# Mid-term Review Report

# AMPLIFYING THE VOICES OF YOUNG PEOPLE WITH MENTAL HEALTH ISSUES IN UGANDA

**Final Report**

**Project partners**: Youth mental Health Norway/Atlas Alliance

**Key stakeholders:** Ministry of Health; District Local Governments (Mbarara, Kanungu, Kampala, Mpigi, Mbale, Soroti, Gulu and Lira; DPOs.

## Project period: 2020-2024

**Submitted by: Justus Atwijukire (Consultant)**

December 29th, 2022

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## Acknowledgement

The Evaluation Team would like to acknowledge and express gratitude to all those who participated in this midterm review of the project and in particular, Ministry of Health-Mental Health Division; Lira and Mbale District Local governments, Board, reference group members and staff of Mental Health Uganda and Youth Mental Health Norway for their time, advice, inputs and logistical support in the preparation of the inception report, data collection tools, data collection and production of this report.

In a unique way, I want to thank the call center clients who participated in the client satisfaction survey to further enrich the report.

It is hoped that this review will provide valuable information to enable Mental Health Uganda, Ministry of Health-Mental Health Division, District Local governments, Organizations of Persons with Disabilities (OPDs) and all stakeholders involved in service delivery to further improve the design and implementation programs that address the specific needs of youth with mental challenges.

As is clear from the above, many individuals and organizations have made significant contributions to this evaluation; any errors and omissions, however, are the responsibility of the Evaluation Team.

Justus Atwijukire
Lead Consultant
**Kampala, December 2022**

## List of acronyms and abbreviations

| | |
|---|---|
| CAO: | Chief Administrative Officer |
| CDO: | Community Development Officer |
| CSOs: | Civil Society Organisations |
| DHO | District Health Officer |
| DAC: | Development Assistance Committee |
| DCDO: | District Community Development Officer |
| DDEG: | District Development Equalization Grant |
| DPO: | Disabled Peoples Organisation |
| KII: | Key Informant Interviews |
| LoP: | Life of a Project |
| MoH: | Ministry of Health |
| MEAL: | Monitoring, Evaluation, Accountability and Learning |
| MHU: | Mental Health Uganda |
| MTR: | Midterm Review |
| NAADS: | National Agricultural Advisory Services |
| NDP: | National Development Plan |
| NGO: | Non-Governmental Organisation |
| NUDIPU: | National Union of Disabled Persons of Uganda |
| NUSAF: | Northern Uganda Social Action Fund |
| NUWODU: | National Union of Women with Disabilities of Uganda |
| OPDs: | Organizations of Persons with Disabilities |
| OWC: | Operation Wealth Creation |
| PDM | Parish Development Model |
| RAs: | Research Assistants |
| VSLA: | Village Savings and Loans Association |
| SDG: | Sustainable Development Goals |
| ToRs: | Terms of References |
| UWEP: | Uganda Women Entrepreneurship Program |
| YLP: | Youth Livelihood Program |
| YMHN: | Youth Mental Health Norway |
| YWDs: | Youth with Disabilities |

# Executive Summary

The Amplifying the Voices of Young People with Mental Health Issues in Uganda project is a multimillion-dollar project funded by Norad through Atlas and Youth Mental Health Norway (YMHN) and implemented by Mental Health Uganda (MHU) with a total budget of Sh. 5,417,452,704 UGX. The five-year project started in 2020 and will end in 2024. The project has two broad objectives; i) Persons with mental health issues claim their rights and exert influence on matters that effect their life (Human Rights) and ii) Persons with mental health issues achieve and maintain maximum self-sufficiency and optimal functioning in interaction with their environments (Health & Rehabilitation). The Amplifying the Voices of Young People with Mental Health Issues in Uganda project was subject to a Mid-Term Review (MTR) during October 2012, during which time representatives of stakeholders and participants were consulted and all key documents and deliverables to date were reviewed.

The objective of the MTR was to objectively determine the progress of the project to date, and to develop recommendations to help optimize the implementation and sustainability of the project in the remaining timeframe for the project. Full details of the MTR are provided in subsequent sections of this report. The main observations and conclusions are summarized below with specific recommendations.

The MTR involved the review and analysis of secondary data, client satisfaction survey, Key Informant Interviews (KIIs) and district level consultations and Focus Group Discussions (FGDs) with Reference Group Members, Board of Directors, and the Call center counsellors/Agents.

**Main findings**

The analysis of both primary and secondary data clearly indicates that the project will most likely meet its intended objectives and will impact positively on the lives of the youth with mental health conditions, their families and community. Overall, the MTR rates the performance of the projects as 'satisfactory' because there was strong evidence that the projects met most of the project objectives and indicators.

The main proposed outcomes from Result 1: Human Rights are that DPOs (Mental Health Uganda) influence national and local decision-making processes and Girls, boys, women and men with mental health issues benefit from national and local level programs and services in target areas. The project has done quite well in advocating for the appointment of district mental health focal persons, increase in budget allocations at national and districts level, monitoring the implementation of the UNCRPD concluding observations and recommendations on psychosocial disability, influencing discussions around mental health issues through social media platforms. The project also strengthened the capacity of Board and staff in policy and advocacy, revitalized the reference group, improved financial management including timely delivery of quality financial reports (using quick books accounting package).

However, no changes in legislation, regulations, and policies that protect the rights PWMIs have been realized although the project engaged the Judiciary through the office of the principal judge to advocate for the legal reforms and implementation of existing legal provisions on mental health. The project needs to devise mechanisms of influencing changes in legislations including engaging the Ministry of Health to finalize the regulations to guide the full implementation of the Mental Health Act for the benefit of persons with mental conditions.

It was also noted that the MHU structures at the local level were weakened by the outbreak of covid 19 and limited funding. More capacity building including allocation of resources to operationalize the functionality of the MHU district structures/associations is important. Without strong MHU structures at national and local level, participation, and representation of persons with mental health problems in elective positions will not be fully achieved.

The project result area 2 (Inclusive health and rehabilitation) aims at contributing to the achievement of the overall project goal of empowering persons with mental health issues to claim their rights and exert influence on matters that effects their life. The result area has one strategic objective of "young people with mental health issues, and those at risk of developing mental health issues, benefit from programmes and services in target areas". The result area 2 has three intermediate results including.

- PWMI are able to access inclusive health and rehabilitation services
- Health and rehabilitation staff have the skills to provide inclusive health and rehabilitation services
- Local and national health policies are influenced by DPOs

With regard to indicator 1(PWMI are able to access inclusive health and rehabilitation services), the project established aToll-free line with 6 trained counsellors and 1 nurse who provided mental health services to more than 2,062 successful callers in one and a half years. The counsellors also provided psychosocial support to 1,691 PWMI against the midterm target of 7,500 clients and conducted 5,918 online counselling sessions against the midterm target of 7,500. The client satisfaction survey conducted as part of the MTR established that 82% of the clients who received phone counselling/consultations reported that they were satisfied with services received, 10% neither agreed nor disagreed while 8% reported that they were dissatisfied with the services received. On the capacity and customer care of the call agents/counsellors, 97% of the clients reported that counsellors were polite and courteous, 94% reported that they were given adequate time by the counsellors to explain their problem/need and 89% reported that the counsellors understood their problems and provided appropriate support. This demonstrates that the current call center agents/Counsellors have the required capacity, positive attitude, and customer care to deliver quality service to the clients.

The MTR however noted a continuous decline in the number of call centre clients received quarterly. The number of new clients reduced by 83% between October-December 2021 and July-September 2022 which demonstrates underutilization of the facility and the counsellors to provide the much-needed services. This could be attributed to limited marketing campaigns conducted to popularize the call center/help line hence the need to devise strategies to further popularize the helpline especially in rural areas where access to information and services is limited.

Under indicator 2 (Health and rehabilitation staff have the skills to provide inclusive health and rehabilitation services), the project developed a user-friendly training manual for counselling and trained 16 staff (1 nurse, 6 counsellors, 9 other staff) in community-based counselling. Additionally, 15 peer counsellors were trained in Kanungu district as part of the project efforts to strengthen community response to mental health issues through peer-to-peer counselling. To strengthen responsible media reporting on mental health issues, the project trained 38 journalists in Kanungu and Mbarara districts in Western Uganda which has contributed to increased media reporting, provision of free airtime on mental health issues and interface between the media and persons with mental health issues. The project also recruited and oriented 6 (3 men and 3 women) reference group members across 4 regions (North, West, East and Central). with a lived experience of mental health issues who have supported the project implementation by identifying key activities and materials for the target group and popularize the mental health issues across the country. However,

it was noted that the peer counselors' structure was only rolled out in one district (Kanungu district) as opposed to 8 project districts due to limited resources. To meet the project targets on improving the skills of health and rehabilitation staff to provide inclusive health and rehabilitation services, the project needs to roll out peer structures in the remaining seven districts.

Regarding indicator three on DPOs influencing local and national health policies, the project has not influenced any local or national health policy apart from supporting the Ministry of Health-Mental Health Division to develop the Terms of Reference for the district mental health focal persons. This is an area that needs to be prioritized in the second half of project implementation. To achieve this, MHU need to map out key local and national health policies in addition to the national mental health policy for prioritization which were not clearly identified in the project design.

Lastly, the MTR noted that a lot of time, effort, and funds have been invested in the gestation and initiation and implementation of the project activities amidst covid 19 pandemic and the momentum needs to be maintained. Key recommendations from the MTR include the following:

i. Allocate resources to operationalize and strengthen the functionality of the district structures/associations and strengthen their advocacy, fundraising and mental health promotion (identification and referrals) capacity.
ii. Strengthen the linkages and coordination between the national level and district associations to improve project implementation and sustainability.
iii. Strengthen joint advocacy to influence changes in specific legislation, regulations or policies and build strong and formal partnerships with relevant stakeholders on specific advocacy agenda. Some of the areas include Mental health Policy and development of regulations, Community mental health care and appointment of mental health focal persons at district level.
iv. Prioritize livelihood support interventions which directly contribute to the wellbeing of the target audience in future proposal development to reduce on the mental health challenges mental health conditions emanating from economic hardships.
v. Improve the engagement of government structures Ministry of Health-Mental Health Division and local governments in the implementation of the project to push for changes in the policy and regulatory framework and service delivery.
vi. Develop and implement an Organizational Development Strategy with clear provisions on membership, fees structures and utilization modalities.
vii. Intensify fundraising/resource mobilization to bridge the funding gap resulting from depreciation of the shilling and inflation in the country.
viii. Review the result framework, performance indicators and targets to set clear targets that will enable the project to measure change from the project interventions at the end of the project.
ix. Establish peer group structures in the remaining districts to facilitate peer to peer support.
x. Improve call centre logistics (including provision of functional laptops?? to counsellors, stable internet connection and reduction on generator noise) to enable counsellors provide quality service to the clients.
xi. Appoint a technical supervisor with experience in psychosocial support to provide supervision, appropriate mentorship, coaching and technical support to the call Centre counselors.

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# 1.0 INTRODUCTION AND BACKGROUND

## 1.1 Background

Mental Health Uganda (MHU) is an indigenous Organization, established in 1997 for people with a lived experience of mental illness, care givers and service providers. Over the years, MHU has registered huge successes in the areas of advocacy for policy, rights and legislative reforms, advocacy for community mental health care, capacity building especially for membership district associations, livelihoods support for people with a lived experience of mental illness, rehabilitation and reintegration of homeless people off the streets of Kampala, user-led programming, anti-mental health stigma and discrimination, among others.

The new MHU strategic plan 2020-2024 places a lot of emphasis on young people with or at risk of developing mental health problems. This is precisely due to the predominantly young Ugandan population, with 78% below 30 years, whereas 75% of mental health problems begin before the age of 24 years.

## 1.2 Purpose of the project midterm review

An internal midterm review was commissioned to assess progress of implementation of the amplifying the voices of young people with mental health issues project, measure success on achievement project goals, strategic objectives and results and help to provide guidance on how to improve implementation for the remaining period. Specifically, the midterm review was conducted to:

I. To critically review implementation and provide an early gauge of key elements such as relevance, effectiveness, efficiency, impact, and sustainability.
II. To document lessons learned and promising practices; and
III. To provide recommendations for modifications to meet the project´s stated goals and objectives.

The midterm review aimed at understanding the key successes and challenges in the implementation of the project and any further cross-cutting or organizational level lessons and specific recommendations for future project designs.

This midterm report therefore presents:

- The perceptions of the partners, participants, and beneficiaries consulted.
- The key points from the programme documents and context literature, as they relate to the relevance, progress, and potential sustainability of the project.
- The evidence for the reviewers' observations and conclusions; and,
- Recommendations for moving forward, in a constructive manner, based on the experience and sound judgment of the midterm review Team.

## 1.3 Project description

Mental Health Uganda (MHU), in partnership with Youth Mental Health Norway, started implementing the "Amplifying the Voices of Young People with Mental Health Issues in Uganda" project in 2020. The project has two broad objectives:

- Persons with mental health issues claim their rights and exert influence on matters that effect their life (Human Rights)
- Persons with mental health issues achieve and maintain maximum self-sufficiency and optimal functioning in interaction with their environments (Health & Rehabilitation).

The project seeks to address the problem of accessibility to mental health care in the districts of Uganda, particularly for youth, by establishing a national toll-free help line where people with, or caretakers of, people with mental health issues can receive a counselling session and/or guidance on where to find appropriate help. In addition, the project seeks to expand the existing MHU peer-to-peer model by offering peers training so that they can provide more specialized support to young people struggling in the communities.

The project is being implemented in 8 districts across 4 regions i.e., Northern region in Gulu and Lira districts; Central region in Mpigi and Kampala districts; Eastern region in Soroti and Mbale districts; Western region in Mbarara and Kanungu districts. The project which started in 2020 will end in 2024.

***Table 1: Key project outcomes and outputs***

| **Program Area and outcomes** | **Outputs** |
|---|---|
| **Result Area 1: Human Rights** | **Persons with mental health issues claim their rights and exert influence on matters that effects their life** |
| Outcome 1: DPOs (Mental Health Uganda) influence national and local decision-making processes<br>Outcome 2: Girls, boys, women and men with mental health issues benefit from national and local level programs and services in target areas. | 1.1 Changes in legislation, regulation and policies that influence the life of target group<br>1.2 Partnerships, networking, alliances and coalitions promoting and/or advocating for disability inclusion<br>1.3 Increased budget allocations to Mental Health<br>1.4 Increased demand for our services after campaigns<br>1.5 Examples of persons reporting improved satisfaction with mental health after receiving counselling on phone or by peer (researcher). |
| **Result Area 2: Inclusive Health and Rehabilitation** | **Persons with mental health issues achieve and maintain maximum self-sufficiency and optimal functioning in interaction with their environments** |

| | |
|---|---|
| Outcome 1: Young people with mental health issues, and those at risk of developing mental health issues, benefit from programmes and services in target areas | 1.1 15,000 phone counselling sessions (PH). 3,000 Peer to peer (P2P).<br>1.2 3,000 persons having received services from peers<br>1.3 150-250 peers trained<br>1.4 Six counselling staff trained<br>1.5 1.5 million NOK raised |

# 2.0 Methodology and ethical considerations

## 2.1 Midterm review Approach

This midterm review focused on establishing whether the project "Amplifying the voices of young people with mental health issue" is on course to achieve its intended objectives/outcomes. The review was guided by the specific evaluation questions jointly developed and drawn along the five OECD Development Assistance Committee (DAC) evaluation criteria – relevance, effectiveness, efficiency, impact and sustainability. A result-oriented midterm review approach was used to measure the extent to which the project objectives and interventions were achieved or are likely to be achieved in the remaining project period. The process was highly participatory involving key project stakeholders (Mental Health Uganda, Youth Mental Health Norway,) at each stage of the review process including the review design/methodology, identification of evaluation questions, deciding the scope and targeted audience for the review, data collection and validation of the findings.

The midterm review utilized secondary data from project documents, progress, and activity reports; conducted client satisfactory survey targeting 20% of the call center clients for the period January-September 2022. In-depth/key informant interviews were conducted targeting the key project stakeholders mainly to establish the process of change; why and how the project results are being achieved or not achieved.

The midterm review focused on the intended results but also documenting unintended positive or negative outcomes of the project to the targeted participants, documented innovations and any deviations from the original project plan that could positively or negatively have affected the achievement of results.

The district consultations were conducted in the two districts of Lira and Mbale which were purposively sampled to represent Eastern and Northern regions where the project conducted advocacy activities to influence budgetary allocations in favor of persons with mental health issues.

The midterm review was conducted internally, using a mix of quantitative and qualitative methods and tools. The process included.

a) A desk top review of the project documents and reports
b) Call centre client satisfaction survey
c) Analysis of MHU call centre data
d) Analysis of Health Management Information system data on mental health
e) Consultations/engagement with selected district local governments where the project is being implemented.
f) In-depth Interviews with MoH-Mental Health Division

g) Engagement with MHU board and reference group members
h) Interaction/engagement with project staff and call centre/helpline agents
i) Youth Mental Health Norway (YMHN).

## 2.2 Ethical considerations

The midterm review was conducted in line with the ethical guidelines and safeguarding procedures relating to evaluators/researcher–human subject relationship. The key ethical considerations and how this evaluation met the set standards are described below.

***Informed consent:*** All participants involved in the evaluation were given information about the purpose of the evaluation and how the data collected will be used prior to seeking their consent. Study participants were informed that participation was voluntary and that they had the right to refuse to participate or to withdraw from the evaluation at any time without loss of any services or benefits entitled to them.

All members of the evaluation team completed an ethics training course prior to data collection to ensure that they adhere to the safeguarding and protection of human subject policies.

***Confidentiality and privacy:*** All the evaluation team kept strictly confidential all the data collected. No personal identifiers such as names were used in the client satisfaction survey and in any reports or publications. The Consultant and Research team adhered to confidentiality and Safeguarding Policies during data collection, analysis and report writing.

***Only assess relevant components:*** The Consultant only assessed the components that were of relevance to this midterm review.

**Training of Research Assistants:** Three experienced and trustworthy Research Assistants were identified and trained to conduct the client satisfaction survey. The survey was conducted virtually (telephone calls) and there was no physical interaction between the Research Assistants and call centre clients. The Research Assistants were knowledgeable of the local languages (Runyakitara, Acholi/lango and Luganda) which were the commonly used languages indicated in the call centre data base.

## 2.3 Data collection methods

Several tools and techniques were used to collect data for the project midterm review. These included;

i. **Review and analysis of secondary data**: The evaluation team analyzed secondary data on the project participants to understand the performance of the project across the key quantitative project indicators. In addition, the evaluation team reviewed the project documents, MEAL documents, implementation plans, monitoring reports, project annual reports, advocacy reports, Organization capacity assessment (OCA) reports and other documents generated by the project.
ii. **Client satisfaction survey:** A random sample of 200 clients was generated from a sampling frame of 724 clients that received a service from the Mental Health toll free line between 1st January to 30th September 2022. The target was to interview 20% of the 724 clients. A total of 147 clients were interviewed representing 74% of the sample and 20% of the 724 clients. The data was collected electronically using google forms

which was downloaded in Comma separated Values (SCV) file and exported to excel for analysis.

iii. **Key Informant Interviews (KIIs) and district level consultations:** This was undertaken with Ministry of Health-Mental Health Division, District Local Governments (DLGs), Project Management Team and Youth Mental Health Norway.

iv. **Focus Group Discussions (FGDs)**: The Consultant held three Focus Group Discussions involving the Reference Group Members, Board of Directors, and the Call center counsellors/Agents.

## 2.4 Analysis and production of the evaluation report

The qualitative data from Focus Group Discussions and Key Informant Interviews were transcribed then organized and analysed to draw conclusions on the objectives of the midterm review. Themes and sub themes were generated using the midterm review objectives and project indicators to inform the data analysis.

Quantitative data from the client satisfaction survey project (secondary data shared) was analysed using Excel to generate percentages and frequencies on the different variables under study. Secondary quantitative data obtained from project documents were also tabulated and presented graphically for interpretation.

The final analysis involved triangulation of data from both quantitative and qualitative data under each of the midterm review questions with findings and conclusions from annual project reports, advocacy campaign reports, activity reports and other project documents; and, finally, correlated with the feedback from the key stakeholders during the validation meeting

# 3.0 MID TERM REVIEW FINDINGS

This chapter presents the main findings of the midterm review basing on the Terms of Reference, project objectives/outcomes and the six DAC evaluation criteria. For each of the project outcomes and the evaluation criteria under consideration, the consultant shall give a rating on the extent to which the criterion has been met.

## 3.1 ASSESSMENT OF PROJECT RELEVANCE

The review established that the amplifying the voices of young people with mental health issues in Uganda project design and interventions met the needs and priorities of youth with mental issues, Mental Health Uganda and the Government. The project contributed to the achievement of sustainable Goal 3: Ensure healthy lives and promote wellbeing for all at all ages by ensuring that young people with mental health issues receive health services (health services, help line, one-on-one counselling, etc.) and peer support services and **rating of excellent.** The objectives of the projects were in line with the third National Development Plan (NDP III) 2020/21 – 2024/25 goal of the Human Capital Development Programme on improving productivity of labour for increased competitiveness and better quality of life for all.

The review established that the project has adequately addressed the needs and priorities of the youth with mental health issues in Uganda by amplifying the voices of the youth and empowering the youths to speak out. It was reported that the advocacy and community sensitization conducted by the project increased public awareness on mental health and contributed to the reduction in stigma towards persons with menta health issues although this could not be verified. The toll-free line has ensured that people who need mental health and psychosocial support services access them.

*The project has empowered me to be able to reach out to more people with mental health challenges. I am now confident, and I have been participating in radio talk shows, advocacy activities and community sensitization on mental health* ***- Reference Group Member, Kampala.***

During the project design, a lot of consultations were held with Youth Mental Health Norway which enabled them to appreciate the institution and the capacity gaps for redress. The involvement of the young people in the design was very important to ensure that the interests of the users are taken into consideration. The consultations and engagement of various stakeholders ensured that critical areas were prioritized. For example, the consideration of the human rights and access to services as one of the key project interventions was important in ensuring sustained advocacy for planning, budgeting, and provision of services for youth with mental health conditions at National and local level.

The establishment of the toll-free line to provide online psychosocial support and information on mental health was timely and necessary in addressing access to mental health care.

At organizational level, the project has contributed to the institutional development through supporting board meetings, organizational capacity assessment (OCA) and helped the organization to improve financial management and reporting using QuickBooks to monitor fund utilization monthly. The organization revised and improved the financial manual moved from the use of excel in accounting to QuickBooks accounting package. The project enabled the organization to revive the reference group which was not functioning.

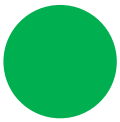
It was however, noted that during the design of the project, the linkage and coordination between MHU at national level and district structures were not clearly defined and supported to strengthen advocacy and awareness efforts. The project does not have a district presence and activities are largely implemented by the centre. The district level mental health structures should have been considered and facilitated to implement some of the activities and to make a follow up advocacy commitment at district level. Secondly, the Livelihood support which directly contributes to the wellbeing of the target audience was not addressed by the project. The project stakeholders noted that livelihood support should have been part of the project to address the economic wellbeing of the people to reduce on the mental health conditions emanating from economic hardships.

Although the two areas identified were pertinent, a single project may not address all the challenges. The project is focused on addressing specific human rights and health challenges identified and prioritized by the organization and the partner during the project design stage. MHU will need to among others mobilize additional resources including developing linkages and alliances with other Atlas Alliance Organisations that support economic Empowerment to link the project beneficiaries for economic empowerment.

## 3.2 ASSESSMENT OF EFFECTIVENESS

This section attempts to assess progress made towards the achievement of the projects' objectives and expected results as described in the project Theory of change and log frames. The section analyses the extent to which the two main pathways of change were or are likely to be achieved and the contributing factors affecting the achievement of the intended results. The following assessment criteria (fig.1) was used to determine the extent to which the project outputs have been achieved and progress towards achievement of the project outcomes.

**The assessment Rating for measuring the achievement of the project objectives and results.**

| | | |
|---|---|---|
|  | Excellent | There is strong evidence that the project ***fully meets all or almost meets all aspects*** of the evaluation criterion under consideration. The findings indicate **excellent and exemplary** achievement/progress/attainment. |
|  | Satisfactory | There is strong evidence that the project is progressing well on ***most*** aspects of the evaluation criterion under consideration. The situation is considered **satisfactory, but there is room for some improvements in the second half of the project implementation.** There is need for a management response to address the issues which are not yet met. |
|  | Attention | There is strong evidence that the project ***only partially meets*** the aspects of the evaluation criterion under consideration. There are **issues which need to be addressed and improvements are necessary** under this criterion to achieve the life of the project (LoP) targets. |
|  | Caution | There is strong evidence that the project ***does not meet the main*** aspects of the evaluation criterion under review. There are **significant issues which need to be addressed** under this criterion. |
|  | Problematic | There is strong evidence that the project ***does not meet*** the evaluation criterion under consideration and is performing very poorly. There are **serious deficiencies** in the project under this criterion. |
|  | Not Sufficient Evidence | There is ***not sufficient evidence*** to rate the project against the criterion under consideration. |

## 3.2.1: RESULT AREA 1 – HUMAN RIGHTS

The project result area 1 (Human Rights) aims at empowering persons with mental health issues to claim their rights and exert influence on matters that effects their life. The result area has two strategic objectives namely.

SO1: Mental Health Uganda influence national and local decision-making processes.
SO2: PWMI benefit from national and local level programs, activities, and services in target areas.

This report analyses and rates the process and progress of the project in achieving the above strategic objectives. The evaluation **rated as 'satisfactory' on** the progress towards the achievement of the result area1. Specific achievements are summarised below.

| | | |
|---|---|---|
| **Effectiveness** | • Advocated for the appointment of district mental health focal persons. In the four project districts of Gulu Lira, Mbale and Soroti, the MH focal persons had been identified but were yet to be offered formal appointment partly due to the absence of the approved ToRs. However, two districts (Jinja and Kyenjojo) which are outside the project coverage had officially appointed the focal persons due to the national level advocacy.<br>• In collaboration with National DPOs, MHU monitored the implementation of the UNCRPD concluding observations and recommendations on psychosocial disability and prepared the shadow report for submission to the committee.<br>• Advocated for the increase in budget allocations at national and districts level. Some of the district local governments (Lira, Mbale and Soroti allocated some funds for the implementation of mental health activities ranging between one and four million shillings.<br>• Strong social media presence to influence discussions around mental health issues. Over 294,000 people were reached through the social media campaign hashtag #LetsTalk #ConversationsChangeLives as part of pre-launch activities. Through the campaign "#LetsInvest #MentalHealthUG" over 195,000 people were reached.<br>• The project strengthened the capacity of Board and staff in policy and advocacy, revitalized the reference group, improved financial management including timely delivery of quality financial reports (using quick books accounting package). The project has also improved the visibility of the organization at national and local levels. | **Rating**  |

## Strategic Objective 1: Mental Health Uganda influence national and local decision-making processes

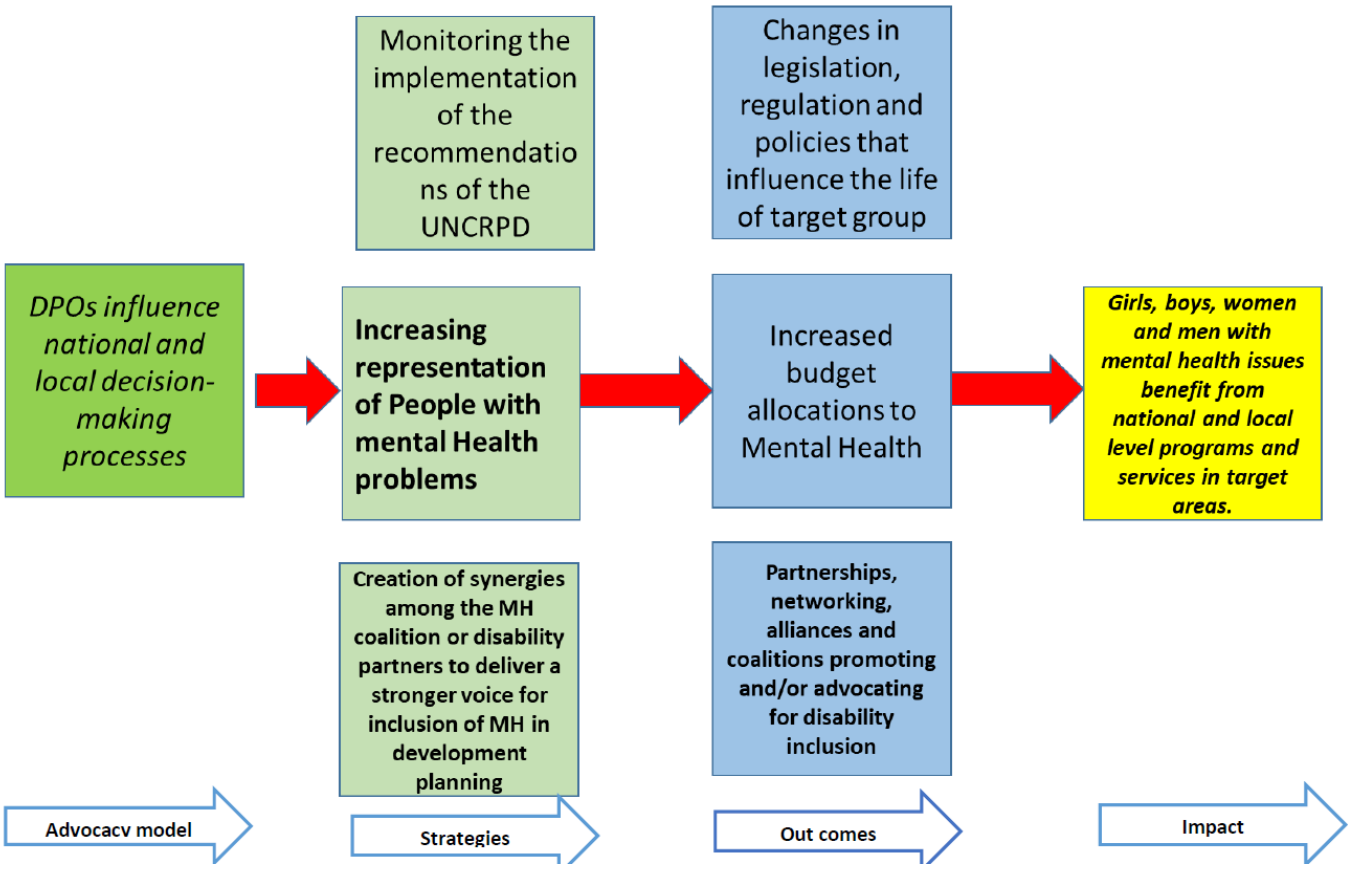
Strategic Objective 1 of the Result Area 1 focuses on Mental Health Uganda's influence on national and local decision-making processes; ensuring that persons with mental health issues claim their fundamental human rights and exert influence on matters that affect their life while strategic objective 2 focuses on ensuring that PWMI benefit from national and local level programs, activities, and services in target areas. The key performance indicators are;

i. Examples of changes in legislation, regulations, and policies that protect the rights PWMIs
ii. Examples of local and national advocacy and awareness campaigns or events that influence decision makers and challenge the general public`s cultural attitudes towards PWMI
iii. Partnerships, networking, alliances and coalitions promoting and/or advocating for disability inclusion

iv. Increased budget allocations to Mental Health

The theory of change postulates that IF DPOs (Mental Health Uganda) influence national and local decision making processes by monitoring the implementation of the UNCRPD recommendations, increasing representation of people with mental health problems and create synergies among the Mental Health coalition or disability partners to deliver a stronger voice for inclusion of mental health in development planning, THEN there will be changes in legislation, regulation and policies that influence the life of the target group, increased budgetary allocation to mental health and strong partnership, networking and coalitions promoting and or advocating for disability inclusion that will ultimately result into persons with mental health issues benefiting from national and local level programs and services in the project areas. This is illustrated below.

*Figure 1: Project Theory of Change*




In order to achieve the project results under area 1 – human rights, the project planned to conduct the following major activities:

- Represent people with mental health issues in councils, committees, forums etc.
- Map mental health services in districts.
- Collect data on district level from callers and peers
- Monitor local and national budget allocations to Mental Health
- Conduct 3 awareness raising campaigns (2021, 2022, 2023)
- Hold 1 national conference
- Produce a research report on the effect of phone counselling and peer services on PWMI`s perceived mental health and quality of life.

- Develop partnerships and networks to facilitate joint advocacy

### *3.2.1.1 Analysis of achievements and Challenges under SO1: Mental Health Uganda influence national and local decision-making processes*

The project implemented a number of strategies and activities aimed at creating awareness of mental health issues in the public and amongst people in governing positions; empower persons with mental health issues to demand for their rights, monitor national and local budget allocations to Mental Health and hold the national government accountable to the commitments under the UNCRPD. This section summarizes the achievements of the project under result area 1 (human rights) basing on the outcome and output indicators. The midterm review established that the life of the project expected results will most likely be achieved. However, this requires strategic investment in advocacy to influence changes in specific legislation, regulations or policies and build strong and formal partnerships with relevant stakeholders on specific advocacy agenda.

#### (A) Mental Health Uganda influence national and local decision-making processes

Under this result area, the project focused on influencing changes in legislation, regulations, and policies that protect the rights of PWMIs, and conduct local and national advocacy and awareness campaigns or events that influence decision makers and challenge the general public`s cultural attitudes towards PWMI

As regards to changes in legislation, regulation and policies that influence the life of target group, the project did not have much influence. The review established that although the Government of Uganda enacted the Mental Health Act 2019 to address gaps in the legal framework for persons with mental health challenges, implementation of most of the recommendations from the CRPD committee on psychosocial support has been slow. The government has not finalized the regulations to guide the full implementation of the law and the progressive provisions of the Mental Health Act have not been fully applied while dealing with cases of persons with mental disabilities. As a result, persons with psychosocial disability continue to experience discrimination and challenges in accessing social services, participation in general elections and property ownership. Many persons with psychosocial disability face several frustrations while trying to access justice through the court system. These include but are not limited to; the use of discriminatory terminology such as "persons of unsound mind" in court documents and processes which entrench stigma; Persons with mental disabilities are also often times denied the right to bring or defend cases and their evidence is deemed to lack credibility; some people with mental disabilities cannot navigate or understand the complex processes required to initiate or defend cases, and no support is provided for them to do so.

The project however, supported the Ministry of Health-Mental Health Division to develop Terms of References (ToRs) for the District Mental Health Focal Persons which were yet to be approved by the Ministry authorities to support the appointment and facilitation of the district mental health focal persons. Secondly, the project engaged the Judiciary through the office of the principal judge to advocate for the legal reforms and implementation of existing legal provisions on mental health, however, not much has been realized.

Changing policies or legislation is a long and slow process that requires joint and coordinated advocacy which was not observed during this evaluation. For example, the Mental Health policy drafted in 2021 has never been finalized and approved. The process has stalled although the MoH-

Mental Health Division was optimistic that will be finalized soon. Due to the unnecessary delays in making policy changes, the project may not achieve much. However, joint and consistent advocacy is required if the project is to realize tangible results under this strategic objective.

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### (B) Local and national advocacy and awareness campaigns to influence decision makers and challenge the general public`s cultural attitudes towards PWMI

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The project designed and implemented a phone awareness raising/marketing campaign at national and local levels. One awareness raising campaign was conducted in 2021 in the eight project districts and erected billboards to market the toll-free line. Following the regional marketing of the toll-free number (0800 21 21 21), the project worked with 9 social media influencers to push the campaign on hashtag #LetsTalk #ConversationsChangeLives reaching out to over 294,000 people as part of pre-launch activities. This increased the awareness of the toll-free line which was launched on 17th May 2021.The evaluation further established that several stories on mental health and the toll-free line featured in the media – audio, visual and print, e.g. https://youtu.be/HQLnllqXPQc; https://www.youtube.com/watch?v=AkKBYpCrZic which increased toll-free number traffic (incoming calls) averaging over 800 per day. However, several of these were testing the facility, driven by the curiosity over the new and unique facility.

Due to insufficient resources, the 2022 awareness raising campaign did not take place. The project however, innovatively utilized the social media to market the toll-free line. Mental Health Uganda shared a lot of content on its social media pages (twitter, Facebook, and Instagram) to start the conversation around mental health and what different actors can contribute to increase investment in the sector. The campaign featured staff members, partners, and 'Champions' (young people with lived experiences of mental health problem and 10 social media influencers who were able to push the campaign on #LetsInvest #MentalHealthUG to reach over 195,000 people. However, the social media has limitations since its mainly accessed by people with smart phones hence denying majority of the youths in rural areas access to information.

MHU initiated and or participated in several advocacy activities to influence the implementation of the UNCRPD concluding observations. The project has facilitated MHU to participate in the World mental health day campaign and International Day of Persons with disabilities. Through these fora's, MHU increased demand for the Ministry of Health to re-open mental health facilities taken over during the outbreak of Covid 19 pandemic. Out of the four districts where MHU conducted advocacy, only Mbale district had not officially handed over the mental health unit as it was temporarily turned into maternity ward after covid 19 pandemic.

During the district mapping of mental health service providers in 2020, MHU evidenced the lack of coordination of all actions and actors in the sector and elaborated the need for MH focal persons to the Ministry of Health. To realize this, the project supported the drafting of the Terms of Reference for a Mental Health Focal Persons which were discussed by key stakeholders and submitted to the Ministry's technical working group for review and consideration. Without approved TORs appointment of the district mental health focal persons will be a challenge. Although the project intensified advocacy on the appointment of district mental health focal persons in the selected four project districts, none of the districts substantively appointed the mental health focal persons. However, all the four districts (Gulu Lira, Mbale and Soroti) had identified the suitable candidates for the position, awaiting formal appointment from the office of the Chief Administrative Officer

(CAO). This continues to affect coordination of mental health activities and service delivery at district level. However, it was noted that the advocacy efforts at the national level influenced other districts to consider the appointment of district mental health focal persons. At the time of the midterm review, the districts of Jinja and Kyenjojo had substantively appointed the district mental health focal persons and the Ministry of Health-Mental Health Division was hopeful that more districts will do the same once the terms of reference had been approved and disseminated. The approval of the terms of reference will among others ensure that districts allocate resources for the mental health focal persons to plan, coordinate and report on mental health service delivery.

Although one of the strategies of the project was to advocate for increase in representation of people with mental health problems in the leadership positions, there were no clear actions implemented to realize this. The gaps and barriers in the electoral laws and discrimination from community members continue to hinder majority of persons with mental health problems to vie for elective positions. For example, the Persons with Disabilities Act 2020, was not specific on the representation of persons with mental health condition on the National Council for Disability and local councils as it did for persons with visual impairments. The responsibility to nominate the representatives of the councils was left to the National Organisations of Persons with Disabilities which have similarly been discriminative to persons with mental health conditions.

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### (C) Mental Health Uganda demonstrate democratic processes, operational capacity and advocacy skills

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On the capacity of Mental Health Uganda to demonstrate democratic processes, operational capacity, and advocacy skills, MHU underwent a due diligence (2018), annual audit 2021, financial checklist and an Organisational capacity assessment (2021) which enabled MHU to identify capacity gaps and vulnerabilities. Basing on the findings, the organisation developed a combined action matrix with clear action areas (48 actions), responsibilities, and deadlines for resolution. The action points were mainly on governance, financial management, human resource, external collaboration and relations, inclusivity, and advocacy among others. At mid-term review, the organization had implemented 10 of the action points and the rest were on-going.

From the review, it was evident that the capacity of MHU has greatly improved. The project has built the capacity of the organization (board and staff) in policy and advocacy, facilitated the board and reference group meetings, supported the recruitment of key staff (especially the fundraising officer), improved financial management including timely delivery of quality financial reports (using quick books accounting package). The project has also improved the visibility of the organization through media engagements, advocacy, and involvement of key stakeholders (DPOs, MoH, District Local Governments and Mental health actors) in the project activities.

The project enabled the revival of the reference group composed of members with lived experiences who have supported organization in the design and implementation of activities basing on their experiences on what works and what does not work, conduct advocacy in the districts, represent MHU in different advocacy and campaigns on radio, national and international events, schools, and communities. The reference group members have innovatively supported mental health service delivery through provision of counselling in schools and communities and increasing awareness on mental health. However, it was noted by the reference group members that they were not involved in some project activities especially the capacity building activities. For example, 1) the policy and advocacy training did not include the reference group members to build their capacity in advocacy

for sustainability, 2) Reference group members did not participate in the development of the training manual and the actual training of the counsellors as persons with lived experiences who would come in to support the call Centre in the absence of the counsellors and 3) reference group members come up with activities but due to limited funds, they are not implemented.

At National level, MHU has internal organizational capacity to conduct effective advocacy. With the project support, MHU organized a three-day training on Mental Health Advocacy targeting the staff and board members to enhance their capacity in formulation and effective implementation of advocacy strategies. The training enabled 20 staff and board members to increase their knowledge and skills in advocacy. During the training, MHU board and staff were able to identify critical advocacy areas and strategies including the need to revive the Mental Health actors' forum/coalition as a platform for advocacy; streamline/organize the management of relations with its membership across the country to reinforces its legitimacy; engage members of the disability movement to address issues of fragmentation, internal competition and capacity gaps for a united and formidable disability movement and to invest in finding space to engage in periodic reviews of the National Development Plan (NDP) at District and national, levels to advocate for inclusion of MH issues among others. To achieve this, there's need for the development of a longer-term joint advocacy strategy on mental health issues (especially gaps in accessing essential drugs, specialized health workers, district mental health focal persons, financing, regulations, and guidelines on community based mental health services among others).

On the MHU structures at the local level, the midterm review established that the structures/ associations existed at the district level during the design of the project however, the outbreak of Covid 19 affected the operations of most of the structures. Most of the structures are weak or non-functioning. To advocate for representation of persons with mental health conditions in local government and structures of persons with disabilities, districts and sub counties, associations need to be strengthened as they provide a platform for individuals who would like to participate in elective positions. It was however, noted that the project did not put resources to strengthen the structures and coordination at district level. More capacity building for district associations is therefore paramount. The project should allocate resources to operationalize the functionality of the district structures/associations and strengthen their advocacy, fundraising and mental health promotion (identification and referrals). Without strong Mental Health Uganda structures at national and local level, participation, and representation of persons with mental health problems in elective positions will not be achieved.

Lastly, MHU needs to develop an Organizational Development strategy that among others formalizes membership registration, membership fees and other obligations, distribution, and utilization of the membership fund between MHU (at National level) and local chapters. Currently, local chapters pay membership, but nothing feeds back into the main secretariat. MHU could explore different models and identify the best option. For example, some organizations have a model where local structures give a percentage of the resources to support the national secretariat.

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**(D) Create synergies among the Mental Health coalition or disability partners to deliver a stronger voice for inclusion of mental health in development planning.**

The project conducted a stakeholder analysis and mapping to identify actors that can make meaningful contributions to mental health service delivery and advocacy. A total of 289 service

providers were mapped of which 70% are located within greater Kampala. The profiling of mental health services improved project referrals from the call centre. However, it was noted that some of the service providers were no longer in existence or had changed the services provided and costs. This requires the project to conduct a verification exercise to validate the data on mental health services mapped.

The project also identified the media as a major stakeholder considering the big audience they reach, yet they remain ignorant on mental health and use stigmatizing language while reporting. To address the challenge, the project organized two media trainings on basic understanding of mental health in Kanungu and Mbarara districts, targeting reporters and news anchors. A total of 38 reporters from over 10 media houses were trained. After the training, there were clear changes in attitudes and the language used in reporting. Other key stakeholders that emerged from the stakeholder analysis included police and judicial officers who were not reached by the project due to limited resources.

To facilitate joint advocacy, the project identified and developed partnerships and networks with like-minded regional organizations including Thrive Uganda, Umbrella of Hope Initiative, JENGA Community Development Outreach and AIDS Health Care Foundation who are members of the national coalition to advocate for improvement in mental health service delivery. However, there's no evidence of formal partnership, written advocacy agenda or existence of a strong partnership between these organizations and MHU in advocating for mental health service delivery. To address this, MHU was developing the ToRs for the national coalition that will strengthen partnership, coordination and joint advocacy for mental health. The project has also developed partnership with the private sector (banks-Stanbic, eco-bank; NGOs-CAIROS International) to provide materials and train their staff on Mental Health at a fee which is looked at as an opportunity to strengthen the sustainability of the organization.

In terms of engaging the Ministry of Health-Mental Health Division, it was noted that they were not consistently engaged in the implementation of the project and would like to be much more involved. This may give the project a mileage to push for changes in the policy and regulatory framework and well as strengthening the coordination of mental health activities at district level through the appointment of the district mental health focal persons.

## (E) Monitoring the implementation of the UNCRPD Committee recommendations.

Mental Health Uganda reviewed the UNCRPD concluding observations and recommendations and identified recommendations on psychosocial disability for advocacy and tracking/monitoring. In 2021, MHU commissioned an internal desk review on the implementation of the UNCRPD concluding observations on psychosocial disability. An extensive review of the relevant literature, analysis of existing data from the Ministry of Health, Mental Health Uganda (MHU) call centre and previous research studies was done. Additional primary data was collected in Lira, Mbale and Kanungu districts through in-depth interviews and stakeholder consultations to generate sufficient information on the key concluding observations. The information generated was used to develop an advocacy paper.

Mental Health Uganda participated in the development of the shadow/alternative report which was spearheaded by the National Union of Disabled Persons of Uganda (NUDIPU). The organization in collaboration with mental health actors also developed a minority shadow/alternative report on specific recommendations on psychosocial disability that were not ably covered in the main shadow

report due to several demands from different organizations of persons with disabilities (OPDs to have their issues captured in the report. The report provides a comprehensive analysis on the recommendations implemented and those that were yet to be implemented with clear action points. However, the report was yet to be submitted to the UNCRPD committee. MHU plans to submit the status report this year as part of the alternative reporting to supplement the civil society shadow report compiled by the National Union of Disabled Persons of Uganda (NUDIPU). It ought to be noted however that, the State Party report, which dictates upon the submission of all these related reports, was due on 25th October 2022 but was yet to be submitted by the time of writing this report.

### 3.2.1.2 Analysis of achievements and Challenges under SO2: Persons (Girls, boys, women, and men) with mental health issues benefit from national and local level programs and services in target areas

The Amplifying the Voices of Young People with Mental Health Issues in Uganda project is expected to influence duty bearers, mainstream organizations and district local governments to allocate and appropriately use funds on mental health in target areas and recognize the unique contribution of DPOs. This involved participation of Mental Health Uganda in national and local government decision making groups/processes (e.g., district councils, community executive committees, school management committees, committees to review/develop legislation/policies/strategies, CBID programs, etc.) and monitoring of local government budgets and the use of funds allocated for mental health in target areas.

#### (A) Participation of Mental Health Uganda in national and local government decision making groups/processes

MHU has been participating in the commemoration of the World Mental Health Days to influence national and local decision-making processes. In 2020, MHU used various platforms including livestreams on Facebook, Instagram posts, and the social media accounts of influencers to advocate for investment in mental health under the global theme “Move for mental health: let’s invest”. MHU participated in the commemoration of World Mental Health Day, specifically to bring to light the already existing investment gap with only 0.7% of the Uganda health budget being allocated to mental health. The advocacy efforts have resulted into allocation of funds for mental health in the target districts.

MHU together with partners like WHO, GIZ, UNICEF participated in meetings to discuss the MoH mental health sector investment case and the mental health component of the Ugandan Covid-19 response. The meetings on Covid 19 resulted into MoH training phone counselling agents on Covid-19 in view of related concerns fronted by callers, especially the provision of home-based care for affected persons.

Mental Health Uganda has worked with the Ministry of Gender, Labour and Social Development and NUDIPU on global UN summit 2022. The organisation has also worked with NUDIPU in the development of the shadow report to ensure that mental health issues are captured and presented well in the report.

## (B) District level governments allocate and appropriately use funds on mental health in target areas

The project in collaboration with identified DPOs and NGOs such as Thrive Uganda, Umbrella of Hope Initiative, JENGA Community Development Outreach and AIDS Health Care Foundation developed a concept paper “Advocacy for Mental Health: Increasing financing for Mental Health sector in Uganda”. The purpose of the concept paper was to advocate for the improvement in care and protection of the rights of persons with mental illness and demand for increased resource allocation to the mental health care service provision. Using the concept paper, MHU and the partners conducted advocacy on increasing financing of the metal health sector in 4 pilot districts of Gulu, Lira, Soroti and Mbale. This resulted into allocation of some funds for psychosocial support in Lira, Soroti, Mbale districts for the financial year 2022/2023 which was not the case in FV 2020/2021 where only Soroti district had a budget line for psychosocial support. For example, Mbale district using the District Development Equalization Grant (DDEG)) allocated 2.2 million under community-based services department and four million under health department for community sensitization and psychosocial support in the financial year 2021-2022. Lira district included mental health in the three-year development plan and allocated three million for mental health community sensitization in the financial year 2022/2023 while Soroti district allocates one million under local revenue for mental health activities every financial year. During district consultations, it was noted that the major issue affecting planning and mental health service delivery is that most of the district local government staff still believe that mental health is a medical issue and not a cross cutting issue which affects planning and consistency in budgeting for mental health.

*Most district staff still think that mental health is a medical issue and should be limited to the department of Health. Mental health should be a cross cutting issue in the national planning assessment tool like gender. So that all departments have specific budgets to implement mental health activities-**Assistant DHO, Lira district local government.***

In Mbale District, it was reported that Department of Community Based Services, Education and Health were all competing for allocation of mental health funds. For example, the Special Needs Education Officer considers mental health as part of special needs and wanted allocation of resources to sensitize the teachers while the department of community-based services wanted the funds for to train community development officers and probation officers who have not been trained on mental health and cannot easily support those in need. This demonstrates limited coordination in planning and budgeting for the mental health activities that could easily be eliminated with the appointment of the focal person.

The two-districts visited indicated that, the changes in government priorities and fund allocation will greatly affect budgetary allocation and mental health service delivery. For example, districts were using the DDEG to allocate some funds to the district priority areas however the government reallocated these funds to the Parish Development Model. This means that districts will need to use local resources to allocates funds for mental health which may not be realized. Secondly, associations of persons with mental health conditions have not benefitted from the mainstream development programs such as Uganda Women Entrepreneurship Program (UWEP), Youth Livelihood Program (YLP) and Emyoga program among others. In the districts sampled, only Anyimler Mental Health Association in Lira district with a membership of 5 people was documented to have received a grant of five million from the national special grant in 2019.

This requires sustained joint advocacy to influence positive change for the benefit of persons with mental conditions.

At National Level, there were positive debates at the Ministry of Health and in Parliament to increase budgetary allocation to prevent and respond to mental health conditions in the country. The Mental Health Division was optimistic about receiving budgetary increment for mental health activities.

“We have not yet received a financial increase. It will be factored into the new financial year 2023/2024. The proposal is to have a 7% budget increment if the activities are well aligned. The increase in funding will also support the activities of the district mental health focal persons”- Commissioner, Mental Health Division, Ministry of Health.

Overall, there’s no guarantee for annual increase in budget allocation for mental health at both national and local level as envisaged at the project design. With shrinking local revenue and unconditional grants allocated to the district local government, there’s need for sustained advocacy at national level (Ministry of Health, Parliament, and Ministry of Finance) to increase the mental Health Division budget that can support the implementation of activities at local level. The project should strengthen advocacy on Mental health Policy and development of regulations, Community mental health care and appointment of mental health focal persons at district level.

On increased demand for mental health care services after campaigns, the midterm review established that in less than one and half years, 2062 clients (76% below 30 years) received various services (psychosocial support, information on mental health and referrals) from the call centre/toll-free line by 30th September 2022. However, due to reduction in the marketing campaigns, the clients received quarterly reduced from 638 between October-December 2021 to 115 between July -September 2022. If the call centre is to serve its purpose well (early excitement not withstanding), it needs to be publicized, otherwise, the number of people receiving the service will continue to drop.

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### 3.2.2 RESULT AREA 2: INCLUSIVE HEALTH AND REHABILITATION

The project result area 2 (Inclusive health and rehabilitation) contributes to the achievement of the overall project goal of empowering persons with mental health issues to claim their rights and exert influence on matters that effects their life. The result area has one strategic objective of “young people with mental health issues, and those at risk of developing mental health issues, benefit from programmes and services in target areas”. The result area 2 has three intermediate results including;

- IR 1.1: PWMI are able to access inclusive health and rehabilitation services
- IR 1.2: Health and rehabilitation staff have the skills to provide inclusive health and rehabilitation services
- IR 1.3: Local and national health policies are influenced by DPOs

In order to achieve the project results, the project planned to conduct the following major activities:

- Develop training manual for counselling staff and peers

- Train staff and peers using the manual.
- Establish national helpline and conduct counselling sessions over the phone and peer-to-peer.
- Conduct activities that focus on mental health (sports, drama, dance, etc).
- Fundraising in Uganda and Norway to ensure help line sustainability
- Contract researcher to conduct interviews with users of our service and peers.

The project midterm evaluation **rated as 'satisfactory' on** the progress towards the achievement of the result area 2. Specific achievements are summarized below.

| | | |
|---|---|---|
| **Effectiveness** | • Toll-free line received more than 2,062 successful calls in one and a half years.<br>• 1,691 PWMI received psychosocial support from phone counsellors (PH) against the midterm target of 7,500 clients. Conducted 5,918 counselling sessions to 1,691 PWMI through phone (PH) consultations against the midterm target of 7,500 This represents 79% achievement of the project midterm target.<br>• 82% of the clients who received phone counselling/consultations reported that they were satisfied with health and rehabilitation services received.<br>• Piloted the peer structure in Kanungu districts with 15 (9 female and 6 male) trained peer counsellors. However, there was no sufficient data to evaluate the work of the peer counselors since they had just been deployed.<br>• Trained 1 nurse, 6 counsellors, 9 other staff (12 female and 4 male) in telephone counselling on mental health who have provided phone counseling and referral services to over 2,062 clients.<br>• Trained 38 media personnel on responsible mental health reporting which increased the media coverage on mental health issues. | **Rating**  |

## (A) IR 1.1: Persons with mental issues are able to access inclusive health and rehabilitation services

With the project funding, MHU launched their national toll-free telephone counselling service in May 2021. The service has six trained counselors and one mental health nurse available to answer calls 8 hours a day, 5 days a week. Since the launch, more than 2,062 calls were received in one and a half years. More than 1,691 PWMI received psychosocial support from phone counsellors (PH) against the midterm target of 7500 clients. The call Centre provided more than 5,918 individual counselling sessions. The toll-free line has provided an alternative source of information and psychosocial support to persons with mental health issues in a country experiencing a shortage of mental health professionals.

The analysis of distribution of calls per region and district indicates that more than half (55%) of the calls are from Central region/districts followed by Northern region (24%), Western region (13%) and lastly Eastern region (8%). In terms of gender, majority (59%) of the calls were from men, 40% were from women while 1% did not disclose their sex.

The data indicates a continuous decline in the number of clients received quarterly. The number of new clients reduced by 83% between October-December 2021 and July-September 2022 (see fig.2 Below). This demonstrates underutilization of the facility and the counsellors to provide the much-needed services. This could be attributed to limited marketing campaigns conducted to popularize the call center/help line. There is need to 1) popularize the helpline especially in rural areas where access to information and services is limited and 2) engage and partner with the Ministry of health-toll free line team to channel calls on mental health to the helpline. According to the Commissioner MoH-Mental Health Division, the calls to the ministry's toll-free line are directed to Butabika Hospital toll-free line (0800211306), yet the hospital provides information only and the MHU helpline would provide much needed psychosocial support to clients.

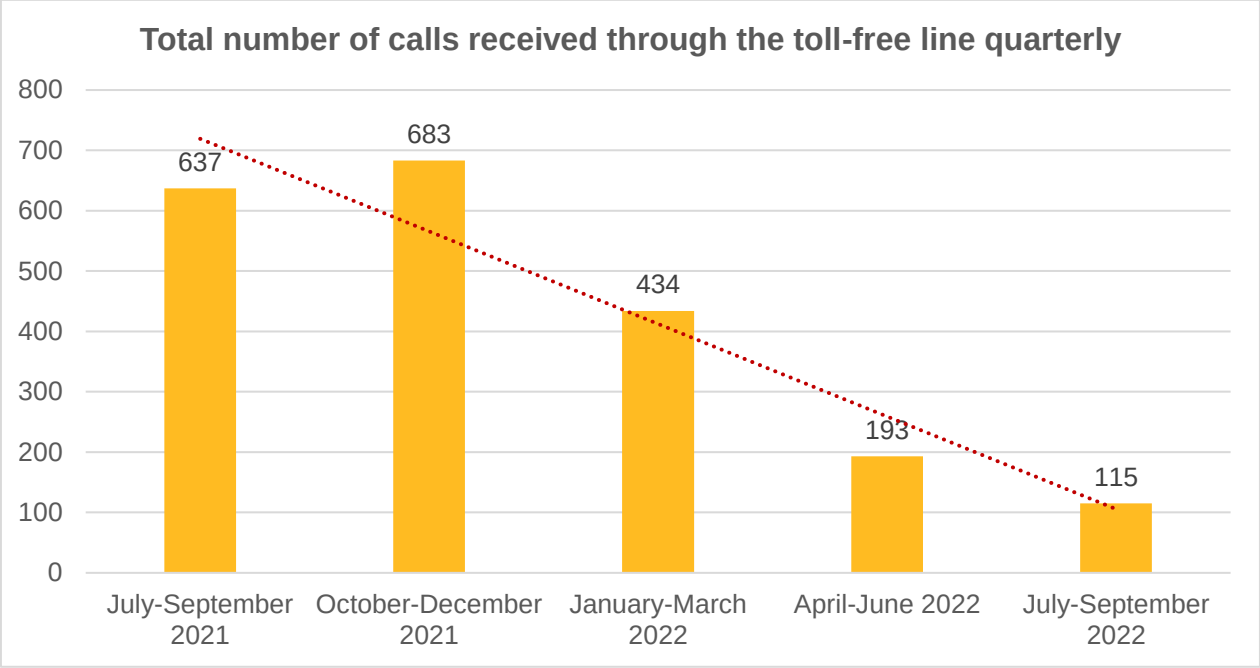


*Figure 2: Toll-free clients received between May 2021 and September 2022*

The project "Amplifying the Voices of Young People with Mental Health Issues in Uganda" mainly targets young people between 18-35 years. The analysis of the call center data indicates that majority (71%) of the call centre clients were indeed young people aged between 18-30 Years who are the target audience for the project. Those above 30 years were 14% and 5% were below 18 Years (Children).

***Table 2: Client age distribution***

| Age Category | Frequency | Percentage |
|---|---|---|
| Below 18 | 103 | 5% |
| 18-24 Years | 837 | 41% |
| 25-30 Years | 611 | 30% |
| Above 30 Years | 294 | 14% |

| | | |
|---|---|---|
| Not disclosed | 108 | 5% |
| **Total** | **2062** | **100%** |

In terms of service provision, it was established that, the toll-free line provided psychosocial support to 82% of the callers, referral to 36% and mental health information to 45% (refer to fig.5 for details). Majority of the clients (55%) had not accessed any service prior to the call. They instead were seeking help from religious leaders, traditional medicine/spiritual healing and peers among others. This clearly indicates a gap in mental health service delivery across the country and the introduction of the toll-free line by the project was timely.

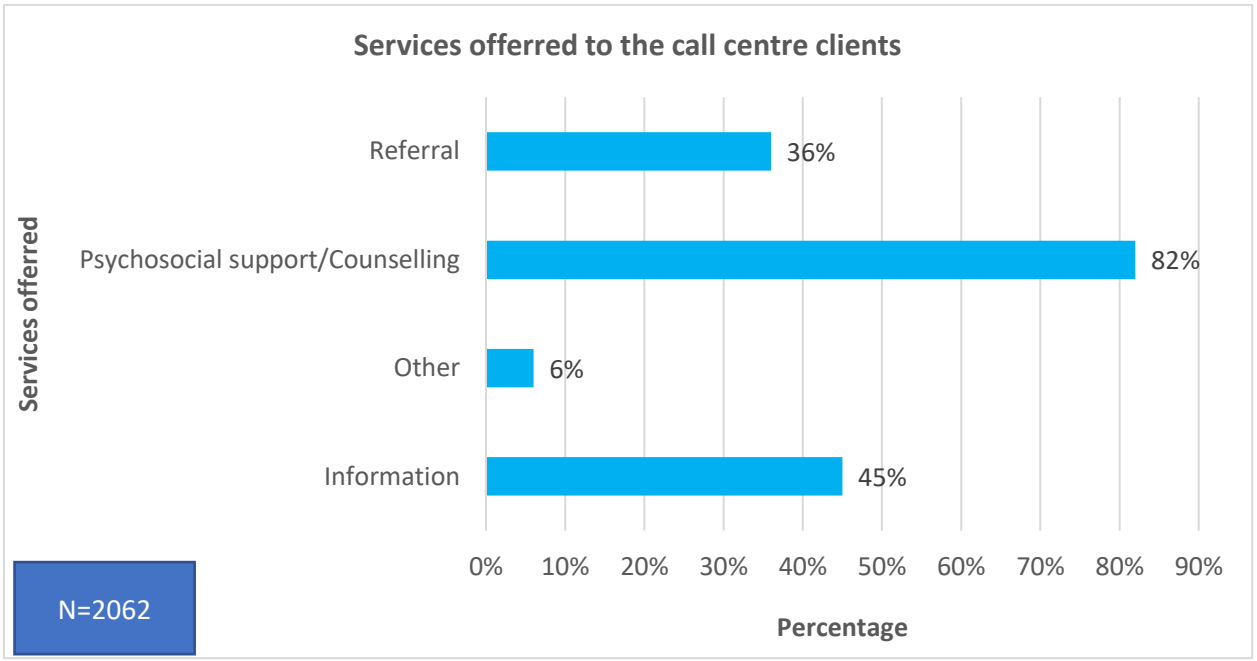


***Figure 3: Services offered to the call Centre clients***

The key challenges experienced by the counsellors in the provision of services include;

- Inadequate capacity to provide psychosocial support to clients on drug and substance abuse.
- Poor internet/low band width which affects the quality of calls leading to call drops.
- Noise from the generator which is mounted next to the call center. When using the generator, it makes it hard to communicate with the clients as most clients are not audible.
- Weak laptops- the batteries are weak, and this affects the calls; when charging and talking on phone, they produce /emit a lot of noise which affects the quality of the service provided.
- Inadequate knowledge in Kiswahili language as most of the counsellors do not know Kiswahili and many callers especially refugees need help.
- Inadequate support supervision and technical support from an experienced/expert in psychosocial support.

The above challenges need to be addressed to enable counselors to provide quality counselling and psychosocial support to the clients. A technical supervisor with experience in psychosocial support need to be instituted to provide supervision, appropriate mentorship, coaching and

technical support to the counselors. The project should also ensure that the wellbeing of the counsellors is put into consideration through engaging them in team building and or self-care activities and psychosocial support.

### 3.2.3 Findings from the Client satisfaction survey

As part of the project midterm review, a customer satisfactory survey targeting 20% of the call centre clients received between January – September 2022 was conducted in October 2022. This was intended to establish their satisfaction levels on the services received through the call center and establish the effectiveness of the referral system specifically on whether the clients actually receive the services after referral and the quality of service received. Total of 147 call centre clients participated in the survey representing 20% of the 742 clients received between January-September 2022. More than half (57%) of the participants were male while 68% were between 18-30 years.

***Table 3: Background characteristics of the client satisfaction survey 2022***

| Gender | Frequency | Percent |
|---|---|---|
| Female | 63 | 43% |
| Male | 84 | 57% |
| **Total** | **147** | **100%** |
| **Age group** | | |
| 18-24 Years | 45 | 31% |
| 25-30 years | 54 | 37% |
| 31-35 Years | 22 | 15% |
| Above 35 years | 23 | 16% |
| Not disclosed | 3 | 2% |
| **Total** | **147** | **100%** |
| **Education Level** | | |
| Primary | 9 | 6% |
| Secondary (O-level) | 58 | 17% |
| Secondary (Advanced level) | 25 | 40% |
| Tertiary | 55 | 37% |
| **Total** | **147** | **100%** |

Majority (72%) of the client satisfactory survey participants had received psychosocial support, 13% referral, 11% received information while 3% indicated that they did not receive any service as indicated in the fig 4 below.

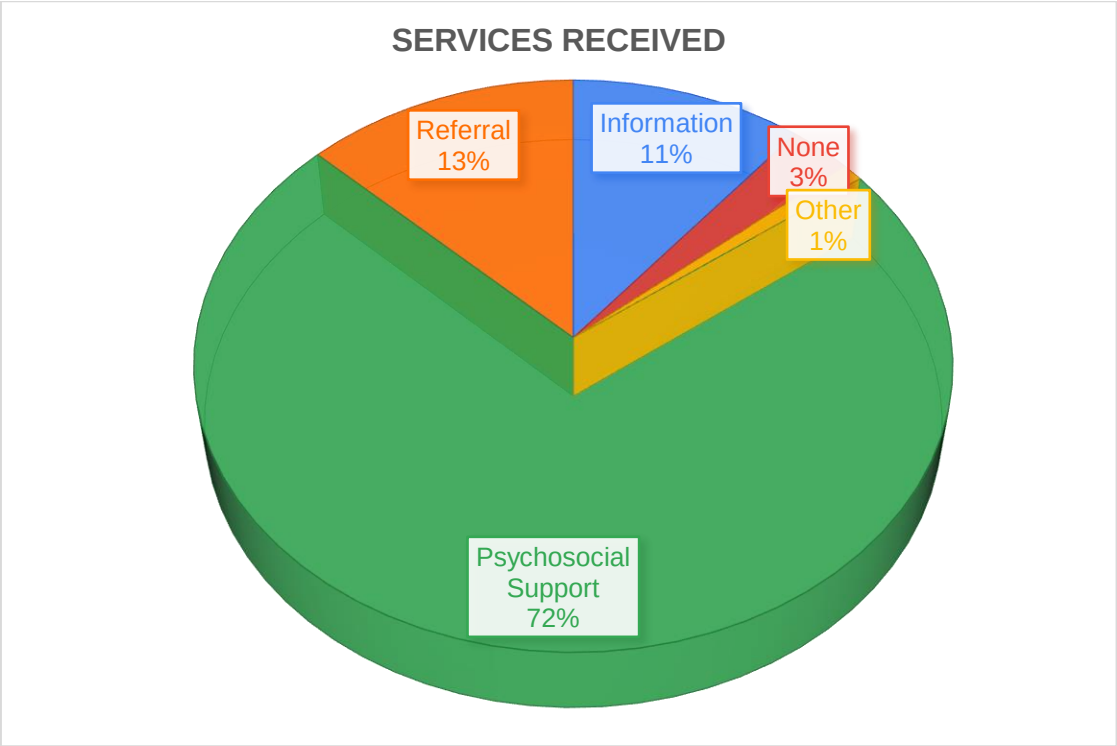


***Figure 4: Services received from the call centre by the client satisfaction survey participants***

The client satisfaction survey established that 82% of the clients who received phone counselling/consultations reported that they were satisfied with services received, 10% neither agreed nor disagreed while 8% reported that they were dissatisfied with the services received. On the availability and accessibility of the toll-free line, 94% strongly agreed/agreed that there was no delay or interruptions during the call. On the capacity and customer care of the call agents/counsellors, 97% of the clients reported that counsellors were polite and courteous, 94% reported that they were given adequate time by the counsellors to explain their problem/need and 89% reported that the counsellors understood their problems and provided appropriate support. This demonstrates that the current call center agents/Counsellors have the required capacity, positive attitude, and customer care to deliver quality service to the clients.

*I was satisfied with the service I received. I am requesting for a face-to-face counseling session and if possible, by the same counselor. I feel comfortable talking to her- Male* ***Call centre client from Kampala.***

*We were supported with counselling. I request to be availed numbers of counselors whom we can contact time and again-****female Call center client from Kampala***

However, very few clients (8%) were not satisfied with the service received because of the counsellors postponing the discussion while others were being referred to other counsellors who unfortunately did not help them.

*They never attended to me. The counselor kept postponing our discussion until I just gave up-Male Call centre client-Wakiso district.*

*I never received any service. I called and I was given another number for a counsellor, but she never picked. Female call centre client Wakiso district*

Generally, the feedback from the client satisfaction survey demonstrates the importance of the call centre/toll-free line to persons with mental health issues, family members and the community. As indicated, most clients were satisfied with the service received and 90% reported that they would not hesitate to recommend the service/toll-free helpline to anyone.

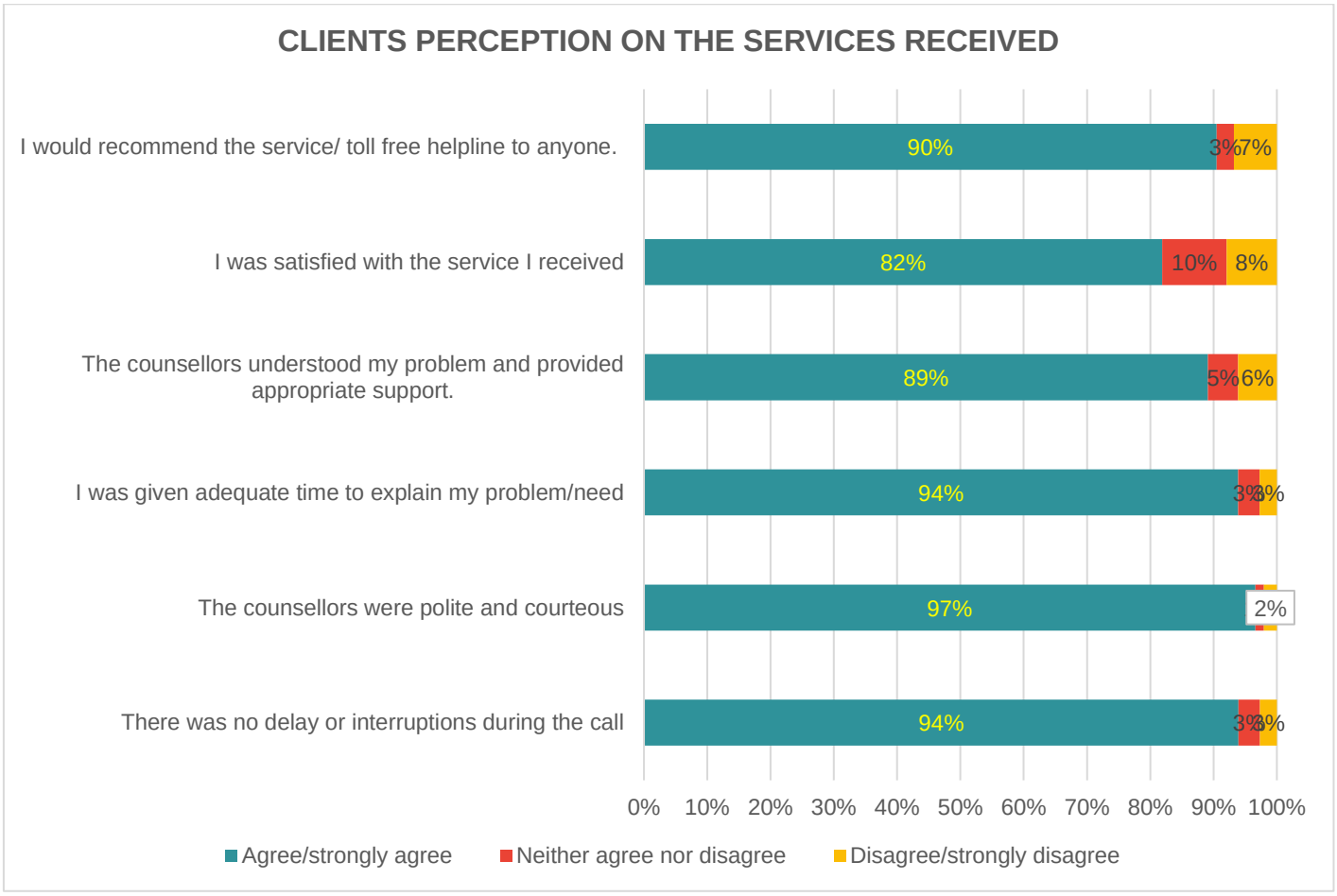


***Figure 5: client perception on the call Centre services received***

Regarding the willingness to pay for the service, more than half (56%) reported that they were willing to pay for the service, 23% were not sure while 21% were not willing to pay. This interesting feedback that MHU needs to explore more for the sustainability of the helpline. Further studies on willingness to pay, the cost and modalities of payment must be explored further if a decision is to

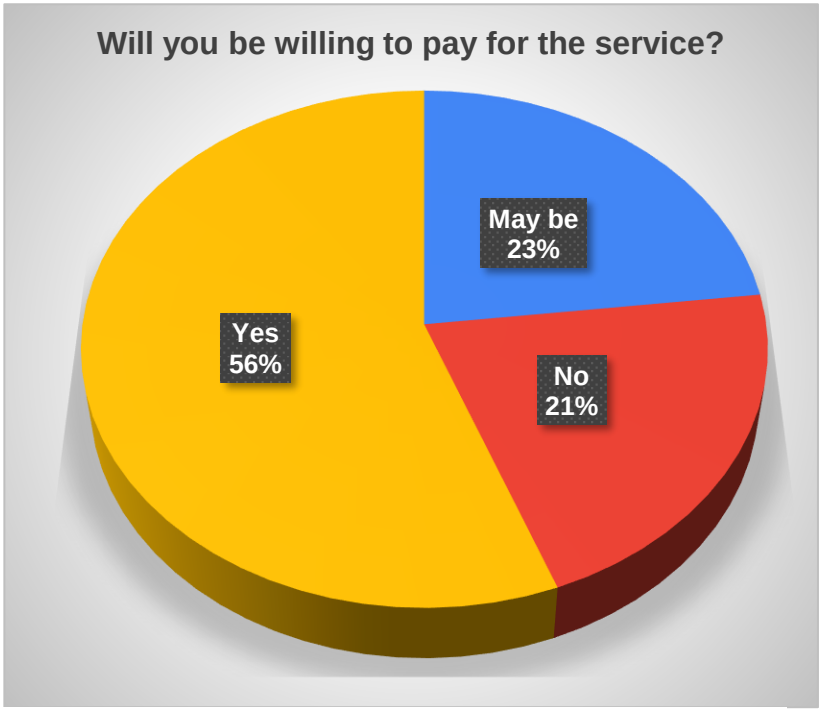


***Figure 6: Client's willingness to pay for the call centre services***

be taken on charging clients given the economic conditions of most people in Uganda and the culture of paying for the services.

In addition to the services provided by the counsellors, some clients were referred for additional services basing on the counsellor's assessment of need by the client. To facilitate appropriate referrals, the project mapped the available (or the absence thereof for that matter) services in the 8 districts of operation. A total of 289 mental health service providers were profiled in the four regions as indicated in table 5 below. Key services provided include treatment (inpatient and outpatient), psychosocial support, awareness raising, rehabilitation, safety, and protection especially for the police stations. It was noted that most (90%) of the mapped service providers provide free services which provides an opportunity for persons with mental health issues to access the services. In terms of geographical distribution, 72% of the service providers are in greater Kampala (Wakiso, Kampala and Mukono).

***Table 4: Summary of the mapped mental health services for referral***

| Mapped Service providers | Region | | | | Grand Total |
|---|---|---|---|---|---|
| | Eastern | Northern | Western | Greater Kampala | |
| CBO | | 1 | | 4 | 5 |
| Faith Based Organization (FBO) | 5 | 2 | 4 | 4 | 15 |
| Government | 25 | 6 | 12 | 98 | 141 |
| NGO | 11 | 9 | 4 | 97 | 121 |
| Private not for profit | | 2 | | 5 | 7 |
| **Grand Total** | **41** | **20** | **20** | **208** | **289** |

Despite the existence of free mental health services, most of the clients referred for additional services did either not go or did not receive the service from the referral point. Of the 56 clients who were referred for the service less than half (46%) went for the service.

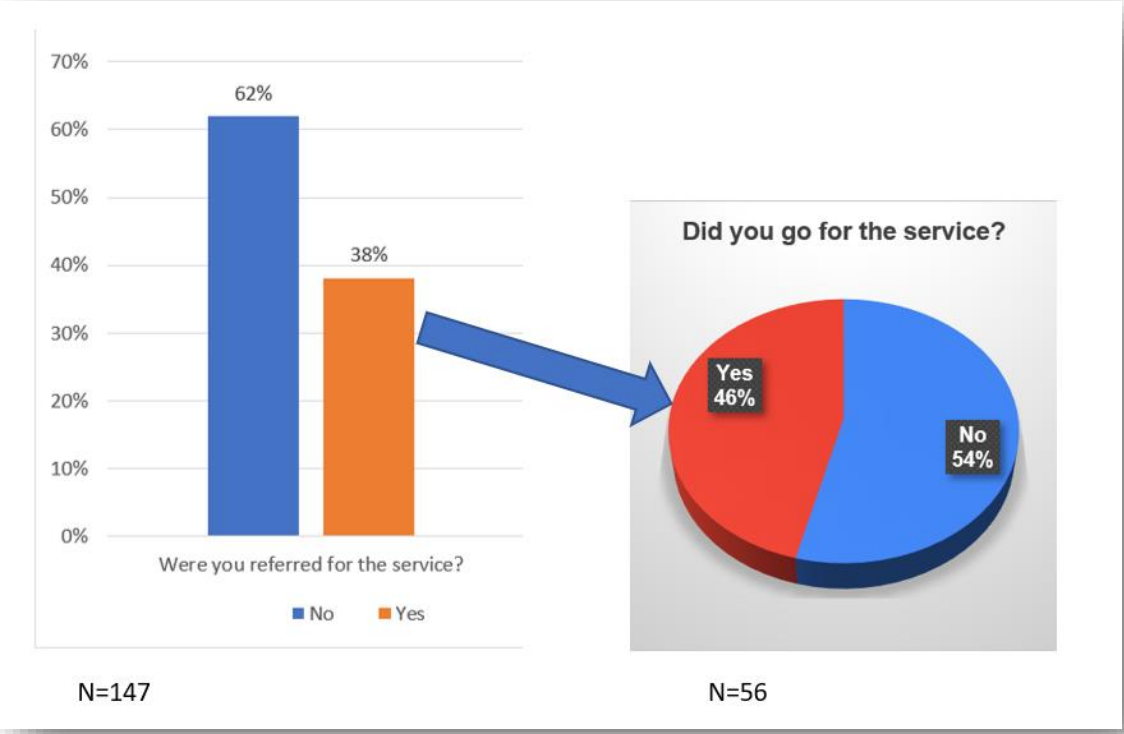


***Figure 7: Referral for additional services***

Out of those (26 clients) who went for additional service upon referral, only 12 received the service. This means that out of the total 56 clients referred only 12 (21%) received the service and only half (6) were satisfied with the additional service received.

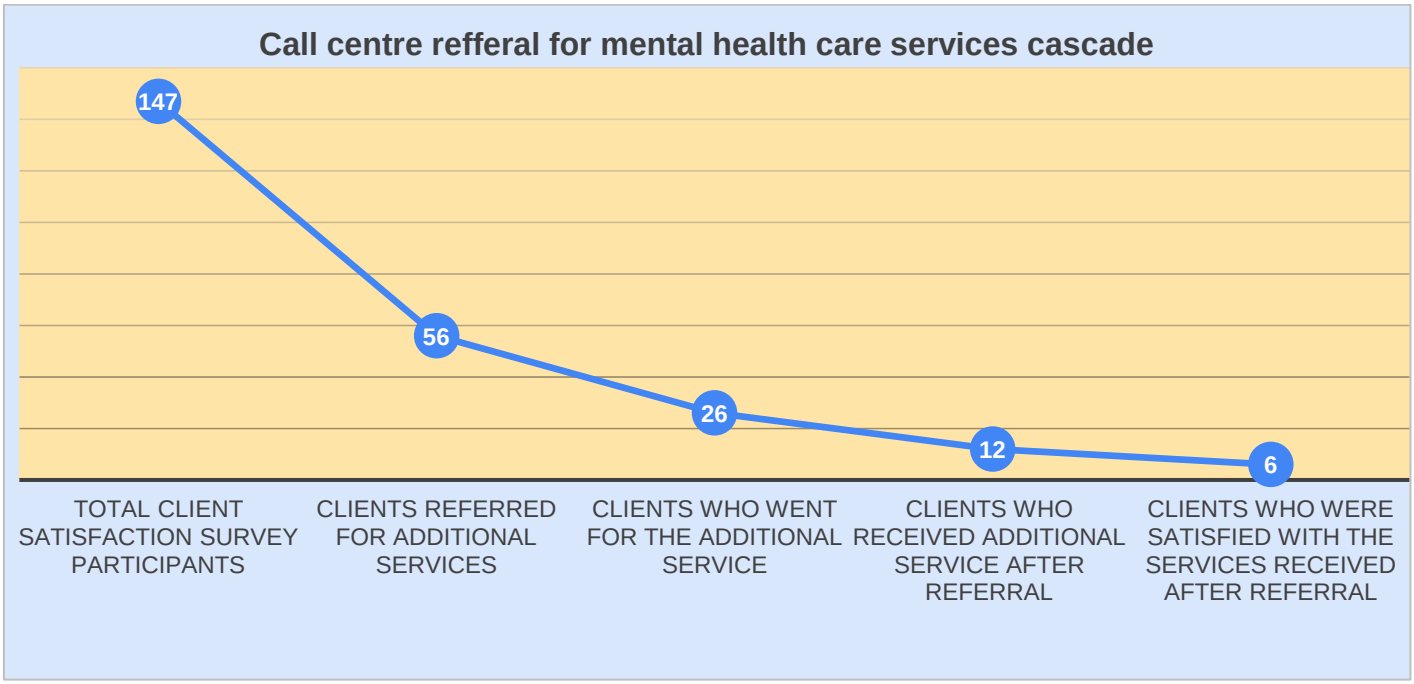


***Figure 8: Call center referral for mental health care services cascade***

The major reasons for not going for the services after referral included clients getting relief/better after the call (60%), lack of transport money (35%), patient refused to go for treatment (14%), patient died (6%) and long distance (6%). There's need to strengthen referral system through engaging and building strong partnerships with the service providers and follow up of the clients after the referral has been made.

### (B) IR 1.2: Health and rehabilitation staff have the skills to provide inclusive health and rehabilitation services

The project developed a user-friendly training manual for counselling staff and peers. This was used to train counsellors and peer structures. Using the training manual, the project trained 16 staff (1 nurse, 6 counsellors, 9 other staff) in community-based counselling, in preparation for the launch of the national toll-free helpline. The trained staff boosted the number of psychiatric health workers in Uganda to support the already stretched psychiatric health workers in public health facilities. In addition, the training of both agents of the toll-free line and other MHU staff, had a spillover effect in a sense that beneficiaries of other MHU projects are able to receive better quality of support from their counsellors. By training more counsellors, the project ensured that staff are available to support the call centre team if need be. Additional 15 peer counsellors were trained in Kanungu district as part of the project efforts to strengthen community response to mental health issues through peer-to-peer counselling. To strengthen responsible media reporting on mental health issues, the project trained 38 journalists (8 female and 30 male) in Kanungu and Mbarara districts in Western Uganda. This was intended to increase media coverage and positive reporting on mental health issues. This has resulted into increased media reporting, provision of free airtime on mental health issues and interface between the media and persons with mental health issues.

The project also recruited and oriented 6 (3 men and 3 women) reference group members across 4 regions (North, West, East and Central). with a lived experience of mental health issues. The group has worked with the project implementation team to identify key activities and materials for the target group and popularise the mental health issues across the country. The reference group members have played a key role in the development of materials (posters translated into different languages) activities that are practical on mental health issues; contributed to development of peer group training materials, increased MHU interaction with the community members as people with lived experiences, created awareness on mental health issues (demystifying the concept of mental health) through mass media, community meetings, religious and schools' events and one on one counselling targeting the youths. This has contributed to the change in attitudes of the family and community members about mental health issues.

The reference group provides an opportunity for the sustainability of some of the project interventions. The feedback from the group members indicated that they are passionate about mental health, enjoy what they are doing with or without facilitation and have made mental health issues a priority. The group have also formed a WhatsApp group to continuously share information, do marketing and share stories.

However, it was noted that the reference group need to be facilitated (airtime, transport) to conduct advocacy and awareness raising at district/regional level. And to be involved in MHU team building activities as part of their motivation.

To meet the project targets on improving the skills of health and rehabilitation staff to provide inclusive health and rehabilitation services, the project needs to roll out peer structures in other districts. As part of the rollout, appropriate mechanisms need to be put in place to facilitate their reporting especially on the activities implemented including peer to peer sessions conducted, advocacy and community sensitization, referral among others. This will improve on documentation and reporting on project results especially peer to peer counselling sessions conducted and people reached with mental health information.

In terms of national staff to provide mental health services, it was noted that districts have inadequate staff and the supervision and monitoring of the delivery of mental health service provision is still weak. At district level, the Regional Hospital Team are supposed to provide supervision and handle complicated cases at Health Centre IV, but this is rarely done. Relatedly, some medicines are not supposed to be administered at Health Centre IV and are only prescribed at Regional Hospitals which are far from the community. Some cases in the community which need referrals to higher medical care eg. Butabika hospital cannot be referred because of limited logistics (logistical support for referrals). The district recommended increased mentorship and provision of continuous medical education for health workers and community-based services department to enable them implement community-based interventions including early detection and provision of appropriate support services. Delays to detect mental health illnesses may be contributing to high cases of domestic violence, child abuse and self-harm if not addressed in time. Community gate keepers (Community Development officers, probation and social welfare officers, para social workers) can play an important role in supporting health workers to prevent and manage cases if trained. This is an advocacy issue that the project can take on with the Ministry of Health and Parliament. Indeed, the peer model that the project has initiated is testament that MHU and partners embrace the same ideology.

### (C) IR 1.3: Local and national health policies are influenced by DPOs

The project has not influenced any local or national health policy apart from supporting the Ministry of Health-Mental Health Division to develop the Terms of Reference for the district mental health focal persons. This is an area that needs to be prioritized in the second half of project implementation. To achieve this, MHU need to map out key local and national health policies in addition to the national mental health policy for prioritization which were not clearly identified in the project design. Having said that, the targets should be realistic knowing that policy reforms take a long time in Uganda.

## 3.3: PROJECT EFFICIENCY

This section examines the efficiency of the project partners, donor, MHU, and district local governments in delivering the project results. The key management functions which influence effectiveness and project efficiency include planning and communication, procurement, performance monitoring and reporting, and financial prudence which ensures best value-for-money (cost-effectiveness). These are explored below.

The midterm review established that there was slow start to the project implementation because of Covid-19 and delays to transfer funds from Norad to Atlas-to YMHN and finally to MHU. The project was expected to start in January 2020 but ended up starting in June/July 2020. Even after the start

of the project, one of the major project components (toll free line) delayed for five months before it was launched in May 2021 due to covid 19 and technical processes involved in starting a helpline in Uganda. The project however mitigated the two challenges by making the toll-free line flexible with provisions for counsellors to provide counselling services at home. To realize this, the project worked with the toll-free phone system provider to install an internet-based facility that allowed counselling agents to work from their homes particularly when the government imposed a total lockdown. The lockdown happened at a time when the facility had just been launched and therefore the demand and curiosity around the service was still very high and counsellors had to meet the demand. This was a big success as most other services in the country could not be accessed during that time.

The project has a very good coordination and communication system internally and externally. Internally, the program team hold periodic (monthly) meetings (including with Finance department) to review project implementation and expenditures and make appropriate decisions. The project also holds weekly meetings with the donor (Mental Health Youth Norway) to share progress, project implementation challenges and changes/adaptations. This coupled with the flexibility and willingness of the donor to allow changes has positively impacted on the project implementation and achievement of results.

The project management team has been making annual and quarterly plans, progressive learning and adaptations which has improved project implementation. All the project adaptations have been made in consultation with the donor. In terms of implementation, the project team, reference group members, peer counselors and district mental health structures are supposed to play a key role in planning, implementation, and monitoring of the project, however, no resources were allocated to strengthen the district structures and to facilitate the associations support the advocacy initiatives and to follow up local government commitments. The district associations if empowered would be supporting the advocacy initiatives at local level since they are based in the district.

Procurement (of equipment and consultants) has been the responsibility of the MHU Management team. It was noted that all the procurements for goods and services went through a bidding process which allowed competition in procurement to choose the best supplier who would deliver the goods and services cost effectively. The MTR established that most of the procurements were done it time.

The MTR noted issues with the project result framework and performance indicators which are limited and do not measure all the aspects of the project interventions. For example, one of the indicators under outcome 1: Mental Health Uganda influence national and local decision-making processes ‘examples of changes in legislation, regulations, and policies that protect the rights PWMIs’ is not specific and measurable. Outputs 2.1 and 2.2 under program area 1: Human Rights do not have annual or life of the project target which makes it difficult to measure change and achievement of results. A clearer and more measurable indicator looking at specific legislations, regulations or policies would improve the planning, implementation, monitoring and evaluation of the project results should have been developed. Relatedly, additional indicators can be generated to measure outputs and outcomes of the project interventions that are currently not well tracked in terms of performance indicators.

With regard to financial prudence, MHU has a clear mechanism for prudence and accountability in line with the donor requirements. The accountabilities are tied to budget inputs (fees and expenses) and invoices and receipts are shared with the donor for verification and documentation to facilitate counter expenditure analysis. The review established that the project has separate bank accounts

and accounting documents; introduced the new mobile wallet system to minimize cash handling, uses quick books to produce monthly variance reports to facilitate timely decision making. There were no reported incidences on financial loss on the project.

However, because of the input-based budget (rather than output-based budget), it is almost impossible to determine value-for-money, as the exact costs of specific events, activities, and capacity-building are unknown (see Table 5, which shows input expenditures to date for each of the result areas). However, it was evident that the project utilized the funds to implement the activities as planned and there were no over expenditures or unrealistic expenditures beyond allowable threshold. At midterm review, the project had spent 53% of the allocated funds. The highest expenditure rates were on procurements (117%), Health and Rehabilitation (67%), other operation costs (65%) and human rights (61%). The areas with less than 50% expenditures include pay roll expenses (42%) and travels.

***Table 5: Income and expenditure statement for the project at MTR***

| Ordinary Income/ Expense | Items | Actual | Budget | Variance | % of Budget |
|---|---|---|---|---|---|
| Income | Program Incomes | 3,145,395,137 | 5,417,452,704 | (2,272,057,566) | 58 % |
| Total Income | | 3,145,395,137 | 5,417,452,704 | (2,272,057,566) | 58 % |
| | | | | | |
| Expense | Travels | 43,390,700 | 98,250,000 | (54,859,300) | 44 % |
| | Audit, Monitoring and Evaluation | 166,936,580 | 296,726,500 | (129,789,920) | 56 % |
| | Procurement | 328,006,338 | 279,627,060 | 48,379,278 | 117 % |
| | Operating Costs | 371,188,406 | 738,539,000 | (367,350,593) | 50 % |
| | Human Rights | 282,002,147 | 460,625,040 | (178,622,893) | 61 % |
| | Health and Rehabilitation | 505,215,951 | 754,220,000 | (249,004,049) | 67 % |
| | Total Other Operating Cost | 787,218,098 | 1,214,845,040 | (427,626,942) | 65 % |
| | Payroll Expenses | 1,170,841,962 | 2,789,465,104 | (1,618,623,142) | 42 % |
| Total Expense | | 2,867,582,084 | 5,417,452,704 | (2,549,870,619) | 53 % |
| Net Ordinary Income | | 277,813,053 | 0 | 277,813,052 | 100 % |
| **Net Income** | | **277,813,053** | **0** | **277,813,052** | **100 %** |

However, given the depreciation of the shilling against the dollar, some of the project activities such as marketing campaigns, establishment of peer structures at district level were scaled down. From the analysis, the project has lost between 8-10% of the projected funds through exchange loses. To mitigate the impact, the project used the same budget to train more staff in policy and advocacy, innovatively used online marketing (social media influencers) to popularize the toll-free line and conduct advocacy on sector financing which reduced considerably the cost of running marketing

campaigns. The project also negotiated with the toll-free line service provider to change the call charges from minutes to seconds which has reduced the charges per call. Other cost cutting mechanisms instituted by the project include integration of marketing campaigns into other projects, engaging the media for free airtime and space and reduction in the helpline maintenance support.

As per the design, the project is intended to secure additional funding for the sustainability of the project interventions starting with the financial year 2023. The goal is to fundraise 1.5 million NOK to support the sustainability of the project specially to cover staff salaries and continuous training of new peers using the developed manual. To realise this, the project has recruited a fundraising officer to support the organisation in proposal development. There's hope in the recruited officer to secure additional funding in the year 2023 and 2024 to meet the life of the project target of 1.5 million NOK.

In terms of the project progress on implementation of activities and achievement of results (mainly out puts), the MTR clearly noted that most of the planned activities were implemented, and the project is on course to achieve the target results. However, as indicated, due to the high costs on the toll-free line (especially in the first one year) and the depreciation of the shilling, some of the activities were not implemented as planned which affected the expected outputs. The most affected activities and outputs were on peer training, participation in national events (seminars/conferences/workshops/programmes/councils/committees) on mental health and marketing campaigns. For example, the project was to conduct 3 awareness campaigns and 1 national conference however only one awareness campaign was conducted in 2021 and had to be aligned to the phone system launch. Similarly, the peer structures were to be established in all the 8 districts, however, this was done only in one district. Below is the summary on the progress towards achievement of project output targets at midterm.

***Table 6: Indicator performance table***

**Impact: Persons with mental health issues (PWMI) claim their rights and exert influence on matters that affect their lives**

| Performance Indicator | Baseline | Midline target | Midterm achievement | % age achievement | RAG Rating |
|---|---|---|---|---|---|
| **Program Area 1: Human Rights** | | | | | |
| **SO1: Mental Health Uganda influence national and local decision-making processes** | | | | | |
| Examples of changes in legislation, regulations, and policies that protect the rights PWMIs | Summary of status of key legislation, regulations and policies in Uganda as of 2019 | Partners to develop policy and stakeholder influence plan. | No changes in legislation, regulations, and policies that protect the rights PWMIs | 0% | |
| Examples of local and national advocacy and awareness campaigns or events that influence decision makers and | Summary of influential advocacy campaigns in period 2016 - 2019 | 2 awareness campaigns and 1 | 1 awareness campaign conducted | 33% | |

| Performance Indicator | Baseline | Midline target | Midterm achievement | % age achievement | RAG Rating |
|---|---|---|---|---|---|
| challenge the general public`s cultural attitudes towards PWMI | | national conference | | | |
| SO2: PWMI benefit from national and local level programs, activities, and services in target areas | | | | | |
| Examples of implementation of project activities and services in target areas (districts) | Examples that are illustrative of the status in target areas as of end 2018 | | Marketing campaign conducted in all the 8 districts<br><br>Advocacy for increased financing in Lira, Gulu, Soroti and Mbale districts | | |
| IR1.1/Output: Mental Health Uganda demonstrate democratic processes, operational capacity, and advocacy skills | | | | | |
| Examples of Mental Health Uganda developing and implementing their respective democratic, organizational, and operational guidelines/practices | Status of MHU as of 2019 (based on OCA, due diligence, or other available resources) | | 10 /48 capacity improvement actions implemented, and the rest were on-going.<br><br>Improved financial management using quick books | | |
| IR1.2: Awareness raising in mainstream organizations and the general public as well as forming alliances with other DPOs. | | | | | |
| Examples of partnerships, networking, alliances, and coalitions promoting and/or advocating for disability inclusion/ inclusion of young PWMI | Summary of DPO alliances in period 2016-2019 | Some: 100 000 view pr. campaign. Increase in media coverage | Marketing campaign: 294,000<br>Social media: 195,000 | 195% | |
| IR 1.3: MHU monitor implementation of the CRPD and SDGs | | | | | |
| MHU systematically monitor the implementation of the CRPD and SDGs (number of recommendations made in total) | | CPRD shadow reporting 2021 | Shadow report produced | 100% | |
| Number of recommendations raised by MHU in the alternative CRPD report that are | | | The shadow report is yet to be submitted | | |

| Performance Indicator | Baseline | Midline target | Midterm achievement | % age achievement | RAG Rating |
|---|---|---|---|---|---|
| included in the CRPD committee's concluding observations | | | | | |
| **Program Area 2: Health and Rehabilitation**<br>SO1: Young people with mental health issues, and those at risk of developing mental health issues, benefit from programmes and services in target areas | | | | | |
| Number of PWMI having received psychosocial support from phone counsellors (PH) and peer to peer (P2P). | | PH: 7,500 | Phone: 1,691 | 23% | |
| | | P2P: 1,500 | P2P: 0 | 0% | |
| Number of consultations, phone (PH) and Peers to peer (P2P) | | PH: 7500. | PH: 5,918 | 79% | |
| | | P2P: 2250 | P2P: 0 | 0% | |
| Number and type of counselling (group, family, individual) | None | No target | Individual: 5,918 | | |
| Examples of girls and boys, women and men with mental health issues in target areas that report improved satisfaction with health and rehabilitation services | | 30 interviews, 1 report | 82% of the client satisfaction survey reported that they were satisfied with health and rehabilitation services received | | |
| IR 1.1 PWMI are able to access inclusive health and rehabilitation services | | | | | |
| Number of persons who live with mental health issues that identified/screened | | No target | 2,062 | | |
| Examples of relevant legal frameworks, policies and budget allocation that ensure disability inclusive health and rehabilitation services | | No target | Three districts (Lira, Soroti and Mbale allocated funds for MH activities | | |
| Examples of activities conducted to spread awareness of mental health on district levels (sports, drama, dance etc) | | 18 activities in 5 different districts | 0 | 0% | |
| IR 1.2: Health and rehabilitation staff have the skills to provide inclusive health and rehabilitation services | | | | | |

| Performance Indicator | Baseline | Midline target | Midterm achievement | % age achievement | RAG Rating |
|---|---|---|---|---|---|
| Number of staff trained<br>- Counselling staff<br>- Peers | | 150-250 | 31 (15 district peer counselors and 16 national level counsellors) | 21% | |
| IR 1.3: Local and national health policies are influenced by DPOs | | | | | |
| Examples of local and national health policies becoming more inclusive and responsive to the needs of PWMI | | | No evidence | | |

## 3.4: OWNERSHIP AND SUSTAINABILITY OF THE ROJECT

The MTR established that there is increasing stakeholders (MHU, MoH-Mental Health Division, District Local Governments, and persons with mental issues) acceptance, recognition and ownership of the project and there are mechanisms established to support the sustainability of the project. For example, the advocacy on increased financing has resulted into inclusion of mental health in the targeted local governments and allocation of some funds to support activities on mental health issues. The Terms of Reference for the district mental health focal persons once approved with enable the districts to officially appoint and facilitate passionate and responsible mental health focal persons to advance service delivery.

At organisational level, the project has strengthened the capacity of the Board, staff, facilitate the review of policies including the financial manual and installation of accounting software which will continue to improve financial prudence and attract more donor funding.

The peer-to-peer service has existed in a structured manner since 2015 and is therefore already an integrated part of MHU`s work. The project will leave the peers equipped with coping strategies, cognitive therapy techniques and de-escalation techniques that will continue to influence their work and training of future peers. This is a cadre of volunteers that are committed and passionate about mental health issues some of whom are people with lived experiences. This provides an opportunity for the organisation to continue advocacy, awareness raising and provision of mental health care services to those in need.

The strong partnerships and networks with like-minded organisations such as Thrive Uganda, Umbrella of Hope Initiative, JENGA Community Development Outreach and AIDS Health Care Foundation provides an important window for building synergies and sustainability of the project. These NGOs will continue to provide support to persons with mental issues especially the young people.

The positive change in attitudes and practices of key stakeholders including family and community members, local government technical staff, has potential for sustainability. The feedback from the participants and key stakeholders especially the reference group members indicated that change was happening and persons with mental health issues will continue to receive positive treatment and support from family and community members.

Building strong partnerships with other stakeholders involved in similar work such as Bwindi Community Hospital, Mobile community drug bank in Kanungu district and use of peer structures to continue providing physical psychosocial support, will contribute to the sustainability of the project.

However, the major sustainability challenge for the project and organisation is on the toll-free line. Although more than half of the client satisfactory survey participants indicated that they were willing to pay for the service, it may be challenging to start charging for the service. This may take time to be realised. The assumption that the membership is willing and should support the project may not work in Uganda. Most members rely on the project for services and not the other way round. In the remaining period, there's need to find alternative sources of funding to support the continuity of the toll-free line since it directly addresses the needs of persons with mental health issues.

The MTR established that MHU was in the process of developing a general fundraising strategy for the organization which will enable MHU to intensify fundraising and resource mobilization for the sustainability of the project and the organisation.

## 3.5: DESIGN AND IMPLEMENTATION GAPS AND CHALLENGES

The MTR Consultant noted the a few gaps and or challenges emanating from the project design, implementation and monitoring.

During the design of the project, the linkage and role between the national mental health structures and the district associations in the implementation of the project was not clearly identified. The district associations remain aloof of the project implementation, yet they could play an important role in the implementation of some of the project activities and follow up of the local government commitments. The project did not allocate funds to support capacity strengthening, membership recruitment drive, advocacy among others. At the project design some of the structures at district were solid and functional but the outbreak of Covid-19 weakened the structures. These structures if well empowered would support the project implementation and in the supervision of the peer structures. Resources need to be allocated to finance the functionality of the district associations.

Relatedly, at the project design, there were no resources allocated to strengthen coordination of the partners at National and local level. This has resulted into poor coordination of mental health partners at national and local level. The MTR established that the project experienced a huge gap around joint advocacy, with so many opportunities passing through the sector with little or nothing done by the mental health coalition members to hold duty bearers accountable. Although the project eventually earmarked some funds to facilitate some joint advocacy work, it's not sufficient. To conduct effective policy advocacy, financing and implementation of legal provisions on mental health, a strong coordination mechanism needs to be put in place and resources allocated for its functionality.

The project indicator performance table was not completed as some of the indicators remained without the baseline data and targets. This makes it had to measure change as a result of the project contribution.

The project has a fixed budget from the donor with no provisions for inflation and exchange loss which has greatly affected the project. The project team had to scale down the implementation of some activities in order to remain within the allocated budget. The Board of directors who plays an oversight role in the organization are also not facilitated to monitor the implementation of the project. This will likely affect the achievement of project targets and objectives or at the very least, the level of ownership.

There was delay starting the project implementation due to Covid-19 and delays in the procurement of the service provider for the toll-free line. The toll-free line is one of the major components of the project and the delay therefore affected the reach and realization of some of the project targets on the clients with psychosocial support.

Weak leadership at national level especially from the Ministry of health may not support policy change. It was reported that the Mental Health Division at the Ministry of Health is understaffed, weak and not proactive. The Terms of Reference for the District Mental Health Focal persons, submitted to the Mental Health Division in November 2021, have never been approved by the ministry senior management team, with a validation meeting only held in August 2022, with financing by this particular project. This has delayed the appointment of the focal persons and service delivery. It was also noted that in some districts, mental health units taken over during Covid-19 have never been returned making availability and access to essential psychiatric services a big challenge. Lack of access to essential medicines due to closure of the units and or stock outs increase relapses and if not addressed will continue to affect the recovery of persons with mental health issues. A gloomy state of the sector does naturally undermine the results of this project.

The inflation and exchange losses have affected the implementation of some of the project activities. At the time of the review, some activities like marketing campaigns, advocacy for increased mental health sector financing, peer training and participation in national and international events had been scaled down. The scaling down of these activities especially the awareness campaigns and advocacy will likely affect the achievement of the results. Strategies need to be devised to sustain awareness and advocacy campaigns at national and local levels where government programs are implemented.

The MTR noted that there was limited exchange learning between the youth in Uganda and Mental Health Youth Norway. For capacity building and sustainability of the project, the youth in Uganda need to get an opportunity to learn from Youth MH Norway in form of exchange visits.

Although MHU has a registration certificate from NGO bureau, the shrinking of civic space by the government may affect the project advocacy efforts. There are a lot of restrictions in securing approvals for advocacy engagements and as a human rights advocacy organization, such restrictions are likely to affect the project.

# 4.0 Conclusions and recommendations

## 4.1 Summary and conclusions

The midterm review established that the “Amplifying the Voices of Young People with Mental Health Issues in Uganda” project is relevant to the needs of persons with mental health issues and is on course to achieve its intended objectives. Given the slow start resulting from Covid-19 pandemic, the project has managed to achieve some of the project targets while others are progressing well as indicated in table 6.

Under result area 1 (human rights), the project advocated for the appointment of district mental health focal persons. The districts of Jinja and Kyenjojo officially appointed the focal persons while Gulu Lira, Mbale and Soroti identified the focal persons but had not been formally appointed; Monitored the implementation of the UNCRPD concluding observations and recommendations on psychosocial disability and prepared the shadow report for submission to the committee; advocated for the increase in budget allocations at national and districts level. Some of district local governments (Lira, Mbale and Soroti allocated some funds for the implementation of mental health activities. The project also increased media coverage on mental health reaching over 294,000 people through the social media campaigns. The project strengthened the capacity of Board and staff in policy and advocacy, revitalized the reference group, improved financial management including timely delivery of quality financial reports (using quick books accounting package).

Under result area 2 (Inclusive health and rehabilitation), the project established a toll-free line and provided mental health care services to more than 2,062 clients in one and a half years. The project conducted more than 5,918 individual counselling sessions to 1,691 PWMI through phone (PH) consultations with 82% of the clients reporting that they were satisfied with health and rehabilitation services received. The project increased the capacity of mental health care providers including identification and training of 15 peer to peer counselors in Kanungu districts, 16 national level staff to provide telephone counselling on mental health who have provided phone counseling and referral services to over 2,062 clients.

The MTR noted that there was efficient utilization of project funds to implement the activities as planned and there were no over expenditures or unrealistic expenditures beyond allowable threshold. At midterm review, the project had spent 53% of the allocated funds and had implemented most of the planned activities. However, given the depreciation of the shilling against the dollar, some of the project activities such as marketing campaigns, establishment of peer structures at district level were scaled down.

The MTR Consultant noted a few gaps and or challenges emanating from the project design, implementation and monitoring that are likely to affect the achievement of project results.
The linkage and role between the national mental health structures and the district associations in the implementation of the project was not clearly identified. The district associations are not fully involved in the project, yet they could play an important role in the implementation of some of the project activities and follow up of the local government commitments. There were no resources allocated to strengthen coordination of the partners at National and local level which has partly contributed to poor coordination of mental health partners at national and local level. As regards to the project performance indicators, some of the indicators are not smart and have no specific baselines and targets which makes it had to measure change as a result of the project contribution.

## 4.2 Recommendations

In order to improve the project implementation in the remaining period and achievement of project results, the following recommendations are proposed, subject to availability of funds.

1) Allocate resources to operationalize and strengthen the functionality of the district structures/associations and strengthen their advocacy, fundraising and mental health promotion (identification and referrals) capacity.
2) Strengthen the linkages and coordination between the national level and district associations to improve project implementation and sustainability.
3) Strengthen joint advocacy to influence changes in specific legislation, regulations or policies and build strong and formal partnerships with relevant stakeholders on specific advocacy agenda. Some of the areas include Mental health Policy and development of regulations, Community mental health care and appointment of mental health focal persons at district level.
4) Prioritize livelihood support interventions which directly contribute to the wellbeing of the target audience in future proposal development to reduce on the mental health conditions emanating from economic hardships.
5) Improve the engagement of government structures Ministry of Health-Mental Health Division and local governments in the implementation of the project to push for changes in the policy and regulatory framework and service delivery.
6) Develop and implement an Organisational Development Strategy with clear provisions on membership, fees structures and utilization modalities.
7) Intensify fundraising/resource mobilization to bridge the funding gap resulting from depreciation of the shilling and inflation in the country.
8) Review the result framework, performance indicators and targets to set clear targets that will enable the project to measure change from the project interventions at the end of the project.
9) Establish peer group structures in the remaining districts to facilitate peer to peer support.
10) Improve call centre logistics (including provision of functional laptops to counsellors, stable internet connection and reduction on generator noise) to enable counsellors provide quality service to the clients.
11) Appoint a technical supervisor with experience in psychosocial support to provide supervision, appropriate mentorship, coaching and technical support to the call Centre counselors.

# Appendices

Terms of Reference

## TERMS OF REFERENCE FOR THE MIDTERM REVIEW OF THE "AMPLIFYING THE VOICES OF YOUNG PEOPLE WITH MENTAL HEALTH ISSUES" PROJECT

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### INTRODUCTION

### Background

Mental Health Uganda (MHU) is an indigenous Organization, established in 1997 for people with a lived experience of mental illness, care givers and service providers. Over the years, MHU has registered huge successes in the areas of advocacy for policy, rights and legislative reforms, advocacy for community mental health care, capacity building especially for membership district associations, livelihoods support for people with a lived experience of mental illness, rehabilitation and reintegration of homeless people off the streets of Kampala, user-led programming, anti-mental health stigma and discrimination, among others.

The new MHU strategic plan 2020-2024 places a lot of emphasis on young people with or at risk of developing mental health problems. This is precisely due to the predominantly young Ugandan population, with 78% below 30 years, whereas 75% of mental health problems begin before the age of 24 years.

### The Project

Mental Health Uganda (MHU), in partnership with Mental Helse Ungdom of Norway, started implementing the "Amplifying the Voices of Young People with Mental Health Issues in Uganda" project in Uganda in 2020. The project has two broad objectives:

**1. Persons with mental health issues claim their rights and exert influence on matters that effect their life (Human Rights);**

**2. Persons with mental health issues achieve and maintain maximum self-sufficiency and optimal functioning in interaction with their environments (Health & Rehabilitation).**

The project seeks to address the problem of accessibility to mental health care in the districts of Uganda, particularly for youth, by establishing a national toll free help line where people with, or caretakers of, people with mental health issues can receive a counselling session and/or guidance on where to find appropriate help. In addition, the project seeks to expand the existing MHU peer-to-peer model by offering peers training so that they can provide more specialized support to young people struggling in the communities.

The project is being implemented in 8 districts across 4 regions i.e. Northern region in Gulu district and Lira district; Central region in Mpigi district and Kampala district; Eastern region in Soroti district and Mbale district; Western region in Mbarara and Kanungu districts.

***Table 7: Key project outcomes and outputs***

| Program Area and outcomes | Outputs |
|---|---|
| **Result Area 1: Human Rights** | **Persons with mental health issues claim their rights and exert influence on matters that effects their life** |
| Outcome 1: DPOs (Mental Health Uganda) influence national and local decision-making processes<br><br>Outcome 2: Girls, boys, women and men with mental health issues benefit from national and local level programs and services in target areas | Changes in legislation, regulation and policies that influence the life of target group<br><br>Partnerships, networking, alliances and coalitions promoting and/or advocating for disability inclusion<br><br>Increased budget allocations to Mental Health<br><br>Increased demand for our services after campaigns<br><br>Examples of persons reporting improved satisfaction with mental health after receiving counselling on phone or by peer (researcher). |
| **Result Area 2: Inclusive Health and Rehabilitation** | **Persons with mental health issues achieve and maintain maximum self-sufficiency and optimal functioning in interaction with their environments** |
| Outcome 1: Young people with mental health issues, and those at risk of developing mental health issues, benefit from programmes and services in target areas | 15 000 phone counselling sessions (PH). 3000 Peer to peer (P2P).<br><br>3000 persons having received services from peers<br><br>150-250 peers trained<br><br>6 counselling staff trained<br><br>1.5 million NOK raised |

The project which started in 2020 will end in 2024. These terms of references have therefore been made to effectively plan and conduct the project midterm evaluation.

**PURPOSE AND SCOPE OF THE MIDTERM REVIEW**

An internal midterm evaluation will be conducted to assess project advances in meeting its stated goals, strategic objectives, results, outputs and predicted targets. The findings will be used to adjust project design, as needed, take concrete actions to ensure high project performance, and project's sustainability.

Specific objectives include:

1) To critically review implementation and provide an early gauge of key elements such as relevance, effectiveness, efficiency, impact, and sustainability.

2) To document lessons learned and promising practices; and

3) To provide recommendations for modifications to meet the project´s stated goals and objectives.

**KEY QUESTIONS FOR MIDTERM EVALUATION**

In line with an Evaluative Thinking approach, the midterm evaluation will pose questions directly related to the project logical assumptions and the results and objectives outlined in the project theory of change, and the evaluation criteria and questions contained in table 1 below:

***Table 8:* Evaluation questions**

| CRITERIA | QUESTION |
|---|---|
| Relevance | • To what extent is the project meeting the needs of project participants?<br>• Are there any interventions or results that are not included, but should be?<br>• Are project participants, and other key stakeholders satisfied with the project? |
| Coherence | • How well does the project complement and link to the GoU priorities and activities as well as to other DPOS? |
| Efficiency | • How are project resources (inputs) being used to achieve expected results and objectives, and to what extent the different activities were cost-efficient?<br>• Were there any changes in the implementation of the project from the original design? What influenced the changes and what were the implications on the project? |
| Effectiveness | • To what extent is the project on track to achieving its intended objectives?<br>• To what extent is the project empowering the youth to promote and protect their rights? |
| Impact | • How many people has the project reached so far and will it be able to meet its targets?<br>• What difference is the project making for the project participants and other stakeholders?<br>• Have there been any positive or negative unintended outcomes? |
| Sustainability | • To what extent are the outcomes of the programs sustainable? |

## APPROACH AND METHODOLOGY

It is expected that this midterm review will be conducted internally, participatory, using a mix of quantitative and qualitative methods and tools. The process will include;

- A desk top review of the project documents and reports
- Design and conduct a call centre client satisfaction survey
- Analysis of MHU call centre data
- Consultations/engagement with selected district local governments where the project is being implemented.
- In-depth Interviews with MoH-Mental Health Division
- Engagement with MHU board and reference group members
- Interaction/engagement with project staff and call centre/helpline agents
- Youth Mental Health Norway (YMHN).

The midterm review will obtain data from both primary and secondary sources for both qualitative and quantitative data. The Quantitative data will be extracted from the call center database for analysis and from the client satisfaction survey to be conducted by the consultant. The call centre data will have no unique/personal identifiers for data security and protection of the subjects. Qualitative data will be collected from the key respondents identified above. Data will be disaggregated as per the project indicators.

## SCOPE OF WORK

The scope of work for the midterm evaluation will include;

**Content Scope**: The midterm review will cover all the components of the intervention; Health and Rehabilitation and human rights.

**Time Scope**: The midterm review will cover the implementation period from 2020 to 2022.The midterm review period will commence in August 2022 and is expected to end October 2022.

**Geographical Scope:** The midterm review will be conducted in Kampala and two selected districts (Lira and Soroti)

**Target group:** Two (2) district local governments engaged in the project, Ministry of Health, call centre agents, MHU Board members, Project staff, YMHN and other key stakeholders involved in the project.

## REPORT STRUCTURE

The midterm report shall be no more than 40 pages and shall replicate the format below;

Title page

ii. Table of Contents

iii. Acronyms

iv. Acknowledgments

v. Executive Summary

vi. Background and Project Description

vii. Purpose and rationale of the midterm review

viii. Methodology, including limitations

ix. Midterm review findings presented under the headings of the key project objectives, outcomes.

xi. Conclusion and Recommendations.

xiii. Annexes:

a. Completed log frame

c. List of participants in meetings and interviews

d. Data collection tools

e. Midterm review ToR

f. Other relevant documents

**TIMELINES**

The assignment is expected to run for 60 days. The implementation timeline will be as follows.

**Table 9: Proposed roadmap for Midterm Review**

| Activity | Deadline |
|---|---|
| Finalize the TOR | 30th July 2022 |
| Review of project documents and development of the tools | 31st August 2022 |
| Design and conduct a client satisfaction survey | 20th September 2022 |
| Consultations/engagement with Mbale and Lira district local governments | 25th-27th September 2022 |
| In-depth Interviews with MoH-Mental Health Division | 28th September 2022 |
| Engagement with the Reference Group and Staff | 29th September 2022 |
| Engagement with Board | 30th September 2022 |
| Analysis of MHU call centre data | 5th October 2022 |
| Preparation and submission of the draft report | 15th October 2022 |
| MHU and YMHN provide feedback | 25th October 2022 |
| Review and submission of the final report | 30th October 2022 |

**MIDTERM REVIEW BUDGET**

This is an internal evaluation that will be led by the Research and Development Consultant of the project. Minor costs will be incurred to engage the district and MoH officials. This cost will be embedded in routine monitoring of the project. Similarly, the engagements with MHU Board and reference group members will be conducted during their quarterly meetings in September 2022.

## MTR tools

**MENTAL HEALTH UGANDA**
**CALL CENTRE CLIENT SATISFACTION SURVE QUESTIONNAIRE**

### PART 1: DEMOGRAPHIC CHARACTERISTICS

| Label | Responses | codes |
|---|---|---|
| A1. District | | |
| A2. Gender of respondent | Male<br>Female<br>Does not respond | 1<br>2<br>3 |
| A3. Age of respondent | Below 18 years<br>18-24 years<br>25-30 years<br>31-35 Years<br>Above 35 years | 1<br>2<br>3<br>4<br>5 |

| | | |
|---|---|---|
| A4. What service did you receive from Mental health Uganda call centre/helpline?? | Psychosocial Support<br>Information<br>Referral<br>Other<br>None | 1<br>2<br>3<br>4<br>5 |
| A4. What is your highest level of education | None<br>Primary<br>Secondary (O-level)<br>Secondary (Advanced level)<br>Tertiary | 1<br>2<br>3<br>4<br>5 |
| A5. What's your main source of income/means of livelihood? | Agriculture<br>Business/trade<br>Formal employment<br>Casual laborer<br>Handouts<br>None | 1<br>2<br>3<br>4<br>5<br>6 |

## PART II. CLIENTS PERCEPTION ON THE SERVICES RECEIVED

| # | Statement | Response (tick one box per statement) | | | | |
|---|---|---|---|---|---|---|
| | | Strongly disagree | Disagree | Neither agree nor disagree | Agree | Strongly agree |
| B1 | There was no delay or interruptions during the call | 1 | 2 | 3 | 4 | 5 |
| B2 | The counsellors were polite and courteous | 1 | 2 | 3 | 4 | 5 |
| B3 | I was given adequate time to explain my problem/need | 1 | 2 | 3 | 4 | 5 |
| B4 | The counsellors understood my problem and provided appropriate support. | 1 | 2 | 3 | 4 | 5 |
| B5 | I was satisfied with the service I received | 1 | 2 | 3 | 4 | 5 |
| B6 | I would recommend the service/ toll free helpline to anyone. | 1 | 2 | 3 | 4 | 5 |

## PART III. COST OF THE SERVICE

| # | Statement | Response | Code |
|---|---|---|---|
| C1 | Did you offer anything for the service you received? | Yes<br>No | 1<br>2 |
| C2 | If yes, what did you offer? | | |
| C3 | Would you be willing to offer or pay something for the service? | Yes<br>No | 1<br>2 |

## PART IV. REFERRALFOR ADDITIONAL SERVICES

| # | Statement | Response | Code |
|---|---|---|---|
| D1 | Were you referred for additional services? | Yes | 1 |

| | | | |
|---|---|---|---|
| | | No | 2 |
| D2 | If yes, which service (s) where you referred for? | | |
| D3 | Did you go for the service? | Yes<br>No | 1<br>2 |
| D4 | If No, why not? | | |
| D5 | Did you receive additional service after referral? | Yes<br>No | 1<br>2 |
| D6 | How satisfied are you with the additional services received after referral? | Yes<br>No | 1<br>2 |

**Thank you for participating in the survey**

**END**

## KEY INFORMANT INTERVIEW GUIDE

### MOH, LOCAL GOVERNMENTS

1. How have you participated in the implementation of this project by MHU? Comment on the general collaboration
2. How well does the project complement and link to the GoU priorities, plans and activities as well as to other DPOS?
3. How has the project benefited a) Your Ministry/Local government; b) Persons with mental illnesses *(document all the results from the project; MH focal persons appointed, budgetary allocation etc*
4. What challenges if any did you encounter while participating into the project?
5. How do you propose they can be addressed?
6. To what extent are the project interventions and results (impact if any, and outcomes) likely to continue after the project?
7. What support have you as a partner provided, can provide (could be now or for the future)?

### MHU BOARD AND REFERENCE GROUP MEMBERS

**Interview guide**

- How relevant is this project to the aspirations of MHU?
- How has the project strengthened the capacity of Mental Health Uganda? Probe for e*xamples of Mental Health Uganda developing and implementing their respective democratic, organizational and operational guidelines/practices; capacity of the reference group members and the board.*
- How has Mental Health Uganda influenced changes in legislation, regulation and policies that influence the life of target group (persons with mental illnesses)? *Probe for;*
    - *Examples of changes in legislation, regulations, and policies that protect the rights PWMIs*
    - *Examples of local and national advocacy and awareness campaigns or events that influence decision makers and challenge the general public`s cultural attitudes towards PWMI*

- What partnerships, networking, alliances, and coalitions promoting and/or advocating for disability inclusion have been created as a result of the project?
- Examples of local and national advocacy and awareness campaigns or events that influence decision makers and challenge the public`s cultural attitudes
- What has gone well in the implementation of the project? What can we learn from successes?
- Are there any interventions that are not included, but should have been included in the design?
- To what extent are the project interventions and outcomes sustainable after the closure of the project? *Probe for financial, social and institutional/governance; sustainability of the tollfree line, peer counselors etc.*

**PROJECT IMPLEMENTATION TEAM**

**Project strategy**

**Project design:**

- How has the project design affected (positively or negatively) the implementation of the project and achievement of expected/intended results?
- Are there any interventions that are not included, but should have been included in the design?
- How well does the project complement and link to the GoU priorities, plans and activities as well as to other DPOS?
- Decision-making processes: were the needs and interests of the target beneficiaries considered during project design processes? Did they participate in the project design?
- Was gender considered in the project design?
- Are there major areas of concern in the project design that need improvement if the project is to achieve its expected/intended results?
-

**ii. Progress Towards Results**

**Progress Towards Results**

Note: Review the logframe indicators against progress made towards the end-of-project targets using the Progress Towards Results Matrix.

- Is the project on course to achieving project targets as indicated in the logframe or indicator performance table?
- To what extent has the project achieved its objectives and the targets?
- What difference is the project making for the project participants and other stakeholders?
- Have there been any positive or negative unintended outcomes?
- Were there any factors or constraints that affected project implementation? If yes, what are those factors? And how did you address them? Probe for technical, managerial, organizational, institutional and national policies.
- Which barriers (if any), are likely to affect the project in achieving its intended results in the remaining period?
- How can the project address those barriers?

**iii. Project Implementation and Adaptive Management**

-

8. **Management Arrangements:**
   - Review overall effectiveness of project management as outlined in the Project Document.
     - Have changes been made and are they effective? Are responsibilities and reporting lines clear? Is decision-making transparent and undertaken in a timely manner? Recommend areas for improvement.

9.
   - Was there efficient and appropriate coordination and monitoring of the project to track progress towards achievement of set targets? *Probe for Examples of successful partnerships between MHU & government.*
   - Review the quality of support provided by the donor and recommend areas for improvement.

10.

**Work Planning:**

- Were there any delays in project start-up and implementation? If any, what caused it? What impact did it have? How was this mitigated?
- Are the project work-planning processes results-based? If not, suggest ways to re-orientate work planning to focus on results?

**Project finance and co-finance**

- Has there been cost effectiveness in project implementation? If yes, how cost effective has been the project?
- Has the project made any changes to fund allocations or made budget revisions? What budget changes have been made and why? Wat was the relevance and effectiveness of such revisions?
- Does the project have the appropriate financial controls, including reporting and planning, which allow management to make informed decisions regarding the budget and allow for timely flow of funds?
- Has the project secured any funding (co-financing)? If yes, what was the source, the amount and how was it used?

**Stakeholder engagement**

- **Project management:** Has the project developed and leveraged the necessary and appropriate partnerships with direct and tangential stakeholders?
- **Participation and country-driven processes:** Do local and national government stakeholders support the objectives of the project? Do they continue to have an active role in project decision-making that supports efficient and effective project implementation?
- **Participation and public awareness:** To what extent has stakeholder involvement and public awareness contributed to the progress towards achievement of project objectives?

**iv. Sustainability**

- To what extent are the project interventions and outcomes sustainable after the closure of the project? Probe for financial, social and institutional/governance; sustainability of the tollfree line etc.

**Financial risks to sustainability:**

- What is the likelihood of financial and economic resources not being available once the funding ends?

Socio-economic risks to sustainability:

- Are there any social or political risks that may jeopardize sustainability of project outcomes?
- What is the risk that the level of stakeholder ownership (including ownership by governments and other key stakeholders) will be insufficient to allow for the project outcomes/benefits to be sustained?
- Is there sufficient public / stakeholder awareness in support of the long-term objectives of the project?

**Institutional Framework and Governance risks to sustainability:**

- Do the legal frameworks, policies, governance structures and processes pose risks that may jeopardize sustenance of project benefits?