district support and progress in linking peer leaders to community health-extension structures.

However, improved referral pathways did not always mean that services were available or affordable. Organizations continued to report PrEP and condom stock-outs, limited specialized services, provider stigma, staff transfers, transport costs and other financial barriers. LMEC's experience showed that referral networks helped maintain continuity during stock-outs, while VOICE and WOPEIN relied on several facilities and partners rather than one provider. The project therefore improved service navigation, provider responsiveness and confidence to seek care, but it could not guarantee commodity supply, eliminate all costs or remove wider legal and structural barriers.

Service-access conclusion Evidence strongly supports improved referral readiness, knowledge of friendly providers and perceived service friendliness. Organizational examples also show escorted referrals, named focal persons, drop-in-center linkages and continuity during stock-outs. However, consolidated data on completed referrals, waiting times, service uptake, health outcomes and sustained commodity availability were not collected.

4.8 Efficiency

The project used an efficient network-based delivery model. UNESO convened leaders from several districts, who then shared knowledge through their organizations and peer networks. Face-to-face training and stakeholder dialogue were reinforced through radio programmes, IEC materials and virtual review meetings, allowing the project to maintain engagement while reaching audiences beyond those who attended the main activities.

Efficiency was further strengthened by working through existing member organizations, health facilities, district structures and community platforms instead of establishing parallel systems. Peer navigators, community champions, drop-in centers and community-led monitoring (CLM) helped extend project benefits beyond the directly trained participants and supported continued referrals and advocacy.

4.9 Impact and contribution

The clearest emerging impact is the shift from organizations mainly receiving information to using knowledge, evidence and relationships to act as advocates, service navigators and recognized district partners. Across the 21 completed tools, organizations reported one or more forms of practical application, including community-led monitoring (CLM), participation in committees and coalitions, peer training, tailored IEC materials, stronger provider relationships, more confident policy engagement and improved referrals.

The contribution pathway is visible in specific examples: Bundibugyo Young Mothers Initiative (BYMI) gained representation on district health, HIV and human-rights committees; Lady Mermaid Empowerment Centre (LMEC) used its referral network to maintain continuity of care during stock-outs; Voice for Community Empowerment (VOICE) strengthened its drop-in center and district representation; Women Positive Empowerment Initiative (WOPEIN) used CLM evidence that contributed to establishment of a new triage area at Wattuba Health Centre III; and Platform for Vulnerable Youth and Adults (PVYA) strengthened engagement with community and cultural structures. These changes are credible contributions of the project, although they cannot be treated as population-level impact without independent outcome data.

Emerging change	Contribution assessment	Evidence strength
Organizational voice	Strong contribution: training and peer learning were repeatedly translated into advocacy, leadership and institutional participation, including BYMI committee representation and PVYA engagement with cultural structures.	Moderate–strong: repeated across tools and supported by practical examples, but mainly self-reported.
District/provider relationships	Plausible contribution through mapping and dialogue. VOICE joined district structures, WOPEIN worked with	Moderate: consistent organizational accounts, but no independent

	eight facilities, and BYMI strengthened relationships with the DHO, DCDO and police.	provider or district stakeholder survey.
Referral navigation	Strong contribution where organizations established named contacts, referral databases, peer navigators and accompaniment. LMEC, WOPEIN and WONETHA provided clear examples.	Moderate: strong mechanism evidence, but no consolidated referral-completion or client-outcome dataset.
Reduced stigma/public support	Some improvement was reported among engaged providers, officials and communities, including friendlier care and greater willingness to collaborate; change was not uniform.	Emerging: positive organizational accounts coexist with stock-outs, stigma, arrests and hostile media responses.
Population SRHR outcomes	The project plausibly improved knowledge, navigation and responsiveness, but changes in population-level service uptake or health outcomes cannot be determined.	Insufficient: no beneficiary cohort, routine service-use trend or health-outcome data attributable to the project.

4.10 Sustainability

Prospects are moderate to high for knowledge, relationships and locally owned practices. Respondents expect trained peers, referral contacts, partnerships, advocacy structures, CLM and stakeholder participation to continue. These are embedded in people and organizations rather than project branding.

Financial and contextual sustainability is less secure. Most gaps/recommendations mentioned funding, laws, stigma, stock-outs, refresher needs or transfer of allies. Sustainability requires written referral arrangements, multiple focal persons, district/QI integration, member sub-grants and continued advocacy.

Likely to continue	At risk without support
Knowledge of leaders and peers	Regular outreach, transport and cascade training
Informal referral contacts	Continuity after officials transfer
Advocacy confidence	National advocacy and media engagement
CLM where adopted	Analysis and action follow-up at scale
Peer and coalition networks	Coordination costs, wellness and fundraising

5. Most Significant Change Examples

5.1 From participant to peer navigator

A trans-led organization reported that a peer in Nabweru/Nansana initially lacked confidence and structured information to support others. After project learning, the peer supported three hotspots by replenishing prevention supplies and sharing accurate information, including where other services could be obtained. The change brought information and commodities closer through a trusted peer.

Why it matters Technical knowledge became peer leadership and practical navigation for a population facing compounded stigma.

5.2 Evidence-based advocacy and escorted referrals

WONETHA used policy and SRHR learning to sharpen messages, document community cases and recruit peer navigators. Navigators conduct awareness, refer and accompany clients. Health workers also joined hotspot outreach, moving information and selected services closer to the community.

5.3 District legitimacy

JEWAG reported that engagement helped it gain district recognition and CBO certification in Mukono District to work officially with sex workers on rights and SRHR. OWEC described stronger influence in Isingiro District. Institutional recognition can open planning spaces and strengthen the credibility of community evidence.

5.4 CLM as an advocacy bridge

SLUM applied learning through CLM in four facilities and used findings for advocacy. A Mbarara District respondent described clients using CLM information to identify services and make informed prevention choices. CLM can connect experience with facility problem-solving when findings are tracked to action.

5.5 Stronger Networks Improving Access and Continuity of Services

One of the most significant changes reported was the ability of member organizations to turn newly strengthened partnerships, referral systems and community-led evidence into practical improvements in service access. BYMI established a sustainable peer-support and referral network in Bundibugyo District, while LMEC used its network of mapped service providers to maintain continuity of care when individual facilities experienced stock-outs. VOICE reported that stronger partnerships helped it secure space for a functional drop-in center, creating a more accessible point of support for community members.

At facility level, WOPEIN reported that evidence generated through community-led monitoring contributed to Wattuba Health Centre III management securing support for a dedicated triage area. In Lira, PVYA strengthened community outreach, referrals and advocacy, including engagement with a cultural institution to broaden local support.

6. Challenges and Adaptive Responses

Challenge	Effect	Response / implication
Restrictive laws	Fear of organizing, reporting and advocacy.	Legal literacy, coalitions, documentation and police dialogue.
Stigma	Reduced service seeking and uneven support.	Peer navigation, provider engagement and sensitization.
Stock-outs	Referred clients could still miss commodities.	CLM, district escalation and alternative referrals.
Limited funding	Constrained outreach, transport and follow-up.	Partnerships, flexible funding and member sub-grants.
Staff transfer	Loss of trusted contacts.	Multiple focal persons, written plans and refreshers.
Workload/wellbeing	Compassion fatigue and reduced capacity.	Wellness, psychosocial support and supervision.
Timing/weather	Attendance disruption.	Earlier confirmation, hybrid access and careful scheduling.

7. Lessons Learned

- Capacity building creates more value when followed by organization-specific action plans, mentorship and evidence of application.
- Health services provider mapping works best with named focal persons, service details, costs/accessibility and feedback route, updated regularly.
- Peer navigators bridge formal training and community change; they need tools, transport, supervision and safeguarding.
- Stakeholder commitments must be assigned, documented and reviewed, especially where officials transfer.
- Public support is not binary: media can open dialogue while revealing continued stigma; both should be monitored.
- Flexible funding is essential in a restrictive, changing environment.
- Gender-transformative learning needs simplification, practice and delayed assessment.
- Community evidence influences decisions when analyzed, targeted, linked to action and followed through.

8. Recommendations

1. Strengthen outcome measurement

Use unique participant records, matched pre/post/follow-up tests, disaggregation, referral records and stakeholder commitment trackers. Measure application after 3–6 months.

2. Fund member-led action

Provide flexible small grants for cascade training, CLM, escorted referrals, district follow-up and rapid response, supported by mentorship.

3. Institutionalize referrals

Verify and update a directory routinely; designate two focal persons per institution; document referral/feedback protocols; review completion and experience quarterly.

4. Deepen provider and district work

Offer KP-sensitive refreshers and orient new staff. Integrate CLM into facility quality improvement and district reviews.

5. Continue legal/policy advocacy

Strengthen legal literacy, case documentation and coalition work. Tailor evidence for health officials, police, legislators, media, cultural and religious leaders.

6. Expand inclusion

Reach more districts and ensure trans women, male and young sex workers, rural/cross-border groups, people living with HIV and people with disabilities participate meaningfully.

7. Address commodity continuity

Use CLM to monitor stock-outs, escalate supply problems, map alternatives and communicate temporary unavailability.

8. Invest in wellness and safeguarding

Provide psychosocial support, supervision, burnout prevention, safety planning and referral support for peers and staff.

9. Measure efficiency

Link costs to outputs/outcomes, calculate unit costs and document in-kind contributions across delivery models.

10. Close the accountability loop

Record each dialogue commitment, owner and deadline; review progress and report back to communities.

11. Conclusion

The project was relevant and responded to key barriers, including limited knowledge, stigma, weak advocacy, poor coordination and referral challenges. All planned activities were delivered, and feedback from 21 sampled organizations across Central, Western, Eastern and Northern Uganda supports the evaluation findings.

The project's strongest achievement was helping organizations turn learning into action. Organizations improved advocacy, referrals, peer support, community-led monitoring, engagement with health workers and government officials, partnerships, internal policies and resource mobilization.

However, the project did not remove all barriers. Stock-outs , stigma, restrictive laws and limited funding continued to affect access to services.
The benefits most likely to continue are improved knowledge, peer capacity, relationships and referral networks. Sustaining outreach, expanding community-led monitoring and strengthening national advocacy will require flexible funding, stronger integration into existing systems and better measurement of results.

Annex 1. Organizational Feedback Reviewed

Organization / identifier	District/area	Region
KWSHI	Kasese	Western
Kabarole Women's Health Support Initiative	Kabarole	Western
MON	Wakiso	Central
Malaba Outfits	Tororo/Malaba	Eastern
OGERA	Wakiso	Central
SLUM	Wakiso (as recorded)	Central
TAI Uganda	Kampala	Central
COPTEC	Wakiso	Central
GAHF	Busi Island/Wakiso (narrative)	Central
JEWAG	Mukono	Central
Masaka KP HIV Prevention & Support Organization	Masaka	Central
Organization for Women Empowerment Center	Isingiro	Western
Empowered at Dusk Women's Association	Bwaise/Kampala	Central
ACHEWE / Mbarara respondent	Mbarara/Western	Western
WONETHA	Wakiso	Central
Women With a Mission	Mbale	Eastern
BYMI	Bundibugyo	Western
Lady Mermaid Empowerment Centre (LMEC)	Kampala	Central
Platform for Vulnerable Youth and Adults (PVYA)	Lira	Northern
Voice for Community Empowerment (VOICE)	Gulu City	Northern
Women Positive Empowerment Initiative (WOPEIN)	Kampala/Wakiso	Central