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THE REPUBLIC OF UGANDA

MINISTRY OF GENDER, LABOUR AND SOCIAL DEVELOPMENT

Uganda Management of Social Risk and Gender Based Violence Prevention and Response Project

SOCIAL IMPACT ASSESSMENT

April, 2017

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DEFINITION OF TERMS

Gender: Refers to social relations, attributes and opportunities associated with being a woman, a man, a girl or a boy and are developed through a socialization process.

Gender equality: implies that all human beings, both men and women, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or prejudices. Gender equality connotes equal access to resources and services.

Gender equity: connotes fairness in the distribution of opportunities and benefits. Equity is the means, and equality is the result.

Gender Based Violence (GBV): Acts perpetrated against women, men, girls and boys on the basis of their gender which cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed or other forms of conflict.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Education: Any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

Sexual Violence: refers to any sexual act that is perpetrated against someone's will or consent. Sexual violence includes a completed non-consensual sex act i.e. rape, defilement, an attempted non-consensual, abusive sexual contact i.e. unwanted touching, and non-contact sexual abuse e.g. threatened sexual violence and verbal sexual harassment.

Young People and Adolescents: The World Health Organization (WHO) defines young people as those aged 10–24 years, while adolescents are defined as those aged 10–19 years.

Intimate Partner Violence: Any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship.

Economic abuse: this abuse in form of, for example, withholding funds, controlling survivor's access to healthcare, employment, and so on (WHO, 2005).

ACRONYMS AND ABBREVIATION

CPC	Child Protection Committee
FCPU	Family and Child Protection Unit
DLG	District Local Government
GBV	Gender Based Violence
GRC	Grievance and Redress Committee
JLOS	Justice Law and Order Sector
KIs	Key Informants
NDP	National Development Plan
NGOs	Non Governmental Organisations
MoGLSD	Ministry of Gender Labour and Social Development
MoIA	Ministry of Internal Affairs
MoLG	Ministry of Local Government
FIDA	Association of Female Lawyers
UDHS	Uganda Demographic and Health Survey
LC	Local Council
WB	World Bank
UBOS	Uganda Bureau of Statistics
IPs	Implementing Partners
ILO	International Labour Organisation
MoJCA	Ministry of Justice and Constitutional Affairs
MoH	Ministry of Health
WHO	World Health Organisation
NPHC	National Population and Housing Census 2014
NSSF	National Social Security Fund
OSH	Occupational Safety and Health
PCR	Positive Cultural Resources
PLHIV	People Living with HIV
PWD	People with Disability
UPF	Uganda Police Force
HURINET	Human Rights Network
UWONET	Uganda Women's Network
SIA	Social Impact Assessment
UOBDU	United Organisation of Batwa Development in Uganda
VAC	Violence Against Children
VHTs	Village Health Teams
YLP	Youth Livelihood Program

EXECUTIVE SUMMARY

Introduction

The Government of Uganda recognizes the burden that gender inequality and Gender Based Violence (GBV) places on social and economic development such as infrastructure investments. Addressing social risks is central to social economic development. Previous studies have shown that, if social risks associated with development projects are not mitigated, they unleash serious adverse effects on the well being of targeted communities especially the marginalised and vulnerable groups. Further, the Government of Uganda, under various projects, including The World Bank funded projects, has recently faced numerous challenges in identifying and responding effectively to negative impacts of infrastructure development projects on vulnerable groups, especially women and girls.

It is in this respect, that the Government of Uganda in collaboration with The World Bank Country Portfolio is undertaking a social impact assessment with the view to identify potential social risks that are likely to impact negatively on the communities as result of implementation of the Uganda Management of Social Risk and Gender Based Violence Prevention and Response Project and recommend appropriate measures to mitigate the potential social risks and facilitate a conducive environment for preventing GBV as well as improving the quality of multi-sectoral response services for the targeted communities and GBV survivors.

Specific Objectives of the Project

The specific objectives are;

i. To increase access to Gender Based Violence (GBV) and gender-based discrimination prevention programs in the workplace in targeted districts;
ii. To increase access to Gender Based Violence (GBV) prevention programs at community level in targeted districts;
iii. To increase access to multi-sectoral response (remedial and protection) services for survivors of Gender Based Violence (GBV) in targeted districts;
iv. To strengthen government capacity to implement GBV prevention and response programs with a focus on work-place and community level interventions.

The Social Impact Assessment (SIA)

The SIA provides precautionary measures to mitigate adverse social impacts of the GBVPR project and ensures adequate screening for the social impact. The Social Impact Assessment looks at issues of social risks that are likely to impact on communities and workplaces in the project areas. It provides guidance for mitigating potential Social risks of development in the project sites. The Social Impact Assessment shall promote gender equality in Uganda as enshrined in the International Instruments, National Policies and Laws. Accordingly, the SIA developed process was informed by the existing Policy Legal Framework at national and international level.

SIA Objectives:

The overall objective is to provide a mechanism for mitigating social risks in order to enhance project benefits in the targeted communities.

Specific Objectives

- To identify potential ssocial risks associated with the project and propose mitigation measures.
- To inform project design, implementation and monitoring mechanisms.
- To identify measures for enhancing project benefits.

Identified drivers of GBV Potential Social Risks and negative impacts

During the social impact assessment a number of social risks and GBV related issues and challenges were identified both in the community and the workplace. At the community level, these include among others; property inheritance, unfavorable land tenure system and landlessness, school dropouts, child labour, child and early marriage and associated teenage pregnancy, polygamy, alcoholism and substance abuse as well as low household income

Social Risks and GBV related issues identified in the workplace are mainly associated with labor influx and GBV. These include among others; Low level of awareness and enforcement of Employment Act and OSH Act, lack of formal contracts of employment and long working hours, unfair workers remuneration to workers, lack of formal annual leave or sick leave, lack of conducive environment for Safe Motherhood, poor safety and health culture; inadequate dissemination of relevant policies and lack of clear Grievance Redress Mechanism.

Whereas efforts are being made to respond to the challenges to mitigate the social risks and prevent GBV, these interventions are largely implemented by NGOs mainly targeting women and girls and remain very limited in scope and coverage.

SIA Mitigation Measures

The Social Impact Assessment proposes a number of mitigation measures which are aligned to the objectives and key components of the Gender Based Violence Prevention and Response Project (GBVPRP) namely; GBV prevention at community level, GBV prevention at the workplace, increasing Gender Based Violence Response and management, capacity building and monitoring and evaluation. Interventions at the community level will be aimed at raising community awareness and building community resilience and competence for GBV prevention and sensitizing communities to the value of public assets and resources.. Appropriate legalisation, tools and guidelines will be provided accompanied by effective monitoring to mitigate adverse social risk impacts at the workplace. Institutional capacity will be built for the duty bearers Health Sector, Education Sector and JLOS) to strengthen GBV response.

Social Monitoring and Reporting

A social Monitoring framework and tools will be developed and used for data collection to monitor and track social risk issues and GBV prevention and response activities. Gender Responsive Performance indictors elaborated under each objective in the M&E Framework will be the basis for data collection. Other existing M&E tools e.g. Gender Auditing Guidelines for the Local Governments, Work place Inspection Tool and Labour Inspection Tool will also be used for monitoring SIA mitigation measures and other safeguards. Quarterly progress reports will be generated to for sharing with the World Bank and other stakeholders to guide SIA implementation and improvement

An independent annual technical audit of the social mitigation measures will be conducted by the World Bank through an independent external partner to assess whether the SIA process is being correctly, adhered to and whether relevant mitigation measures have been implemented effectively by project and other stakeholders. This review will serve as a mechanism for tracking progress in achieving the intended results and to pick lessons that inform subsequent implementation.

1.0 INTRODUCTION

The Government of Uganda recognizes the burden that gender inequality and Gender Based Violence (GBV) places on social and economic development. Addressing social risks is central to social economic development. Previous studies have shown that, if social risks associated with development projects are not mitigated, they have serious adverse effects on the well being of targeted communities especially the marginalised and vulnerable groups. There are also instances where development projects are misused, destroyed by communities especially if communities are not actively engaged and sensitized to the value of these projects. The Government of Uganda under various projects, including The World Bank funded projects, has recently faced numerous challenges in identifying and responding effectively to negative impacts of infrastructure development projects on vulnerable groups, especially women and girls.

As part of implementation of this policy, The World Bank Country Portfolio is supporting the Ministry of Gender, Labour and Social Development (MoGLSD) to implement a project to increase access to Gender Based Violence (GBV) prevention and response programs and multi-sectoral response services by groups at risk in targeted 13 districts. It is in this respect, that the Government of Uganda in collaboration with The World Bank Country Portfolio is undertaking a social impact assessment in the targeted districts with the view to identify potential social risks that are likely to impact negatively on the communities as result of implementation of this project and recommend appropriate measures to mitigate the potential social risks and facilitate a conducive environment for preventing GBV as well as improving the quality of multi-sectoral response services for the targeted communities and GBV survivors.

1.1 Project Background

The World Bank is supporting the Government of Uganda through the Ministry of Gender, Labour and Social Development (MoGLSD) to address Social risks arising from the complaints and grievances of communities, workers and other stakeholders, as a result of infrastructure projects being implemented or overseen by government. This is to be achieved through mitigation of social risks and Gender Based Violence (GBV) Prevention and Response Project (GBVPRP). This project is consistent with the Bank's twin goals of ending absolute poverty and boosting shared prosperity and is also in line with the objectives of the World Bank's 2011 regional strategy for Africa. The project preparation is guided by the following principles:

i. Focusing on operationalizing the National Policy on the Elimination of GBV by strengthening government systems.
ii. Building on lessons-learned and impact evaluation data of GBV interventions in Uganda as well as on global best practice.
iii. Supporting critical national activities in 13 selected districts where comprehensive GBV prevention and response activities will be implemented. These districts shall include Kisoro, Kamwenge, Kamuli, Apac, Kabarole, Wakiso, Mukono, Masaka, Sironko, Alebtong, Zombo, Hoima and Mbale.

1.2 Project Objective and Scope

Project Development Objective
To increase access to Gender Based Violence prevention programs and multi-sectoral response services by groups at risk in targeted districts.

Specific Objectives

- **i.** To increase access to Gender Based Violence (GBV) and gender-based discrimination prevention programs in the workplace in targeted districts;
- **ii.** To increase access to Gender Based Violence (GBV) prevention programs at community level in targeted districts;
- **iii.** To increase access to multi-sectoral response (remedial and protection) services for survivors of Gender Based Violence (GBV) in targeted districts;
- **iv.** To strengthen government capacity to implement GBV prevention and response programs with a focus on work-place and community level interventions.

1.3 Project Component and Description

The project is to focus on mitigating Social risks and preventing GBV as well as on improving the quality of multi-sectoral response services for survivors. The project is supporting the implementation of the National Policy and Action Plan on the Elimination of Gender Based Violence (2016) and National Strategy for the Creation and Enhancement of Gainful Employment in 13 targeted districts. Key project beneficiaries are government officials in MGLSD, MoH, MoJCA, MoIA (Uganda Police Force) and the most at risk groups to Social risks and GBV.

The project has three components namely;

i. Component 1 - Gender Based Violence Prevention (in the workplace and at community level)
ii. Component 2 – Gender Based Violence Response (Health, Police, Justice, Law and Order Sector Response)
iii. Component 3 - Project Management, Capacity Building and Monitoring and Evaluation

1.4 Project Implementation Arrangement

The project is to be implemented by the MoGLSD and MoH through mainstreaming of project interventions into government programmes and operations. The Permanent Secretary, MoGLSD is to be supported by a full-time Project Coordinator to serve as Project Manager responsible for overseeing day-to-day coordination of project implementation.

Given the multi-sectoral nature of the intervention the overall project implementation is to be coordinated in strong partnership with Ministry of Local Government, Ministry of Internal Affairs, Ministry of Justice and Constitutional Affairs (JLOS Secretariat), and Uganda Police Force. MoGLSD is to work and competitively select Non-Governmental Organizations (NGOs) that will engage communities in preventing and responding to cases of GBV. Gender Based Violence prevention activities at community level under (Component 1B) are to be implemented in

partnership with Faith Based Organizations, traditional institutions and civil society organizations selected on a competitive basis to implement agreed programme interventions within components.
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2.0. THE SOCIAL IMPACT ASSESSMENT (SIA)

The Social Impact Assessment looks at issues of social risks that are likely to impact on communities and workplaces in the project areas. The aim of the SIA was to identify potential social risks and recommend appropriate measures for mitigating potential social risks of development in the project sites. The SIA focused on a wide range of social risks such as; violence in communities especially against the vulnerable persons such as women, men, persons with disabilities and children; child abuse and labour, sexual abuse and harassment and exploitation, economic deprivation due to unfair employment opportunities, exploitation of workers and denial of opportunities among others.

2.1 Justification for SIA

The Government of Uganda under various projects, including The World Bank funded projects, has recently faced numerous challenges in identifying and responding effectively to negative impacts of infrastructure development projects on vulnerable groups, especially women and girls. Therefore, the Government of Uganda considers it most prudent to conduct social impact assessment studies on all social development project in order identify potential social risks that are likely to impact negatively on the communities as result of implementation of this project and recommend appropriate measures to mitigate the potential social risks. Equally, implementation of the Uganda Management of Social Risk and Gender Based Violence Project must comply with Government commitments to implement measures to mitigate adverse social impacts of the project and ensure a conducive environment for preventing GBV as well as improving the quality of multi-sectoral response services for the targeted communities and GBV survivors.

2.2 SIA Objectives:

The overall objective is to provide a mechanism for mitigating social risks in order to enhance project benefits in the targeted communities.

Specific Objectives

- To identify potential ssocial risks associated with the project and propose mitigation measures.
- To inform project design, implementation and monitoring mechanisms.
- To identify measures for enhancing project benefits.

2.3 SIA Development Process

The SIA was developed through a wide consultative process ensuring broad participation of all the relevant stakeholders to solicit input. These included; representatives from the MoGLSD, MoH, MoIA (Police), MoJCA (JLOS), MoLG, UNRA, local government authorities technical and political leaders, GBV service providers and users of health services, Road Construction Supervisors, Contractors and Workers, and community leaders. The Consultant worked closely with the MoGLSD and the World Bank throughout the execution of assignment to ensure that the work done meets the client's expectation. This was realized through joint stakeholder consultations in the districts, regular briefings, and consultative meetings.

In the three districts of Kamuli, Kabarole and Kamwenge, one hundred sixty three (163) community representative were consulted; seventy one (71) women; and ninety two (92) men. This was approximately 44% to 56% respectively. In Kisoro alone, given its uniqueness, one hundred seventy seven (177) were interviewed. To ensure inclusion, selection of participants was scientifically determined with guidance of district staff. Consideration of specific communities was informed by levels of GBV prevalence (based on sub-county case reporting) and for actual participants considered gender, age groups, responsibility (knowledge base) as well as positions to capture policy and implementation perspectives. Lists of participants in consultative fora are annexed for reference.

As part of the development process an assessment was undertaken in the four (4) purposively sampled districts of Kamuli, Kamwenge, Kabarole and Kisoro to estimate, in advance, the potential social consequences that are likely to impact on the process of implementation and the social set up of the beneficiary community as well as to evaluate functionality and existing capacity to handle Social Safeguards requirements.

2.4 Methodology

Data Collection Methods
A mix of data collection methods was adopted for this assessment. These included;

Desk Review: Relevant documents that enhance social risk management and promote equal opportunities to various groups of people were reviewed. Documents reviewed included among others; the World Bank safeguards policies, Convention on Elimination of all forms of Discrimination Against Women (1979), Uganda GBV Diagnostic Study Report (2016), the Constitution of the Republic of Uganda (1995), the National Social Protection Policy (2016) and the National Policy on Elimination of Gender Based Violence (2016) and the National Equal Opportunities Policy (2006).

Technical Briefings: The Consultant attended initial meetings organized by the client i.e. MoGLSD and The World Bank for technical briefings. These meeting provided an opportunity for the consultant to improve their understanding of the TORS and expectations of the client. A joint post-field workshop was conducted for all field teams to share experience and harmonize findings. In addition feedback meetings were conducted with the client and The World Bank to ensure continuous input in throughout the assessment process.

Key Informant Interviews: Key informant interviews were conducted with the district technical officers, political heads, cultural leaders, private service providers like the NGOs and to collect expert opinions about social risks and the GBV situation in the community and the work place. Gaps, challenges and recommendations regarding GBV interventions were documented.

Group Interviews: Group interviews of 5- 10 correspondents were conducted for men and women workers from construction sites to help collect workers opinions about Social risks and GBV as well as labour/employment conditions and procedures. The Consultant ensured the interviews were voluntary, guaranteed privacy, transparency and free interaction with the workers.

Focus Group Discussions: Focus Group Discussions for men, women, children, youth and the Child Protection Committee (CPC) were conducted to generate community opinions about Social risks and GBV and document challenges and recommendations. Focus Group meetings ensured a broad participation of community members including; children, community leaders, VHTs, religious and traditional leaders, community volunteers, representatives of CBOs and other community resource persons.

Participants Observations: Keen participants' systematic observation was done to further understand people's motivation and attitudes towards social risks and GBV. Observations were done in hospitals, schools and GBV Shelter settings and served to augment the findings and to triangulate data from the different sources.

3.0 POLICY AND LEGAL FRAMEWORK

The Social Impact Assessment shall promote gender equality in Uganda as enshrined in the International Instruments, National Constitution (1995), Policies and Laws. Accordingly, the SIA development process was informed by the existing Policy and Legal Framework at national and international level.

3.1 International Legal Instruments

The international legal framework includes the ratified International and Regional Agreements that promote gender equality, support prevention and response to GBV. Table 3.1 below outlines some of the relevant international conventions that have been ratified by Uganda.

Table 3.1 Relevant International Conventions Ratified by Uganda

Convention	Year
Conventions on the Rights of the Children 1989	1990
Convention on Elimination of all Forms of Discrimination Against Women 1979	1987
Convention Against Torture and other Forms of Cruel, Inhuman and Degrading Treatment 1984 accession	1986
Abolition of Forced Labour Convention 1957 (No.105)	1963
ILO Convention on Worst Forms of Child Labour , 1999(No.182)	2001
Equal remuneration Convention No.100	2005
Discrimination (Employment and Occupation) Convention No 111	2005
UNESCO Convention on Safe Guarding of Intangible Cultural Heritage, 2003	2009
Convention on the Rights of Persons With Disabilities, 2006	2007
Beijing platform for Action 1995	1996
The African Charter on Human and People's Rights 1981	1986
The African Union Heads of State Solemn Declaration on Gender Equality, 2004	2005
the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol, 2003)	2010

3.2 National Laws and Regulations

The 1995 Constitution of the Republic of Uganda is the parent legislative framework underlying the gender equality within its Chapter 4 on Protection and Promotion of Fundamental and other human rights and freedoms by guaranteeing every Ugandan equality and freedom from discrimination, respect for human dignity and protection from inhuman treatment, protection from slavery, servitude and forced labour, and protection from deprivation of property.

Other legislations that promote gender equality including elimination of GBV are: the Penal Code Act Cap 120 which criminalizes and penalizes most forms of GBV against women, men and children, the Domestic Violence Act 2010 provides for the protection and relief of victims of domestic violence, punishment of perpetrators of domestic violence and procedures, the Children's Act Cap 59 and the Children (Amendment) Act, 2016 provides for protection of children, strengthening the provision for guardianship, strengthening the conditions for inter country adoption and prohibits corporal punishment including mandatory reporting of cases of violence against children by teachers, health and social workers, the Persons with Disabilities Act, (2006), the Prohibition of Female Genital Mutilation Act, 2010 and the Prevention of Trafficking in Persons Act, (2009).

Legislation relevant to the workplace include: Employment Act No 6, (2006); the National Equal Opportunities Policy, 2006; the Equal Opportunities Commission Act, (2007); the Uganda National Employment Policy, (2011); the Labour Disputes (Arbitration and Settlement) Act No. 8, (2006); the Labour Unions Act No. 7, (2006); the National Child Labour Policy (2007); the National HIV/AIDS and the World of Work Policy (2007); the Local Government Act; Minimum Wages Board and Advisory Council Act; The National Women's Council Act; the Occupational Safety and Health Act No. 9, (2006) and the Workers' Compensation Act, (Cap 225) among others.

3.2.1 Relevant National Policies and Plans

A number of national policies and plans relevant to GBV have been reviewed and these include;
The Uganda Gender Policy (2007) and the National Action Plan on Women (2007) encourages Government, civil society, and UN agencies to put gender equality at the center of all strategies and interventions, including those that address GBV.

The National Policy on Elimination of Gender Based Violence (2016) provides a framework for the implementation of comprehensive GBV prevention measures and provision of multi-sectoral support services for survivors. It also outlines the role of various state and non-state actors at local and national levels, strategic actions, and milestones for measuring progress. The new policy plays a key role in addressing critical gaps in GBV response, such as the lack of functioning referral systems that coordinate heath, social, law enforcement, and judicial sectors.

Uganda Vision 2040, (2013) stipulates a plan to promote equal opportunities and enjoyment of human rights for both men and women, provides for care and protection of vulnerable groups either by age, social class, location, disability, gender or disaster, ensure gender responsive policies, programmes and actions.

National Development Plan NDP II (2015/16-2019/20) emphasizes gender equality as a basis for development and the elimination of GBV as a key strategic action;

The Social Development Sector Plan (SDSP) 2015/16-2019/20 underlines the expansion of GBV prevention and response programs as a priority area of action.

In addition, there are other policies including: National Strategy to End Child marriage and teenage pregnancy (2014/2015 – 2019/2020); The National strategic plan on violence against children in schools (2015-2020); and The National Action Plan on Elimination of Gender Based Violence in Uganda (2016 - 2021) guides efforts towards reduction of GBV prevalence in all its manifestations and ensure a coordinated mechanism for elimination GBV from all societies in Uganda

4. 0 POTENTIAL SOCIAL RISKS AND THEIR NEGATIVE IMPACTS

Through consultations with the representatives of the community members and intended project beneficiaries, local leaders, construction workers, and other key stakeholders in the districts, the assessment identified a number of potential social risks that are likely to impact negatively on the project at both community and workplace level. These are presented and discussed under sections 4.1 and 4.2 below.

4.1 Potential Social Risks associated at the Community Level

- **Likely Distortion of Traditional Roles of Men as Heads of the Family and Sole Family Providers as a Result of Overempowerment of Women and Girls:** Whereas, empowerment of women and girls will have positive impact in a short run, there are community fears that in the long run the gains of empowerment might result into excessive promotion of women and girls' rights at the expense of men and boys. This may in turn result into increased cases of GBV at household level due to power differentials associated with change in roles of men and women in the family. These changes may undermine the traditional roles of men in patriarchal society where a man is the head of the family and controller of all resources. On the other hand, men are abdicating their roles as family providers and therefore abandon their homes in search for other women who are economically self-sustaining.
- **Exclusion of the Most Vulnerable and Marginalized Groups**: During FGDs, representatives of the members of the community were worried that some vulnerable groups who are voiceless such as; the PWD, PLHIV, OVC, adolescents, migrant workers and the elderly may be missed out in the selection of project beneficiaries. One elderly and disabled man in Bulopa retorted, "*to me these projects are like when your step mother wants to prepare food for her children and uses you to fetch water, look for firewood and run all sorts of errands; but when the food is ready, you never even get to know where it is served!"*
- **Likely Increase of Family Conflicts and Disintegration due to Enhanced Legal Enforcement:** There were perceptions among some community members that through increased legal enforcement of GBV laws, more men perpetrators are likely to be prosecuted and jailed. Women and children felt this may lead to increasing stigmatization, potential retaliation and insecurity to GBV survivors by. This may deny children and other dependants the right to enjoy parental (especially fathers') care leading to school drop-out, insolence, child labour, child marriages and teenage pregnancy etc. In tears and bitterness, Jenifer (not real name) in senior two narrated her GBV experience after the mother had left home "..... *I wanted to commit suicide but had no money to buy poison"*
- **Non-Male Involvement in programme interventions on GBV:** Men representatives who participated in FGDs expressed fears that men are not likely to be targeted by the project. From their past experience, previous GBV projects had not targeted them as beneficiaries but as perpetrators. One man loudly retorted, *"We are here today because these visitors want to tell us about the project. You wait; this is the last we participate. Everything on GBV is for women; yet we also get tortured!"*
- **Inadequate Capacity to respond to the Overwhelming Demand for GBV Services Outstripping Available Resources:** District leaders, intended beneficiaries and service

providers were optimistic that increased awareness of GBV prevention and response services is likely to result in increased demand for services on the one hand, on the other hand, they expressed fear of increased workload for the health workers who are already overstretched. In the same vein, there were fears by the community that, the limited infrastructure at health facilities would not cope with the increased number of GBV victims hence compromising **quality, privacy and confidentiality** of the survivors.

- **Poor Handling Of GBV Cases at the Community Level due to weak community Structures and Political Interference:** Community consultations revealed that the existing weak community structures coupled with political interference may lead to disregard of the project guidelines, consequently undermining equity in distribution of resources. They further noted that previous initiatives like Youth Livelihood Funds and the, Global Fund had been mismanaged due to political interference. They further noted that, GBV cases may not handled effectively; they cited lack of transparency in the local leadership (LCs), Local Council Courts, Police and Courts of Law. Some structures e.g. LC courts overstep their mandate by negotiating capital offences out of court or fail to refer cases. It was reported that, sometimes Police does not thoroughly investigate reported cases thoroughly, thus creating a sense of mistrust and frustration among the community. "There were voices in groups saying, "*The rich never lose cases"*, meaning that those who have resources (money or status) always win, while others said, *"Okukuwamu akatono tikasinga kulekera police yonka?*. Literally meaning that it is better to accept a small token from a perpetrator because if the case is taken up into the courts of law, you get nothing.
- **Competing Project Priorities Affecting Routine Family Schedules:** The project emphasizes community participation and women involvement. There is a likelihood of committing a lot of time to the project at the expense of other income generating and routine domestic activities e.g. care for the family.
- **Financial Barrier to Access GBV Services:** Whereas the project is intended to provide free services, community members were worried that some associated costs like transport to service centres; legal fees etc. may not be affordable especially by the needy GBV survivors.
- **Failure to Address Community Priority Needs:** Where as the project is perceived to be useful to the community, community representatives observed that other priority community needs that influence GBV in the community e.g. water, education, livelihood and food security have not been addressed.
- **Denial of GBV Survivors quality GBV (multi-disciplinary) Services due to Poor Coordination of the Duty Bearers**: The district leadership in Kisoro was concerned about coordination of GBV interventions at the district level It was observed that some NGOs offering GBV services were not registered in the districts and therefore were not reporting to district authorities. There were fears that if this is not addressed, it might affect equity and quality of services.
- **Poor Service Delivery due to Poor Monitoring and Mismanagement of Project Funds:** Community members were worried about monitoring of project activities and management of project funds. They felt there was need to effectively monitor project activities on regular basis to identify key bottlenecks for corrective action and planning

more effective GBV interventions that benefit the community. They also noted with concern, a big potential for the mismanagement of project funds by the duty bearers through connivance with and the technical staff and political leaders. This is likely to limit anticipated gains for the target populations, leaving the communities in their existing status quo. During the FGD in Kamuli district a woman was applauded when she stood up and said, to caution *"this time do not do business as usual. Bring whatever you want to give us be it seeds, money, implements, etc. If you want a local woman to benefit, hand everything to us not through leaders above"*

4.2 Potential Social Risks associated at the Workplace

- **Increase in Case Backlog:** Effective implementation and enforcement of Labour Laws is likely to increase the number cases reported and filed in court. This will in turn worsen the already existing huge case backlog due to limited number of judicial officers.
- **Increased Cost of Routine Monitoring, Reporting and Follow-Up:** Effective implementation of the project will require increased routine monitoring, reporting and follow up of GBV cases by inspectors. This will increase the budget required to cater for additional staff and facilitation.
- **Retrenchment of Workers:** Effective implementation and enforcement of Labour Laws will result in improved working environment and better remuneration of workers which in turn will increase production costs. There are fears that employers will retrench workers to cut costs leading to unemployment. While at the same time increasing the workload of the remaining workforce.

4.2.1 Other Key Findings at the Workplace

This section highlights identified social risks associated with labor influx and GBV as generated through document review and consultations with key stakeholders

Low Level of Awareness Of Employment Act and OSH Act: According to the HR Manager of a Road Contractor, the Employment Act with related regulations, terms and conditions exist. However, these have not been adequately disseminated, neither are they clear on maximum working hours and remuneration, forms of harassment, affirmative allocation of tasks, and whistle blowing protection among others. Consultations with the respondent workers revealed that they were not aware of the terms and conditions of employment.

Lack of Formal Contracts of Employment and Long Working Hours: The assessment observed that there were no formal contracts contravening the Contract Act and Employment Act. For example, it was noted that at one of the construction sites, employees worked for 13 hours a day including lunch hour. Time sheets are recorded in Chinese without any translation thus workers are unable to calculate their wages contrary to the Minimum Wages Advisor Boards and Wages Council Act.

Unfair Workers Remuneration: In Kamwenge, road construction workers are paid UGX 500/= per hour which amounts to UGX 4000/= for the eight hours daily remuneration to cater for accommodation, meals and transport. This is the same hourly rate for overtime and on public

holidays contrary to the Employment Act. This type of remuneration denies workers access to quality health care, education, social services and promotes GBV.

Family/Work Life Imbalance: FGD with female workers revealed that the lack of guidelines on family/work life balance has contributed to broken family/boy/girl relationships, resulting in increased GBV at family level and poor parenting of children. It was further revealed that, due to physiological sexual demand, workers are conditioned to workplace intimate relationships, resulting into GBV and high risk of transmission of HIV and other sexually transmitted diseases.

Breach of Leave Entitlement: FGD with workers revealed that workers were not given their due leave entitlement. It was noted that only 11 days of leave per year was granted to some workers, while Supervisors were denied leave without their formal consent or compensation. Furthermore, workers stated that they are expected to continue working when sick, because failure to do so results in none payment of a daily wage. This is in breach of leave provisions and procedures spelt out in the Employment Act.

Lack of Conducive Environment for Safe Motherhood: There are no national regulations and guidelines on flexibility of work schedules for pregnant workers, rotation or provision of alternative tasks to pregnant women or support for breastfeeding mothers in workplaces. In Kamwenge, female workers revealed that they are given maternity leave of two (2) months only contrary to 60 working days (equivalent to 3 months) as stipulated in the Employment Act 2006. Female workers revealed that a fellow pregnant worker was terminated when the contractor noted that she was not performing efficiently as expected. However, female workers at senior management level in the Consultant's/Supervisor's team are permitted to return home to breastfeed their babies.

Poor Safety and Health Culture; National guidelines and regulations on mitigation of social risks within the working environment are poorly disseminated which affects enforcement and self regulatory mechanisms. During the FGD with male workers, it was revealed that PPE given is inadequate and inappropriate. Workers are not oriented on the safety and health risks attributed to their work, neither have they undergone any pre-employment, routine, biological monitoring and post-employment medical examinations to monitor their health conditions in respect of the tasks being performed. High fire risk areas like mechanical workshops are not provided with fire protection and response mechanisms. Workers in Kiko camp in Kamwenge expressed a sense of discrimination in provision of welfare amenities e.g. toilets were inadequate, (1 stance was provided for 50 construction workers, no urinal, no hand washing facility) and located approximately 1½ km from mechanical workshop.

Violence in the Workplace: According to the Labour Officer in one of the districts assessed, employment regulations and guidelines are poorly disseminated. A lot of focus has been put on sexual harassment and less on other forms of violence like psychological, economic and physical which are considered high. Male workers confessed that they are beaten, abused and instructed to work in highly risky environment with limited protection. Female workers revealed that they work long hours and are psychologically tormented and sexually harassed, or threatened to be harmed if they don't give in to sexual advances. The Labour Officer noted that, investigations of compensatible accidents have no linkage to GBV which is a likely predisposing factor to accident occurrences.

Inadequate Dissemination of Relevant Policies: Key Informant interviews with the district technical staff revealed that policies and guidelines related to gender equality have not been adequately disseminated in the workplaces and local governments. This has resulted in poor reporting and handling of GBV cases from the workplaces due to the low level of conceptualisation of social risks and GBV.

Labour, Safety and Health inspections: The assessment established that there is no monitoring tool for tracking social risks and GBV in the workplace, hence the magnitude of these incidents cannot be established.

Accident Reporting Forms: LD Form 31 used in reporting and investigation of compensatible accidents does not provide clear guidance on investigation of these accidents in relation to social risks and GBV. Thus reoccurrence of accidents remains high and this is manifested in reduced productivity and increase in health care expenses. From the consultations, sometimes the Labour Officers are impeded from fully investigating workplace accidents due to reported complexities regarding ownerships of the workplaces.

Police Form 3, Medical Examination of an Injured Person: The Senior Medical Officer, HC IV, revealed that the PF form 3, lacks a section or question on the place where the incident occurred (whether at the workplace or in the community)"; making case filtering impossible.

Low Awareness on Whistle Blowing Protection Guidelines: The Whistle Blowers Protection Act, 2010 has not been disseminated and there are no developed guidelines to operationalize the Act. This has hampered reporting of GBV cases due to fear of 'Whistle Blowers" losing their jobs, especially where they are subordinates to the perpetrators.

Lack of Clear Grievance Redress Mechanism: Consultations with KIs in the project districts revealed that there are no national grievance redress guidelines for GBV cases in workplaces, which affects reporting, investigation, preventing and responding to any cases. Consultations with workers revealed that although suggestion boxes have been introduced, they are under-utilised due to low level of awareness as to the purpose of these boxes, lack of confidentiality and lack of feedback on resolutions made. The assessment established that Disciplinary Committees have been established but only addresses address performance related issues, while other grievance redress mechanisms such as counseling or transfer to another duty station or forced leave are being applied to resolve conflicts.

It was further established the selection of members and functioning of Disciplinary Committee was dominated by the management team, thus causing intimidation of the victims especially junior workers and lacks workers representatives. This affects investigations of complaints, and results into unfair judgement of victims.

Non unionisation of workers; According to Consultants on the Kamwenge road construction, there is low level of awareness about functions of unions and employers' associations in the construction industry and as such their grievances are never heard. Most of the workers are casual temporary labourers.

4.3 Social Cultural Issues Fueling GBV in the Community

In addition to the identified social risks associated with the project, the SIA also identified social cultural issues fueling GBV in the community. These include;

Property Inheritance: Property inheritance impacts negatively especially on the welfare of the women and children because they are denied the right to inherit property. From the FGDs in Kamuli and Kamwenge, it was revealed that when a husband dies, his property automatically reverts to the extended family/clan leader for management. This leaves widows and children vulnerable and at the mercy of the decisions of the wider family.

Land Tenure System and Landlessness: In the project sites, it was found out that most women do not own land. Land is controlled by men, practically more used by women while men utilize the proceeds which puts women at a risk of economic dependency on men. GBV cases tend to increase after harvest when men usurp powers of marketing and control of money, disregarding women who toil and suddenly lose control over the proceeds. This was confirmed at GBV Shelter in Kamuli where there was no single woman because women were busy preparing gardens for planting. One community member conversant with the shelter said, *"You come back in July during harvesting season. You will find the Shelter full of victims…"*

School Dropouts: There is high school dropout rate reported in all assessed project sites, resulting mainly from poverty, GBV and Violence Against Children (VAC). In Kamwenge District, it was noted that school dropout is high among girls and is generally caused by poverty where poor parents who are struggling to get basic needs see it as a luxury to spend on scholastic materials even when education is free. Parents claim that girl children are expensive to educate compared to boys. In Kamuli, children reported that they had been affected by GBV; for example, they had to take on their mothers' role of caring for the siblings while some known children had dropped out of school because of broken homes due to GBV.

Child Marriages: Child marriages are prevalent in the project districts. For example, consultations in Kamuli and Kamwenge districts revealed that girls are seen as a source of income and they are forcefully married off at a tender age, as early as 12 years. On the other hand, young girls voluntarily opt for marriage to escape harsh family conditions, especially when they drop out of school. During an FGD with Kiyunga Youth Development Group in Mbulamuti Sub-County (Kamuli District), the consultants noted many young girls (around 20-25 years) were mothers and already divorced because they had eloped with men/boys at early ages to escape from cruel stepmothers, while others had had babies before marriage. Today, the same girls have failed in their marriages/relationships, returned or stuck with the same cruel stepmothers, with one or two children to look after!

Polygamy: Focus Group Discussions revealed that culturally, men are allowed to have more than one wife, in cases where first wives fail to give birth, giving birth to single sex children (girls), growing older and their sexual libido reducing and/or when the men get more money. Polygamy increases the burden of the husband to provide for their households; this increases GBV in families where such a husband fails to fulfill his obligations. It is also associated with GBV among wives, between wife and husband and against children.

Alcoholism and Substance Abuse: Alcohol and substance abuse are increasingly becoming serious factors in promoting GBV and other social issues. Consultations in Kisoro, Kamwenge and Kabarole districts established that men engage in irresponsible alcohol and substance consumption. In Kamwenge District, alcohol consumption was cited as a key driver for poor parenting styles and abuse of children's rights. This vice manifests in overspending, multiple sex partners, abdicating family roles and responsibilities which in turn accelerate GBV in homes.

Livelihood: The rural populations in project areas derive their livelihoods from subsistence agriculture, growing mainly maize, sweet potatoes, bananas and ground nuts; livestock keeping, and fishing; as well as adhoc paid labour. However, some of the people are employed in the formal sector. From field consultations, it emerged that due to economic hardships some people are engaged in illegal activities like child labour, sex work, and environmental degradation for example burning charcoal. Kiyunga Youth Drama Group had some interesting experience to share. Members are well organized with clear leadership and engaged into savings, drama and income generating activities (tents, chairs for hire). Straight Talk trained the group in baking and hair dressing but did not retool them so they have not put their skills to use. The group was of the view that if the MoGLSD gave them some support they could procure drama and music equipment to expand the scope of their income generation. Since the GBV project has a livelihood component, such gaps are likely to be addressed.

4.4 Current Social Risk and GBV Interventions

The SIA established that, there are various initiatives addressing social risks and GBV at the community and workplace. However, these initiatives were largely implemented by NGOs with donor support and were faced with a number of gaps and challenges. The proposed mitigation measures are intended to address some of these challenges. Some of the key interventions implemented at community level are presented in table 4.1;

Table 4.1: GBV Interventions at Community Level

Organization	Interventions	Target
Local Government	Coordination and capacity building of local structures	Child Protection committees, Para socials, VHTs, etc.
JLOS	Legal services, capacity building, monitoring	Community, GBV Survivors, Judicial Officers, Police
Police (Family and Child Protection Units)	Awareness in communities, Law enforcement, counselling & guidance, referrals, handling cases	Families (men, women & children), victims of GBV and VAC, juvenile offenders
Plan International	IEC materials, education, awareness	Communities, school children
UWONET	GBV Shelter Management, legal aid, sensitization and mediation	GBV survivors (women and children)
FIDA	Free legal aid	Women
Media Houses	Information Dissemination	Wider communities
BRAC	IEC, Psychosocial Support, Livelihood, Microfinance	Women, Children, OVC
World Vision	Psychosocial Support, Education, Water	OVC, Youth, Women
JOY For Children	Psychosocial Support, Sensitization	OVC, PLHIV
Muhabura Diocese	Psychosocial Support (Spiritual) Resettlement, food, clothing	OVC, Women

Bantwana	Sensitization, capacity building	Children
UOBDU	Education, legal support, capacity building, Sensitization	Indigenous Minority Peoples (Batwa)

4.4.1 Social Risks and GBV Interventions at the Workplace

Some interventions though limited, are being implemented to address social risks and GBV at the workplace. These include;

- Safety and Health Committees have been established to regularly monitor safety and health conditions and institute mitigation measures
- Workplace trainings or orientations on safe methods of work
- Grievances are reported to the supervisor or labour officer who advises on redress mechanism. Sometimes the perpetrator is transferred while criminal cases are reported to police for further investigation.
- Workplaces have internal guidelines on work procedures and reporting of grievances e.g. suggestion boxes
- Disciplinary Committees have been established to provide avenues for fair hearing to workers in cases of disciplinary proceedings against a worker.

4.4.2 Gaps and Challenges

The assessment identified a number of specific and cross-cutting challenges affecting GBV and other social risk interventions. These include;

Lack of Awareness of the Existing Laws and Regulations: There is a general lack of awareness of existing laws especially those related to GBV and where knowledge of such laws is available, they are not being applied.

Inadequate and Unpredictable Funding: Substantially GBV prevention and response initiatives are donor funded by bilateral and international agencies through local and international civil society organisations, e.g. UWONET, Plan International, FIDA, ACTION AID etc. Funding is not holistic and is unpredictable in nature and does not guarantee sustainability once the donors pull out when project cycle ends. There are no specific budgets for management of social risks and GBV prevention and response.

Lack of Transport: Community structures like, cultural leaders, CPCs and VHTs lack means of transport for community outreaches and follow-up of the reported GBV cases in courts of law. Equally, JLOS Field support lack transport to follow up reported GBV survivors. This has in turn constrained their contribution to the GBV prevention and response in communities.

Inadequate Infrastructure: Health centers do not have specialized rooms for GBV services and lack privacy for counseling services to the GBV survivors. There are no specialized services for GBV in health facilities particularly in lower level health centres. This has resulted in limited uptake and quality of GBV services. While Kamuli Hospital has 4 GBV trained staff and attempts to integrate GBV in other services such as treatment and care, and referral for specialized examinations in cases of rape and defilement; the hospital has no space designated for GBV services. Instead,

there is a GBV Corner that is in the open at the triage. It could be useful for the project to partition existing space but this too has implications as the existing space is filled to capacity, (given that Kamuli Hospital was a HC1V but upgraded to a hospital status). Maybe, construction of temporary shelters (using containers) and training staff at lower level health units could motivate staff and beneficiaries to induce demand driven service uptake.

Limited Technical Capacity: Health providers have limited knowledge and skills to manage GBV victims. Health facilities have inadequate trained personnel, commodities and tools to gather and preserve forensic evidence to facilitate prosecution of GBV perpetrators in courts of law.

Inadequate legal support and community monitoring: Many GBV cases reported at FCPU at police are often dropped before concluding investigations due to lack of evidence. Family members may not be willing to give evidence to support the victim in courts of courts of law due to their close relations with the perpetrator. There are also delays in filing and hearing of cases. It is alleged that police and LCs connive to get bribes from perpetrators and consequently drop the reported cases prematurely. From JLOS perspective, there are child to child sexual abuse cases that are difficult to deal with since they require special expertise. These factors have undermined GBV prevention and response efforts in the project area.

Equally, there are also a number of gaps and challenges that are specific to workplaces. These include;

- Lack of confidentiality or impartiality expressed by supervisors and Grievance Redress Committees members. Workers are unable to speak freely about any grievance during meetings as they are intimidated by presence of their bosses;
- Language barrier which affects communication or compliance to safety and health instructions;
- Lack of Minimum Wages for workers that has promoted the high level of exploitation and unfair remuneration;
- Communities are not cooperative with workers, view this as an opportunity for exploitation e.g. they increased rental charges for road construction workers and are falsely accused of sexually abusing young girls in the neighbouring community; and
- Poor Inspection due to irregular work place visits by the Labour Officers to orient workers on their rights and monitor compliance with labour laws. OSH Act and other relevant guidelines

Small Scale Rehabilitation of Health Centers, Police Stations and District Office for MOGLSD: The SIA team further reviewed the proposed small scale rehabilitation of health centers, police stations and District Office for MOGLSD. This will be limited to small scale internal repairs, painting and portioning and are therefore not expected to have any significant adverse social impacts. The management of negative environmental and health and safety impacts have been adequately addressed through the Environmental Management Framework.

4.5 Positive Impacts Associated with the Project

Despite the above identified social risks that are likely to negatively impact on the project, there are some likely positive impacts. These include;

- Successful project implementation will lead to reduced GBV prevalence, harmonious families as well as improved quality of life of GBV survivors and targeted communities in general
- Reduced sexual violence and harassment especially among the girls will boost girls' school enrolment.
- Increased awareness of the existing laws among the workers and employers will lead to enhanced implementation of the laws and policies leading to improved work environment and increased efficiency
- Improved working relationship between contractors and beneficiaries leading to harmonious co-exist and improved corporate image

5.0 RECOMMENDED MITIGATION MEASURES TO ADDRESS SOCIAL RISKS

The Social Impact Assessment proposes measures to mitigate the identified social risks in order to enhance project impact in accordance with the objectives and key components of the project namely; GBV prevention at Community level, GBV prevention at the workplace, Increasing Gender Based Violence Response and Management, Capacity Building and Monitoring and Evaluation as presented tables 5.1, 5.2, 5.3 and 5.4 below.

Table 5.1: Recommended Mitigation Measures for GBV Prevention at Community level

Identified Potential Social Risk (Negative Impact)	Proposed Mitigation Measure
Likely distortion of traditional roles of men as heads of the family and sole family providers as a result of overempowerment of women and girls	• *Consensus building on acceptable or unacceptable community social norms and grievance redress mechanisms at family level.* • *Continuous education of women and men on their roles and responsibilities in the context of changing society dynamics as well as on the benefits of the empowerment of women and girls for the common good*
Exclusion of the most vulnerable and marginalized groups from the design and implementation of infrastructure development projects	• *Ensure effective implementation of the National regulations and laws designed to protect the marginalized people in particular, Equal opportunities Act, (2007)* • *Create and implement an affirmative action for inclusion of the marginalized groups. All marginalized groups will have the opportunity to participate in and benefit from the project* • *Integration of poverty alleviation initiatives in GBV prevention for the most vulnerable population groups (PWD, PLHIV, OVC, adolescents, migrant workers etc.)*
Likely increase in family conflicts and disintegration due to enhanced legal enforcement	• *Promote legal literacy and mediation of GBV conflicts among communities* • *Constructive engagement of the media for effective GBV and social risks awareness in the community.* • *Meaningful engagement with influential community leaders – political and technical*
Non-male involvement:	*Promotion of "MaleEngage" as an approach for meaningful engagement of men as advocates as well as beneficiaries of GBV prevention and response services*
Poor handling of GBV cases at the community level due to weak community structures and political interference:	• *Empowerment of political leaders and "Key Gate Keepers" (parents/guardians, community leaders including cultural and religious, and other Community Resource Persons) for GBV prevention* • *Strengthening of community structures and supporting them to track, report and refer GBV cases for appropriate management.*
Weakening of traditional social safety nets and disempowerment of traditional structures due to the introduction of GBV shelters	• *Empower cultural leaders and traditional structures on matters of handling GBV cases including, identification and referral* • *Protection of positive cultural resources. The project will include provision for preservation and engagement of cultural institutions.*
Competing project priorities affecting routine family schedules	• *Ensure effective community participation in scheduling of project activities and avoid scheduling of activities during pick days and cultural events e.g. Market days, public holidays, funerals etc.* • *Sensitizing communities to the value of public assets and resources.*
Failure to address community priority needs	*Integration of interventions that address community basic needs such as (water, education, livelihood, food, charcoal stoves etc.) as mitigation measures for GBV prevention and other social risks in the community*

Table 5.2: Recommended Mitigation Measures for GBV Prevention at the Workplace

Identified Potential Social Risks (Negative Impacts)	Proposed Mitigation Measures
Lack of Awareness of the Existing Employment Act and Labour Laws and Regulations:	*Ensure provision and wider dissemination and enforcement of all relevant labour laws, regulations, tools and contractual agreements (Employment Act, OSH Act, Workers' compensation, Labour Unions Act and NSSF etc.) in all workplaces* *Empower and facilitate Labour Inspection Function to educate and monitor implementation of relevant policies and legal instruments*
Increase in work related Case Backlog due to Effective implementation and enforcement of Labour Laws	*Adopt alternative dispute resolution methods i.e. reconciliation, mediation and arbitration for use in Labour courts to address case backlog*
Disharmony amongst communities and Contractors, project staff/workers	• *Promotion of mutual partnership and networking of project staff, construction workers with the employer and community members (including signing of MOUs) to ensure harmonious co-existence between the community and contractors as well as project staff.* • *Contractors and IPs should institute a practice of Social Corporate Responsibility –giving back to the people; this could be in form of a water source, rehabilitation of schools or health units as well as providing scholarships to needy children in the neighboring communities.*
Lack of confidentiality or impartiality by Supervisors in Grievance Redress Committees	*Training of GRM Committee members on GBV handling and human rights to expose them on social risks management and GBV prevention; rehabilitation and psychosocial support services in the workplace to ensure appropriate coping mechanisms to reduce on effects of violence at the workplace.*
Increased Cost on Routine Monitoring	*Strengthen partnerships with other sectors to adopt multi-sectoral planning, monitoring and evaluation*
Retrenchment of Workers to cut increased costs associated with work environment improvement and better remuneration of workers	*Institutionalize standardized codes of conduct for workers and contractors in all workplaces and ensure their enforcement*

Table 5.3: Recommended Mitigation Measures for GBV Response

Identified Potential Social Risk (Negative Impact)	Proposed Mitigation Measure
Denial of justice to the needy GBV survivors and other vulnerable groups in court proceeding	• *Prioritization of the needy GBV survivors and other vulnerable groups in court proceeding e.g. creating fast track initiative in Courts of Law to deal with, pregnant, breastfeeding offenders to protect the unborn and infants.* • *Adopt alternative dispute resolution methods i.e. reconciliation, mediation and arbitration for use in Labour courts to address case backlog* • *Training of the District Chain Linked Committees members on members on GBV handling and human rights, rehabilitation and psychosocial support for Survivors, overall coordination and monitoring of GBV activities at district level*
Financial barrier to access GBV response services	• *Promotion of pro-bono services to the needy GBV survivors through mobilization of Lawyers and advocates to provide free legal services* • *Provision of relief items e.g. clothing, food, transport, sanitary ware to the needy GBV victims*
Denial of GBV survivors quality (multi-disciplinary) services due to poor coordination of the duty bearers:	• *Promote strategic partnerships and networks to facilitate multi-sectoral planning, coordination and reporting of social risks and GBV interventions at all levels. This will promote synergy and facilitate optimal use of available technical and financial resources* • *Ensure formulation and operationalization of standard guidelines on the basic minimum standard for GBV response at community level*

Table 5.4: Recommended Measures for Institutional Capacity, Management and Monitoring

Identified Potential Social Risk (Negative Impact)	Proposed Mitigation Measure
Inadequate Capacity to respond to the overwhelming demand for GBV Services Outstripping Available Resources:	• *Iinstitutional strengthening of the lead sector (MoGLSD), participating sectors (MoH, MoES, MoJCA, MoIA, JLOS, Police and Prisons) to respond to the increased demand for services; i.e. training and equipping personnel with appropriate skills and tools to improve their competences to respond to GBV e.g. skills in collection and preservation of forensic evidence and referral for medical officers, laboratory technicians, clinical officers, nurses and Midwives* • *Development and updating of Standard Operating Procedures (SOPs) for all the Sectors to standardize management of GBV cases* • *Supporting infrastructure development and systematic review of guidelines for optimal utilization for GBV services e.g. Shelters, GBV corners, safe rooms at Police stations, audio- video hearing as well as special gadgets and interpreters for PWDs (e.g. brails for the blind, hearing aid) and transport for coordination units at district and lower levels* • *Integration of GBV Response services into health care services delivery and other social services*
Poor service delivery due to poor monitoring and mismanagement of project funds:	• *Institutionalization of social risk and GBV indicators in the Social Sector M&E Framework to strengthen the National data collection system on GBV for timely comprehensive reporting* • *Promote and support operational research as part of project implementation for evidence-based programming in GBV and other social risks mitigation* • *Community empowerment for program and financial monitoring for increased social accountability*

6.0 MAINSTREAMING SIA MITIGATION MEASURES IN PROJECT DESIGN

The recommended mitigation measures outlined above have been reviewed by the project preparation team. Project design takes into account the need to provide dedicated support to groups identified as vulnerable and marginalized. The findings of the SIA have been factored into the current design of the proposed project components outlined below.

Overall approach

Project design acknowledges the fact that GBV is widespread nationwide and accepting attitudes towards GBV play an important part in the high GBV prevalence rates observed in Uganda. The project takes into account the additional risks of GBV posed by the implementation of large scale infrastructure projects by including a specific focus on GBV in the workplace. However, the proposed intervention is also based on the assumption that GBV in the workplace or instances of GBV directly related to labor influx cannot be addressed in isolation. Addressing these particular manifestations of GBV requires a focus on the underlying social norms and values at community and household level that may create an environment where GBV is condoned. Communities, informal institutions and families can discourage survivors from accessing services and lodging formal complaints. Therefore, the project has included a strong focus on GBV prevention also at community level with an emphasis on gender transformative training and behavior change.

In line with global best practices and based on the overall situation analysis of GBV in Uganda, the project will focus on both preventing GBV and on improving the quality of multi-sectoral response services for survivors in targeted districts. Global evidence indicates that effective prevention programs encourage GBV survivors to come forward and seek services. It is therefore important that awareness raising and gender transformative training be accompanied by improvements in the availability and quality of response services.

The proposed approach builds on tried and tested interventions in Uganda particularly in terms of prevention programs. In order to maximize GoU investments in this area, the project will adapt and take to scale prevention programs which have been developed in Uganda, have been rigorously evaluated and therefore have a proven track record in reducing GBV prevalence.

Finally, project design has taken into account the constraints in providing high quality services at district and sub-county level. This includes inadequate staffing levels for police stations, high turn-over of staff at the level of health facilities, significant case backlog in the criminal justice system and existing capacity constraints on the part of community development officers and probation officers. In order to put in place a sustainable approach to GBV response, the project has adopted a mainstreaming approach, rather than a more costly center-based service delivery strategy. Under the overall coordination of the MOGLSD and the high level Steering Committee, the project will support the enhancement and adoption of a clear referral pathway for the management of GBV cases with the involvement of key sectors. This referral pathway will inform the development of further Standard Operating Procedures (SOP) and case management guidelines in the Health Sector, Uganda Police Force and Department of Public Prosecution.

Component 1 – Prevention of Gender Based Violence

This component will strengthen MoGLSD's capacity to develop and implement a set of comprehensive GBV prevention interventions. In particular this component will focus on: (i) promoting behavior change and addressing social norms and values that may enable or condone GBV at community and household level as well as in the workplace; (ii) strengthening referral mechanisms and ensuring information on available services for GBV survivors is available and widely disseminated at community level and in the workplace (in prioritized sectors). Acknowledging the additional risk of GBV posed by large influx of labor, this component includes a specific focus on putting in place systems that would allow MoGLSD to monitor and address instances of GBV linked to public investments in infrastructure.

Sub-component 1 A – Preventing Gender Based Violence in the workplace (US$ 2.9 million).

The GoU recognizes the challenges in identifying and effectively responding to risks of GBV associated with labor influx in large infrastructure projects. Therefore, interventions to mitigate risks of GBV in the workplace, including sexual harassment, physical violence, sexual assault, emotional and psychological violence, exploitation among others, have been prioritized with a specific focus on public sector infrastructure investments. This component will focus on the following activities, which will be national in scope and focus primarily on strengthening MoGLSD capacity to monitor and address issues of GBV in the workplace as follows:

(i) Strengthening the legal framework to address GBV in the workplace, by: a) conducting a review of existing legislation and supporting the development or amendment of laws and regulations, including the employment act and occupational safety and health act; b) developing a framework to assess risks of GBV in the workplace as part of the labor inspection system. This will also include a focus on the interaction between the labor force in infrastructure investments and the broader community. The assessment will be developed with a focus on the following sectors: roads, oil and gas, energy and water; c) designing and rolling out a training program for labor inspectors at national and district levels on the application of the GBV assessment framework; d) improving the technical inspection tools currently in use, such as the Occupational Health and Safety (OHS) checklist to monitor risks of GBV in infrastructure projects as well as the mitigation measures put in place. As a mitigation measure, SIA recommends that, MoGLSD should work with JLOS to adopt alternative dispute resolution methods i.e. reconciliation, mediation and arbitration for use in Labour

courts to deal with the potential increase in case backlog as a result of enhanced labour law enforcement. Labour Inspectors will be trained to roll out this approach in the Labour courts.

(ii) Supporting MGLSD to oversee the design and implementation of Grievance Redress Mechanisms (GRMs) in selected sectors to handle issues of GBV in the workplace (including those pertaining to the interaction between workers and the broader community). The project will fund: the development of guidelines for the design of GRM promoting/encouraging the reporting of cases of GBV in the workplace; b) the development of procedures on how to effectively refer cases of GBV that maybe captured through these enhanced GRM; c) the training of relevant sectoral agencies on the design and management of such GRM in coordination with the MGLSD. The SIA recommends that training of GRM Committee members be carried out on GBV handling and human rights to expose them on social risks management and GBV prevention; rehabilitation and psychosocial support services in the workplace to ensure appropriate coping mechanisms as well as enhanced confidentiality and impartiality in GRM processes so as to mitigate violence at the workplace The MOGLSD will work closely with the following line agencies to pilot these enhanced GRMs: Ministry of Energy and Mineral Development, Ministry of Water and Environment and the Ministry of Works and Transports.

(iii) Increasing Public Awareness of GBV Including of GBV in the Workplace. This will include: (a) the development and dissemination of simplified information on the policy and legal framework to address GBV in the workplace, including referral pathways; (b) the design and implementation of a multi-media campaign on GBV prevention (including but not limited to the workplace); and (c) piloting awareness raising and behavior change intervention addressing GBV in the workplace in strategic sectors. This will be done in collaboration with employers, the private sector, and labor unions. The pilot will include signalling interventions by employers and public commitments to eradicating GBV in the workplace as well as an external monitoring mechanism in partnership with the private sector and civil society. In addition, the project will support MGLSD's ability to monitor the implementation of issues pertaining GBV in the workplace.

The SIA recommends promotion of mutual partnership for harmonious co-existence. to address disharmony and conflicts among local communities and project staff/workers and contractors, the project will (a) promote mutual partnership and networking of project staff and construction workers with the community members through regular consultative meetings and implementation of joint programs that benefit both parties (including signing of MOUs) to ensure harmonious co-existence; (b) contractors and IPs will be encouraged to institute a practice of Social Corporate Responsibility –giving back to the community; this could be in form of a water source, rehabilitation of schools or health units as well as providing scholarships to needy children in the communities.

Sub-Component 1B - – GBV prevention and referral at community level. (US$ 16.5 million)

In order to address the underlying causes of GBV and tackle social norms and values that may condone GBV, the project will invest significantly in awareness raising and behavior change at community level in the 13 focus districts highlighted above. The approach to prevention builds on tried and tested models which have been rigorously evaluated in Uganda. Through the proposed project, GoU will develop a national protocol for community based prevention programs bringing together: (i) whole of community awareness behavior change and awareness raising interventions; (ii) specific interventions focusing on adolescent girls and boys and

combining gender transformative training with livelihoods support; and (iii) community based referral system and provision of psycho-social support at community level. The full package of activities described below will be designed by MoGLSD with the support of specialized technical assistance. These interventions will be implemented by the MoGLSD in partnership with civil society organizations selected on a competitive basis and with strong district level presence. MoGLSD at district and sub-county level will closely supervise the implementation of the prevention program[1]. Community Development Officers, in particular will participate actively in initial community mobilization activities with the civil society partners.

The detailed protocol for the community based prevention activities will be developed within six months of project effectiveness and include the selection sub- counties per district for the implementation of activities targeting adolescent girls and boys. While awareness raising activities and the establishment of a community-based referral system will take place district-wide, specific activities targeting adolescents are expected to take place in two sub-counties per district. The protocol will be finalized once civil society organizations have been contracted during year 1 of project implementation. The three elements of the community level prevention interventions are as follows:

(i) Community-wide awareness raising and promote behavior change: The identification, training and mentoring of a team of community as key agents of change who will implement a community mobilization intervention targeting opinion leaders, cultural leaders, key community based organizations as well as older men and women that play a key role in perpetuating accepting attitudes towards GBV (and IPV in particular). The SIA recommends; (a) consensus building on acceptable or unacceptable community social norms to prevent GBV at family level, (b). Promotion of **"MaleEngage"** as an approach for meaningful involvement and participation of men as advocates as well as beneficiaries of GBV prevention and response services; (c) constructive engagement of the media for effective GBV and social risks awareness in the community.
This element of the approach is expected to foster changes in social norms, attitudes and behaviours at community level. It will focus specifically on transforming gender relations and power dynamics.

(ii) An economic empowerment intervention targeting adolescent girls and boys: Through the initial community mobilization step, facilitators will identify and target a selection of adolescent girls and boys – with priority given to out of school youth- in each community to support their economic empowerment in combination with gender transformative training. Based on Uganda best practice interventions that have been rigorously evaluated, livelihood interventions with groups most at risk can play a key role in preventing GBV. The livelihoods component will deliver a mix of market-oriented vocational training and mentorships arrangements, business development and financial literacy skills to girls and boys and then seek to link these adolescents to existing credits and savings schemes. Evidence from Uganda indicates that livelihoods' support is most effective when combined with life-skills and gender-transformative interventions targeting both boys and girls. The project will therefore invest in group formation and conduct awareness raising interventions with adolescents to strengthen the livelihoods interventions. The SIA recommends integration of poverty alleviation initiatives in GBV prevention for adolescents girls and boys.

*(iii) The third element of this package will be to strengthen community-level response and referral mechanisms for GBV survivors***.** At present, a very small proportion of women and girls who are abused actually

report violence to anyone. Women survivors face multiple barriers to speaking out, and in particular, to accessing formal services. This community response and referral intervention will train the community facilitators in close coordination with district level MoGLSD staff that implement community awareness raising activities (see i) as well as key community structures (e.g. village health teams, local council, religious institutions, schools) on GBV response. The aim will be to ensure that GBV survivors have trusted individuals and mechanisms to who they can report violence and through whom they can get access to the services – informal and formal – they need Trained Community Activists, supported under the project who will act as victims' advocates for referral to services and will be also have access to the necessary funding to provide emergency support to destitute survivors of GBV (covering the costs of transport, purchase of clothing and hygiene items as needed). In addition, the project will invest in developing and rolling out a training module for the provision of psycho-social support at community level. The training will be based on the guidelines for the provision of psycho-social support developed by the MoGLSD in 2016 and will be provided by civil society partners to community facilitators and where feasible to Trained Community Activists. This acknowledges the staffing limitations at both MoGLSD and MoH level to provide this specialized service and the fact that community facilitator and activists are often the first port of call for survivors. Civil society partners will in addition provide more specialized psycho-social support through their staff at district level based on the initial screening conducted at community level.

In order for referral from community level to formal response services to increase and be effective, it will be important to increase community awareness of these services and the options available to GBV survivors, and address the multiple barriers (social, economic, geographic) that survivors face that so demand and service take-up is increased. Evidence and lessons from existing programs also suggests that the following are essential: (i) Individuals (in this case community facilitators) who can act as victim advocates, explaining options to women and girl survivors, facilitating their own decision and then accompanying them to the services; (ii) Community facilitators will also be able to provide additional support on a case by case basis to highly vulnerable and marginalized survivors of GBV that face further barriers to accessing services (this would include minor costs for transport, food, shelter, clothes and basic necessities that may be needed for highly vulnerable survivors); (iii) support to service providers to enable them to deliver effective survivor-centered services: In addition to the top down directives, training and protocols that medical practitioners, police and judicial staff receive, programming experience suggests that further support is needed to help staff response to survivors needs effectively, respecting their rights and in line with the law. This also supports bottom-up accountability of providers to communities and GBV survivors. The SIA recommends (a) strengthening of community structures and supporting them to track, report and refer GBV cases for appropriate management; (b) empowering cultural leaders and traditional structures on matters of handling GBV cases including, identification and referral (c) Provision of relief items e.g. clothing, food, transport and shelter to the most highly vulnerable and needy GBV victims

Finally, the MOGLSD will pilot the provision of support for shelter interventions in two selected districts (Kamuli and Kisoro). This would entail the continuation of the support currently provided by Uganda Women's Network in Kamuli from 2018 onwards as well as the establishment of a new partnership with a civil society organization in Kisoro for the establishment of a new advisory center and shelter in partnership with district authorities. These advisory centers will provide psycho-social support, referral to livelihood opportunities, legal aid. Staff at the advisory center will act as victims'

advocates and support the GBV survivor to access relevant services (health, police and judiciary). In addition, in both districts, an off-site shelter in an undisclosed location and linked to the advisory center will provide temporary accommodation to survivors who are not able to return to their households and communities. In addition, the project will support additional analytical work to assess the feasibility of expanding GoU support to additional advisory centers and shelters currently being funded by civil society organizations in critical districts. The SIA recommends (a) supporting infrastructure development to accommodate (GBV Shelter, GBV corners) (b) systematic review of operational guidelines of Advisory Centres and GBV Shelters to ensure proper management and optimal utilization

Implementation of activities at community level will follow a phased approach as follows:

First 6 months - Start up-phase: CSOs will receive technical assistance and capacity building to prepare them to deliver the interventions at community level. During this period, all partners will also work to refine and document the community-level package of interventions, both to ensure consistency where important and adaptation to specific contexts. A community entry protocol will be followed to prepare for implementation and this will include: mapping of existing community structures; mapping of service providers; mapping the location and accessibility of services; a social profile of the community including main types of GBV, specific social norms and particularly vulnerable groups; the identification, selection and training of 'community facilitators'. During this period baseline data will also be collected to enable effective monitoring and impact evaluation.

Months 7- 42: Sequenced implementation of interventions starting with engagement of the district leaders as an entry point; community awareness raising and behaviour change activities; followed by life-skills education and livelihoods and economic empowerment of adolescents. In order to be mutually reinforcing, whole of community mobilization activities and specific activities targeting adolescents will take place in parallel at community level. The livelihoods intervention will be combined with gender transformative training. Building on the Uganda experience of implementing livelihoods interventions (particularly the NUSAF series of programs) as well as global best practices on livelihood interventions with adolescents, the project will invest first in group formation. This initial phase is expected to take place over 12 to 24 months. This will include mobilizing adolescent boys and girls, providing life skills and financial literacy support and initiating the establishment of savings groups. During that process, community facilitators will work with the groups to provide life-skills education and conduct awareness raising and gender transformative training activities. This will take place as the savings groups' mature and increase their level of savings. Following a set of pre-established graduation criteria, savings groups will be assessed for readiness to proceed with additional vocational skills training of their members (following a market analysis of skills in demand), business development services and the provision of start-up grants for their members and linking them to micro finance schemes. . This phasing is intended to improve the sustainability of the economic activity targeted adolescents will engage in. Based on the Uganda data and global evidence it is expected that only a proportion of the savings groups initially targeted would be able to graduate to this second phase. Similarly, the livelihoods development process will be accompanied by the provision of further modules of life-skills and gender transformative training (focusing on reproductive health, gender relations, power dynamics among others). This second phase is expected to take place between month 24 and 42 of project implementation.

Months 43 – 60: Consolidation and sustainability assessment by civil society partners. Given that the project will include an impact evaluation focusing specifically on GBV prevention, end-line data collection will take place during this stage in the project cycle.

Component 2 – Gender Based Violence Response

Overall this component will strengthen the responsiveness of front-line service providers: Health Sector, Uganda Police Force and the Department of Public Prosecution to cases of GBV and improve their ability to provide quality care to survivors. This component will: (i) strengthen national coordination systems, (ii) support the enhancement and adoption of comprehensive guidelines for referrals; (iii) the development standard operating procedures and; (iv) national training curricula. In addition, dedicated resources will be allocated to these core services in the 13 focus districts to directly improve their capacity for quality of the service provided. This will be key to ensure that these key sectors are able to effectively deal with a potential increase in reporting and in demand for services stemming from the implementation of awareness raising and GBV prevention activities implemented under Component 1. Given the significant social barriers to reporting GBV, it is expected that the majority of cases in the targeted areas will reach formal services through the community-based referral system put in place in partnership with civil society. However, when survivors approach health centers/ hospital or police stations directly, staff at these service points will equally liaise closely with the civil society partner at district level and refer survivors of violence for: (i) additional support that may be required at community level; and (ii) further guidance on how to access other response services that may be needed.

Sub-Component 2A – Strengthening the Health Sector Response to GBV (US$9.3). The main objective of this sub-component will be to strengthen the Uganda health sector responsiveness to GBV with a focus on (a) strengthening sector leadership and governance; and (b) strengthening provider capacity to respond to GBV.

Key activities under this sub-component will be as follows:

(i) Strengthening sector leadership and governance by supporting MoH to establish a technical working group on GBV and developing a sector specific strategy for mainstreaming GBV[2]. This sub-component will also support the mapping of health sector GBV actors and service providers to enable better coordination of these stakeholders by MoH. Institutional capacity will be further strengthened by establishing a network of GBV focal points at national and sub national levels and at the level health facilities in the targeted districts. In addition, integrated GBV services in the health sector will be established with linkages to services from the Justice Law and Order Sector (JLOS)[3]. Particular attention will be paid to the collection, preservation and recording of forensic/medico-legal data and its sharing with UPF for subsequent investigation.[4] The SIA recommends promotion of strategic partnerships and networks among service providers (MoH, JLOS, IPs) to foster synergy and facilitate optimal use of available technical and financial resources

[2] This will include the adoption of the WHO Global Standards on Gender Based Violence Management
[3] This is in line with the Kampala declaration 2012 signed during the IGAD conference
[4] Based on the demand for such follow-up on the part of the survivor

(ii) Strengthening provider capacity to respond to GBV. Key activities under this sub-component will focus on: (a) Re- printing GBV training manuals developed by MoH, (b) training Health Care Providers (HCP) including community health workers in targeted districts using the above materials. The training will focus on GBV case screening, medical case management including the correct collection of forensic evidence and accurate record keeping and reporting; (c) updating and disseminating management protocols and guidance notes for practioners (job aides) developed specifically by the health system in Uganda. These materials will be distributed countrywide starting with the project target district. In addition, the project will fund an assessment of the current capacity to provide mental health services for survivors of GBV and prepare an options paper for MoH on how best to strengthen such services in targeted districts.

In addition, the project will also aim to build medico-legal response capacity of HCP. The project will support the adoption printing and distribution of the draft medical - legal manual.[5] The manual will be used to train HCP's as well as experts from police and judiciary with a focus on handling forensics, preparing for court hearings and filling of police and medico-legal forms (3[6], 3A, 24 & 24A). The project will further strengthen forensic evidence collection by procuring sexual assault evidence kits for targeted districts[7]. The project will aim to integrate the kit into the national essential medical supplies list.

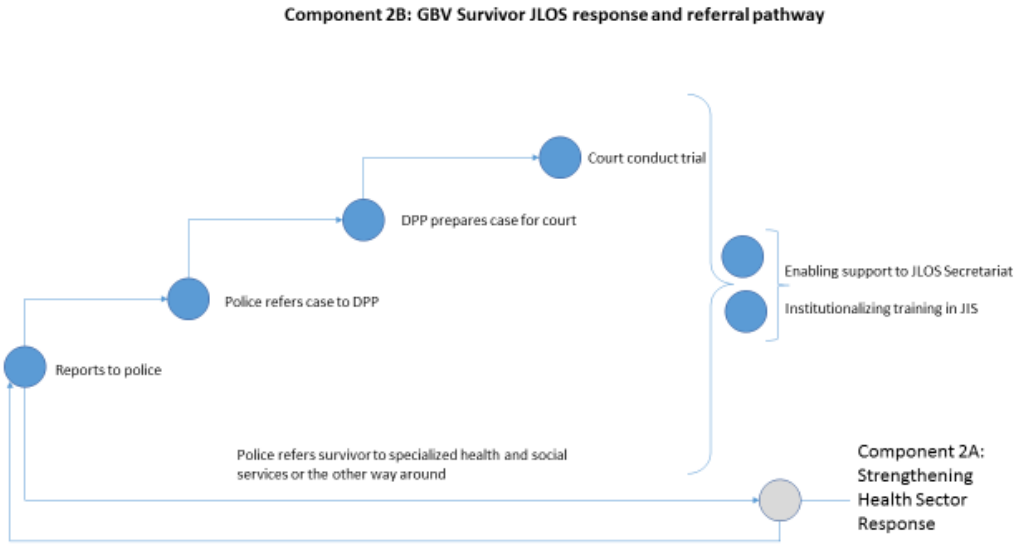
In order to improve the quality of services provided to survivors of GBV the project will institutionalize integrated GBV case management at different service points in targeted health facilities (e.g. Maternal, Newborn and Child Health (MNCH), HIV Youth Friendly Services, Family Planning Casualty units). This is expected to ensure that sufficient numbers of adequately trained staff are available to manage GBV cases. In order to improve the quality of front-line services the project will also ensure the availability of medical equipment and essential commodities at health facilities for effective management of SGBV cases (with a focus on Pre-exposure prophylaxis kits and emergency contraceptives). Finally, this sub-component will fund small scale rehabilitation of health facilities (painting, small internal repairs and provision of screens or partitions as well as lockable cupboards) to create adequate conditions for consultations and counselling where those don't currently exist. The SIA recommends, capacity strengthening of the Health Sector to respond to the increased demand for GBV services; i.e. training and equipping personnel (medical officers, laboratory technicians, clinical officers, nurses and Midwives) with appropriate skills and tools to improve their competences to respond to GBV e.g. skills in collection and preservation of forensic evidence and referral.

This sub-component supports the operationalization of Uganda's GBV Policy within the mandates and roles of the participating JLOS institutions: the JLOS Secretariat, Justice Studies Institute (JSI), Department of Public Prosecution and Uganda Police Force. The intervention logic of the sub-component is to strengthen a GBV survivor focused response and referral pathway through key JLOS institutions. The JLOS referral pathway involves reporting to the police that after processing the report and evidence of GBV would hand over the case to the DPP for trial in court. Under the Project, the entry of a GBV survivor to the JLOS referral and response pathway is two-

[5] The medical- legal manual was jointly developed by MoH, WHO, Judiciary and FIDA-Uganda with the support of the Democratic Governance Facility

[6] Form 3 is critical for the recording of forensic/medico-legal information enabling further investigation and potential prosecution of cases.

tracked: the survivor may come either first to a health care provider and then be referred (i.e. Component 2A) or, the survivor may come to the police directly (see illustration). This 'chain link between' the Project's health and UPF support will be reflected in the UPF standard operating procedures (SOP) and training (see below).

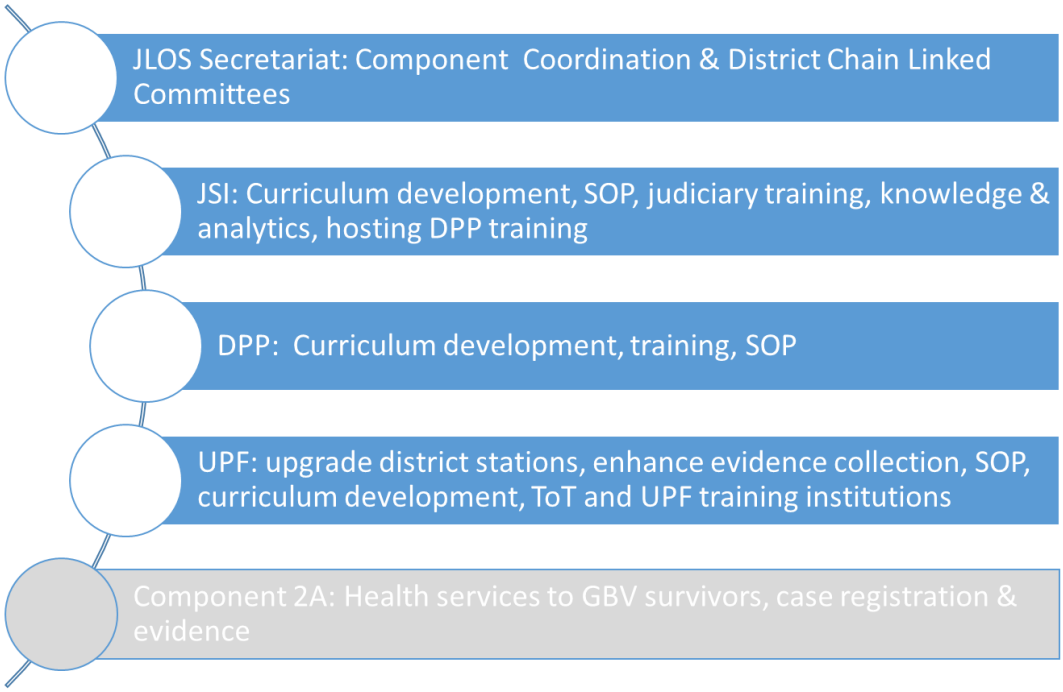


Activities

The institutionalization of GBV response is aligned with the overall set-up of the Justice Law and Order Sector. This includes enabling support to the JLOS Secretariat. The Senior Technical Advisor- JLOS Secretariat would be the project focal point. A full-time Technical Expert would be housed in the JLOS Secretariat to support the national focal point, strengthen the JLOS Secretariats coordination function and enable GBV mainstreaming in the DCC. The Justice Studies Institute will receive support to institutionalize further JLOS GBV analytics, knowledge and training activities for the judiciary.

Investments in institutional capacity will be made through curriculum development, pre-service and in-service training, and standard operating procedures (SOP). Training target audiences include judicial officers, prosecution officers, and police officers. SOP for the police, DPP and courts will be developed/enhanced to guide staff actions and behaviors, and to enable staff performance review. SOPs for the police will include procedures for handing over cases from the police to the DPP. Furthermore, basic investments will be made in collecting, securing and storing evidence.

Basic investments in existing police stations in selected districts will be made to ensure private space for interviewing GBV survivors and proper keeping of records.



Activities

(i) **Strengthening the JLOS Secretariat (JLOS-Sec.) and the Judicial Studies Institute (JSI).** The JLOS-Sec. and JSI will be supported to play their mandated roles of JLOS coordinator, and JLOS Think Tank and training institution for the judiciary, respectively

The JLOS Secretariat works on the basis of a multi-year strategic plan. It is expected, that the GBV activities under the project will be incorporated in this strategic plan. As part of its regular work, the JLOS Secretariat interacts with the Chain Linked Committees based in each District (DCC) that oversee and coordinate the overall JLOS sector reform program at district level. A full-time Technical Expert will be housed in the JLOS-Sec. will provide/manage provision of technical assistance at national level and also support to DCCs in targeted districts for their engagement in the activities set out below.

JSI and the JLOS-Sec will support the development of a costed action plan outlining options to address the current backlog of GBV cases. As of March 2017, there are reportedly between 26,000 and 40,000 backlogged criminal justice cases. The project will support the development of a comprehensive, strategic and costed plan of action for the sector outlining options for the fast tracking of GBV cases. The Chief Justice has commissioned a report to analyze and make recommendations on measures to overcome this backlog and avoid future backlogs. The report is expected to be finalized and submitted for consideration by the Chief Justice in the first quarter of 2017. It is expected that this report will make specific recommendations on GBV cases. The project will facilitate the development of a strategic plan elaborating the follow-up to these recommendations from a GBV survivor perspective.

(ii) **National GBV Curricula for JLOS (police, DPP, courts).** The JSI will be supported during the first two years of the project by Curriculum Development Coordinator, who will work together with the respective institutional focal points and designated departments.

Police curriculum development: will be anchored in the UPF training department and provided through UPF training institutions. A Curriculum Development and Training Specialist will be housed in the Directorate of Research Planning and Development. The specialized nature of the UPF GBV curricula, that will cover general training on GBV as well as specialized technical training under the purview of the UPF Criminal Investigations Department (CID) requires the support of Specialized Technical Assistance (STA) to be attached to the police human resources and training department. The approach includes building in a cadre of in-house trainers through ToT and upgrading of skills of current police trainers. A training needs assessment will detail these requirements. The delivery of the training curriculum will include UPF officers in targeted districts. STA requirements that may include international TA, if relevant. It is permissible to bundle the STA requirements under a framework firm contract.

DPP and JSI curriculum development. The DPP will conduct a GBV training needs assessment, develop a DPP specific GBV curriculum, and provide this in-service training. Likewise, the JSI will go through the same steps to develop a GBV curriculum for judicial officers. Specialized short-term technical assistance may be required and is expected to be available in Uganda.

(iii) **Developing and operationalizing new Standard Operating Procedures (SOP)**. Institutionalizing the Uganda GBV policy necessitates updating current SOP to support the standardized management of cases and monitoring of the effective implementation of the GBV policy. The respective SOP for the UPF, DPP and Courts will provide clear standards for professional behaviours and attitudes. SOP promote internal and external transparency and accountability. The project will support monitoring activities to establish if GBV cases are handled in line with the updated SOP and guidelines to be put in place in these institutions. The SOP will be rolled out in conjunction with the pre-service and in-service training activities for the UPF, DPP and Courts.

(iv)**Support small scale rehabilitation of police stations in targeted districts** – to ensure minimum conditions of privacy for interviews with survivors of GBV and the establishment of safe rooms (where survivors will be able to stay temporarily in secure conditions).

The SIA recommendations a number of mitigation measures to improve GBV response under the the participating JLOS institutions; (a) capacity strengthening of the JLOS sector to respond to the increased demand for services; i.e. training and equipping personnel with appropriate skills and tools to improve their competences (b)training of the District Chain Linked Committees members on members on GBV handling and human rights, rehabilitation and psychosocial support for Survivors, overall coordination and monitoring of GBV activities at district level (c) prioritization of the needy GBV survivors and other vulnerable groups in court proceeding e.g. creating fast track initiative in Courts of Law to deal with, pregnant, breastfeeding offenders to protect the unborn and infants (d) Promotion of pro-bono services to the needy GBV survivors through mobilization of Lawyers and advocates to provide free legal services (e) supporting infrastructure development to accommodate safe rooms for GBV survivors at Police stations.

Component 3 - Project Management, Capacity Building and Monitoring and Evaluation (US$7.8 million

(i) This component will cover overall project management and tracking costs to ensure efficient and effective coordination, fiduciary management, monitoring and evaluation at national and local community levels. This will be done through dedicated technical assistance to the implementing agencies, institutional strengthening, and purchase of critical equipment and small scale rehabilitation of the district offices for Probation Officers, Labor Officers and Community Development Officers. This component will include support for strengthening existing coordination structures the sustainability of project activities and the training of critical staff at national and sub-national level.

(ii) Review and roll-out of a National System for data collection on GBV. The project will further support key measures to ensure effective data collection and information management on GBV. The project will assess the data currently being collected through the National GBV Database and the Occupational Health and Safety Database currently managed by MOGLSD as well as the data on GBV currently collected through the Health Management Information System (HMIS). The project will develop alternatives to strengthen data collection building on/streamlining the use of these platforms for review by GoU. Following a decision by the Steering Committee on the most appropriate approach, the project will support the roll-out of the streamlined data collection system to the 13 targeted districts.

(iii) Implementation of an analytical work-program on GBV with a focus on: (i) conducing an Impact Evaluation (IE) focusing specifically on the proposed GBV prevention activities; and (ii) support the implementation of additional critical studies in the area of GBV including: (i) working with UBOS to improve data collection on GBV in the workplace; and (ii) operational options paper on the funding of critical shelters by GoU.

The SIA recommends (a) institutional strengthening of the lead sector (MoGLSD), participating sectors (MoH, MoES, MoJCA, MoIA, JLOS, Police and Prisons) to respond to the increased demand for services through training and equipping personnel with appropriate skills and tools (b) development and updating of Standard Operating Procedures (SOPs) for all the Sectors to standardize management of GBV cases (c)supporting infrastructure development for GBV service provision e.g. Shelters, GBV corners, safe rooms at Police stations, audio- video hearing as well as special gadgets and interpreters for PWDs (e.g. brails for the blind, hearing aid) and transport for coordination units at district and lower levels (d)Integration of GBV Response services into health care services delivery and other social services (e) institutionalization of social risk and GBV indicators in the Social Sector M&E Framework to strengthen the National data collection system on GBV for timely comprehensive reporting (f) community empowerment for program and financial monitoring for increased social accountability to ensure efficient utilization of project resources. Given that some GBV interventions are ongoing under the overall supervision of MoGLSD, it would be important to carry out a capacity gap analysis of MoGLSD in order to inform spot capacity building.

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ANNEX 1: SIA DATA COLLECTION TOOLS

TOOL 1: KEY INFORMANT INTERVIEW GUIDE FOR DISTRICT LEVEL

Key informants were purposively selected to collect expert opinions about social risks and the GBV situation in the community and the work place in the four districts of Kabarole, Kamuli, Kamwenge and Kisoro. The respondents included the following;

1. LC 5 Chairperson
2. Chief Administrative Officers
3. Vice chairpersons LC 1, LC 2 and LC 3
4. Secretaries for Gender and Community Development at LC 5
5. District Engineers
6. Labour Officers
7. District Health Officers (DHOs)
8. District Education Officers
9. Magistrates Grade 1 and Resident State Attorneys
10. Community Development Officers in charge of gender/probation, culture and disability
11. Uganda Police Force (Districts) – Community Liaison Officer (CLO)
12. Representatives of Elderly and Women Councils from LC 3
13. Representative of Faith Based Organisations (Catholic, Anglican, Pentecostal & Muslims)
14. Cultural leaders
15. Contractor, Safety and Health Officer & representative of Safety and Health Committees or Workers' Committee, Labour Officer; for workplace
16. Environmental Officers
17. NGOs dealing in GBV and VAC
18. GBV Survivors/victims in the shelters
19. Perpetuators and Male Champions where they are/known
20. Health facility in charge and responsible for GBV
21. Secretaries for Education
22. Manager of GBV Shelter in Kamuli

General Questions for the District Respondents

1. What are the existing social and cultural norms in your community (facilitator identifies negative and positive)
2. How do these social and cultural norms impact on GBV? (probe magnitude of GBV and who is most affected)
3. What are the risk factors that have contributed to vulnerability to GBV?
4. What has your organization done to address these risk factors and respond to GBV cases?
5. Has GBV prevention and response been integrated in policy, program, work plan and budget? (Probe: amount of funds allocated, release and utilization)
6. What sectors are implementing GBV programmes? (probe for successes and challenges)

7. What can be done to mainstream GBV in all sectors?
8. How does GBV impact on development programmes in your district?
9. What is the likely impact of the project on your district?
10. What factors are likely to hinder the success of the project in your district?
11. How do we mitigate the negative factors that are likely to affect the project?
12. Are there mechanisms to prevent and mitigate GBV amongst the staff? (probe for challenges, successful interventions/practices)
13. Have you been receiving any services in response to GBV? If yes, what are these services and who offered them? (probe for services offered at Health centers, Police and Justice, survivors)
14. Which organisations (NGOs/CBOs, private sector) are implementing GBV interventions in your district/community? (probe type of interventions, successes and challenges, identify good practices and success stories)
15. How can NGOs/CBOs working in your district/community be supported to offer more comprehensive GBV services?

Questions for the Health Centre Respondents

16. What are the common GBV cases reported to your health Centre?
17. Of the GBV cases reported which ones have you been able to work on? (Probe on staffing levels, training/skills, commodities, room for examination of GBV survivor, collection of forensic evidence, referral systems and any other challenges)
18. What prevention measures do you have for GBV victims?
19. What kind of support would you require to improve management and prevention of GBV cases at your health Centre

TOOL 2: FGD GUIDE FOR WORKPLACE SETTING

General Questions for the Construction Workers

1. Describe terms and conditions of work. (probe working hours, remuneration, working conditions, allocation of tasks by gender in relation to remuneration, toilets separate for respective sexes, flexibility for pregnant women and breastfeeding mothers)
2. What are your entitlements or leave? How long is the leave (specify duration for maternity and paternity leave)
3. How do you balance your work and family life (immigrant workers, working schedules, past 500pm or weekends family life?
4. Does your organisation have child safe guarding policy and how is it implemented (probe employment of children – child labour
5. What is the common understanding of GBV? (probe for sexual harassment and GBV)
6. What are the most common violence that happen to men, women (of different age groups) in the work place?
7. Are there any GBV issues that you have noted before? Yes, or No. If yes what are the major causes? How were they handled? (Participants write on piece of paper, probe sexual harassment and quote some voices.
8. If No to 7, in case of occurrence, how best would such cases be handled? If yes which partners were involved and what roles did they play?
9. What is your organisation position on GBV issues? Probe GBV prevention and response, policy, GBV committees, disciplinary Committee and Workers Committee, suggestion boxes) (participants write on paper; probe for sexual harassment and quote some voices)
10. What is the composition, functionality and issues discussed by Workers' Committee?
11. What could be the interventions to address GBV in the workplace? (Probe for whistle Blower blowing protection and retaliation
12. What kind of capacity assistance dos your organisations require to effectively address and manage GBV at the work place?

TOOL 3: KEY INFORMANT INTERVIEW GUIDE FOR GBV SHELTER
Survivors and Mangers - Kamuli District

The team visited the shelter to verify conditions; key questions were prepared for survivors and managers of the GBV Shelter. Keen observation was also made further understand operations of the Shelters and GBV Survivors motivation and attitudes towards GBV

Questions for Survivors

1. How did you get to know about the GBV Shelter?
2. What is your experience of the GBV Shelter? Probe for utilisation, accessibility, acceptability, functionality
3. Is it relevant to have a Shelter in your district?
4. If No, Why?
5. If Yes, Why?
6. How best can the Shelter be managed? (probe for recommendations)

Questions for Management

1. How do survivors come to the Shelter? Probe for referral systems /pathways
2. What is your experience of the GBV Shelter? Probe for utilisation, accessibility, acceptability, functionality
3. What challenges are experienced by the Shelter?
4. What are the recommendations for improvement

Observation Checklist

1. Observe location of the Shelter? (Probe security, accessibility, sign posts, etc.)
2. Are there basic facilities? (toilets, kitchen, stores; cleanliness and their functionality)
3. Are there leisure facilities e.g. television, radios, indoor games and outdoors activities? Probe for functionality, utilisation and accessibility)

TOOL 4: FGD GUIDE FOR MEN AND WOMEN GROUPS

Focus Group Discussion questions were prepared to be asked to the different population segments including women, men, youth and children as indicated below:

- Men's Group – 18 and above
- Youth Group (mixed Female& male) aged 15 to 35 years
- Women Group – 18 and above (FGD)
- Child Protection Committees at sub-county levels – FGD
- Consider GBV for GBV survivors (if GBV survivors are many)

General Questions for the Construction Workers

1. What are the existing social and cultural norms in your community (facilitator identifies negative and positive)
2. How do these social and cultural norms impact on GBV?
3. Who is most affected (probe men, women, adolescents and children)
4. How can this project strengthen positive social and cultural norms in addressing GBV?
5. How can this project address the negative social and cultural norms in addressing GBV?
6. What is being done to address social and cultural norms that impact on GBV in your community? Probe who is doing what? (Government, NGOs, CBOs, etc.)
7. How will the family set up be affected by the project interventions?
8. What are the community fears about the Project? (life style, status of community, reproductive health practices)
9. How will the family set up be affected by the project intervention?
10. When a GBV case happens, how is it managed at individual, family/household, clan, Community levels) (Probe for reporting procedures and referral systems)
11. Are there any challenges in handling GBV in your community? Probe for those at individual, family/household, clan community services, health centres, police and justice; quote voices)
12. Please suggest possible ways of handling GBV in your community. (Probe for those at individual, family/household, clan community services, health centres, police and justice)
13. Describe any traditional medicine practices that are available in responding to GBV cases. How can these be integrated with project of health interventions e.g. among the indigenous groups?

END THE INTERVIEW WITH THANKS.

ANNEX 2: GUIDANCE FOR CONDUCTING INTERVIEWS AND FGDs

GUIDANCE FOR CONDUCTING INTERVIEWS AND FOCUS GROUP DISCUSSIONS

1. The team will be constituted of 2-3 people. One person takes the role of the **facilitator**, and leads the interview or discussion; the second person is the **note-taker**, responsible for documenting the discussion. However team members can take turns in different roles.
2. Meeting venues should be chosen with care. The venue should be neutral as well as also ensure privacy so that discussions cannot be overheard by others
3. At the start of any information collection session the Team Leader should introduce members of the team**, explain the aims** to the group or individual, why you want to talk to them and roughly how long it will take. Participants should be provided with clear information about the assessment so that they can **decide if they want to participate or not**. They should also be informed that they can stop or withdraw from the discussion if they so wish.
4. Before starting the discussion, it is important to address **ethical issues** that may arise in particular consent to participate for those adolescents under 18 years of age and confidentiality to protect the identity of participants.
5. The interviewer should **listen carefully** to what the people say, should be **open-minded** and **non-judgemental.** make sure that cultural or social barriers do not hinder discussion
6. All information provided in the discussion should be recorded by the note-taker. The note-taker **should be factual** recording what is exactly what was said and write down as much of the information provided by participants as possible including any **debates and disagreements** within the group, as well as key phrases, quotes used.
7. At the end of the session, the team should **thank the participant(s)** for their time, and inform them of any **feedback** processes that are planned.
8. After each data collection session the team should **produce a session report**. This should be based on the field notes taking during the session, and should summarise all of the key information provided on each discussion topic. All team members present at the discussion should check that the report truly represents the discussion and the views of the participants (and not of the facilitator or note-taker).

ESSENTIAL QUALITIES AND ETHICS

Team members should adhere to essential qualities and ethics critical for the success of the assessment. The guiding principle is that the **best interests of the community** should be protected at all times, and that the assessment activities should **do no harm** to participants.

Essential qualities of a team member would include

- Be a good listener, patient and willing to listen and learn from the people being consulted
- Good communication skills, including knowledge of local languages where necessary

- Cultural sensitivity - being aware and respectful of local customs, norms and beliefs
- Be comfortable talking about sex and related issues, and have a non-judgemental attitude towards young people having sex (including outside of marriage)
- Avoid raising expectations that won't be met by the assessment
- Experience of working with districts and communities

Key Ethical Issues To Consider

- Team work.
- Respect for each other and value the options of the people you consult
- Continuous learning.
- Self-drive and motivation among members.
- Concentration on work and professionalism.
- Confidentiality.
- Honesty.

ANNEX 3: INDIVIDUALS AND GROUPS INTERVIEWED

FGD of Construction Workers at Bigodi Sub-County China Railway Construction Seventh Group

SN	Name	Sex	Institution	Designation	Contact No
1	Tukundane Dickens	M	CRSG	HRM	0774251705
2	Atukunda Apollo	M	CRSG	PRO	0782410238
3	Dan Iga	M	UNRA	Project Engineer	0783012425
4	Naturinda Nicholas	M	CRSG	Environmentalist	0775460770
5	Nankunda Catherine	F	KDLG	Labour Officer	0783104210
6	Dr Mugisa John	M	Private	WB Consultant	0772463386
7	Okumbuke Shabn	M	KDLG	DHO/PSWO	0785837711
8	Willy B Tibwitta	M	Gauff	Res. Engineer	0795719800
9	Businge Mike	M	Gauff	Dep. Res.Eng.	0772912153
10	Mary Mugabe F	F	Gauff	Environmentalist	0772464440
11	Mugena Hellen	F	Gauff	Asst. Sociologist	0772410811
12	Peninah Asasira	F	CRSG	Health Safety Off	0784132271
13	Dr Balizi Achban	M	RukungiriSNO /MS	Sen. Med Officer	0772334632
14	TumushabeGeorge	M	Bigodi HC 111	Sen Clin. Officer	0772626863
Total 14: 4 women; 10 men					

Kabarole Male Workers					
1	Twomuhangi P	M			
2	Nyakahuma Rajb	M			
3	Musinguzi Bazilio	M			0706837824
4	Arinaitwe Enock	M			0789043214
5	Gwamanyi Moses	M			0785970208
6	Munyamboga Landos	M			0782044437
7	Kaluma Franco	M			0779322845
8	Robert Mugabe	M			0779366403
9	Byaruhanga Godfrey	M			0773246900
Total = 9 Male workers					

Male Workers at Bigodi sub-county, Kamwenge District					
1	Said Mawanda	M			0777745116
2	Twine Mugabe Julius	M			0788838619
3	Tukorekyi Christopher	M			0785573388
4	Byamukama Christopher	M			0759231208
5	Richard Mufumbiru	M			0785981008
6	Kacumbi Phillios	M			0776660428
Total = 6 men					

Female Workers at Bigodi Sub County, Kamwenge District					
1	Tumwakire Rosemary	F	Asst Surveyor		0754549812
2	Nankunda Immaculate	F	Cleaner		0786333581
3	Nayebale Memory	F	Cleaner		0770307772
4	Birungi Lucy	F	Cleaners		0778307772
5	Tumusiime Loice	F	Lab Techn.		0787741250
6	Nayebare Juliet	F	Office Asst		0771648606
7	Monica Atim	F	Surveyor		0776369789
Total = 7 female workers					
KIs at Kabarole District Technical Team					
1	Ogwanga Godfrey	M	Depty. CAO	KDLG	0772494669
2	Monday Christopher	M	Senior Labour Officer	KDLG	0783415711
3	Dr Mugabi Richard	M	DCDO	KDLG	0772563113
4	Brenda Kyomugisha	F	Regional CDO	KDLG	0772567672
Total =4; 3 men and 1 woman					

District Level Participants consulted as key Informant Interviewees in Kamuli District				
SN	**Name**	**Institution**	**Position**	**Telephone**
Political Leaders at District Level				
1	Thomas Kategere	Kamuli DLG	District Chairman	0782530844
2	Galisansana Vincent	LC V Council	Vice Chairman	0772688370
District Technical Team				
3	Ben Otim Ogwelle	Kamuli DLG	CAO	0772410633
4	Banafamu Robert	Kamuli DLG	District Planner	0772624999
5	Mmerewoma Leo	Kamuli DLG	DCDO	0772614540
6	Akello Ruth Agnes	Uganda Police	Corp Asst. In-charge, FCPU	0772466192
7	Richard Lagada	Kamuli DLG	CDO Probation/Gender	0754177807
8	Mboizi Joshua	Kamuli DLG	Senior Probation Officer	0772374243
9	Magada W. David	Kamuli DLG	Senior Labour Officer	0772982464
10	Akoyo Charles	Kamuli DLG	District Education Officer	0772634978
11	Banafamu Robert	Kamuli DLG	District Planner	0772624999
12	Mmerewoma Leo	Kamuli DLG	DCDO	0772614540
Hospital Staff				
13	Watilo Charles	Kamuli Hospital	Ag Med. Sup	0701085246
14	Joweriah Kasiri	Kamuli Hospital	Nursing Officer	0782388180
Cultural Leaders				
15	Woira Henry	Bugabula Chiefdom	Isabalangira (Chief Royal)	0772829849
16	Waibi Febiano	Kyabazinga's Office	Administrator	0779681591
17	Ndembi Kisige	Kyabazinga's Office	Executive Member	0784627632
Some of the NGOs Operating in Kamuli District				
18	Emukule Patrick	Plan International	Programme Manager	0772344770
19	Namudiba Sandra	UWONET/Shelter	District Coordinator	0700196517
20	Nabirye Harriet	GBV Shelter	Matron	0779817770

Total interviewed =20; 2 politicians, 10 technocrats, 2 hospital staff, 3 cultural leaders and 3 NGOs. Of the 20; 4 were women and 16 men NB. Men to women ratio are always higher in higher positions.

Members of the District Child Protection Committee who participated in the FDG				
SN	**Name**	**Sub-County**	**Title**	**Contact No**
1	Kasujja Robert	Bugulumbya	Community Devpt. Officer	0755272506
2	Zzime Ssalongo	Kitayunjwa	Child Protection Committee	0784850938
3	Kitugundu Paul	Namasagali	Community Devpt. Officer	0776720782
4	Bazira John	Kitayunjwa	CPC Member	0785020014
5	Namukose Susan	Butansi	CPC Member	0776132565
6	Katuntu Benon	Kitayunjwa	CPC Member	0776404809
7	Koloobe Mwazimigi	Busota	CPC Member	0776388921
8	Stanley Aubwa	Kitayunjwa	CPC Member	0775059821
9	Wekyali Daniel	Namwendwa	CPC Member	0774611511
10	Kitamirike Fatuma	Kitayunjwa	CPC Member	0751828588
11	Alitobeera Esther	Bugulumbya	Community Volunteer	0751554968
12	Itanga James	Nabwigulu	Community Volunteer	0705867090
13	Isoloibi James	Nabwigulu	Community Volunteer	0774069094
Total CPC members attended =13; 3 women and 10 men				

FGD with (opinion & political leaders as well as vulnerable men) from Bulopa Sub-county				
SN	**Name**	**Parish**	**Title**	**Contact**
1	Muwangala Moses	Bulopa zone/village	District Councillor	0782240196
2	Musimi Rogers	Kabanda zone	Student Vacation	0758070490
3	Mabango Edward	Bulopa	Farmer	0773844986
4	Mufumbiro Richard	Bulopa	VHT & Secretary LC1	0772234059
5	Mugaya Godfrey	Mpakitonyi zone/village	Councillor	0759709316
6	Kintu Moses	Mukoka Zone	Gen-Secretary	0773847684
7	Muyemba Edirisa	Bunaabi Zone	Community Member	0782022937
8	Lubonge Charles	Bunaabi	Peasant	0753229890
9	Kikungu Fabiano	Bunaabi	Community Member	
10	Lukanda Joseph	Mpakitonyi	Peasant	0784693541
11	Mukombe God	Bunaabi	Community Member	0718008045
12	Kisoma Asuma	Bunaabi	Student	0753166873
13	Mutambuze Jonathan	Bunaabi	Chairperson for Youth	0703379075
14	Kasuti Jeffery	Bunaabi	Farmer	c/o 0750055646
15	Kasuku Thomas	Bunaabi	Farmer	
16	Muganza Thomas	Bunaabi	Farmer	
17	Nakabona	Bunaabi	Chair for the Elderly	
18	KisomaJuma	Bunaabi	Change .Agent for AEGY	0771611612
19	Kintu Isah	Bunaabi	Plumber	0756925026
20	Mafabi Sooka	Bunaabi	Farmer	
Total was 20 men including opinion, political and community leaders different zones and villages				

FGD with Women from Namwendwa sub-county				
SN	**Name**	**Zone**	**Title**	**Contact**
1	Byobona Siida	Buyingo	Social Worker	0750476699
2	Nassaka Catherine	Town board	Hair Dresser	0774353671
3	Aliseka Suzan	Buyingo	Business Woman	0753027048
4	Nangobi Jennifer	Buyingo	Teacher	0789139471
5	Buuza Norah	Town Board	House wife	0773996156
6	Ndikyeganantya Cissy	Namwendwa	House wife	0759070929
7	Mukyala Cissy	Namwendwa	House wife	0787511001
8	Namukombe Susan	Buyingo	Business woman	0775754895
9	Basiwiire Dorcus	Town Board	Business woman	0701595147
10	Baaza Rehema	Namwendwa	Business woman	0759392437
11	Nabiryo Aisha	Town Board	Business woman	0750972250
12	Mwebeza Sharon	Town Board	Business woman	0756099358
13	Wamala Aida	Town Board	Business woman	
14	Nangoma Harriet	Buyingo	Business woman	
15	Ndibulyawa Annet	Buyingo	Business woman	0785768789
16	Asiimwe Kevin	Buyingo	Business woman	
17	Monica Woire	Buyingo	House wife	
18	Mukyala Serina	Buyingo	Farmer	0758186756
19	Musoga Fuwa	Buyingo	House wife	
20	Ajula Brenda	Namwendwa	Hair Dresser	0753692231
21	Naigaga Arivini	Buyingo	House wife	
22	Namukombe Edisa	Buyingo	House wife	0753502845
23	Mureu Grace	Buyingo	Farmer	075094080
24	Nabirye Fred	Buyingo	Farmer	0704555830
25	Naigaga Zulaika	Town Board	House wife	0778414576
26	Nambi Phoebe	Town Board	House wife	0755934799
27	Ikuluba Monica	Buyingo	Farmer	
Total number of women was 27 women from different zones of Namwendwa Sub-county				

	Meeting with Children/Adolescents in High School aged 13 to 17 years				
SN	**Name**	**Sex**	**Age**	**Class**	**Contact**
1	Nandudu Immaculate	F	15	S2	Nil
2	Nakawooma Scholastic	F	15	S1	
3	Mwesigwa Frank	M	15	S1	
4	Wotaaba Peter	M	15	S1	
5	Kisambira Eric	M	15	S1	
6	Mwesigwa Nicholas	M	16	S2	
7	Kabega Moses Reagan	M	15	S2	
8	Nanyimba Rebecca	F	16	S2	
9	Babirye Mary	F	15	S2	
10	Nanteza Cissy	F	17	S2	
11	Namugolo Phiona	F	16	S2	
12	Kawongolo Samuel	M	16	S2	
13	Namusana Esther	F	16	S2	
14	Nambubi Cissy	F	15	S2	
15	Namumbya Leah	F	13	S2	
16	Kyazike Saphia	F	15	S2	
17	Ssebbowa Joshua	M	16	S2	
18	Gwayira Henry	M	14	S2	
19	Owino Dan	M	16	S2	
20	Mukasa Joel	M	16	S2	
21	Namatovu Cissy	F	15	S2	
22	**Baalwa Isabirye Dan**	**M**	**69**	**School Director**	**0759204616**
23	**Erubiye Joseph**	**M**	**36**	**Deputy Headmaster**	**0783437578**
Students interviewed were 21; 11 girls and 10 boys. The School Director and Deputy Head teacher were met separately for a courtesy call, not interviewed.					

Meeting with Youth Kamuli Youth out of School at Bukakande, Mbulamui Sub-county

SN	Name	Sex	Age	Status	Village
1	Nololo Asuman	M	20	Single	Buwoloma
2	Nangobi Edisa	F	24	Divorced	BusaanoBulukaire
3	Kaudha Betty	F	22	Single, has 1 kid	BusaanoBulukaire
4	Nabirye Betty	F	21	Single, has 1 child	BukofuBukumbi
5	Mopyenda Teddy	F	20	Single, has 2 kids	BukofuBukumbi
6	Bagole Dan	M	21	Single	BusuuyiBukapiti
7	Bwayera Maria	F	21	Singe, has 1 kid	BusuuyiBukapiti
8	Zaina	F	20	Single, has 1 kid	BusuuyiBukapiti
9	Isma	M	22	Single	BukofuBukumbi
10	Federiko	M	19	Single	Busuuyi
11	Mutesi Regina	F	25	Married	Busuu
12	Mukoda Lukiya	F	24	Married	Busuuyi
13	Wakita Sarah	F	25	Married	Busuuyi
14	Babirye Joan	F	18	Single	BukofuBukumbi
15	Wanyana Rose	F	25	Married	BusanoBulukaire
16	Naigaga Amina	F	20	Single, has 1 kid	BukofuBukumbi
17	Nakayima Annet	F	20	Single, has 1 kid	BukofuBukumbi
18	Isanga Peter	M	25	Single	Bugabala
19	Kayima Ema	M	21	Single	BukofuBukumbi
20	Nakato Martha	F	23	Single, has 1 kid	Bukambe
21	Mugaya Stephen	M	24	Married	Bukose
22	Isabirye Leo	M	21	Married	Bukose

Total = 22 Young people (including divorcees, never married and with babies); 14 female, 8 male.

ANNEX 4: FIELD PHOTOGRAPHIC DOCUMENTATION

Group Interview with Road Construction Project Consultant/Supervisor and UNRA Staff -Kamwenge District

Key Informant Interview with the Human Resource Officer - Road Contractor, Kamwenge District

One of the GBV Shelters visited by during the SIA, Kamuli GBV Shelter, Kamuli District

FGD with Out of School Youth in Mbulamuti Sub county, Kamuli District