

EVALUATION OF UNFPA SUPPORT TO THE PREVENTION, RESPONSE TO AND ELIMINATION OF GENDER-BASED VIOLENCE AND HARMFUL PRACTICES

2012-2017

Uganda Case Study

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Evaluation of UNFPA support to the prevention, response to and elimination of gender-based violence, and harmful practices

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Acronyms and Abbreviations

ACCS	Advisory Consortium on Conflict Sensitivity
AOR	Area of Responsibility
AWP	Annual Work Plan
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CM	Child Marriage
CMR	Clinical Management of Rape
CPD	Country Programme Document
CORT	Collaborative Outcomes Reporting Technique
CO	Country Office
CRRF	Comprehensive Refugee Response Framework
CSO	Civil Society Organisation
DaO	Delivering as One
DCDO	District Community Development Officer
DFID	Department for International Development
DEVAW	Declaration on the Elimination of Violence Against Women
DLG	District Local Government
DV	Domestic Violence
ECP	Emergency Contraceptive Pill
FAO	United Nations Food and Agriculture Organization
FBO	Faith-Based Organisation
FGM	Female Genital Mutilation
FIDA	International Federation of Women Lawyers
GBV	Gender-based Violence
GBViE	GBV in Emergencies
GDP	Gross Domestic Product

GE	Gender Equality
GEEW	Gender Equality and Empowerment of Women
GoU	Government of Uganda
HC1	Health Center Level 1
HP	Harmful Practices
HRBA	Human Rights-Based Approach
IASC	Interagency Standing Committee
ICGLR	International Conference on the Great Lakes Region
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
INGO	International Non-Governmental Organisation
IP	Implementing Partner
JLOS	Justice Law and Order Sector
JPFGM	UNFPA-UNICEF Joint Programme 'Female Genital Mutilation (FGM): Accelerating Change'
JPGVB	Joint Programme on Gender-Based Violence
JPGE	UN Joint Programme on Gender Equality
KAP	Knowledge Attitudes Practice
MAGs	Male Action Groups
MGLSD	Ministry of Gender, Labour and Social Development
MISP	Minimum Initial Service Package
MOH	Ministry of Health
MOS	Ministry of Sports and Youth
MOU	Memorandum of Understanding
MSR	Multi-Sector Response
NDP	National Development Plan
NPEGBV	National Policy for Elimination of Gender-Based Violence
NAPEGBV	National Action Plan for Elimination of Gender-Based Violence

NGO	Non-Governmental Organisation
OHCHR	Office of the High Commissioner for Human Rights
PEP	Post-Exposure Prophylaxis
PMNCH	Partnership for Maternal, Newborn, and Child Health
PRDP	Peace, Recovery and Development Plan for Northern Uganda
ReHOPE	Refugee and Host Population Empowerment
RH	Reproductive Health
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
ToC	Theory of Change
TOR	Terms of Reference
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Household Survey
UGX	Ugandan Shilling
UNCT	United Nations Country Team
UNDAF	United Nations Development Action Framework
UNFPA	United National Population Fund
UNHS	Uganda National Household Survey
UPR	Universal Periodic Review
UNSCR	United Nations Security Council Resolution
VAW(G)	Violence Against Women (and Girls)

1. Context and background

National context

Uganda

Uganda's 1995 constitution and broader normative and policy frameworks reflect global standards, are strongly supportive of Gender Equality (GE) and, within recent policy documents, address gender-based violence (GBV) explicitly. Uganda is a state party to nearly all international human rights conventions as well as relevant regional protocols. Uganda was active in the post 2015 development process; it was one of first countries to integrate the principles and goals of the Sustainable Development Goals (SDGs) into its National Development Plan (NDP) even before the global documents had been finalized. Both GE and GBV are featured in Uganda's second NDP and evident in diverse sectoral plans. The National Health Sector Plan reflects a rights-based approach and acknowledges international conventions.

The National Action Plan on Elimination of Gender Based Violence in Uganda (2016-2020) frames the issue of GBV as an urgent development priority and factor to address in achieving Uganda's development goals for 2020. Similarly, the interconnected work on ending child marriage and teenage pregnancy is framed by the new dialogue on leveraging for development the demographic dividend of a large, youthful population.

Uganda is rich in natural resources but marked since independence by a series of internal conflicts which have only recently abated. Although there are dramatic regional differences in socio-economic development, public sector investment, access to services, and health, education and rights indicators within Uganda¹, the country has reported a consistent average annual economic growth rate of 6.4% since 2002. The 2016—2020 United Nations Development Action Framework (UNDAF) noted that the country has built "*sufficient momentum for take-off*".

Despite the strong normative framework on GE, including regulations, guidelines, protocols and even district level laws and ordinances, actual implementation of the policies has been challenging. For women and girls, there has been mixed progress. Education is one of the positive indicators with net enrollment for girls higher than for boys at both primary (80% to 79%) and secondary (29% to 27%) levels: the pattern at primary level holds in both urban and rural areas, although it varies significantly by region. Although overall literacy rates for females over 10 years of age remain below males (70% compared to 78%), a six % point increase in the female rate since 2012 contributed significantly to a 4% increase in the national literacy rate.² Despite this progress, the maternal mortality ratio remains high at 438 per 100,000 live births. Maternal deaths account for 18% of all female deaths and girls age 15-24 account for up to 28% of maternal deaths. Uganda has "*one of the highest rates of teenage pregnancy in sub-Saharan Africa*": 24% of girls aged 15 to 19 overall, with the majority of pregnancies taking place within marriage reflecting a high level of child marriage (49% by their 18th birthday). Complications of pregnancy and childbirth are the leading cause of disability and death among female adolescents in Uganda.³

¹ In Karamoja region, an estimated 74.2 % of the population live below the poverty line. Food insecurity stood at 56 % in 2014, with 36.9 % of children in Karamoja exhibiting significant stunting due to insufficient food.

² Uganda National Household Survey, 2016/2017

³ Ibid., 2011; Better Life for Girls Project Summary, n.d.

Responsibility (AOR) within the cluster system of the global humanitarian architecture.

GBV and harmful practices

Based on Uganda Demographic Household Survey data (UDHS), Uganda has a high rate of reported GBV⁴. The 2011 UDHS indicated that overall prevalence rates by type of violence were 56% for physical violence, 27.7% for sexual violence and 42.9% for spousal emotional violence. Sexual violence has reportedly decreased from 39% in 2006 to 28% in 2011. Sixty % of women report having experienced any violence. In a 2009 study by the Uganda Law Reform Commission, half of the women surveyed reported experiencing violence on a daily or weekly basis, and 35% of working women reported marital violence. Although all women aged 15 to 49 years report a decrease in physical violence (27% in 2011, down from 34% in 2006), the rate reported among pregnant women (16%) has remained the same. Only 2% of survivors reported the violence.

Violence affects women and children disproportionately, however, men and boys also experience violence. The UDHS shows that the percentage of men aged 15 to 49 reporting experiencing violence overall increased from 20 % in 2006 to 22 % in 2011, although the percentage experiencing sexual assault decreased during the same period from 11% to 9%.

The most recent data from the UDHS 2016 show that women are more than twice as likely to have experienced sexual violence at some point in their lives as men (one in five or 22% for women; one in 10 or 8% for men). The pattern holds for reports of recent sexual violence: 13% of women and 4% of men reported experiencing sexual violence in the 12 months preceding the survey. Older women are more likely to report having experienced recent sexual violence than younger women aged 15 to 19. 13% to 16% of older women and 5% of younger women reported recent sexual violence. Women in urban areas (9%), women in Acholi sub-region (5%), and never married women (1%) are less likely than other women to report recent experience of sexual violence. Experience of sexual violence ever and in the past 12 months is lowest among women with more than secondary education.

A 2007 report by the Ministry of Health (MOH) identified the most prevalent types of violence at that time as wife battering (30%), defilement (25%), rape (20%), marital rape (13%) and sexual exploitation (12%). It identified perpetrators based on where the violence occurred, noting that in households the most common perpetrators are intimate partners, in families they are relatives, and in the community. They include armed combatants, 'gatekeepers' and 'those in authority'. Women in rural areas with low education and low economic status were more likely to experience physical violence.

Although much of GBV and harmful practices (HPs) remains hidden and the health and development costs of such violence insufficiently explored, Uganda has also contributed to early efforts to document the enormous costs of GBV. A recent study used well tested interpolation and statistical techniques to monetize the cost of the response to Domestic Violence (DV) in Uganda: it estimated that health care providers

⁴ The statistics cited to illustrate the scale of the problem and the differential experiences of males and females reflect reported cases of GBV. For survey-based data, respondents must understand what is meant by the term, recall if (and when) it happened, and be willing to share that information with an interviewer. Although the UDHS survey uses methods which maximise the likelihood of accurate information, there are potentially biases based on differences in willingness to report or even an understanding of the descriptions of different categories. For administrative data, additional biases may limit women's ability to access services or men's willingness to seek services.

spend about UGX 18.3 billion annually to deal with the effects of GBV, police UGX 19.5 billion while the local councils spend UGX 12.7 billion. This does not account for the loss of productivity or other longer-term impacts of DV.

It was estimated that GBV incidents cost the Ugandan economy about UGX 77 billion annually.

Within the refugee settlements services must cope with high rates of violence and very high rates of concealing violence on the part of both refugees who are 'protecting their culture' and the host communities who view the available GBV services as for the refugees, and so 'self-censor' and do not report or pursue services. Nonetheless, in one week in May 2017, UNHCR identified and addressed 20 new cases of sexual and gender-based violence (SGBV) in Bidibidi settlement, bringing to 430 the total number of cases identified and addressed in the first four months of 2017 in a single settlement. The culture of silence results in part from lack of familiarity with the services, leaders covering up reported incidents, and threats against the families of survivors by the families of perpetrators living within the same settlement. Agencies have resorted to home visits to follow up on suspected cases.

The complex relationships within the refugee districts are affected by these domestic conflicts. During the height of the influx of Sudanese refugees in early 2017, community leaders reported that they themselves were also threatened and attacked by families 'dissatisfied' with the leaders' involvement with solving an incident. With the assumption that GBV will resolve as refugee populations become more stable, some of the humanitarian agencies addressing GBV have withdrawn as the refugees have settled. However, the evaluation heard that the need for GBV services remains significant as refugees become migrants: different types of pressures arising with life outside the camps drive the violence, e.g. economic stresses, and competition for limited resources in the resettled areas.

Not evident in the GBV statistics above, are the percentages impacted by HPs. The early work on GBV focused particularly on domestic and sexual violence, influenced in part by the lens of wartime and conflict. However, the 2016 National Policy for Elimination of Gender Based Violence (NPEGBV) defines as a 'form' of GBV harmful traditional practices such as female genital mutilation (FGM), early and forced marriages and bride price-related violence, and highlights GBV and FGM as national priorities in Uganda. UNFPA's documents refer to the "*harmonization*" of the work of FGM with the work on GBV: the expanded focus on child marriage emerged when the GBV work was already well established and thus has been linked from the start.

The estimated prevalence of FGM in girls and women aged 15 to 49 in Uganda was 1.4% based on the UDHS for 2011. It is practiced in Kapchorwa, Kween and Bukwo, and among the Tepeth people in Karamoja. In comparison to many of the other countries in Africa, Uganda has a very low rate nationally, however, within practicing groups, it is high (50% among the Sabinu and Tepeth and 95% among the Pokot and Kadama).

Local government actors in Moroto district asserted that the practice came from the Kalenjin ethnic groups in Kenya who 'married across the border', which also explains the challenges with the practice going underground by 'going across the border'. This is despite the fact that Kenya passed its own law banning FGM one year after Uganda and in the same year in which Uganda produced regulations helping to operationalize the law.

The practice of forced and early marriage is still prevalent, although it has declined in the recent past. Legal age at marriage in Uganda is 18. In 2013, Uganda was ranked 16th among 25 countries with the highest rates of early marriages. UNICEF's 2016 report indicates that 10% of girls marry by age 15 and 40% by age 18. Based on data from the UDHS, this represents a decline from 2006 (53% of women aged 20 to 49 were married before the age of 18) and from 2011 (15% of ever married women aged 20 to 49 married by 15 and 49% by 18).

UNFPA-Uganda's approach to the issue of child marriage is linked with work on ending teen pregnancy. Common drivers contribute to both teenage pregnancy and child marriage for the vulnerable 4.3 million Ugandan girls aged 10 to 24, whether in-school or out-of-school.⁵ Estimates are 90% of teenage pregnancy takes place within marriage in Uganda. The overall teenage pregnancy rate is 25%, although higher in rural areas (26.7%) compared to urban areas (18.8%) and in the poorest households (33.5%) compared to wealthiest households (15.1%).

In an illustration of the challenges of addressing pervasive GBV including teen pregnancy, Ugandan crime statistics show a high and increasing rate of reported 'defilement' (defined by law as having sex with a girl under the age of 18⁶). In 2011, defilement was the most reported serious crime, accounting for 49.5% of all serious crimes reported in Uganda. A report on the progress of the Joint Programme on Gender Based Violence (JPGBV) explained that a large number of GBV cases before the court were not being addressed because the chief magistrate in two districts had an enormous backup of legal cases to review, most of them cases of defilement. The Women's Refugee Commission study of child marriage in humanitarian settings, which included a case study on Uganda, noted that: "*Child marriage provided families with legal protection from defilement, which is a crime in Uganda*⁷. *Child marriage was also viewed as providing protection from rape, which occurred with some frequency when girls undertook work (most typically, domestic labour) outside the home*". As UNFPA's own Project Summary for the Better Life for Girls campaign noted: "*All these early marriages and teenage pregnancies for girls aged less than 18 years, are in and by-themselves (sic), defilements!*".

Economic and social context

Capitalizing on Uganda's positive economic growth and the potential demographic dividend of a very large cohort of young people, the Government of Uganda (GoU) has outlined a 30-year vision to "*develop from a predominantly peasant and low-income country to a competitive upper middle-income country by 2040*". The first of a series of five-year plans was launched in 2010—2011 and coincided with the end of the first Peace, Recovery and Development Plan for Northern Uganda (PRDP I), bringing a very different focus on "*growth, employment and prosperity for socio-economic transformation*." The focus of the 2nd NDP (2015/2016—2019/2020) is "*strengthening Uganda's competitiveness for sustainable wealth creation, employment and inclusive growth*." UNFPA was closely involved in its formulation by providing technical assistance in integration of population, reproductive health (RH) and gender issues.

The proportion of the Ugandan population living below the national poverty line declined from 39% in 2002 to 19.7% in 2011, surpassing the country's Millennium Development Goal target of 25%. The country

⁵ Uganda Bureau of National Statistics (UBOS), *National Population and Housing Census, 2014*

⁶ The legal definition is very precise with respect to what must take place to constitute 'defilement'.

⁷ Although child marriage is also a crime, it is not as likely to be prosecuted.

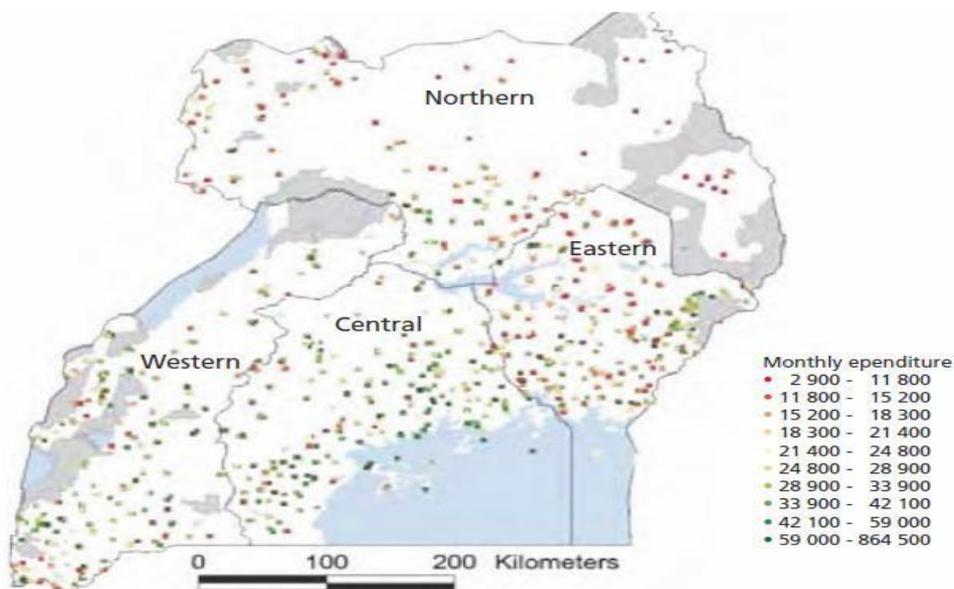
reduced the proportion of the population living on USD 1.90 per day or less, from 53.2% in 2006 to 34.6% in 2013. However, the 2016 UNHS indicates that, between 2013 and 2016, there was an overall increase in income poverty reflecting the impact of the drought on commodity prices and basic supply of food - the drop in income varied greatly by region of the country.

Uganda's unemployment rate is low for the region. It is an urban problem with urban areas reporting rates three times that of rural areas. It is also a problem disproportionately impacting youth. A 2012, UBOS report indicated that young people (using Uganda's definition, i.e. aged 18 to 30) represented 64% of the unemployed.

Although only 16.44% of Uganda's population was living in urban areas in 2016, the urbanization rate was 5.43%, indicating a significant shift towards a market economy. Although an estimated 72% of Uganda's working population is in the agricultural sector, during the period 1990 to 2015, the structure of the Ugandan economy changed significantly with the services sector leading the charge. The share of agriculture value added in GDP declined from 56% in 1990 to 24% in 2015; the share of industry grew from 11% to 20% (with manufacturing increasing at a slower pace, from 6% to 9% of GDP); and the share of services went from 32% to 55%. Respondents highlighted that work addressing GBV needs to anticipate and prepare for 'an urban Uganda'.

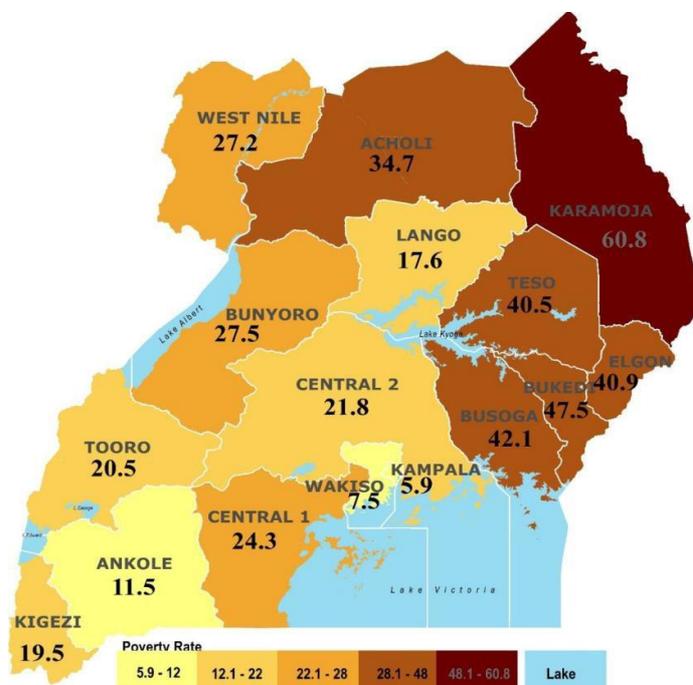
The 2016 UPR of Uganda's compliance with its 2011 recommendations documented the dramatic differences in resources and outcomes of large parts of the country. Further, the report lamented that the distribution of the benefits from the dramatic economic growth to this point has not impacted the situation of the largest percentage of Ugandans. These patterns are reflected as well in the UNHS undertaken by the UBOS with GoU funding and technical support from UNICEF and the World Bank. Although sampling for the UNHS is representative, the survey takes into account the categorization of districts within the Peace and Recovery Development Plan (i.e. severely affected by the past conflict; sporadically affected; spillover districts; and mountainous regions), highlighting the dramatic differentials in poverty and other

Figure 2: Monthly expenditure for rural households Uganda as a proxy for poverty levels (Universal Periodic Review, 2016)



indicators, and the decline since 2012—2013 in services and resources in the most disadvantaged regions.

Figure 3: Poverty Estimates/Rates: percentage in poverty by district *Population and Development*
(UBOS, UNHS, 2016/2017)



Uganda has one of the youngest populations in the world with 70% aged 24 years and younger, and 52% under 15 years of age. A 3% annual population growth rate reflects a sustained high fertility rate (5.4 in 2016) with low contraceptive use and a notable decline in mortality rates (the infant mortality rate has declined from 54 deaths per 1,000 live births in 2011 to 43 deaths per 1,000 live births in 2016). Uganda’s population has more than tripled since 1969: it was 34.9 million in 2014; it is expected to reach 83 million by 2040. The large youth population is the focus of current planning efforts to leverage the demographic dividend and

intensification of focus on contraceptive access and family planning.

UNFPA response, including GBV and harmful practices interventions

UNFPA has invested significantly in Uganda’s efforts to address GBV and harmful practices. This investment has produced significant achievements in terms of laws, policies, regulations, protocols and guidelines at the national level and adapted for the sub-national level. Uganda’s experience with the role out of the human rights-based approach (HRBA) to addressing maternal mortality and morbidity; integrating a focus on GBV into work on sexual and reproductive health (SRH) and with adolescents; engaging key government stakeholders through evidence-based programming and diverse approaches to partnership and collaboration with sister agencies in coordinated efforts have been identified as good practice approaches in efforts to link human rights and SRH rights work. The challenge remains operationalizing these policy tools and government commitments.

The 8th UNFPA Country Programme

UNFPA Uganda is presently in the second year of its 8th Country Programme (CPD) which was developed in consultation with a wide spectrum of partners, including the government, civil society, development partners, United Nations organisations, academia and the private sector. The CPD is aligned with national priorities, as outlined in National Vision 2040, National Development Plan II (2015/2016-2019/2020), the United Nations Development Assistance Framework (2016—2020) and the UNFPA Strategic Plan 2014—2017, and contributes to one of Uganda’s urgent priorities, harnessing the demographic dividend.

Under the 8th CPD, the sole output for Outcome 3: ‘Gender equality and women’s empowerment’ states:

“national and district governments have the capacity for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence prevention and response services, including in humanitarian settings. Specific strategies focus on the following: (a) supporting behavioural change strategies for addressing gender-based violence, female genital mutilation, teenage pregnancies, and child and forced marriage; (b) supporting advocacy for integration of gender-based violence prevention and response, and human rights in sexual and reproductive health programmes; (c) advocating for enforcement of policies and laws on gender-based violence; (d) providing technical support to the Ministry of Gender, Labour and Social Development and civil society to develop and implement multi-sectoral service standards and protocols that meet human rights standards; (e) supporting the Ministry of Gender, Labour and Social Development and civil society to monitor implementation, track accountability and report on sexual and reproductive health and rights commitments in regional and international instruments, including by using the Gender Score Card.”

The emphasis on addressing the diverse manifestations of gender-based discrimination and forms of GBV is evident across all components of the 7th and 8th country programmes. This is operationalized in efforts to plan jointly and think ‘cross-programmatically’ when developing a new initiative. It is further supported by UNFPA’s collaboration with sister agencies with expertise in different but relevant sectors. Thus, work on teen pregnancy, child marriage, FGM and maternal mortality are conceptually linked and programmes include elements related to services, safe spaces, normative change, human rights and to income generation. The Better Life for Girls project, which is managed from within the International SRH Rights unit, incorporates the SafPal application developed for girls and young women aged 14 to 20 to prevent and report sexual harassment. The work on a rights-based approach to addressing Maternal Mortality and Morbidity (MMM) and UPR recommendations on SRH rights emphasize GBV and adolescent health. Although the national prevalence of FGM is low, the principles of the community-based behaviour change strategies adopted reflect community-level work on child marriage. Work on child marriage emerged from work on teen pregnancy and is now highlighted through support from the Global Programme.

This integration is also reflected geographically. The maps of the 7th and 8th country programmes illustrate the impact of two overarching programming decisions on GBV on the scope of UNFPA’s work under the 8th programme. The grouping of the ‘pins’ showing where the gender, GBV and dedicated HP programmes are operational, illustrates UNFPA’s efforts to work in partnership and link work on GBV and HPs with broader GE work. The expansion of districts covered from the 7th to the 8th programme illustrates UNFPA’s adherence to the new 30%/70% policy of the Ugandan government which requires that, where entities are investing in refugee settlements as part of humanitarian response, they must also invest in host communities. This means that former ‘refugee districts’ are now integrated into UNFPA’s core programming efforts. These linkages could create valuable efficiencies and synergies.

Figure 4: Map of UNFPA's 7th country programme, Uganda

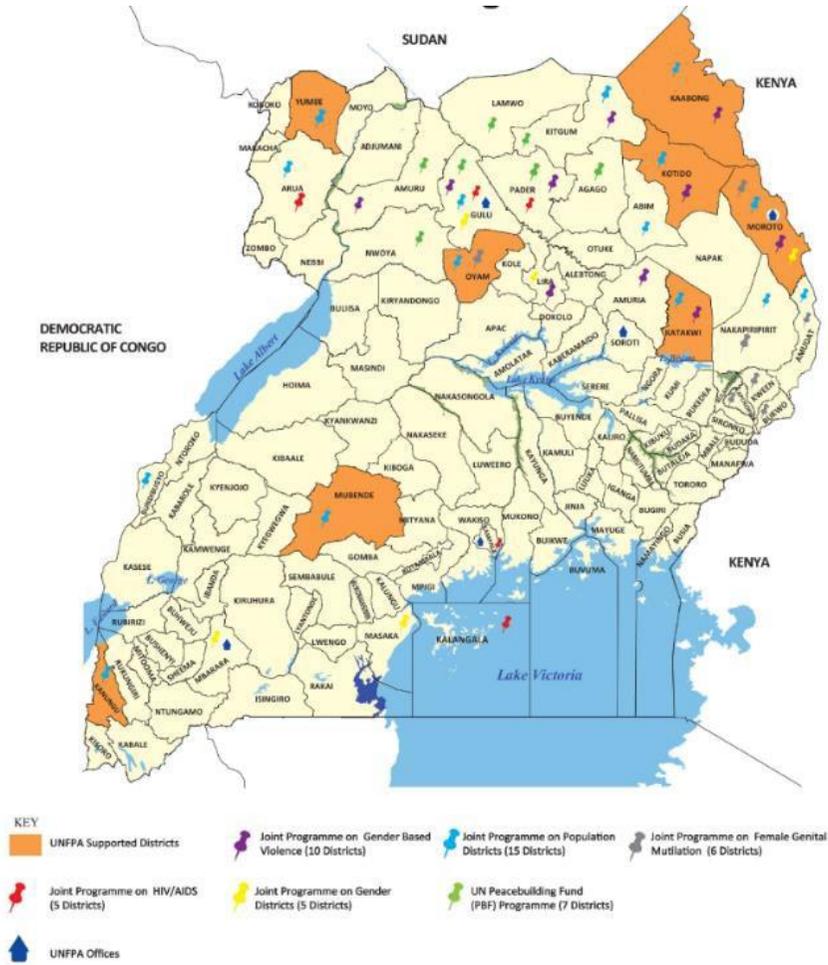
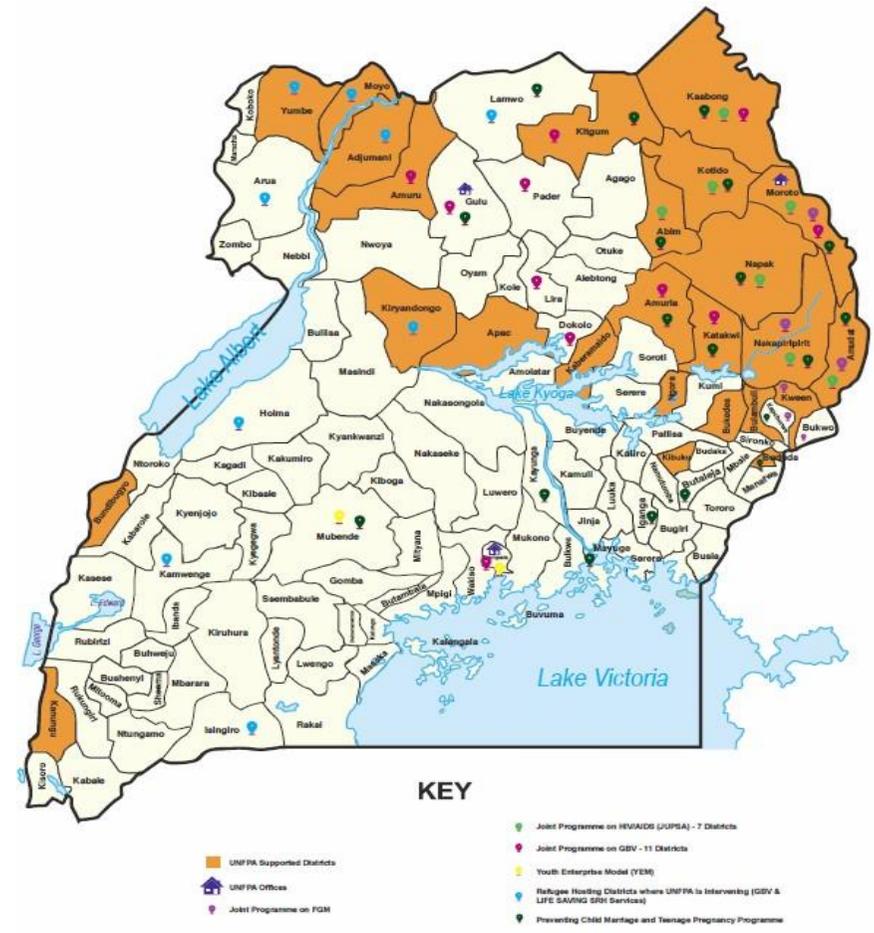


Figure 5: Map of UNFPA's 8th country programme, Uganda

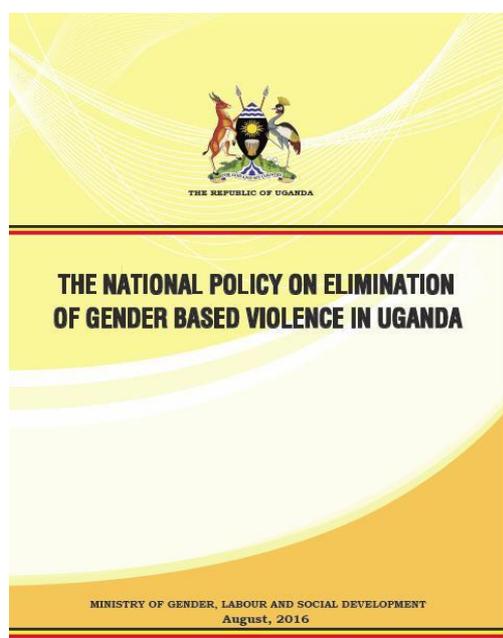


Programme Intervention Area 1: Laws, policies, and regulations

Uganda has a particularly strong normative legal framework informing the work on GBV and harmful practices. The majority of Uganda's laws, which directly address GBV specifically, were enacted prior to 2012. Between 2008 and 2011, three laws, two national plans, and four political declarations addressing GBV were set in place. These include: The Domestic Violence Act 2010 (Regulations 2011); Prevention of Trafficking in Persons Act 2009; Penal Code Act, Cap 120; Employment (Sexual Harassment) Regulations of 2012 and the International Criminal Court Act, 2010. The prohibition of Female Genital Mutilation Act of 2010 was followed by regulations to guide application of the law in 2011. The government of Uganda launched its first ever National Strategy on Ending Child Marriage and Teenage Pregnancy (2014/2015 – 2019/2020) in June 2015 and, by 2017, 30 districts had begun implementation, with an additional 51 districts allocating funds to address the issue. A recent achievement is the Children (Amendment) Act of 2016, which considers both GBV and harmful practices.

The Domestic Violence Act addresses all forms of violence including sexual violence. It “...*categorically states that there is no excuse for domestic violence and that there can be no ‘consent’ to acts of domestic violence, including the ‘ordinary wear and tear of marriage’*”, although it does not address marital rape. The Marriage and Divorce Bill (which goes beyond prevention to address some of the fundamental

Figure 6: Visual of the National Policy on Elimination of Gender Based Violence in Uganda



inequalities driving violence and incorporates some of the most contentious elements removed from the Domestic Violence Act) remains tabled in parliament. Marriage and divorce are also priority topics for traditional leadership structures, reflecting their patriarchal base.

The National Policy on Elimination of Gender-Based Violence in Uganda and the associated National Plan of Action on Elimination of Gender-Based Violence in Uganda (2016)⁸ are aligned with all relevant prior policies and help summarize the broad body of national laws, policies and international commitments which support efforts to address GBV. The primary outcomes identified by the policy are a reduction in negative attitudes, a reduction of prevalence of GBV, and increased comprehensive care for survivors. The policy focuses much attention on not only ending impunity for perpetrators of violence, but creating an enabling environment for accountability of stakeholders. More importantly, the National Policy delineates five major additional sectoral policies of relevance (e.g. community

⁸ The National Policy on Elimination of Gender Based Violence and the associated National Plan of Action are aligned with and/or reinforce: The National Gender Policy (2007), the National Action Plan on Women (2007), the Uganda Action Plan on UN Security Council Resolutions 1325 & 1820, the Justice, Law and Order Sector Investment Plan, the Social Development Sector Plan (SDSP), and Health Sector Strategy and Investment Plan (HSSIP) among others. In addition, Uganda is signatory to the majority of international and regional agreements of relevance to GE and ending GBV since 1990.

development, equal opportunity), highlighting their contributions to addressing GBV and noting that the GBV policy cannot be implemented in isolation.

The policy describes the term GBV as being used interchangeably with violence against women (VAW), citing the Convention on the Elimination of All Forms of Violence Against Women. However, in an addition which has reverberated in Uganda, it noted that because men can also be victims of GBV, the definition includes *“any harm that is perpetuated against a person’s will on the basis of unequal relations between women and men as well as through abuse of power”*. This addition facilitated the inclusion of men’s reported experiences of violence in the national GBV database, has encouraged a popular discourse on the drivers and impacts of GBV against men, including DV, and provided a foundation for the significant revision of original male involvement policy from a focus on men’s support for women’s use of services, to a focus on the experience of both men and women with violence.

Programme Intervention Area 2: Health Sector response to GBV

As a strong supporter of GE, Uganda was an early adopter of a dedicated health sector response to GBV. Some of the impetus for early action was based on the fact that GBV is a risk factor in HIV transmission, and thus addressing GBV was integrated into HIV services such as prevention of mother-to-child transmission (PMTCT). With UNFPA support the MOH developed and disseminated guidance on integration of GBV into SRH services, and training for health workers on clinical management of GBV. This was done together with other key technical entities within the National GBV Working Group, and was followed by the adaptation and production of guidelines, standard operating procedures, protocols and tools to support improved response of the health sector. By 2007, national clinical guidelines for SGBV had already been issued: they were revised in 2012 to enable health workers at community level to support survivors, including provision of emergency contraception and post-exposure prophylaxis (PEP) to prevent HIV/AIDS.

This focus on services is also reflected in the work on harmful practices. The work on FGM includes services for survivors of FGM including repairs. The work on child marriage is grounded in work on teen pregnancy and includes a strong adolescent-friendly services component.

One of the key contributions of the health sector to work on GBV is documentation of the scale of the problem. The MOH is credited with strong monitoring and evaluation components in broader MNCH work which can be leverage to inform the development of the GBV database. The challenges of the health sector relate in part to its decentralization, unequal distribution of resources, and overall lack of human resources.

Programme Intervention Area 3: Intersectoral response to GBV

The JPGBV drew from and significantly expanded the health sector work already very advanced in 2007. Launched in 2008 with support from the government of Norway, the JPGBV was the defining initiative for UNFPA’s contributions on addressing GBV. It served as a dynamic platform for UNFPA’s test of a multi-agency strategy, which leveraged the technical and political strengths of several UN entities. The approach fostered greater inter-sectoral cooperation, including the development of GBV taskforces and coordination units within the local government structures. Four UN agencies participated: UNFPA (leading agency), UNICEF, UN Women and FAO. International and national non-governmental organisations

(NGOs), community-based organisations and local governments were implementing partners (IPs).

Situated in the regions which were just emerging from an extended, highly destructive, and very violent period of conflict with substantial internal displacement of large populations, the lessons learned from the JPGBV continue to contribute to efforts to address GBV in the humanitarian setting of the refugee areas on Uganda's west and southern borders. In many ways, the sub-regions of Acholi, Lango, Teso and Karamoja covering 11 districts in total faced greater capacity-building and resource issues post conflict than the refugee camps emerging in the west of the country during this period. The multi-agency partnership, which launched the effort to respond to thousands of returning internally displaced persons (IDPs), found that the humanitarian agencies withdrew as they moved in, leaving such work to local government structures which had been severely impacted by the conflict. The experience in the post-conflict communities helped to deepen an understanding of the linkages between violent community conflict and interpersonal GBV, and between experiencing and perpetrating violence.

The overall goal of the programme as articulated in the final evaluation of Phase 2 was: *"To contribute to the creation of a gender-based violence free society in North and North Eastern Uganda, where women and girls are protected and empowered to assert their rights and are treated with dignity and respect"*. The specific objectives focused on reducing social tolerance for GBV, fostering an enabling legal and policy environment for accountability on both response and prevention (with particular focus on women and children), ensuring that those who report *"in the areas of health, justice, psychosocial support and police/security"* have greater access to high-quality (and child-friendly) services and strengthening partnership, learning, coordination and implementation of the programme.

Phase 1 from December 2008 to March 2011 established the basic architecture combining a multi-sectoral response with income generation and livelihoods programming. The focus of this early phase reflected the influence of the 2008 Goma Declaration, which also informed the development of Uganda first National Action Plan on VAW focusing on *"the protection of women and girls from GBV, particularly rape and other forms of sexual abuse"*. The goal of the programme was: *"Increased access to and availability of high quality and child friendly GBV response services for GBV survivors who self-report in the areas of health, justice, psychosocial support and police/protection."*

Phase 2 from April 2011 to June 2014 (including a six-month, no cost extension) was integrated with and funded in part by the Government of Uganda's recovery and development efforts in the Acholi region of Northern Uganda supported by the UN Peacebuilding Fund. The objective of PRDP II was *"a commitment by Government to stabilise and recover the North through a set of coherent programmes in one organising paradigm that all stakeholders will adopt when implementing their programmes in the region."*

The final bridging phase of the programme focused on consolidating the gains and structures set in place in prior phases, and thus supported limited new programming: it began in 2015 and ended in 2017.

UNFPA, working within the limited scope of its original mandate, focused largely on health services including psychosocial services. The latter inspired UNFPA’s prevention approach using counselling to support reflection on the relationships between power, control and GBV. The trauma counselling component of UNFPA was described in the final evaluation for the programme funded by the UN peacekeeping programmes, the only joint programme component which “*actually addressed conflict and peacebuilding*”. Many of the same principles within this early approach are reflected in the SASA! community-focused methodology adopted in Phase 2, which helps to guide reflection on how power is used and how imbalances in power contribute to GBV - all as a basis for adopting new behaviours and shifting normative patterns. SASA!’s ‘stages of change’ model derive from behavioural psychology, which

Figure 7: The SASA! approach: how it works



informs the “*long-term, systematic strategies aimed at social norm change*”. The other significant innovations in Phase 2 also reflected this focus on personal change and normative influence: work with men and boys, and the significant engagement of cultural and religious leadership. The evolution and scope of the JPGVB offer important learning opportunities for UNFPA’s global-level work on the development of the continuum approach in part because of this

grounding in the fundamental tensions in immediate post conflict and post-conflict settings.

UNFPA’s contributions to Phase 1 of the JPGVB focused on the agency’s comparative strengths in service provision, counselling linked to service provision, and work with women and youth. It engaged agencies with sectoral expertise outside UNFPA’s mandate whose programming added structural dimensions to the response (e.g. addressing access to justice, livelihoods, and poverty). The emphasis was on tailored capacity building in each of the sectors, with a dedicated focus on addressing the gaps in the security and judicial systems; advancing beyond referral pathways by setting in place coordination mechanisms at national and district levels; and development of tools to facilitate referrals and legal action. In 2013 alone, the national GBV Standard Operating Procedure (SOP) was produced, followed by the production of 13 additional SOPs adapted for district local government level.

Dedicated training was provided for police and the defense forces on health and social development within the context of GBV prevention and response to prepare for establishment of Child and Family Protection units within the police stations for which a trainer’s guide was produced. The guide focuses on GBV and violence against children, but also addresses how to manage children in conflict with the law, reflecting in part the challenge of meeting the needs of returned child combatants. One of the most significant contributions was the revision of the Police Form 3 (PF3), which was used for SGBV case management and gathering forensic evidence. The revision allowed a much broader range of health professionals - e.g. clinical officers and midwives - to complete it, thereby improving access to response services for survivors.

Figure 8: Gender-Based Violence Incident Report form

The Justice Law and Order Sector (JLOS) integrated content and commitments on SGBV into JLOS Strategic Investment Plan (SIP III), drafted JLOS’s gender policy and formed a gender working group. Following the finalization and dissemination of the regulations on FGM, a dedicated training in Moroto District included 38 personnel from the court, probation office, health centers and the local councils.

In 2016, UNFPA supported a pilot test of specialized courts to help resolve a significant backlog of GBV-related cases. UNFPA also supported tests of other strategies for solving the issue of the slow judicial response and process. The use of paralegals at community level was one strategy, although it did not ‘resolve’ the case. Traditional dispute and mediating mechanisms, often preferred by those for whom the formal justice system is difficult to access, were already actively involved in DV issues.

UNFPA supported the inclusion of work on GBV into the routine work of cultural institutions. The final report on Phase 2 of the JPGBV noted that cultural institutions remain highly respected in Uganda and are often the first point of contact for GBV cases. There were some reports that the police may actually refer to the alternative mechanisms. With support from UN Women, FIDA documented best practice

experience with using such mechanisms to achieve justice for survivors in Acholi and Karamoja. Although concern has been expressed about the risk that traditional mechanisms will not represent the interest of the survivor and are more likely to support maintaining 'social order', the JPGBV emphasized that *"having productive partnership based on good appreciation of standard legal framework, laws and systems improve the chances of delivering quality services for victims of GBV."* There is insufficient data on what percentage of cases are referred to traditional courts and how those cases are resolved.

The tools developed were key inputs for a critical element of any national response to GBV: a national level database to track cases and case management. This was launched in the final phase of the UNJPGBV and, accordingly given the structure of the partnerships, housed within the Ministry of Gender, Labour and Social Development (MGLSD), although with operational linkages to the larger e-government database planned. This tool should help to provide more recent broad-based data on patterns, perpetrators and response to GBV which is critical for programming.

The second key structural component of the JPGBV, intended to address prevention more than response, was a livelihood initiative supported by the FAO. The potential of a combination of income and a transformative approach had been demonstrated within the Intervention with Microfinance for Aids and Gender Equity (IMAGES) programme, a well-documented intervention closely linked with HIV prevention work in South Africa.

For the JPGBV however, the integration of these structural components with the psychosocial focus of the remaining work was difficult: the theory of change (ToC) regarding how some components contributed to the objectives of the programme or fostered synergies with other components was not well defined. The lesson in the need for an understanding of the change is instructive for UNFPA's engagement in multi- and inter-sectoral programming on GBV, as well as many of the programmes addressing young people which are often inter-sectoral.

Programme Intervention Area 4: The Joint Programme on Gender Equality - an intersectoral response to GBV

A 2011 WHO publication on Uganda's readiness for addressing GBV noted that there were a great many actors already involved in provision of some or all of the components of a multi-sectoral approach. The document highlighted key challenges to be resolved in advancing the multi-sectoral response (MSR): three of the most important were the lack of coordination and irregular distribution of the current services, which were not prioritized by government; the lack of regulation and monitoring and evaluation plans for interventions; and the weaknesses of the justice system(s) which *"ignore, deny and tactically condone violence against women and children and protect suspected perpetrators"*.

The lessons learned from the JPGBV work had already highlighted the challenge for UNFPA as a health-focused agency of fostering linkages among the key sectors of security, judiciary, and health while also strengthening and holding them accountable for their respective roles. The UN Joint Programme on Gender Equality (JPGE), launched in 10 districts in 2010 with support from DFID, included a larger group of agencies (UNFPA, UN Women, UNDP, UNCDF, FAO, ILO, OHCHR, WHO, UNICEF) each leveraging their own expertise in a conceptually coordinated approach to addressing gender inequality and expanding opportunities. The JPGE formally engaged expert agencies, which focused on their comparative

advantage, but also broader planning and resource mobilization for gender work. The programme included elements reinforcing the JPGBV (such as integrated services to address SGBV and civil society capacity to advocate and demand delivery on gender laws and policies) linked with outcomes on educational opportunities for girls, gender-responsive budgeting and planning, and interagency coordination. The structure of the programme was also intended to demonstrate efficiencies in management, coordination in programming, and greater accountability.

Within the UNJPGE, UNFPA was the lead agency for the outcome area of GBV to “*improve access to legal, health and psychosocial services to SGBV survivors.*” In a step beyond the coordinated sector actors model of the JPGBV, under the JPGE, UNFPA supported the establishment of five GBV shelters to provide health, legal and psychosocial services, including temporary safety to reduce stigma, protect survivors from further harm while they are accessing justice, medical treatment and undergoing healing process. Operational guidelines for the shelters were produced to help scale the effort.

A 2011 decision to link under one steering committee the JPGE, JPGBV, and the Joint Programme on FGM produced a JPGE with a special focus on both providing opportunities as well as ending violence and harmful practices. An early evaluation report indicated that several participating agencies were inspired by the experience as a step towards Delivering as One (DaO). In fact, over the course of the JPGBV, UNFPA tried various approaches to partnership, for example working in consortiums, Memorandums of Understanding (MoUs), joint financing and joint programming. As an agency able to bridge multiple sectors, UNFPA was well positioned for this role, and the reports and knowledge management products produced reflected this emphasis. In addition, sustained collaboration on UNFPA’s part may have helped mitigate some of the territorialism regarding gender issues which has challenged other country programmes.

Programme Intervention Area 5: Humanitarian response

UNFPA is the lead development partner addressing GBV as part of a humanitarian response in the refugee settlements on Uganda’s borders. The agency supported a basic response following the international guidelines, tools and commodities approach of the Inter-Agency Standing Committee (IASC), including Minimum Initial Service Package (MISP) training and dignity kits. As the refugees remained and settled, UNFPA supported implementing agencies to expand to multi-sectoral services, and added training and commodity for the clinical management of rape, which had not been set in place with the original response. GBV referral pathways were based on an adaptation of the SPHERE model, which informs most humanitarian health sector planning. Although health services within the settlements could provide direct services and the security personnel coordinate with camp management, the legal services required transport to courts 70 kilometers away. However, they served as important reminders that, even as refugees, accountability to Ugandan law applied.

The relatively constant and stable settlements enabled a further expansion of the emphasis on prevention. Many of the same approaches and methods for addressing GBV in the post-conflict areas of the north were then adapted in the Congolese settlement areas, including establishment of a GBV coordinating taskforce involving settlement managers, development partner representatives, service providers, and community volunteers. The latter also helped to monitor for GBV incidents in the settlements and bring it to the coordination team (e.g. in one settlement, a reported gang rape prompted the coordination mechanisms

to ask for additional lighting and patrols). These actors also encouraged community dialogues. Male action groups (MAGs) were established and from within male role models were recruited.

With the addition of the South Sudanese refugees in the northwest, there was need for improved coordination within UNFPA: UNFPA's contributions during the peak influx of Sudanese refugees in early 2017 were challenged by the scale of the problem, lack of clarity regarding the operational modality (cluster/non-cluster), new conditions for bringing commodities into Uganda, and negotiating the shift to an approach which prioritizes a coordinated response to both the refugee and host populations. The Country Office (CO) invested in the capacity building and organizational structures of its own staff to manage the demand. This included a workshop with all staff to increase awareness on humanitarian programming, development of a Minimum Preparedness Plan for the office, support for the training of 26 district health team members and NGO staff from five districts on MISp, and one representative each from UNFPA and ACORD to participate with the RH Coordinators on the Norwegian Refugee Council Surge Capacity Initiative. UNFPA supported NGO implementing partners to hire 12 midwives and 14 GBV project officers, while seven district local governments received emergency reproductive health (ERH) kits via the MOH.

UNFPA supported the MGLSD to ensure that GBV was reflected in the National Contingency Plan for Disaster Preparedness and to 'engender' the Strategic Plan on Disaster of the Office of the Prime Minister.

The GBV prevention activities were deepened in the northwestern settlements, including coordination mechanisms, work with men as well as work with youth and with the SASA! methodology to support reflection for change. District-specific action plans were developed and supported for the implementation of the SASA! Methodology, and assessments conducted to measure impact on awareness and attitudes. Fortunately, some of the same partners implementing SASA! in the north are also IPs on the humanitarian response in the northwest. SASA! has been used by some of the IPs in the northwestern settlements.

The evaluation heard some concern that the SASA! methodology has been insufficiently adapted for the context of the settlements. One of the concerns is the pace of the process in communities which change so rapidly, including through the additional burden of recently arrived refugees. The evaluation also understood that UNHCR is considering asking all agencies working on the humanitarian response to adopt the approach.

The integration into the humanitarian response of elements tested in the post-conflict regions of the north is consistent with new approaches to addressing refugee situations being pursued by Uganda nationally. Uganda is also a test case for implementation of The Comprehensive Refugee Response Framework (CRRF), which emerged from the New York Declaration on Refugees and Migrants (2016) and focuses on providing refugees protection and social and economic development in their host country and on return to their country of origin. In Uganda, this is embodied in the Settlement Transformation Agenda within NDP II and reflected in the Refugee and Host Population Empowerment Strategic Framework (ReHoPE).

ReHoPE operationalizes Uganda's 2006 Refugee Act and 2010 Refugee Regulations, which direct that refugees be integrated within host communities and have access to basic and social services on a par with Ugandan nationals. The ReHoPE Strategy and approach is led by the Government and the UN in partnership with the World Bank, donors, humanitarian and development partners, civil society, the private sector and others. The Strategy states that *"ReHoPE will ensure that the humanitarian mandate is protected but that it is seen through a development lens in order to enhance both sets of responses without*

undermining either.” It describes a rights-based approach that prioritizes equity, human rights, gender responsiveness, and women’s empowerment, including a gender analysis to measure the services that matter most to women such as accessibility to health care, ambulances, safe delivery practices and SRH rights. It remains to be seen how the multi-sectoral response to GBV and the components of the Joint Programme could be adapted for this larger scale effort while balancing the need for immediate response in an emergency.

Programme Intervention Area 6: FGM, child and early marriage and work with youth

Although FGM is practiced by a relatively small percentage of the Ugandan population (1.4%), significant attention and financial resources have been devoted to the issue. The programme follows relatively closely the Tostan approach in which community reflection on the harmful effects of the practice of FGM leads to consensus and declaration of intent to abandon the practice.

Major progress on this issue was made following Uganda’s joining the UNFPA-UNICEF Joint Programme ‘Female Genital Mutilation/Cutting (FGM/C): Accelerating Change’ (Joint Programme FGM) in 2009. Parliament moved to outlaw the practice in 2009, followed by The Prohibition of Female Genital Mutilation Act in 2010 and its regulations in 2011. The programme can report significant progress on communities, which have declared abandonment as well as prosecutions of female genital cutters.

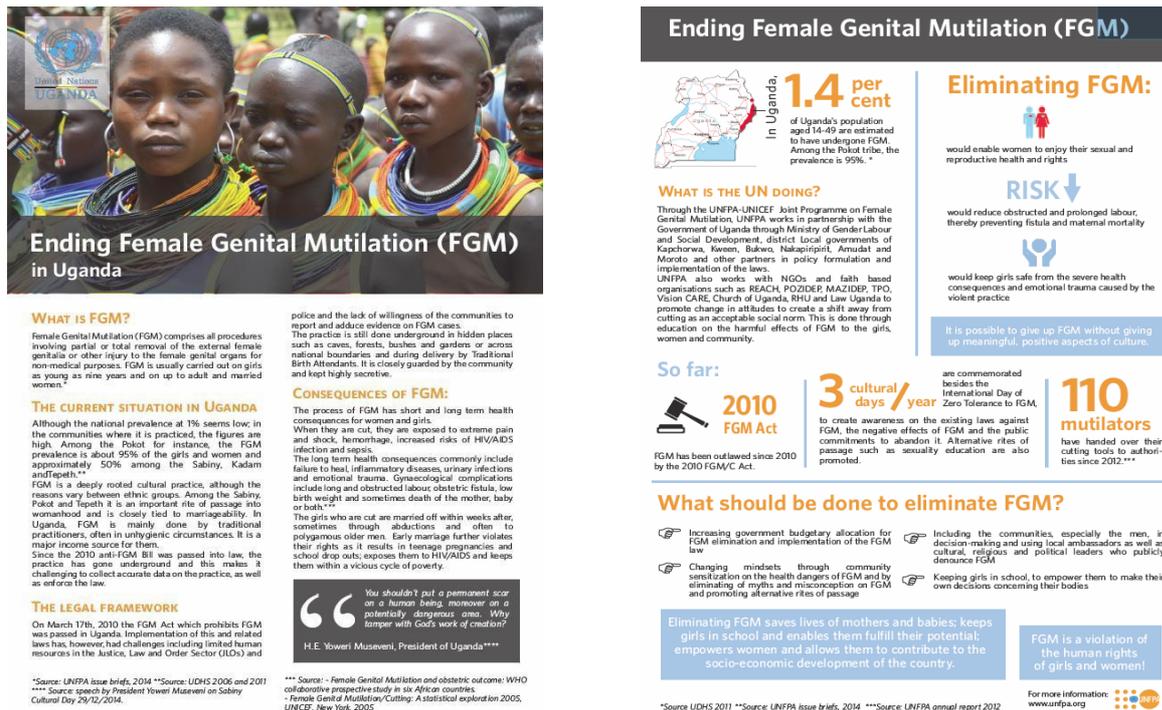
FGM is now well integrated with the broader agenda on GBV and offers potential for strengthening the focus on social norm change to address GBV and FGM.

Concerned that as a response to the outlawing of the practice, FGM had “*gone underground across the border into Kenya*” Uganda, with UNFPA support, has been preparing research to inform an East African agreement addressing issues of cross border jurisdictions and tracking cases of FGM. As with GBV, the concern is that failure to successfully apply the law and prosecute sends the message that there is impunity for those who practice.

Addressing the cross-border influence of Kenyan groups is a focus of national actors, including the Church of Uganda which has leveraged its cross-border hierarchy and structures to facilitate dialogue and even agreements among district leaders on both sides. The jurisdictional issues combined with the sheer logistics of following up on cases in which perpetrators can “*see you hiking up the mountain six hours in advance*” and have support on both sides, continue to frustrate JLOS’s efforts to enforce the law and policies as both a GBV and harmful practices violation.

There is also concern that the practice is changing: for example, it is now performed on younger girls less likely to resist and is not accompanied by a public celebration. Recognizing that the size of the affected population is too small to be able to measure trends using population-based data, UNFPA in 2016 supported an in-depth study on FGM in the regions where this is practiced.

Figure 9: FGM Fact Sheet



Ending Female Genital Mutilation (FGM) in Uganda

WHAT IS FGM?
Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical purposes. FGM is usually carried out on girls as young as nine years and on up to adult and married women.*

THE CURRENT SITUATION IN UGANDA
Although the national prevalence at 1% seems low, in the communities where it is practiced, the figures are high. Among the Pokot for instance, the FGM prevalence is about 95% of the girls and women and approximately 50% among the Sabinu, Kadam and Tepeth.**

THE LEGAL FRAMEWORK
On March 17th, 2010 the FGM Act which prohibits FGM was passed in Uganda. Implementation of this and related laws has, however, had challenges including limited human resources in the Justice, Law and Order Sector (JLOS) and

police and the lack of willingness of the communities to report and advance evidence on FGM cases. The practice is still done underground in hidden places such as caves, forests, bushes and gardens or across national boundaries and during delivery by Traditional Birth Attendants. It is closely guarded by the community and kept highly secretive.

CONSEQUENCES OF FGM:
The process of FGM has short and long term health consequences for women and girls. When they are cut, they are exposed to extreme pain and shock, hemorrhage, increased risks of HIV/AIDS infection and sepsis. The long term health consequences commonly include failure to heal, inflammatory diseases, urinary infections and emotional trauma. Gynaecological complications include long and obstructed labour, obstetric fistula, low birth weight and sometimes death of the mother, baby or both***.

The girls who are cut are married off within weeks after, sometimes through abductions and often to polygamous older men. Early marriage further violates their rights as it results in teenage pregnancies and school drop outs, exposes them to HIV/AIDS and keeps them within a vicious cycle of poverty.

"You shouldn't put a permanent scar on a human being, moreover on a potentially dangerous one. Why tamper with God's work of creation?"
H.E. Yoweri Museveni, President of Uganda****

Ending Female Genital Mutilation (FGM)

Eliminating FGM:
would enable women to enjoy their sexual and reproductive health and rights

RISK
would reduce obstructed and prolonged labour, thereby preventing fistula and maternal mortality

would keep girls safe from the severe health consequences and emotional trauma caused by the violent practice

It is possible to give up FGM without giving up meaningful, positive aspects of culture.

So far:
2010 FGM Act
FGM has been outlawed since 2010 by the 2010 FGM/C Act.

3 cultural days/year
are commemorated besides the International Day of Zero Tolerance to FGM, to create awareness on the existing laws against FGM, the negative effects of FGM and the public commitments to abandon it. Alternative rites of passage such as sexuality education are also promoted.

110 mutilators
have handed over their cutting tools to authorities since 2012****

What should be done to eliminate FGM?

- Increasing government budgetary allocation for FGM elimination and implementation of the FGM law
- Changing mindsets through community sensitization on the health dangers of FGM and by eliminating of myths and misconceptions on FGM and promoting alternative rites of passage
- Including the communities, especially the men, in decision-making and using local ambassadors as well as cultural, religious and political leaders who publicly denounce FGM
- Keeping girls in school, to empower them to make their own decisions concerning their bodies

Eliminating FGM saves lives of mothers and babies; keeps girls in school and enables them fulfill their potential; empowers women and allows them to contribute to the socio-economic development of the country.

FGM is a violation of the human rights of girls and women!

For more information: www.unfpa.org

*Source: UNFPA issue briefs, 2014 **Source: UDHS 2006 and 2011 *** Source: speech by President Yoweri Museveni on Sabiny Cultural Day 29/12/2010. **** Source: - Female Genital Mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. - Female Genital Mutilation Cutting: A statistical exploration 2005, UNICEF, New York, 2005

*Source UDHS 2011 **Source: UNFPA issue briefs, 2014 ****Source: UNFPA annual report 2012

Child marriage is, as a practice, far more prevalent than FGM. Messaging on child marriage is infused in many priority programmes for UNFPA from sexuality education to maternal health interventions. The 2014 baseline survey on GBV recommended that more dedicated attention should be paid to this issue. In that same year, UNFPA supported the MOH to launch a campaign to end teen pregnancy⁹. That campaign provided an initial foundation for work on child marriage, given that the majority of teen pregnancies are reported to take place within marriage. The work has since been expanded, significantly linked with other initiatives addressing the needs of all girls - remaining in school, access to life skills including vocational training and income generation for children out of school, health services, safe spaces, and community awareness - all of it supported by multiple donors, including support from the Global Programme to Accelerate Action to End Child Marriage (Global Programme).

The National Strategy on Ending Child Marriage and Teenage Pregnancy (2014/2015–2019/2020) was launched in June 2015 and, within two years, 30 districts had begun implementation with an additional 51

⁹ UNFPA has supported multiple campaigns on ending teen pregnancy and empowering girls including End Teenage Pregnancy campaigns: 'First things First: Books Before Babies' and 'Let Girls Be Girls'. These efforts brought to the issue a wide variety of stakeholders: government ministries, departments, agencies, CSOs and development partners. These have adopted the campaigns and continue to support broader work on ending child marriage.

districts allocating funds to address the issue. The Better Life for Girls programme (a USD 6.5 million, two and half year programme supported by KOICA, Global Programme, and SIDA) was launched in 2016 with a focus on SRH outcomes and 'social economic' (sic) empowerment for adolescent girls, and will contribute towards ending child marriage.

It recently launched the 'Live Your Dream' campaign which focuses on girls' dreams, but also speaks to parents and communities about enabling those dreams.

The work on child marriage has fully embraced the livelihoods approach, which was only nascent in the early JPGBV. The BRAC programme on livelihoods and life skills education for girls was supported to integrate SRH rights into its empowerment and livelihoods for girls programmes in 19 districts (seven Karamoja districts and seven districts of Eastern Uganda; three districts in Acholi; Mubende and Kampala). The work of BRAC has significant international support and will be taken up by the World Bank for work in selected districts. The programme was just beginning to work with young boys as the evaluation was completed.

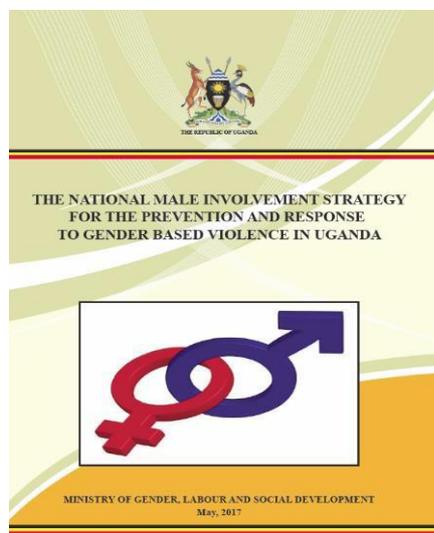
Programme Intervention Area 7: Fostering social norm change and working with men and boys for gender justice

The programme's focus on men and boys has evolved significantly over the course of learning from the Joint Programme on GBV. What began as an effort to leverage male-dominated events to sensitize them on the impact of violence, mobilize male champions, and engage men in community watch efforts to identify incidents of GBV, has evolved to include a focus on 'male role models' who both practice and preach. It also involves MAGs, which provide space for men to reflect on their own experiences of violence and their roles in addressing it, and broader community dialogues using SASA!, which provide a structure for reflection on GBV violence with women as well.

UNFPA supported outreach within key male events as well as to the key male-dominated security forces on GBV. In addition to the police who were an integral part of the multi-sectoral response, UNFPA also supported the MGLSD to work directly with the Uganda Peoples Defense Forces (UPDF), including the peacekeeping missions. The initial focus was the provisions of UN Security Council resolution 1325, 1820 and the Goma Declaration. The CO annual reports noted that work with the defense force improved their appreciation of their role in preventing GBV at family, community and in the course of duty. Building on that investment, UNFPA fostered male engagement programmes in the security forces and district local governments worked directly to mobilize and strengthen MAGs.

The work with men was identified as a good practice model in male involvement in GBV prevention and

Figure 10: Visual of the 2017 National Male Involvement Strategy for the Prevention and Response to Gender Based violence in Uganda of the MGLSD



response in conflict, post- conflict and humanitarian settings based on the methodologies employed. The work with men has been undertaken by several of the key UNFPA partners working in both post-conflict and humanitarian settings (International Refugee Committee, American Refugee Committee) as well as government service providers in the health and security sectors. The MAGs are a key component of the normative change elements of the programming addressing prevention of teen pregnancy and child marriage.

The media strategy on GBV is relatively recent and the programme has moved slowly and carefully to avoid any miscommunications or misunderstanding of messages, which is important in broadcast media which reach large audiences but provide limited opportunities for discussion. With radio, one key concern is placement, i.e. ensuring that messages on GBV are not followed by music or an announcement that seems to endorse GBV.

As noted previously, UNFPA has been very proactive in working with traditional authorities, cultural leaders, and faith-based organisations. In 2013, the Joint Programme developed an Action Plan to guide “*the integration of RH, GBV and HIV in the routine work of cultural institutions*”. This is largely based on their cultural and normative influence as well as their reach to areas of the country often not reached by others.

Programme Intervention Area 8: CEDAW and Universal Periodic Review

UNFPA’s broader inter-agency collaboration work through the human rights and protection working groups has been highlighted as promising practice informing the efforts of the regional office to strengthen all CO’s contributions to the UPR (Human Rights Council review process), which is a global oversight mechanism to ensure that countries are adhering to or implementing the international human rights conventions and agreements which they have signed or ratified. UNFPA-ESARO has been actively documenting implementation of SRHR-related recommendations in the region, identifying patterns of the recommendations and response as well as how to strengthen the process at country level.

Although Uganda was only recently reviewed through the UPR process, UNFPA has been very pro-active domestically, working with the Uganda Human Rights Commission in bringing together key stakeholders to assess Uganda’s response to the UPR recommendations related to SRH rights, and training human rights experts on integration of SRH rights issues into broader human rights monitoring tools. This collaboration was highlighted as best practice in fostering transparency of the UPR process. The CO was successful in using data and evidence on SRH rights issues to engage government in a more affirmative response on the relevant recommendations, including additions on adolescent health. Uganda’s work highlights in particular rights issues pertaining to GBV and harmful practices. At the global level during the 2016 UPR sessions, Uganda was recognized for its role in the 2013 rollout of UNFPA’s human rights-based approach to preventing maternal mortality and morbidity.

UNFPA supports the MGLSD and civil society to monitor implementation, track accountability and report on SRH and rights commitments in regional and international instruments, including by using the Gender Score Card. Uganda's GBV programming contributed substantially to the good scores on the Scorecard in the last two rounds.

Programme Intervention Area 9: Regional and global level advocacy

UNFPA Uganda has supported and continues to support several regional initiatives, including garnering a mention in the Goma Declaration for the agency's technical support on the issue of sexual violence in conflict. During the period under review, this included support for research to inform the drafting of a Regional Protocol for East Africa to address the cross-border cooperation issues surrounding FGM, including implementation of national laws and adherence to the UN resolutions together with a *Handbook for Community Resource Volunteers* as a reference and accurate source on the law. UNFPA has supported ESARO's work on strengthening the response to the UPR recommendations on SRH and has contributed to the process more broadly, as noted above.

Although it occurred prior to the period of the evaluation, a strong foundation for Uganda's regional and global leadership on GBV issues was set during the period following the internal conflict in Northern Uganda. At that time, the country was elected as a non-permanent member of the UN Security Council for two years, unanimously endorsed by the African Union. During the month in which Uganda held the presidency of Security Council, it held a debate on post-conflict peace building at the ministerial level presided over by the Ugandan Minister of Foreign Affairs, which considered recommendations from the SG on strengthening the UN response in post-conflict situations. Consistent with the country's regional leadership on these issues, the government launched the African Union campaign to end child marriage concurrent with Uganda's own strategy.

2. Methods

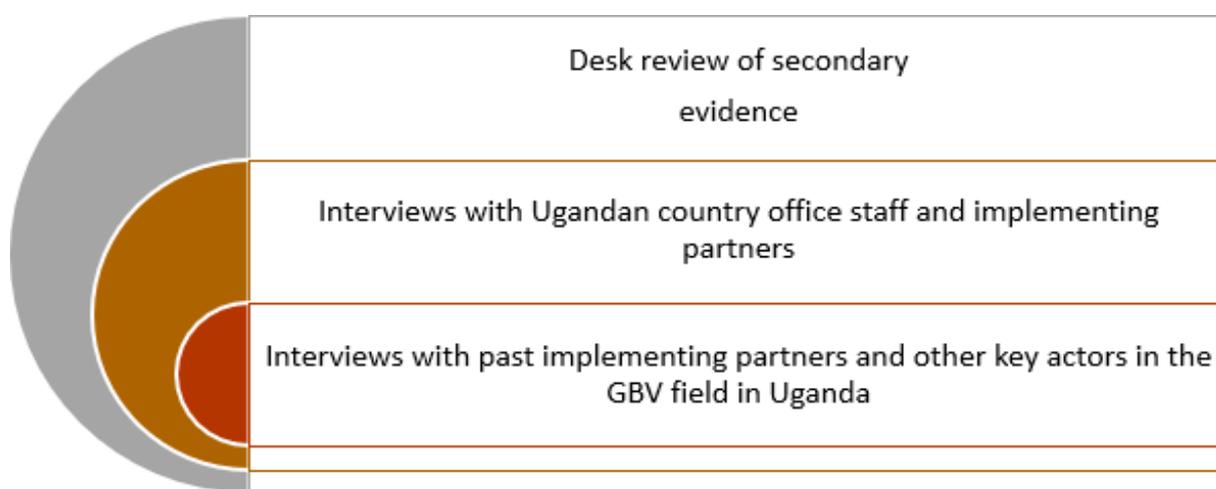
This case study is part of a global evaluation that is framed by the Collaborative Outcomes Reporting Technique (CORT)¹⁰ and complemented by a portfolio analysis. CORT is a participatory branch of contribution analysis. The stages of CORT include: 1) scoping (participatory theories of change mapping); 2) data trawling (desk review); 3) social enquiry; and 4) outcome (expert) panels and summit workshop to validate the performance story.

The Uganda case study is a contribution to the overall CORT evidence, and is validated by a reference group to support participatory analysis and interpretation of the performance story for UNFPA in a given context.

Overall, the case study consulted with 250 people: 98 of them in (individual) one-on-one meetings. Of those consulted, 58% were female.

Evidence from primary data was organized by key evaluation criteria and synthesized and combined with secondary data, using realist synthesis. Evidence on the achievement of outputs primarily came from secondary data; evidence on the mechanisms of change and strategic relevance of UNFPA interventions primarily came from primary data.

The case study was based on three lines of evidence:



¹⁰ Available at <http://betterevaluation.org/plan/approach/cort>.

3. Findings

EQ1 Stakeholder priorities and human rights based approach

To what extent is UNFPA’s work on preventing, responding to and eradicating GBV and HPs – including UNFPA’s internal policies and operational methodologies – aligned with international human rights norms and standards, implemented with a human rights-based approach, and addressing the priorities of stakeholders?

<p>Finding 1: UNFPA programming reflects global, regional and national normative frameworks on GE and human rights as well as agreements and guidelines on HRBA and on humanitarian response. Interventions are aligned with the current national development plan as well as sector-specific plans of those government entities contributing to a comprehensive approach to response and prevention. UNFPA’s direct contributions to normative and operational guidance on gender, violence, and humanitarian response at the regional and global levels provides a unique opportunity to leverage Uganda’s experience with both the work of the OHCHR and the recent consensus on the need for a more comprehensive and sustained approach to refugee response.</p>	
<p>Evaluation assumption</p>	<p>Alignment of UNFPA interventions at global, regional and country levels with international, regional and national policy frameworks, including strategic plan outcomes.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • All programming is explicitly framed with reference to relevant global and regional agreements and conventions and also to national level laws, policies and guidelines. These agreements and laws are reflected in many district-level ordinances as well. • Uganda is a state party to eight of the nine core international human rights instruments and many of the associated optional protocols, as well as most of the key regional instruments relating to women and children’s rights and health. Uganda has been reviewed twice under the UPR (2011 and 2016): between the two reviews important progress was made on services within GBV; enforcement of the law on FGM and passage of the sexual offenses law; and launch of national strategy on child marriage. • Uganda was one of four countries in the region to lead on implementation of a human rights-based approach to maternal health, which informed broader SRH issues as well. Even the recently concluded Health Sector Strategic Plan III (2010/2011—2014/15) recognized that health is a human right and acknowledged the guidance of international agreements. • Uganda has been at the forefront of a new global agenda to change the way in which countries manage displaced populations and refugees, including how services are provided and the needs of the host population met. The outcomes of this new approach have significant resource implications. • UNFPA Uganda undertook complete alignment to the (new) Strategic Plan (2014—2017). • UNFPA followed the lead of the UN Country Team (UNCT), and delayed the start of Phase 2 to align it with the new UNDAF.

The coherence of frameworks at national level reflects joint planning, a history of collaborative work on the issue, UNFPA’s strong relationship of mutual respect with the MGLSD, and Uganda’s own longstanding commitments to GE and a HRBA. Uganda was one of four countries in the region to commit to undertaking a human rights assessment of state accountability for improving Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), following a 2013 workshop on rights-based approaches and in keeping

with a commission by the UN Office for Human Rights, PMNCH, and WHO. UNFPA has been very respectful in exploring the dimensions of GBV which address sexual diversity - a key element of the global normative discourse particularly from the human rights perspective, but a source of much recent political controversy within Uganda.

All UNFPA programming is explicitly framed with reference to all relevant global and regional agreements and conventions as well as national level laws, policies and guidelines. The JPGBV Phase 2 evaluation affirmed that the programme was not only aligned with the national development plan but with district-level plans, which Phase 1 had helped to shape. UNFPA Uganda undertook complete alignment to the global Strategic Plan (2014—2017), following a clear roadmap that covered 2014—2015 annual work plans (AWPs) and the Bridging Programme of the JPGBV.

The new UNDAF was significantly updated to reflect gender issues, and is aligned with the 2nd National Development Plan. The decision to delay the start of the 8th country programme to be able to align with the UNDAF helped ensure that UNFPA's investments are also in sync with national-level planning and priorities. The synergies between the national plan and the country programme are a critical factor in the JPGBV's concerted efforts to develop sub-national infrastructure, capacity, and political and financial support for transferring over the work to district-level development committees.

Uganda has been at the forefront of a new global agenda to change the way in which countries manage displaced populations and refugees, including how services are provided and the needs of the host population met – specifically on the UN Framework for post-conflict programming, the UN Peace Recovery Action Plan (UNPRAP). The CRRF, which emerged from the New York Declaration on Refugees and Migrants (19 September 2016), focuses on providing refugees protection and social and economic development in their host country, and on return to their country of origin. Uganda has embraced this approach: The Steering Group of CRRF is led by the government, facilitated by UNHCR and focuses on five phases/levels of response, and the key policies and mechanisms needed for implementation.

UNFPA is most involved in the second phase of the response framework focused on 'Emergency Response and Ongoing Needs'. However, support for community-based normative and behaviour change contribute to the third and fourth phases of the response framework, i.e. 'Resilience and Self Reliance' and 'Expanded solutions'.

Uganda's 30/70 policy, which balances refugee response with investment in host communities, reflects these new global principles, leverages the dividend of Uganda's progressive policies, and contributes to avoiding conflict between the host and refugee communities which would risk entangling Uganda in neighbouring conflicts.

Finding 2: Integration of GBV-related prevalence and social norm-related questions in the tools of population-based data sources has helped inform targeting and design of GBV response and prevention efforts. The scope and depth of the situation analyses, which have informed UNFPA's GBV and HP programming, vary by context reflecting quality of data (e.g. in the north) and access to data (e.g. in the northwest) and gaps in data have limited the ability to measure and attribute outcomes and contributed to shortcomings in programming. Programming on harmful practices has been informed by small scale in-depth studies. UNFPA also helped to establish the foundation for more complete analyses through development of tools, protocols, reporting systems and the capacity to use them, all of which support a unified National Database on GBV.

Evaluation assumption	UNFPA interventions based on comprehensive situation analyses of affected populations in development and humanitarian contexts.
Case study evidence	<ul style="list-style-type: none"> • UNFPA has played a central role in strengthening the GBV focus within the UDHS. • The original design of the JPGBV was based on a limited assessment of need and capacity and lacked rigorous baseline data. • A rigorous baseline was not conducted until 2014 which showed significantly high levels of GBV, and the attitudes and overall sense of impunity which sustained it. • The necessary data for assessment in humanitarian settings varied based on the phase of the emergency and the management of data sources. • An in-depth study on FGM-affected communities was completed to inform programme design based on an understanding of highly localized drivers and changes in practice. • With support from the Global Programme, Uganda undertook an Adolescent Health Risk Behaviours' Study (lead by a group of sister agencies, including UNFPA, UNICEF, UN Women, UNAIDS and WHO in partnership with Makerere University School of Public Health) to understand factors associated with child marriage and complement an additional formative study on what drives child marriage. • UNFPA supported development of the National GBV Database. The evaluation found some confusion regarding how the data from this source could be used to inform response and programming, and insufficient understanding of the limitations of administrative data. • Uganda was a key test case in early efforts to develop a methodology for estimating the costs of GBV in contexts with poor data systems. • There is insufficient data and analysis to inform programming in two important areas of GBV response: 1) the management of cases in the 'parallel' system supported by cultural and religious institutions and 2) the seasonality of GBV (patterns associated with the weather, climate, agriculture, and economic cycles).

There are an inherent design challenges in conducting a situational assessment for a multi-sectoral and multi-intervention initiative such as those which have been featured in UNFPA Uganda's response to GBV and HPs. Particularly without a clear ToC, it is difficult to disaggregate the synergistic effects of programme design. The more recent efforts to link conceptually work to address harmful practices (e.g. child marriage, teen pregnancy, FGM and GBV) and holistic programmes enabling a more complete response to, for example, child marriage¹¹, provide opportunities to develop a more complete ToC.

UNFPA has played a central role in strengthening the GBV focus within the UDHS, which is the source for a composite index of need for targeting interventions at district level. A limitation of the UDHS is its inability to link its findings to interventions in time or space and changes in the definitions or interpretations of key variables over time (e.g. categories of GBV). National-level advocacy and awareness raising by diverse constituencies can also influence reporting. UNFPA also supported the integration of GBV material in a national HIV prevalence survey which informed programming of the Global Fund.

¹¹ The synopsis of country-level initiatives for work on child marriage notes of previous work: *"Most programme interventions have had limited coverage; focused on single issues such as education, reproductive health, economic empowerment, and leadership skills among others thus limiting their effectiveness in holistically addressing underlying gender related issues of child marriage in the country"* (UNFPA, background to the Global Programme, n.d. page 1)

The original design of the JPGBV was based on a limited assessment of need and capacity, but lacked a rigorous baseline and mapping of resources and potential partners. Several factors contributed to this: 1) the complexity of the programme which addressed multiple drivers, but without a clear articulation of the assumptions informing design; 2) an overall lack of data on GBV as evidenced by the reliance on police reports to inform a key MOH and WHO assessment in 2010–2012 and the Northern Uganda Conflict Analysis of ACCS in 2013); 3) weakened district level structures.

A rigorous baseline was not conducted until 2014 which showed significantly high levels of GBV, and the attitudes and overall sense of impunity which sustained it. Insufficient mapping of capacity limited effective coordination and equal access to the core components of a multi-sectoral response.

At the operational level, the JPGBV was a source of learning. Assumptions about the distribution and contributions of IPs needed to be very detailed. The multi-sectoral approach needed to be differently structured in every district and each partner had their own localized expertise and relationships. One component of the sectoral response might have been offered in one area while it was not in a neighbouring area, resulting in significant gaps in some places and major overlap in others. This made referral pathways a challenge and belied a multi-sectoral approach through joint programming in some areas.

The necessary data for assessment in humanitarian settings varied based on the phase of the emergency and the management of data sources. The situation in the southwestern camps made it possible to collect more reliable demographic and needs data to inform programming: the unanticipated scale of the emergency in the northwest contributed to a lack of data (e.g. on pregnancy) to inform even the basic MISP interventions. Concern was also expressed about the difficulty of accessing that data and the inability to link data on host and refugee communities which was essential for implementation of the 30/70 policy.

Although an emergency may provide much more information on IPs, sector-specific planning can be difficult. In the case of the recently arrived South Sudanese refugees, the cluster system was not in operation, and data managed by UNHCR and the Office of the Prime Minister was difficult to access. Concern was expressed that, although UNFPA was tasked with distributing dignity kits, the agency was unable to get information on pregnant women to assure timely intervention. Among the Congolese refugees in the southwest who feared returning home, UNFPA was able to provide services based on location, sex and age.

UNFPA supported development of the tools and broad outlines for the National GBV Database, which is being funded by a different development partner although still situated within the MGLSD. The evaluation found some confusion regarding how the data from this source could be used to inform response and programming, and insufficient understanding of the limitations of administrative data derived from programmes with limited scope. As the data cannot be used to measure prevalence, the most important contribution of this source would be case management data, which could provide insight into programmatically relevant proximate determinants and aggravating factors, characteristics of perpetrators, and patterns in case disposal and resolution.

There is much hope that the national database can allow for not only more frequent, but deeper and even comparative analyses of patterns of GBV and response across the spectrum of settings in Uganda. The database is now active in 98 districts. It draws its data from the PF3 (see p. 19) and other forms, and thus

capacity building is critical for assuring the quality of the data, including clear and consistent definitions and criteria to distinguish types of violence and multiple injuries and repeat visits.

Uganda was also a key test case in early efforts to develop a methodology for estimating the costs of GBV in contexts with poor data systems and in which the response to violence includes the utilization of 'standard' structures (e.g. health services) as well as 'traditional structures (e.g. local councils). This will be a key resource for programme planning in emergency contexts and could be a powerful advocacy tool.

There is insufficient data and analysis to inform programming in two important areas of GBV response: 1) the management of cases in the 'parallel' system supported by cultural and religious institutions and 2) the seasonality of GBV (patterns associated with the weather, climate, agriculture, economic cycles, etc.). Several case studies of GBV in Uganda noted higher rates of reported sexual violence during the harvest season and of violence against children at the start of the agricultural year.

Although 'affected populations' is typically understood to mean beneficiaries at community level and survivors of violence, the experience of the JPGBV illustrates the importance of understanding the constraints of/maintaining relationships with IPs who are critical to an effective programme. The most obvious example was the judiciary, which remains a major bottleneck. However, even those actors from the sector who helped UNFPA to successfully support Special Court session to clear a backlog of cases made clear that *"...if UNFPA wants to work with the judiciary, it needs to learn about and understand the judiciary"*. This related to not only the need to protect witnesses, but also judicial staff and to appreciate that confidentiality process is different in a service context.

Another example is UNFPA's longstanding area of strength, i.e. the health sector. Health practitioners who were, through using PF3, able to perform a forensic exam, did not want to have to follow through for court appearances: the cost, time demands of repeated appearances and last-minute postponements, risk of backlash if their testimony failed to win the case, and facing the relentless cross examination of the defense, all combined to discourage their participation. Of note, MOH employees were central to the work, but not included in many of the planning discussions. Indeed, the MOH was a more nominal presence on the GBV working group and also produced their own male involvement strategy four years before the MGLSD.

Although population-based data sources illuminated changes in the practice of FGM in the affected districts, an in-depth study on the affected communities was completed to inform programme design based on an understanding of highly localized drivers and changes in practice. In part because FGM affects a relatively small and highly concentrated population, changes in practice are difficult to detect based on population-based data or administrative data. A measure of change was needed five years after the implementation of the laws and regulations prohibiting FGM in 2010 *"to assure appropriate geographical focusing of the measures with due attention to the differences within each district and ethnic group"*. Such micro-level studies are less resource intensive and could help to compensate for the lack of baseline measures of GBV as a means to tailoring programming.

In fact, programming related to child marriage was informed by formative research, including quantitative measurements of adolescents use of services and risk behaviors. The Better Life for Girls programme has a baseline in place along with routine data quality audits to identify issues with collection and processing of data. Although the baseline was undertaken by Makerere University School of Public Health rather than

UBOS as originally planned, these investments in data collection may benefit the broader health sector as well.

<p>Finding 3: UNFPA has been proactive in supporting gender transformative approaches on GBV, including a livelihoods intervention in the inter-sectoral approach of the JPGBV. The assumptions regarding how such interventions prevent or reduce GBV is not always clearly articulated in programme documentation. The structure of a ToC would, at a minimum, facilitate monitoring for unintended consequences of interventions. As examples, UNFPA has advanced the work on GBV through engaging more conservative groups whose constituencies are more clearly supportive of ending violence than of promoting GE; and as the ‘protection’ approach used to address violence against children is not supportive of women’s agency, UNFPA and UNICEF have had to balance messaging and remain aware of the limitations of the medium.</p>	
<p>Evaluation assumption</p>	<p>UNFPA interventions are based on gender analysis and address underlying causes of GBV and harmful practices through non-discrimination, participation, and accountability.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • The JPGBV expanded from a multi-sectoral response to an inter-sectoral response in large part to accommodate structural level interventions impacting women’s status. • Uganda was one of four countries in the region to lead on implementation of a human rights-based approach to maternal health, however, the linkages at levels below policy, planning and national dialogue are not as clear. The SASA! methodology adopted in Phase 2 and now being introduced in multiple initiatives on GBV and conflict reflects a human rights-based empowerment approach and self-reflection for sustainable behaviour change. The linkages and synergies between the use of SASA! and the work with men are not systematically documented. • The use of the term ‘gender’ in the context of both popular discourse and programme documents on GBV in Uganda acknowledges that experiences of men and boys are a contributing factor to male involvement in perpetrating violence. The focus on men’s experience is reflected in the thoughtful work at community level regarding destructive gender-ascribed behaviors for men, which encourage violence, aggression, and substance abuse.

The JPGBV expanded from a multi-sectoral response to an inter-sectoral response in large part to accommodate structural level interventions impacting women’s status. The assumptions regarding the FAO livelihoods component of the Joint Programme and its expected contribution or synergies with other components were not consistently articulated over the various phases of the programme, and not sufficiently documented in the evaluations. The FAO component was variously justified as: 1) a way to provide women with independent livelihoods, which were assumed to give them greater power in the household; 2) a means for women to make substantial and influential contributions to the household budget therefore making peace within the household (indeed, one evaluation tool measured how many women covered 100% of their household expenditures, though not necessarily an indication of power); 3) a way for the woman to meet basic family needs and thereby keep peace in the family, and 4) when the programme reached out to men, a way to lessen men’s frustration with the investment made in their wives which they could not access.

Important unintended consequences, which needed to be addressed, were: whether the intervention increased workload for women who had to maintain their income and household fields; a reallocation of household resources away from the woman whose partner assumed she could rely on the project; an

increase in demands of other relatives on a household with additional resources which would only aggravate GBV. Although a flexible ToC is critical in addressing complex social issues, shifts in emphasis need to be systematically documented and their impact anticipated. The pathways through which such interventions affect GBV need to be clearly articulated, as control over new resources can also trigger efforts to control and thus violence.

Uganda was at the forefront of countries in the region to test a HRBA to addressing maternal mortality and morbidity, including undertaking an audit of all relevant laws, policies and practice with a human rights perspective. GBV and harmful practices feature in work on maternal mortality and morbidity. However, the degree to which a HRBA is adopted in work on GBV is not clear.

The SASA! methodology adopted in Phase 2 and now being introduced in multiple initiatives on GBV and conflict reflects a human rights-based empowerment approach and self-reflection for sustainable behaviour change. There is an implicit assumption that the SASA! methodology is gender sensitive, although the actual process of implementation may vary based on the constraints of context. This is likely to be very different in refugee settings compared to post-conflict settlements. Several research efforts have highlighted the degree to which shifts in gender power during the time in the refugee camps - where men had little to do and women had the best options for earning income - contributed to violence when couples were no longer in the settlement.

The linkages and synergies between the use of SASA! and the work with men are not systematically documented. Strengthening the gender transformative potential of the work with men and the scale potential of SASA are interlinked. The National Policy on Men's Engagement notes that Uganda addressed the issue of men's experience of violence as early as the 2000 review of the Beijing Platform for Action. The 2005 study of the costs of GBV (funded by UNFPA) was reinforced with additional funding provided to the Economic Research Council to include men in the sample resulting in more insights, but a less powerful sample size for women. The JPGBV was developed in a context already very attuned to men's concerns.

The evaluation understood that 'gender' in the context of both popular discourse and programme documents on GBV in Uganda helps to balance the disproportionate focus on women and girls, and emphasizes men's and boys' experiences of violence as well. The experiences of men and boys are critically important in their own right and as a contributing factor to male involvement in perpetrating violence. The focus on men's experience is reflected in the thoughtful work at community level regarding destructive gender-ascribed behaviors for men, which encourage violence, aggression, and even substance abuse. It is also reflected in the less nuanced language within national policy documents and media messaging, for example reporting of DV by men "*when they can no longer put up with it*", or messaging for women which advise "*not refusing sex*" for your husband as "*it leads to violence*". These discontinuities are to be expected with complex social change processes and require diligent monitoring and sustained working relationships if the overall goal is to be kept in mind.

UNFPA succeeded in sustaining partnerships with cultural leaders and religious institutions, which may have objected to violence, but did not necessarily share UNFPA's position on GE and women's voices. Negotiating the support of such actors without compromising on key gender principles required open communication and consistent reviews. This may have been even more challenging with the JPGBV's deepening focus on violence against children (based on UNICEF's contributions) for which a 'protection'

approach is expected. The evaluation heard concern that, much like the traditional mediation structures at community level, the churches emphasized maintaining the family unit over addressing the needs of the survivor. As assumed authorities on marriage, churches would likely be a first recourse.

Work on harmful practices has been informed by a rigorous gender analysis and understanding of the underlying drivers of FGM and child marriage, linking these with teen pregnancy. The synopsis for the Better Life for Girls programme notes of previous work: *“most programme interventions have had limited coverage; focused on single issues such as education, reproductive health, economic empowerment, and leadership skills among others thus limiting their effectiveness in holistically addressing underlying gender related issues of child marriage in the country.”*¹² The programme itself integrates three major funding streams to address schooling, health services, sexuality education, life skills, participation, community norms, and vocational training.

EQ2 Most relevant interventions

To what extent is UNFPA programming on GBV/HPs systematically using the best available evidence to design the most effective combination of interventions to address the greatest need and leverage the greatest change?

Finding 4: UNFPA’s interventions leverage both the agency’s technical strengths in SRH and in linking practice, services and normative change and its strategic skills in supporting initiatives connecting sectors, different levels of government implementation and diverse partnerships. UNFPA’s longstanding technical expertise on women’s health and rights within the UNCT which was the justification for their leadership of the national GBV programme, is now shared with UN Women, however, the ability to bridge policy and health practice and to engage with non-traditional allies on gender issues, including men and traditional and religious communities, remains a valuable contribution.

Evaluation assumption	UNFPA interventions are aligned with its comparative strengths across settings informed by a robust mapping of other in-country stakeholders and support, including at sub-national level or in areas/populations at risk.
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¹² UNFPA, background to the Global Programme, n.d. page 1

Case study evidence	<ul style="list-style-type: none"> • UNFPA serves as an important 'connector' fostering technical and operational level linkages between the MGLSD and other line ministries. • The lack of synergy between the JPGBV and the JPGE (raised in the evaluation of the JPGE), may have reflected issues with overlap of portfolios and contributions. This was less of an issue in the political space where the combined advocacy power helped to leverage the longstanding relationships of UNFPA and the MGLSD and support substantial progress at national level. At the operational field level (the focus of UNFPA's contributions within the JPGBV), the JPGE partnership disappeared with potential implications for the sustainability of GBV work fostered by the JPGE. • The focus on sexual violence, which is a strength of UNFPA's response, may have limited work on other forms of GBV. • Both the 8th CPD and the National Policy make clear that accountability is a focus of the new phase of work on GBV. The experience under the 7th country programme suggests that work with the judicial sector is not UNFPA's comparative strength. There are other mechanisms which foster accountability within the community that fit well with UNFPA strengths and the contributions of SASA!. • A strength of UNFPA that was not sufficiently leveraged early in JPGBV was the normative work on FGM. New programming on child marriage explicitly links services, education, income and normative change efforts, including an approach to normative work which reflects longstanding methods used in work on FGM.
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UNFPA's efforts at joint partnerships - through IP consortia and joint programming - have helped to both position GBV work within the broader agenda of GE and, possibly, facilitated a handover to UN Women of the work on access to justice addressing VAW, and on aspects of the issue of violence against children to UNICEF.

The jointness of the major effort on GBV in Uganda allowed agencies with a common focus on violence but a different constituency to work relatively harmoniously with less territoriality. In the context of development of a national policy and framework, various agencies were able to hold their issue while also addressing the concerns of others (e.g. sexual violence for UNFPA, DV for UN Women, and violence against children for UNICEF). At the level of general strategy, UNFPA is able to bridge the various agency perspectives and embrace social norm change, access to justice and services.

UNFPA serves as an important 'connector' fostering technical and operational level linkages between the MGLSD and other line ministries. An important test of these linkages will come with the National GBV Database, which is housed in the MGLSD. As the MGLSD does not have a services portfolio or comparative advantage on data, the database will be most valuable for planning if it is effectively linked to the rest of the e-government agenda on social protection, supporting an inter-sectoral response.

The lack of synergy between the JPGBV and the JPGE (raised in the evaluation of the JPGE) may have reflected issues with overlap of portfolios and contributions. This was less of an issue in the political space where the combined advocacy power helped to leverage the longstanding relationships of UNFPA and the MGLSD, and support substantial progress at national level. At the operational field level (the focus of UNFPA's contributions within the JPGBV) the JPGE partnership disappeared, with potential implications for the sustainability of GBV work fostered by the JPGE.

With the growth of UN Women and the significantly greater emphasis on children (as evidenced in the evolution of the national dialogue on GBV), UNFPA will need to choose its focus while maintaining the spirit of cooperation. The evaluation heard debate over how to leverage UNFPA's relative strengths to address GBV. There was concern that UNFPA's priority focus on GBV may have been distorting, i.e. that the Joint Programme on GE effectively "*became another GBV programme*". There was suggestion that UNFPA should refocus on its comparative strength of family planning and SRH. One respondent expressed concern that as "*...one million Ugandans are added every year and when the resource crisis comes, the refugee population will be blamed for it*". UNFPA was best positioned to address this pressure. There was some concern expressed that the focus on sexual violence, which is a strength of UNFPA's response, may have limited impact on other forms of GBV.

With the start of its 2014 Strategic Plan, UNFPA returned to its core technical strengths and constituencies, expanding the map of new actors and leveraging existing resources through integration of GBV issues in broader SRH interventions, including within school and youth programmes. Fistula, which had typically been linked with early childbearing and child marriage, was of interest to UNFPA based on possible associations with sexual violence.

Both the 8th CPD and the National Policy make clear that accountability is a focus of the new phase of work on GBV. The experience under the 7th country programme suggests that work with the judicial sector is not UNFPA's comparative strength (despite success in supporting the integration of work on SGBV into the JLOS sector strategic plan), it was not until late in the process that specific tasks were included in the work plan. However there are other mechanisms which foster accountability particularly at the level of service provision within the community, which fit well with UNFPA strengths and the contributions of SASA!.

Mapping comparative strengths should be iterative over the course of any intervention, particularly one fostering broad-based social change. UNFPA's early contributions to addressing GBV in Uganda leveraged the agency's comparative strengths in translating global standards into national normative frameworks and operational tools to actualize them. Testing of new strategies such as work with men, helplines and an award-winning phone application which allowed users to report an incidence of GBV to the right authorities in real time were part of UNFPA's implementation agenda. Balancing normative work and the resource-intensive services strengths of UNFPA may need to respond to shifts in available resources.

A key comparative strength of UNFPA, which may not have been sufficiently leveraged early in JPGBV, was the normative work on FGM. This would have introduced another perspective on the work at community level and could also have helped leverage global leaders who address both HPs and GBV. This is addressed in part within recent work on child marriage and teen pregnancy: The Better Life for Girls campaign includes objectives on 'community abandonment' of these practices (teen pregnancy is included) for which MAGs' role in conducting community-level dialogues, including on GBV, feature significantly. As with the MAGs of the JPGBV, and the work with SASA!, the conceptual linkages between men's contributions and the key outcomes need to be better developed.

As UNFPA redefines its role on GBV at the global level with the advent of UN Women and at the national level, its comparative strength on the normative frameworks, services, and immediate action universe of addressing the issue of GBV within communities fleeing conflict across other borders risks isolating its

contributions. This mirrors the challenge of balancing work on GBV and harmful practices at the global normative and programming level in a context in which humanitarian crisis is becoming ‘the new normal’. UNFPA’s significant history as a trusted and reliable ally on highly sensitive issues - even when faced with loss of funding from a global actor now battling the international community on restrictions of parents’ right to corporal punishment - and UNFPA’s leadership within the AOR GBV position the agency to help bridge these divides.

What can UNFPA do/what is UNFPA doing?	Who else can do this?	What is different about UNFPA?
Multi-sector response to GBV	UN Women	Experience with addressing GBV through services, policy and normative change, behaviour change, including engaging men and boys through services, working with the education sector, and in community-based interventions. Able to work with men and boys in gender transformative approach rather than protective or punitive only approach.
Inter-sectoral approaches, which address underlying drivers as well as leverage other entities, to provide complementary inputs and leverage data to inform programming.	UNDP, World Bank (IBRD)	Addressing SRH and services, which are at the heart of the current problem. Planning and programming explicitly informed by a human rights-based approach.
Service delivery expertise, including in humanitarian settings	UNHCR	Understanding of response and prevention of GBV in contexts along the humanitarian-development continuum and in refugee, IDPs, returning populations, and host communities. UNFPA’s experience of working in development contexts will contribute substantially to the GoU and UNCHR’s new ReHoPE initiative, which directs that <i>“the humanitarian mandate is protected but that it is seen through a development lens in order to enhance both sets of responses without undermining either”</i> , and includes a focus on women’s empowerment. UNFPA brings the added value of leveraging operational, normative, and global coordination roles for synergies at all levels.
Work in humanitarian and development contexts and across multiple ministries	UNICEF	Experience with addressing culturally sensitive issues related to sexuality and power, which are at the center of GBV; experience with youth and adult populations and particularly adolescent girls who are the majority of those impacted by GBV in most settings, reflecting their sexual potential and pressure to marry.

Because other country case studies have highlighted debates about restricting UNFPA to addressing sexual violence, leaving DV for UN Women, it bears some consideration. From a legal point of view, a distinction between criminal and civil law may be at issue. However, there is a risk in this bifurcation as the common fundamental drivers are best addressed together. In addition, the focus on sexual violence, which would reflect the beginnings of the Joint Programme, may result in a disproportionate emphasis on interpersonal violence. A disproportionate emphasis on sexual assault of the JBGBV was one of the

observations of the evaluation of Phase 2: *“this form of GBV is what seemed to have been emphasized by the programme because of the prevailing war situation and insecurity in the regions of intervention.”*

The early dedicated focus on GBV within Uganda addressed two major concerns, which are still balanced in the normative frameworks and prevention work, but necessarily addressed together in the services response for which UNFPA is best positioned. Work on sexual violence has been informed by Uganda’s regional and global leadership on sexual violence in conflict. Work on DV has been a dedicated focus of key leaders within the women’s movement. Aspects of the struggling Marriage and Divorce Act may speak to DV, as does the issue of marital rape, which is reported separately.

As in many contexts, in the Ugandan normative frameworks sexual violence and DV have their own laws and regulations. What would have been the most controversial elements of the Domestic Violence Act were incorporated in the Marriage and Divorce Bill, which was tabled and sent back for review. The Centre for Domestic Violence Prevention (CEDOVIP), as a lead NGO on GBV and particularly DV both within Uganda and globally through leadership’s involvement in the DFID ‘What Works’ initiative, launched a well-developed campaign in 2014 identifying and taking to task the duty bearers who have failed to operationalize and actualize the 2010 Domestic Violence Act, an effort which helped focus attention on the complex set of actors who must also be held accountable on broader issues of rights and gender.

The National Gender Based Violence Policy and Action Plan reflect the more integrated approach of the global discourse and call on the multiple duty bearers highlighted in the campaign on accountability for implementation of the Domestic Violence Act, while basing the overall effort within the MGLSD as the most inter-sectoral of all ministries. Although approved as a policy and already being implemented, the President signed it conditionally, protesting that it was too focused on global standards and norms and needed to address what had been accomplished by Uganda. He also asked for additional research to illuminate the drivers of GBV at the household level in particular, indication that the DV elements may have been a key concern.

<p>Finding 5: At each phase of the JPGBV, the key partners participated in a critical reflection on the progress to date, which informed the next phase, including lessons learned on partnership. The assumptions regarding social change and drivers of GBV - including in the rapidly evolving context of post-conflict Uganda – were given less critical review. The lack of a clear (but flexible) ToC with explicit assumptions was most evident in the discourse on male engagement, the lack of clear synergy at the design of the programme with the work on FGM and child marriage, and adolescents and youth, and an over-emphasis on aggravating factors such as the problem of abuse of alcohol.</p>	
<p>Evaluation assumption</p>	<p>UNFPA interventions based on coherent and robust theories of change, which can adapt to rapidly shifting situations and contexts.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • A retrospective review of the JPGBV suggests an implicit, instrumental ToC in which population-based data informs changes in laws, policies and regulations followed by operationalizing the laws through guidelines and technical tools to improve services. Access to the services is facilitated by removing the constraints on the demand side through income and agency. Law is a narrow pathway through which to pursue behaviour change, and the impact of the income interventions on agency were not well documented. • Work with social normative change came late to the JPGBV despite the example of FGM. However, this gave an advantage in being able to critically analyse diverse methods to find a

fit with Uganda’s unique dynamics. As noted, this is explored in the work of the Better Life for Girls programme, although it is also linked with the male contributions component and thus difficult to disaggregate.

- Work on GBV is significantly influenced by the past experience of internal conflict, neighbouring conflicts, and new and established refugee communities. Drivers of change may be hard to identify among populations displaced, without many structures, and with multiple stresses.

A retrospective review of the JPGBV suggests an implicit, instrumental ToC in which population-based data informs changes in laws, policies and regulations followed by operationalizing the laws through guidelines and technical tools to improve services. Access to the services is facilitated by removing the constraints on the demand side through income and agency. Law is a narrow pathway through which to pursue behaviour change, and the impact of the income interventions on agency were not well documented. Some of the most valuable learning shared from UNFPA’s experience with the JPGBV relates to implementation and partnership strategies (e.g. the need to map how multiple partners will work together to provide a common package of services), and the importance of clear agreements between joint partnering agencies regarding their respective roles and accountability.

A key finding is that *“after eight years of intensive investment in the Joint Programme”, there was “a need to graduate this work (to) move beyond the original theory of change”,* and to identify and address the underlying drivers of GBV. A similar message on underlying drivers was reflected in the government’s request for additional research on drivers at the household level. The shift to the SASA! methodology reflects a more proactive effort to address underlying drivers. As the introduction to the method itself notes: *“while factors such as alcohol use or poverty contribute to the perpetration of violence, the imbalance of power between women and men is a root cause of violence against women”*¹³. This suggests the need to look more closely at the process of change. There are important lessons on normative change emanating from the Joint Programme on FGM which are accessible to the Uganda office.

The narrative within programme documents does suggest that over the course of the Joint Programme, UNFPA developed a growing awareness of important differences in patterns and effective responses to GBV in the three contexts in which UNFPA was working, i.e. refugees, post-conflict returning IDPs, and low-level local conflict in Karamoja.

The final evaluation of the JPGBV included an analysis of changes in awareness, attitudes, experience and reporting of GBV comparing at baseline (done in 2014 to inform the bridging phase) and end point, and distinguishing the results for the post-conflict north and Karamoja. The results suggest that awareness and attitudes in Karamoja fell short of the programme target, a greater percentage of women interviewed in Karamoja reported that they had experienced GBV in the previous six months and there was a significant increase in over baseline in the percentage of respondents ever reporting a GBV case.

The mixed outcomes in Karamoja were attributed to *“supply side constraints particularly seasonality of crop food production”,* notably that Karamoja has only one crop a year and respondents were more likely to report having missed a meal. However, the differences in context between Karamoja and the north are not solely related to crop cycles and overall poverty, and the interactions of poverty with the underlying

¹³ *Raising Voices, SASA! Mobilizing Communities to Inspire Social Change, 2015.*

drivers of GBV need to be considered - all the more so because livelihoods were part of the Joint Programme in Phase 2.

The example set by UNFPA’s more in-depth assessment of the differences in the patterns related to FGM in the different communities within which it is practiced in Uganda illustrates this point. It suggests that current tools and methodologies for GBV could, at a minimum, differentiate between contexts across the humanitarian-development spectrum.

EQ3 UNFPA leadership and structures

To what extent did UNFPA’s international leadership, coordination, and systems enable sufficient resources to be made available in a timely manner to achieve planned results?

<p>Finding 6: UNFPA was successful in mobilizing political support for new normative frameworks and policies and in-kind support from key stakeholders in implementation. The reasons for the failure to mobilize sufficient financial resources to sustain this investment are not yet fully understood: it could be a failure to engage the right stakeholders, implicit assumptions about roles and responsibilities of implementing partners and UN entities, or a lack of appreciation for the cost of sustaining dedicated services.</p>	
<p>Evaluation assumption</p>	<p>UNFPA support is sustained to GBV and specific harmful practices across strategic plan periods at the global, regional and country levels.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • The Joint Programme was plagued with delays in funding of as much as six months on a repeat basis which impacted the quality and the viability of many elements of the work and did not support consistency of service delivery. • The programme was designed to maximize sustainability through building capacity and coordination mechanisms within existing government structures and CSO programmes. Unfortunately, planning did not take into account high personnel turnover, particularly in the regions observed by the evaluation team. • GBV coordination at the national and subnational levels was initially funded entirely with donor support (GoU provided in-kind resources, including office space). When the JPGBV ended, very few districts were able to replace the coordination funding with state resources. • Key components of the work on GBV and HP are being strategically integrated into core SRH programming for which funding is reliable. • Significant new resources are anticipated for others’ work on GBV, but concerted effort will be needed to ensure that these efforts reflect and learn from this experience.

Due in large part to the consortium structure and parallel partnerships at national and sub-national levels, lack of clarity about the role of the leading NGOs, the time pressures of the one year AWP of UNFPA, and delays in processing of work plans, the Joint Programme was plagued with delays in funding of as much as six months on a repeat basis, which impacted the quality and the viability of many elements of the work and did not support the consistency of service delivery so very critical in addressing survivors.

The programme was designed to maximize sustainability through building capacity and coordination mechanisms within existing government structures and CSO programmes. It mobilized in-kind resources from government and partners in the form of people, offices, local government staff, etc. Unfortunately, planning did not take into account high personnel turnover, particularly in the regions observed by the

evaluation team. The district-level health cadre in Uganda faces staff shortages, high turnover, poor preparation and practicum, low morale and few opportunities for advancement: this has undermined broader efforts to implement a rights-based approach to sexual reproductive, maternal, newborn and child health (SRMCNH). It should be noted that, despite limitations, the capacity-building efforts of UNFPA’s work on GBV programmes are some of the most concrete and operational examples of strengthening a rights-based approach.

Funding for GBV coordination at the national and subnational levels was budgeted in very few districts. A comparison of how well the programme has fared in districts providing different kinds of support could provide important lessons on sustainable strategies. A 2014 review of Uganda’s implementation of a rights-based approach for SRMNCH (one of four country reports commission by the UN Office of Human Rights) noted progress on programming and planning, but also need for HRBA to be “*better institutionalized in planning and budgeting processes.*” A subsequent progress report referenced nascent efforts to advocate for more resources.¹⁴

In keeping with the shift in the current strategic plan, key components of the work on GBV and HP are being strategically integrated into core SRH programming for which funding is reliable. Although GBV and HPs have always been a part of these broader agendas, the GBV work can now contribute substantively and potentially methodologically to these larger elements of UNFPA’s portfolio.

Significant new resources are anticipated for others’ work on GBV, but concerted effort will be needed to ensure that these efforts reflect and learn from this experience. Key lessons learned regarding joint programming within the UN may help inform the Spotlight Programme (funded by the EU), or the GREAT programme work in the north. The World Bank, although it has identified very specific and different points of intervention, may be able to both fund and address many of the technical issues of the national GBV database, but cannot solve gaps in the national infrastructure needed to provide quality and representative inputs. UNHCR has already begun testing the SASA! methodology in other settings, and the original guidelines on shelters should inform the work of SURGE.

Finding 7: UNFPA’s focus on a practical operationalization of a human rights-based approach, its respectful management of contentious issues, and its consistent efforts to put government forward first are widely acknowledged. The work has situated GBV within the broader agendas of GE, peace-making, and humanitarian response and conflict recovery, all issues that have given Uganda global visibility as an informed and innovative leader. UNFPA’s proactive pursuit of the principles of DaO and its honest assessment of lessons learned from different approaches to partnership make a lasting contribution to the UNCT.

Evaluation assumption	UNFPA provides leadership on SRH, health and GE within international, regional and national fora and in UN coordination.
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¹⁴ Buwa Dragudi, *Assessing the Cycle of Accountability for Sexual, Reproductive, Maternal, Neonatal, Child Health and Human Rights in Uganda*. Uganda Report, 2014. Executive Summary p. 4; Annex 1 Recommendations. A/HRC/27/20.

Case study evidence	<ul style="list-style-type: none"> • The 2014 UNDAF Gender Scorecard review credited the high score given by the Uganda UNCT to gender programming in which UNFPA was a major contributing agency, including the JP for GE for which UNFPA was the GBV lead. The overall poorer score for Uganda resulted from problems with the work on gender budgeting and monitoring and evaluation. • The Scorecard assessment noted that although UN Women chaired the gender convergence group, the leadership model should “<i>expand from a fixed system leadership model to a rotational system that shares the co-leadership responsibility more broadly amongst agencies while maintaining UN Women as a consistent presence in the key leadership position in line with their mandate</i>”. The assessment raised concerns about an “<i>over-reliance</i>” on UN Women and on the need to leverage the value of other gender experts. • During both the Congolese and Sudanese Refugee responses, UNFPA provided input directly through the Office of the Prime Minister coordination mechanism for humanitarian response, as well as through its continued support of the GBV Reference Group within the MGLSD.
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The UNCT scored a 4.6 on the gender scorecard, above the minimum standards level on programming, due in large part to the existence of the three joint programmes addressing GE: the Joint Programme on Gender Equality funded by DFID; the Joint Programme on Gender-Based Violence funded by Norway; and the Joint Programme on Female Genital Mutilation funded via UNFPA headquarters. The three gender joint programmes were run under a single steering committee to help streamline operations and improve coordination.

Efforts were also taken to mainstream gender in other joint programmes. The UNCT worked collectively to undertake joint advocacy and awareness-raising initiatives around issues, including Beijing +20 and GBV. The next UNDAF was significantly revised to reflect the gender content, which had been missing from the previous framework, and aligned with the National Development Plan, including the timeline.

The UNCT enthusiasm for the joint programmes was evident: “*joint programmes offer rich opportunities for synergistic programming that allow agencies to contribute to a larger goal by working in their niche area in coordination with partner agencies. Joint programming can address women’s equality/gender equality issues by involving a broad base of stakeholders and more holistically targeting root causes of gender inequality.*” As a precursor to a DaO approach, the Joint Programme on GBV seems to provide a good example. The 2017 Gender Scorecard exercise focused on GBV including joint programmes at national level, and referral pathways and case management at sub-national level, a strategic choice expected to improve dramatically the UNCT performance on gender.

The final evaluation of the Joint Programme on GE, however, reported no added synergies as a result of the formal structure including UNFPA. This may have reflected mission overlap as UNFPA’s work on the JPGBV and Joint Programme on GE which were closely aligned.

UNFPA’s was acknowledged for consistently putting the line ministries and government actors forward, avoiding micro-managing either funding or messaging, willingness to engage with even divergent interests in an effort to protect the issues and provide some political space for the ministry, and willingness to allowing some flexibility with message in order to garner important political buy-in. UNFPA was well positioned to help translate the global normative guidance, which is so significantly reflected in Uganda’s national documents, into operational programmes. UNFPA has used its technical authority to hold a space

for less visible and user-friendly elements of the work, including economic factors, work with men, determining the costs of GBV and the response to GBV, and exploring the profound impact of sustained conflict on patterns of violence.

Unfortunately, UNFPA’s global leadership on data for planning and programming on GBV specifically has not been as evident in Uganda. This may be attributable to many factors, including reliance on a ministry that is often underfunded and does not demonstrate a particular strength in data issues, and has no services portfolio of its own which might provide opportunities to build that capacity. UNFPA has supported strengthening of data capacity within the health sector (both directly and as part of programming on child marriage), and fostering linkages between the two ministries that would both fit with Uganda’s e-government strategy and strengthen the capacity of the ministries.

Although UNFPA contributed significantly to the early phases of preparing for a national GBV database, support for the database has come from Norway. The management of the database is handled by MGLSD. UNFPA focal points reportedly were unable to access any information, except by requesting a specific analysis of the technical team. The GBV statistics are included in the Uganda Police Force’s Annual Crimes Statistical Data Report informing the security sector. However, UNFPA’s comparative advantage in linking across ministries in a multi-sectoral approach is not reflected in the database, which does not link the GBV data with the information management systems of MOH, Ministry of Justice and Constitutional Affairs, MOS, Ministry of Education and Sports. It does not yet link the data on GBV in refugee contexts managed by the Office of the Prime Minister with the data on the host communities, thus making planning for the 30/70 ReHoPE approach very difficult. The reason for this is reportedly the need to maintain the confidentiality of the survivors’ data, however, the use of single registry identifiers should solve this issue.

Finding 8: The overlapping partnerships among the JPCBV, JPGE and FGM brought efficiencies in synergies and avoiding overlap, but likely increased transaction costs and contributed to delays in disbursement, leading to multiple delays in implementation. How these lessons are applied remains to be seen.

Evaluation assumption	UNFPA systems and structures support economy, efficiency, timeliness and cost effectiveness.
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Case study evidence	<ul style="list-style-type: none"> • UNFPA’s efforts to build internal capacity for technical support and the strategy of requiring joint conceptualizing and planning produced efficiencies and synergies. • UNFPA commitment to an inter-sectoral approach and the need for capacity at the sub-national level improved economy and efficiency for those at the front line. • UNFPA’s experimentation with difficult partnership modalities was inefficient in terms of transaction costs and costly in terms of negative impacts on longstanding relationships. • UNFPA’s one-year AWP (universally applied) was not well matched with the longer timeframes and added process of a joint programming efforts. • Concerns regarding the rigor of monitoring, coupled with a lack of baseline at the start of the JGGBV, makes it difficult to determine if resources were used to maximum efficiency. • With pressure on UNFPA to programme within a year, some longstanding partners were offered significant amounts of funding for quick turnaround midway through the programme year - an offer which illustrated a lack of understanding of the sub-partner relationships and the time involved in financial management. • The current work on GBV within programming for girls is similarly complex and inter-sectoral, although lessons learned are still emerging.
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UNFPA’s efforts to build internal capacity for technical support and the strategy of requiring joint conceptualizing and planning of an intervention with relevance to more than one portfolio (for example, work on adolescent services and maternal health) likely produced efficiencies and synergies. UNFPA is both leveraging resources more effectively, fostering synergies, and strengthening technical capacity, through requiring that programme officers include colleagues working on different but related portfolios in the early conceptual work on new initiatives. There is not a set structure of teams, but the linkages are identified based on the case: for example, UNFPA was asked by DANIDA to discuss an adolescent and youth project with a strong focus on teen pregnancy, and the programme officer responsible for youth asked the programme officer responsible for maternal health to join.

UNFPA’s commitment to an inter-sectoral approach and the need for capacity at the sub-national level to ensure coordination at the level of service, likely improved economy and efficiency for those at the front line, including survivors. Client satisfaction surveys asked about time savings, however, did not capture other advantages of such an integrated approach.

Some questions were raised about the efforts to build technical expertise of UNFPA national-level staff. The evaluation heard two conflicting viewpoints: 1) resources should be used to build the capacity of national-level implementing partners and UNFPA was no longer investing sufficient resources in training local partners who provided important continuity and relationships; 2) such capacity building was particularly important in the challenging area of GBV, all the more so as UNFPA had chosen partners who were outside the mainstream of the women rights community.

The added value of a multi-sectoral approach was accepted in principle, although the non-sustainability of the shelter model and government’s failure to commit adequate financial resources to continue their operation illustrated some of the limitations. Uganda was not able to launch a one-stop approach and even the shelters, which facilitated the integration of services, were and remain a source of controversy and frustration with lack of sustainable solutions.

Although UNFPA's investment in the relationship with the MGLSD has been critical to enabling a cross-sectoral response, at the current, more technical phase of the work, the technical data, and even conceptual limitations of the MGLSD are a handicap. UNFPA is able to embrace a multi-sectoral approach on its own, leveraging its own diverse relationships.

UNFPA's experimentation with difficult partnership modalities was inefficient in terms of transaction costs and costly in terms of negative impacts on longstanding relationships. UNFPA staff have acknowledged where partnership has not worked and have been willing to formalize relationships, when needed, to be more effective. There was near universal agreement that the administrative and partnership experiment with consortiums offered many lessons. One of the most important was the failure of clearly delineating where and with whom each entity was working, and the lack of clarity regarding the responsibilities and liabilities of the lead NGO. When a decision was taken to shift to direct agreements midpoint, a single overworked staff member ended up being responsible for eight IPs and the overall project.

For some new partners, the challenges of working with the lead NGO have made them very cautious about future collaboration. For some old partners, the qualified audit sparked by the financial management of others in the consortium resulted in a challenge to their limited resources from other donors, a major issue in difficult times. UNFPA's one-year AWP (universally applied) was not well matched with the longer timeframes and added process of a joint programming efforts. The combination may have contributed to funding disbursement delays.

The Phase 2 evaluation - including the years 2012 and 2013 - raised concerns regarding the rigor of monitoring and the degree to which the JPGBV funds were used to support programming, which complemented and added value to the core programmes of each of the IPs. This lack of clarity, coupled with a lack of baseline at the start of the programme, staggered baseline data from some of the partners, and the lateness of the 2014 baseline, which informed the final phase of the JPGBV, makes it difficult to determine if resources were used to maximum efficiency.

The concerns raised by the Phase 2 evaluation related to lack of clarity on how the AWPs for the JPGBV were distinguished from the AWPs of the core programmes of those IPs. Although a monitoring tool was provided, it was not implemented as intended. This, combined with the challenges of the different partnership modalities tested by UNFPA over the course of the JPGBV and the significant overlap with the activities and partners of the JPGE, makes it difficult to assess which partnership approach was most effective.

With pressure on UNFPA to programme within a year, some longstanding colleagues were offered significant amounts of funding for quick turnaround midway through the programme year, an offer which illustrated a lack of understanding of the sub-partner relationships and even the time involved in responsible oversight of sub-contractors' financial management.

EQ4 Strategic partnerships

Evaluation question 4: To what extent has UNFPA leveraged strategic partnerships to prevent, respond to and eliminate GBV, including support to the institutionalization of programmes to engage men and boys in addressing GBV-related issues?

Finding 9: Diverse and longstanding partnerships with a wide range of civil society actors and key government actors has been a defining feature of UNFPA work on GBV in Uganda. Just as UNFPA has managed to hold a space for sensitive and difficult issues, it maintains relationships with both the women’s rights community, and stakeholders who are not in full agreement with some of UNFPA’s core objectives. This investment to protect the work on GBV presents many challenges for defining the relationship, including how to monitor the message to ensure that it reflects the global normative frameworks and UNFPA Strategic Plan. Given the changing roles within the UN family, there is reason for UNFPA to cultivate new portfolios with existing partners who are working in both the development and humanitarian space.

Evaluation assumption	Diverse and inclusive partnerships engaged through well-governed and accountable partnerships that offer mutual benefits, including with civil society and men and boys.
Case study evidence	<ul style="list-style-type: none"> • UNFPA sustains partnerships and collegial relationships with a wide range of actors. • Partnerships have been supported through different modalities among implementing partners (consortiums, individualized agreements, networks) and allied agencies (joint programming, MOUs, participation in UNCT initiatives), not all of which have been productive arrangements. • UNFPA’s willingness to engage with groups, which may not agree with its position, was evident in advocacy work. • As the messaging on GBV is adapted to context, many focus on longstanding vices around which there has been simple, consistent messaging from other influencers (including district leadership and the church), which tends to dilute messaging on rights and power. • At the national level, garnering the support of the churches and other religious groups has been key. The concern is that churches may include strong messages against violence, but their primary approach is reconciliation and maintaining family unity. • UNFPA has sought out diverse and innovative partnerships with civil society actors and supported efforts to deepen their gender transformative work. • One of the most appreciated contributions of UNFPA’s work has been the focus on ensuring male involvement in promotion of GE and reproductive rights in the country programme. • One of UNFPA’s most important strengths is partnerships with several different ministries and positioning the agency to support a multi-sectoral approach.

UNFPA sustains partnerships and collegial relationships with a wide range of actors, including technical and implementing agencies, advocacy and cultural groups, ministries of several sectors, and many groups from the global movement on women’s rights. Partnerships have been supported through different modalities among implementing partners (consortiums, individualized agreements, networks) and allied agencies (joint programming, MOUs, participation in UNCT initiatives), not all of which have been productive arrangements.

One of UNFPA’s most important strengths is partnerships with several different ministries and positioning the agency to support a multi-sectoral approach. Under the JPGBV, UNFPA established partnerships with the MGLSD, MOH, the Ministry of Education, the Judiciary and the Office of the Prime Minister. Many of the most important recent initiatives on GBV have been done in partnership with MGLSD. The current

UNDAF noted that among national stakeholders, UNFPA's focus on the MGLSD was insufficient, that the Ministry was not included in original UNDAF meetings, although it was a partner and that the Ministry lacks technical competency.

Other non-national partners expressed concern that the Joint Programme's highly service-oriented strategy was being spearheaded by a ministry with no services portfolio, and which was dependent on the good faith engagement of other ministry actors. These concerns suggest the importance of linking UNFPA's work on GBV with other ministry partners. The strategy under the current country programme emphasizing the integration of GBV issues in core programming facilitates this. The work on teenage pregnancy and child marriage both within and apart from the Global Programme includes services which leverage longstanding partnerships with the MOH, while also incorporating work with the education, youth and community-based government entities. UNFPA has sought out diverse and innovative partnerships with civil society actors and supported efforts to deepen UNFPA's gender transformative work (i.e. working with the SASA! Methodology; work with men and boys with CARE; work with the University of Makerere School of Women and Gender Studies on identifying patterns and drivers of violence). The most recent UNDAF noted that UNFPA had "*a good balance with non-national partners*". Even as the Joint Programme drew to a close and UNFPA has had to reconfigure this work, these same actors have remained engaged in other portfolios of work and have remained informal partners.

The long duration and the multiple layers of substantive and technical coordinating and advisory structures supporting both the JPGBV and Joint Programme on GE have enabled frank and instructive exchanges on strategy, implementation modalities, and trends within the national and regional communities of practice. The insights on partnerships and design are captured in the final evaluation and 'lessons learned' report.

UNFPA's willingness to engage with groups, which may not agree with their position, was evident in descriptions of their advocacy work on the Marriage and Divorce Bill, which included "*one-on-one meetings with MPs who oppose the bill, workshops with traditional and religious leaders who are not supportive for the bill*". As the messaging on GBV is adapted to context, many focus on longstanding vices around which there has been simple, consistent messaging from other influencers (including district leadership and the church), which tends to dilute messaging on rights and power. For example, the Ker Kwaro Acholi proposed a "*bylaw against alcoholism to prevent GBV*".

At the national level, garnering the support of the churches and other religious groups has been key. The challenge had been the numerous pentecostal and evangelical churches, which lack a central authority, may be led by independents, but are particularly exigent on the role of women. The Inter-Religious Council provides a unifying entity to help reach the splinter groups and the mix of traditions within it, and its explicit focus on peace building in post-conflict areas of Uganda is helpful. Like the traditional cultural mechanisms, the concern is that faith-based organisations may include strong messages against violence, but their primary approach is reconciliation and maintaining family unity. More than the protection messaging around violence against children, it becomes an issue of whether women have agency or a voice.

One of the most appreciated contributions of UNFPA's work has been its focus on ensuring male involvement in promotion of GE and reproduction rights in the country programme. The articulation of

the objectives for this very innovative work has varied overtime and at implementation level where it must negotiate normative resistance. The work has included loosely structured male groups and the programme in Amuru and Kitgum districts where each role model man was assigned 10 households to follow, using several techniques. One evaluation noted that men needed training and direction on how to reach out and expand the numbers of men involved.

The JPGBV strategy of engaging male activists as both monitors to identify or report cases of violence or abuse and as social change agents educating their peers on GBV and GE was adapted for the work with adolescent girls on teen pregnancy and child marriage. The multi-faceted Better Life for Girls Programme provides education, services, vocational training, safe spaces and a multi-media campaign to encourage parents and others to end child marriage. It also supports the development of MAGs to *“meet on a routine basis to dialogue on ways to prevent teenage pregnancy...act as an alert system and report to the LC cases of child marriage, defilement and GBV”*, and engage communities on issues around teenage pregnancy. In the first half of 2017, their functionality was assessed based on records of dialogues, cases referred and income-generation projects, the proceeds of which are used for transport, stationery and refreshments for discussion groups. As global work on child marriage is informed by a generic ToC, this may present an opportunity to clarify the pathways through which MAGs foster change.

Another key entry point for men was the 2012 UNFPA support to sensitize the UPDF, including the peace keeping missions, on the provisions of UNSCR 1325, 1820 and the Goma Declaration, which improved their appreciation of their role in preventing GBV at family, community and in the course of duty.

EQ5 Contribution to outputs

To what extent has UNFPA contributed to advocacy and policy dialogue for strengthened national policies, national capacity development, information and knowledge management, service delivery, and leadership and coordination to prevent, respond to, and eradicate GBV and harmful practices across different settings?

<p>Finding 10: UNFPA has supported diverse approaches to advocacy: at the national level as an expert, in partnership with joint agency initiatives, and through building capacity and knowledge of professional associations, cultural groups, religious networks, and CSOs. At the grassroots level, UNFPA has supported community leaders and volunteers - with an additional focus on male activists - in raising awareness, identifying instances of GBV, and helping to mobilize community discussions to foster social normative change. UNFPA has supported the development of coordination mechanisms and collaborative work at district level, but has not been effective in supporting district-level advocacy to mobilize resources for sustaining these investments. This reflects to some degree UNFPA’s limited services lens at implementation level, as well as the challenges of the context for this work.</p>	
<p>Evaluation assumption</p>	<p>Advocacy, dialogue convening and coordination advances national operationalization of international commitments, including through co-leadership of the GBV area of responsibility.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • UNFPA effectively leveraged both expertise and political access to advance advocacy for initiatives of the JPGBV and to launch survivor shelters. • The diverse mix of agencies acting within the JPGBV helped expand entry points and messages for advocacy on a response to GBV. • UNFPA mobilized key professional entities, including a women lawyers’ advocacy group that successfully advocated for magistrates to support special court sessions on GBV, and celebrities, including world class runners, in support of an end to FGM. • UNFPA engaged religious and cultural groups to support a progressive agenda through declarations, regular messaging and service provision including, for example, adolescent friendly spaces in religious institutions to address child marriage. • UNFPA leveraged the experience from these diverse strategies in addressing child marriage, linking the issue as well to teenage pregnancy and building on their comparative strength of work with health services. • UNFPA leveraged its leadership role in GBV in emergencies (GBViE) at the national level to integrate more of a prevention approach in the work in humanitarian contexts. • The national commitments are reflected at local levels as well.

The context within which the JPGBV was designed and implemented presents significant challenges in both building the base of support for GBV programming in some of the poorest and least-resourced districts in Uganda, and in mobilizing effective grassroots advocacy in a region still emerging from internal conflict. Despite this, UNFPA effectively leveraged both the expertise and the political access and influence of the agency partners within the JPGE to advance advocacy for initiatives of the JPGBV, and to launch the survivor shelters, which were both a safe space and facilitated better coordination of multi-sectoral service provision. The diverse mix of agencies acting within the JPGBV helped expand entry points and messages for advocacy on a response to GBV. The JPGBV’s regular coordination meetings and technical

working groups provided substantive input to inform advocacy efforts and fostered strong partnership with the chairing entity (MGLSD).

UNFPA also mobilized key professional entities, including the national policemen’s association through formal declarations of support and as a participant in street-level education campaigns on ending GBV, and a local chapter of an international women lawyers’ advocacy group, which successfully advocated for magistrates to support special court sessions on GBV. UNFPA tested innovative approaches to awareness raising, including a marathon event focused on FGM which engaged world class runners, several of whom come from the communities practicing FGM, and garnered international attention. It further engaged religious and cultural groups to support a progressive agenda at both the political level through declarations and among their adherents through regular messaging and through service provision. UNFPA established formal partnerships with a national-level network, which covers the spectrum of religious orientations, and the Church of Uganda as a key implementing agency on GBV and FGM.

The national commitments are reflected at local levels as well. Early in phase 2 of the JPGBV, four out of six key counties in Kanugu District had produced official resolutions on GBV prevention. Multiple district governments adopted ordinances, passed laws, and some committed funding to work on the issue. The key component insufficiently addressed was internal and civil society advocacy for mobilization of resources to sustain the work, particularly at the district level. This was a missed opportunity during the bridging phase.

Finally, the CO leveraged its leadership role in GBViE at the national level to integrate more of a prevention approach in the work in humanitarian contexts in an example which can help inform global discussions on the approach to GBViE.

<p>Finding 11: UNFPA has contributed to strengthening implementation based on capacity building, provision of tools and operational guidelines, as well as support for clarification of responsibilities (both the referral chain and national directives from e.g. the MOH) and articulation of a more inclusive vision for addressing GBV and HP at national level. In addition, leveraging its implementation role on GBViE, UNFPA has helped to redefine interventions at the humanitarian level to include prevention strategies with a community-based, normative focus. However, high rates of turnover present a challenge to sustainability. The adaptation of elements of UNFPA’s work by other development partners may provide time to develop better resource mobilization strategies.</p>	
<p>Evaluation assumption</p>	<p>Strengthened national and civil society capacity to protect and promote GE through development and implementation of policies and programmes across the development-humanitarian continuum.</p>
<p>Case Study Evidence:</p>	<ul style="list-style-type: none"> UNFPA has supported intensive, short-term capacity building, integration of GBV-related content in national professional curricula, and partnerships and collaborations which helped to break down barriers among different national stakeholders in addressing GBV. This level of collaboration was also evident in work addressing child marriage and teen pregnancy. UNFPA has strengthened the capacity of international and local NGOs to support local government coordination, services provision, and community mobilization to address the needs of survivors and reduce social tolerance for GBV as well as for child marriage, teen pregnancy and FGM.

- A key element of the JPGBV was regular joint monitoring visits, which provided an opportunity for partners to share with each other and identify potential synergies.
- UNFPA has worked with international entities such as WHO, professional associations such as the women’s lawyers group, and key technical actors to develop regulations, guidelines, referral pathways, protocols, forms and data tools to operationalize policies, and help to institutionalize capacity.
- At the district level, efforts were made to sensitize the wide range of duty bearers who are not directly implicated in the referral pathway.
- Working with key partners, many of whom operate in both the humanitarian and development sectors in Uganda, UNFPA supported the adaptation for refugee settings of the pilot approaches to prevention of GBV originally tested in post-conflict settings.
- In 2016, UNFPA supported extra-ordinary measures to quickly clear the backlog of cases, lest inaction reinforce a sense of impunity.
- UNFPA supported traditional councils’ documentation of their cultural principles and rights related to marriage and divorce.
- There is a growing understanding of the importance of the proper completion of the PF3 for all subsequent stages including care, evidence, and data.
- Overall, capacity-building efforts across sector teams at district level have been undermined by high rates of turnover.
- In a few cases, the GBV coordination mechanisms are facilitating better coordination across the entire district team.
- The Joint Programme is now informing a new generation of development partners focused particularly on GBV response.

UNFPA has supported intensive short-term capacity building, integration of GBV-related content in national professional curricula, and partnerships and collaborations which helped to break down barriers among different national stakeholders in addressing GBV. It has strengthened the capacity of international and local NGOs to support local government coordination, services provision, and community mobilization to address the needs of survivors and reduce social tolerance for GBV. A key element of the JPGBV was regular joint monitoring visits, which provided an opportunity for partners to share with each other and identify potential synergies.

UNFPA has worked with international entities such as WHO, professional associations such as the women’s lawyers group, and key technical actors to develop regulations, guidelines, referral pathways, protocols, forms and data tools to operationalize policies and help to institutionalize capacity. At the district level, efforts were made to sensitize the wide range of duty bearers who are not directly implicated in the referral pathway (e.g. school actors, lower level clerks): the focus of this effort was to review the application of the law and their responsibility for referring to the proper channels when a survivor comes to them for help.

Working with key partners, many of whom operate in both the humanitarian and development sectors in Uganda, UNFPA supported the adaptation for refugee settings of the pilot approaches to prevention of GBV originally tested in post-conflict settings, as part of overall national support for recovery in the north. This is congruent with Uganda’s new strategic approach to working with refugee populations and host communities and reflects new global standards as well.

One of the most significant bottlenecks in multi-sector response has been relative slowness of the judicial system, both in initial engagement and in processing cases. This is due to many factors, including insufficient mediators, limited options apart from magistrate, and an overwhelming number of cases resulting from awareness-raising efforts. This was not compatible with the short-term timeframes imposed in part by the annual funding cycle. In 2016, UNFPA supported extra-ordinary measures to quickly clear the backlog of cases, lest inaction reinforce a sense of impunity. This strategy should be carefully evaluated for sustainability and possibly unintended impact at the micro-level.

UNFPA also supported traditional councils' documentation of their cultural principles and rights related to marriage and divorce which traditional edits were described by the evaluation of Phase 2 as reflecting UN Human Rights. Given that 70% of GBV cases first approached these local entities, which then referred to the police as appropriate, assuring that survivors rights are well protected is critical.

During Phase 2 of the programme, trainings were held on the PF3 form (214 participants) and gender-sensitive management of GBV cases (nearly 450 participants), although the final report for the period noted that high turnover rates were eroding that investment. Trainings were also undertaken for magistrates and every district committee coordinator. The evaluation of Phase 2 documented that 84% of district leadership was sufficiently familiar with the programme, and community level leadership was familiar with the programme implementation.

There is a growing understanding of the importance of the proper completion of the PF3 for all subsequent stages, including care, evidence, and data. The consolidated report on Phase 2 of the JPGBV indicated that *"90% of police posts are aware and have PF 3 forms and police and health staff able to fill them for survivors requiring legal redress"*. Yet a May 2016 joint monitoring visit found many stations lacking the forms, and reticence on the part of health personnel to complete them given their fear of the time-consuming and sometimes 'brutal' court processes. This suggests a need to work more effectively with the health sector on their responsibilities under the law, but also to account for the impact of these new responsibilities on provision of everyday health services.

Overall, capacity building efforts across sector teams at district level have been undermined by high rates of turnover, particularly among the police who, the KAP surveys have shown, are the most important entry point for survivors willing to work within the justice system, rather than rely on the mediation of local traditional courts and judges. This has led to a call for ongoing training, however, sustainable solutions need to be found.

At district level, although UNFPA has supported the capacity building of individuals and associations responsible for addressing the needs of survivors and introduced a GBV-focused methodology to support community dialogue and prevention, the short-term focus on response, and an inward focus on balancing power dynamics within households and communities, did not empower these actors to become effective internal or external advocates for the resources necessary to sustain the programmes put in place. The consolidated report of Phase 2 suggests some expectation that the addition of SASA! will serve this advocacy goal, i.e. the SASA! approach has *"enhanced ownership and laid a basis for sustainability for GBV prevention and response."* The final phases of the SASA! methodology may have supported this, although this was not possible to assess. The programmes have remained donor-dependent and non-sustainable.

There are, however, examples of programming being sustained even without additional funding support. A 2016 monitoring visit and evaluation visits to the programme areas showed that district coordinating structures are continuing to function at least minimally, despite limited financial resources. In a few cases, the GBV coordination mechanisms are facilitating better coordination across the entire district team.

The Joint Programme experience is now informing a new generation of development partners focused particularly on GBV response within, and as a means to addressing challenges within conflict, refugee and post-conflict situations. Based on this broader appeal and the accessibility of the SASA! tool, this particular component may be adopted by the leading coordinating agency in the northwest settlements. One partner is developing what is largely an income and poverty-oriented intervention but with a dedicated component addressing SGBV, including through leveraging the case management and referral pathway approach initially put in place by the JPGBV. Another will support capacity building and further development of the national database including a coordinated approach among development partners of district-level capacity building.

<p>Finding 12: UNFPA has strengthened the GBV focus within the population-based data sources for which it has long provided technical assistance. UNFPA has been less successful in influencing the process around the development of a national GBV database. There is an over-emphasis on the lessons from process (referral chains, partnerships), a lack of a clear ToC, and UNFPA’s historical reliance on population-based data rather than evaluation. UNFPA has not facilitated the kind of knowledge sharing that can communicate the nuances and synergies of programming, particularly in the work on GBV. This type of resource is particularly important in a complex multi-sectoral programme and with the use of tools with potentially very broad impact such as SASA! and MAGs. Both data and reflective research and analysis are lacking in the humanitarian context.</p>	
<p>Evaluation assumption</p>	<p>Enhanced information and knowledge management to address GBV and harmful practices, including increased availability of quality research and data for evidence-based decision making.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • With input from UNFPA and others, the 2016 UDHS included questions on VAW and men. • UNFPA encouraged integration of GBV into the first comprehensive HIV prevalence survey to inform inclusion of GBV in the work of the Global Fund. • During Phase 2, UNFPA made significant advances in setting in place globally comparable administrative data systems for monitoring work on GBV. There remain issues with data quality for which capacity building at implementation level is critical. • Under the Better Life for Girls programme, UNFPA has invested in a baseline completed in end 2016 and monitoring mechanisms, including audits of data collection. Reports from early 2017 highlighted a range of challenges, including processing of data but also filling of forms and definition of terms. These are some of the same challenges facing the broader GBV database. The intent under this programme is to include SRH indicators in the Education Management Information Systems to link SRH outcomes and educational outcomes for girls. • Although there are challenges in the vertical linkages within the data system, the gaps in the horizontal linkages are of greater consequence, i.e. a multi-sectoral approach demands a multi-sectoral dataset and thus the GBV inputs needs to be effectively linked with data from other ministries. • UNFPA has produced valuable knowledge management resources on the lessons learned from partnership efforts under the JPGBV.

UNFPA has produced valuable knowledge management resources on the lessons learned from

partnership efforts under the JPGBV. These will be of particular value in negotiating the new roles and defining the contributions of the multiple entities addressing GE. One of the most important lessons is that the full UNCT and the Resident Coordinator need to be engaged in monitoring and enforcing joint agreements: it is too large a job for any one entity. With substantial input from UNFPA, Uganda has served a key case study in multiple comparative international initiatives to test methodologies and review good practice related to GBV. This includes the costing study undertaken by ICRW in 2005 and a review of programming related to men in conflict and post-conflict situations undertaken by Sonke Gender Justice. With input from UNFPA and others, the 2016 UDHS included questions on VAW and men, i.e. DV (also known as spousal violence or intimate partner violence) and violence by other family members and unrelated individuals. UNFPA encouraged integration of GBV into the first comprehensive HIV prevalence survey to inform inclusion of GBV in the work of the Global Fund. UNFPA has supported further analysis of the 2011 UDHS to examine the associations between GBV and maternal health, adolescent fertility and teenage pregnancy and well as between sexual violence, unintended pregnancy and STIs in Uganda. UNFPA also provided technical support in the design of the UDHS sub-analysis in which community effects are considered.

During Phase 2, UNFPA made significant advances in setting in place globally comparable administrative data systems for monitoring work on GBV through building the capacity of IPs working in northern Uganda to use UNFPA's GBV Information Management System. This was partially supplanted by the Norway-funded effort to create a new unified database, —reflecting concern with different data tools being used by major development partners. A rigorous, accessible, and globally comparable intervention-linked data source to inform both advocacy and programme needs is critical to ensure that learning from the Uganda case study is most effective.

The unified database on GBV is still very much under development which provides opportunity for it to be informed by learning and reflections from the experiences of the Joint Programme as well as other initiatives, including the dedicated systems of the Better Life for Girls programme. There are issues with data quality for which capacity building at implementation level is critical. Although the database is intended to provide real time information, this is limited by data entry. As internet connections are very poor, the District Community Development Officer (DCDO) may have to upload the data after leaving the district to get better access, a practical solution but one which also risks violating confidentiality principles.

As the database relies on data provided not in response to a survey, but in pursuing services, there are many risks with under-reporting. A recent assessment of the database indicated that gaps may occur for many reasons, including cultural contexts where some types of violence perpetrated by intimate partners is viewed as normal, where a woman fears reprisal upon disclosure, or where the level of stigma around such violence in the given society is high. There are cases of deliberate refusal to report by the victim, such cases are 'ignored'. While recording the data, the victim may fail or refuse to give the required information: for example, a survivor may not give the details of the perpetrator who deliberately fails or refuses to turn up. In the case of harmful practices reported, the same challenges may exist between generations, and the possible ambiguity of accountability in the case of FGM law may discourage reporting.

Although there are challenges in the vertical linkages within the data system, the gaps in the horizontal linkages are of greater consequence, i.e. a multi-sectoral approach demands a multi-sectoral dataset and thus the GBV inputs needs to be effectively linked with data from other ministries. There was some confusion regarding what the data base can provide in terms of programme-relevant information. As the database is not sufficiently representative to provide prevalence data, its most valuable contribution would be an analysis of patterns in case management. For example, a quick analysis of available ‘case management decisions’ from a district level sample provided suggests that the frontline decision making on disposition of cases may need closer review: the defilement cases were referred for management, DV cases were counselled and “reintegrated back into the community” and child neglect cases saw no action. Unfortunately, the shift of the database to a case approach was reportedly put on hold until basic problems are solved (e.g. that “every social worker has a different answer when asked what is an incident of GBV”).

There was some evidence of capacity to use the data gathered for district-level decision making. Those trained include the members of the GBV working group, although only the District Community Development Officer inputs the data. Gulu district reported using the data for planning and advocacy. Data was also used to make the case for witness-protection measures in court settings.

Unlike FGM, which has a low prevalence and is more limited to a geographic area in Uganda, child marriage rates are high and the practice is widespread. Research by the Women’s Refugee Committee and the 2014 review of accountability mechanisms for a rights-based approach to SRH suggest that there may be linkages between incidents of defilement (which has long been a punishable offense) and child marriage, which is more recently addressed in a comprehensive national strategy. UNFPA’s own strategy for addressing child marriage links it to teenage pregnancy, although highlighting that 90% of such pregnancies are within marriage. A deeper understanding of these patterns could be informed by the research undertaken to inform the launch of the initiatives addressing child marriage in Uganda, but should remain a consideration in efforts to strengthen the GBV database (e.g. linking it to relevant data within the educational systems IMS).

<p>Finding 13: UNFPA has contributed substantially to strengthening integration of services for survivors and the establishment of dedicated integrated service models such as the shelters. It has supported the development of locally adapted referral pathways, including within humanitarian settings. It has introduced key innovations such as safe rooms, and helplines, and tested new tools to improve access such as a cell-phone application, making it easier to report incidents of sexual violence for adolescent girls in particular. Within the work addressing child marriage and teen pregnancy, it has trained trainers on the provision of adolescent-friendly services to train providers in 17 districts.</p>	
<p>Evaluation assumption</p>	<p>Quality services promoting GE, freedom from violence and wellbeing.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • 15 districts (and six NGOs) were deemed to have the capacity to implement one-stop shelters. • At the national level, five government sectors (Security, Social Development, Health, Education, and JLOS) were deemed to have “functional capacities for GBV prevention and response”. • To support work on child marriage, 726 health professionals at all levels of the health system were trained on adolescent-friendly services in the first year of the BL4G programme.

15 districts (and six NGOs) were deemed to have the capacity to implement (i.e. trained staff, work plan, annual performance reports, institutional policy/guidelines and coordination) while three districts on FGM, eight district NGO alliances. and six FBOs had institutionalized GBV programmes, i.e. action plans, annual performance reports, activities, top leadership involvement, community outreach, trained leadership and IEC. UNFPA provided support for refuge of 83 Pokot girls that chose to stay at Lakas Primary School in Amudat district during holidays, indicating that they did not want to be cut.

At the national level, five government sectors (Security, Social Development, Health, Education, and JLOS) were deemed to have “functional capacities for GBV prevention and response” (defined as at least five staff trained, a designated focal point, a work plan and a budget) and were “implementing international instruments and national legislation for GBV prevention and management”.

Although not yet evaluated, the Better Life for Girls programme with funding from multiple donors supported, not only the training of health personnel, but also the integration of SRHR content and services into Empowerment and Livelihood for Adolescents Programmes (ELA) in 19 districts.

EQ6 Contribution to outcomes

To what extent has UNFPA support contributed to the prevention, response to and elimination of GBV and harmful practices across different settings?

<p>Finding 14: UNFPA support has contributed significantly to the response to GBV and harmful practices and the prevention of FGM. Support has strengthened accountability through facilitating application of the law and reinforcing social sanctions which discourage ‘visible’ or attributable acts of violence. Most significantly, support has encouraged active participation of communities and men in particular to create the conditions, which prevent violence. However, rigorous means to measure the small changes which could be expected from these interventions are not yet in place, making it difficult to interpret the data.</p>	
<p>Evaluation assumption</p>	<p>GE and sexual and reproductive rights policies enforced.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • Despite a strong normative, regulatory, and implementation frameworks, actual outcomes on enforcement of rights policies in the formal judicial sector were limited. • By the middle of Phase 2 of the JPGBV, the work with men had significantly matured, adding strength to efforts to monitor and enforce at community level the policies on GBV. This was reinforced in other communities through a similar strategy within the Better Life for Girls programme. • Despite the challenges inherent in a very slow judiciary process, prosecutions for both HPs and GBV did increase in most of the areas identified for interventions. • The most significant progress has been on FGM which impacts a well-defined community and for which perpetrators are easily identified.

Despite strong normative, regulatory, and implementation frameworks, actual outcomes on enforcement of rights policies in the formal judicial sector were limited due to the somewhat limited readiness of justice law and order institutions to implement laws, and limited awareness of laws among rights holders to demand rights. One respondent noted that for duty bearers the political cost of passing the law was

manageable, but that the political cost of implementing the law was too great and thus a two-phased strategy would be needed. For rights holders, even with the knowledge of their rights, the costs were higher, i.e. the risk of a backlash against efforts to hold culprits accountable in a court of law (or even a public health center), the time and cash demands of the process, the uncertainty of completing the process or a positive outcome, and (although seldom discussed) the risk of losing the only source of support.

By the middle of Phase 2, the work with men had significantly matured, adding strength to efforts to monitor and enforce at community level the policies on GBV. MAGs providing space for reflection were more visible (38% of 66 sub-counties had established groups, including multiple groups in one county), the male role models in some districts accompanied the SASA! volunteers, and Strengthened Male Action Groups (SMAGs) were engaging role models who were more influential in the community, including district leadership. Messaging for men had been explored in the media strategy. And the database was tracking reports of men's experience of violence. The work was highlighted by Sonke Gender Justice as an example of promising practice. This experience informed the inclusion of a similar strategy addressing child marriage and including reporting cases of defilement.

During the period under review, UNFPA has not given sufficient emphasis to either basic monitoring or intervention-based research. The official JPGBV baseline was not conducted until 2014 and was not in time to inform the development of Phase 2, or to significantly inform the Bridging Phase which was a continuation of the same overall strategies. The lack of monitoring and baseline limited what could be said about outcomes and impact. More importantly, gaps in programming would not have been systematically detected, even when they may have contributed to unintended consequences.

A joint monitoring visit with key development partners 'discovered' the fact that health and police personnel were not aware of the changes to the PF3 form, health personnel were not trained on how to complete the form, and in many service points, the form was not available. Although UNFPA took immediate action to rectify this, including training in all relevant districts, such significant gaps in implementation need to be identified earlier, if not anticipated. Even with over 20 monitoring visits during Phase 2, the approach is not sufficiently systematic to replace a more traditional monitoring system.

Despite the challenges inherent in a very slow judiciary process, prosecutions for both HPs and GBV did increase in most of the areas identified for interventions. The most significant progress has been on FGM, which impacts a well-defined community and for which perpetrators are easily identified. UNFPA supported efforts to address some of the procedural factors inhibiting effective access to formal justice for gender and GBV-related crimes, including work with the Uganda Human Rights Commission and others on a review of the Evidence Act, tools for accountability, monitoring and tracking of SRH rights overall, and a witness protection law. UNFPA also pursued the 'micro-measures' of supporting photocopying the PF3 form to ensure that the necessary forensic data was collected and provision of motorcycles to speed the pursuit of perpetrators, as well as support survivors and trained volunteers to accompany survivors to court.

The National GBV Database is a focus of efforts to improve reporting. Even with significant improvements in the data quality, it is still subject to the limitations of data based on reported cases. It is difficult to distinguish between an increase in incidents and an increase in incidents reported; a seasonal shift in types or frequency of violence; changes in practice such as a decrease in the age at which FGM or child

marriage take place; a shift in the characteristics of the perpetrators (less intimate partner violence but more interpersonal violence overall); or a shift from the formal justice system to traditional mediation mechanisms. These differences should influence intervention design and even target populations for key messages.

The work on child marriage has adapted some of the same strategies as the work on GBV and includes a focus on GBV, but has also set in place a foundation for more rigorous monitoring and evaluation, i.e. process, services, and outcomes. This is still in the early stages of development.

<p>Finding 15: UNFPA has been involved in multiple iterations of provision of life-saving services, including the MISP, a variety of adapted kits, along with training in clinical management of rape (CMR), and emergency obstetric care (EmOC). Although there are administrative challenges that have gotten in the way, much has been accomplished. The ability to evaluate impact is limited by lack of control over the data on GBV from both the refugee and host population settings.</p>	
<p>Evaluation assumption</p>	<p>GBV and harmful practices integrated into life-saving structures and agencies.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • UNFPA Uganda was chosen as a featured 'best practice' within UNFPA's knowledge management competition. • Over 6,500 survivors were provided with legal, health, psychosocial and protection services. • The overwhelming inflow of new refugees in 2017 resulted in delays in provision of some critical commodities.

UNFPA Uganda was chosen as a featured 'best practice' within UNFPA's knowledge management competition for an intervention on Emergency Life Saving Response for Pregnant Women and GBV Survivors in Transit and Refugee Settlement Camps in South Western Uganda.

By the end of Phase 2, in the 17 focus districts, an average of 70% of hospitals and health centres level 1 (HCs 1) had in place minimum standards for management of GBV cases (i.e. two staff at each unit trained in GBV, a copy of management protocols, stocks of key treatments PEP, ECP), and 100% of the police facilities had the ability to fill the revised police forms (three of them). Over 6,500 survivors were provided with legal, health, psychosocial and protection services.

The overwhelming inflow of new refugees in 2017 resulted in delays in provision of some critical commodities. An important gap was training and kits for the CMR: a significant concern based on the reports of arriving refugees and some of the reports from community activists in the settlements.

Finding 16: The SASA! methodology being used in multiple GBV interventions, provides a structured way to engage all groups within a community and to empower individuals to address change needed at their own level and at the level of the larger community. It is a sustainable and non-controversial way to encourage grassroots advocacy.	
Evaluation assumption	Informed, effective and inclusive participation in decision making to change social norms.
Case study evidence	<ul style="list-style-type: none"> • The uptake of SASA! has been dramatic with summary annual figures such as “256 activists undertook 896 events reaching 15,875 individuals”. • 78% of survey respondents reported “change in the community attributable to SASA!” • The challenge remains how to scale the approach, which is time intensive. • In light of UNHCR’s interest in the SASA! methodology and the global and national support for testing new approaches, a concerted effort to measure outcomes in refugee settings would be valuable. • Political declarations by key cultural leaders were not sufficiently followed up and perhaps given too much credence (i.e. they did not represent a commitment on the part of the leader or group to actively address GBV). • Work on child marriage is pursuing very different campaign strategies for change, including multi-media approaches.

The uptake of SASA! has been dramatic with summary annual figures such as “256 activists undertook 896 events reaching 15,875 individuals”. Feedback from the activists and other community leaders suggest a positive impact. The package for SASA! includes simple M&E tools, which focus on outcomes. A SASA! rapid assessment was conducted in both Pader and Agogo districts to establish the degree to which the SASA! approach was changing knowledge, attitude and practice in the community. 78% of the respondents reported “change in the community attributable to SASA!”.

Understanding what changes can be measured at each phase of the programme will help avoid early judgement of its effectiveness in addressing GBV in the challenging settings within which it is being disseminated. A review of district-level reports suggests that the SASA! method is being slightly adapted in each site, either the messaging in the case of church groups, the actors in selected districts, MAG representatives go with the SASA! volunteer, or the role of the community agents (in one district, they are activists, peer educators and also accompany survivors to services). Another consideration is how interventions paired with SASA! may influence outcomes.

Of more significance is the fact that, due to the late addition of SASA!, the time needed to build capacity and the measured pace of the intervention itself, several key partners were not able complete the full cycle of the SASA! phases before the Joint Programme ended, notably phases 3 and 4 (Phase 3 ‘Strengthening Skills and Connections between community member’s and Phase 4 ‘Trying New Behaviors, Celebrating Change’).

The challenge remains how to scale the approach which is time intensive: the leading normative change methodology groups have launched a new project to think rigorously about what factors need to be considered in scaling up and how to replicate the approach, but remain flexible to allow adaptation to

context.

In light of UNHCR’s interest in the SASA! methodology and the global and national support for testing new approaches, a concerted effort to measure outcomes in refugee settings would be valuable. The Congolese refugee settlements and transit centers are sufficiently established to be able to gather key demographic and health data, which may help to monitor impact.

Some attention has been focused on the impact of media and local-level advocacy in preventing FGM. Because the methodology used includes public-level declarations of intent to abandon, this is considered the outcome and a proxy for normative change. The programme final report noted that political declarations by key cultural leaders were not sufficiently followed up and perhaps given too much credence, i.e. they did not represent a commitment on the part of the leader or group to actively address GBV.

The work with child marriage also adopts an ‘abandonment’ approach with public statements, but without adhering to the SASA! approach. However, there is insufficient data to determine if this is effective.

<p>Finding 17: The JPGBV set high standards for coordinated quality services from four different sectors, working in one of the most disadvantaged and stressed regions of Uganda. Although UNFPA supported the development of tools to guide service provision, the most valued and (reportedly) most availed service of the four, counselling and psychosocial support, requires the participation of well-trained staff. Recent efforts to set in place a more sustainable solution through integrating capacity building within health and medical schools offers much promise, however, the time gap between end of project and deployment of new trained professionals suggests that an interim measure working with post-certification or shorter training regimes in social work schools may be necessary.</p>	
<p>Evaluation assumption</p>	<p>High quality, accessible and effective services for SRH and wellbeing.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • Both the technical capacity and coordination mechanisms to provide high-quality services and an impressive supply of services were evident at the end Phase 2 of the JPGBV. • By the end of Phase 2, in the 17 districts, an average of 70% of hospitals and HCIs had minimum standards for management of GBV cases. • UNFPA worked with MGLSD and CSOs to establish five GBV shelters, serving over 3,700 in 2014. • Following passage of the law and regulations, FGM/C case management was integrated into the existing services of selected health centers. Corrective surgeries were performed or planned for 90 cases of FGM. • In Kampala where access to legal services is more possible, 653 clients received legal aid provided by FIDA in 2014. • The prototype GBV helpline was established in four key districts and within a period of a year had received 3,575 calls and of those referred for services, over two-thirds of them were satisfied with the services. • Although still undergoing evaluation, the work with child marriage built on the success of the helplines and expanded the reach with the SafPal App, which allows adolescents to report sexual harassment quickly.

Both the technical capacity and coordination mechanisms to provide high-quality services and an impressive supply of services were evident at the end Phase 2 of the JPGBV. Over the course of the final phase of the programme, meaningful progress was made in a limited number of districts on a commitment of financial resources for the dedicated work on GBV as well as exploring mechanisms such as medical and health training institutions, which provide long-term solutions to the issue of loss of human resources for service provision. Future support from partners beyond UNFPA for service provision was not yet clear apart from the shelters which, as the least sustainable service, had been handed over to a DFID partner.

By the end of Phase 2, in the 17 districts, an average of 70% of hospitals and HCIs had minimum standards for management of GBV cases (i.e. two staff trained in GBV, a copy of management protocols, stocks of key treatments PEP, ECP), and 100% of the police facilities have the ability to fill the revised police forms (three of them). Over 6,500 survivors were provided with legal, health, psychosocial and protection services.

UNFPA worked with MGLSD and CSOs to establish five GBV shelters that were operational in five districts, serving over 3,700 in 2014. In Kampala where access to legal services is more possible, 653 clients received legal aid provided by FIDA in 2014. The prototype GBV helpline was established in four key districts and, within a period of a year, had received 3,575 calls and of those referred for services, over two-thirds of them were satisfied with the services.

Following passage of the law and regulations, FGM/C case management was integrated into the existing services of selected health centers reinforced by the training of 20 health care workers. Corrective surgeries were performed or planned for 90 cases of FGM.

EQ7 Sustainability

To what extent have UNFPA’s interventions and approaches contributed (or are likely to contribute) to strengthening the sustainability of international, regional, national and local efforts to prevent and eradicate GBV and harmful practices, including through coverage, coherence and connectedness within humanitarian settings?

Finding 18: The political will and national ownership of work on GBV and harmful practices is manifest in the substantial progress on normative frameworks. The operational will to put these guidelines into practice and fund them remains the challenge.	
Evaluation assumption	<ul style="list-style-type: none"> Political will and national ownership of GBV and harmful practice interventions, including integration of GBV and harmful practices into national financing arrangements.

Case study evidence	<ul style="list-style-type: none"> • The substantial normative guidelines and technical tools set in place at national level to support addressing GBV are likely to remain in place. • The operationalization of these policies takes place at district level where additional resources are in short supply, experience with outside interventions mixed, and political power is limited. • The MGLSD and 15 of 17 targeted districts had “<i>functional multi-sectoral GBV coordination structures</i>”. • The declarations, basic structures for coordinated services, and beginnings of a meaningful community dialogue suggest strong political will and national ownership at that level. • Some of the local-level structures developed by IPs were successfully handed over to sub-district government. • The JPGBV remained dependent on donor funding. The national government provided an estimated USD 78,000 annually for REACH’s work on FGM abandonment, however, an equivalent investment was not made in the broader GBV programme. • Elements of the GBV work have been integrated into programming around child marriage.
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The substantial normative guidelines and technical tools set in place at national level to support addressing GBV are likely to remain in place, although history suggests that changes in key leadership may lead to major revisions in the short term (the revision to the Male Involvement Strategy being an example). The operationalization of these policies takes place at district level where additional resources are in short supply, experience with outside interventions mixed, and political power is limited. Thus, the lack of resources set in place at district level to support this work is an indication of lack of will on the part of actors other than the communities most affected.

Public declarations of support for addressing GBV and HPs were made by the national representing agencies of the Ugandan Police Force, the Inter-Religious Council, and multiple cultural leaders. 67% of the sub-counties in Kanungu district had developed resolutions on GBV prevention. Moroto & Gulu District Council also developed district-level ordinances.

The MGLSD and 15 of 17 targeted districts had “*functional multi-sectoral GBV coordination structures*” (defined as a TOR, trained staff, regular meeting and up-to-date reports on their actions). At the sub-national level, 15 DLGs had incorporated GBV into the district development plans, four with budgetary support. 42 sub-counties had MAGs. The six districts and sub-counties in which FGM is practiced, had ‘district FGM abandonment alliances’ formed or integrated into the GBV coordination structure. The declarations, basic structures for coordinated services, and beginnings of a meaningful community dialogue suggest strong political will and national ownership at that level.

Some of the local-level structures developed by IPs were successfully handed over to sub-district government based primarily on the long and trusting relationship between the INGO and the local leadership, rather than mobilization of new resources for the work on GBV. The lack of funding for district-level implementation may reflect the relative priority given to the issue, to the ministry and to the region at the critical levels of government.

The JPGBV remained dependent on donor funding. The national government provided an estimated USD 78,000 annually for REACH’s work on FGM abandonment, however, an equivalent investment was not made in the broader GBV programme.

<p>Finding 19: The technical capacity to prevent and respond to GBV and harmful practices remains. The barriers to implementation range in cost from insufficient supply of commodities and the need for additional training or guidance, to serious human resource shortages. With the new influx of resources for addressing GBV, a mapping of what remains in place and what is needed would both leverage the material and good will investments of the JPGBV, and accelerate the investments of the new actors. A mapping of new actors is already being undertaken by the ministry and partners, but a mapping of existing resources and investments is missing.</p>	
<p>Evaluation assumption</p>	<p>Capacity of local and national stakeholders to prevent and respond to GBV and harmful practices.</p>
<p>Case study evidence</p>	<ul style="list-style-type: none"> • By the end of phase 2, substantial progress had been made on setting in place the human, technical and coordination resources to meet the overall objectives of the JPGBV. • Although most survivors were coming to the health facilities on time, key medical supplies were out of stock. • Health workers for whom the PF3 had been modified such that they could complete it, thereby improving access for survivors, were uncomfortable testifying in court. • When health workers challenged whether they had to address cases of GBV, a central letter was written reminding them of their mandates and penalties for failure to comply. • Linkage of the GBV work with the GBV focus within child marriage programming could reinforce previous investments, such that training on adolescent friendly-health services reflects the needs of GBV as well as child marriage and FGM survivors.

By the end of phase 2, substantial progress had been made on setting in place the human, technical and coordination resources to meet the overall objectives of the JPGBV. The final bridging phase focused on reinforcing the capacity already in place. The small budgets made available by selected districts were dedicated to the shelters or linked to the implementation of PRDP III. Although most survivors were coming to the health facilities on time, key medical supplies were out of stock, requiring costly travel to get access.

Not all health centres visited were comfortable completing the PF3, and although guidelines had been developed, they were not visible during the joint visit. Health workers for whom the PF3 had been modified such that they could complete it, thereby improving access for survivors, were uncomfortable testifying in court. When health workers challenged whether they had to address cases of GBV, a central letter was written reminding them of their mandates and penalties for failure to comply.

An evaluation of the programme in Acholi sub-region observed that there were only two chief magistrates in the region and that they were burdened with a huge backlog of cases, a significant proportion of which were defilement and thus possibly the result of the awareness-raising process. A May 2016 stakeholder visit to four districts found that a very substantial percentage of those originally trained had been transferred or replaced, and thus continuous orientation was needed.

Finding 20: With UNFPA’s new global role as coordinator of the GBV AOR, the Uganda Country Office has a unique opportunity to leverage for global learning a comparative assessment of the lessons learned from inter-sectoral and multi-level interventions to address GBV response and prevention in refugee and post-conflict settings, as well as two different modalities of humanitarian operations (cluster and non-cluster). This contribution is all the more significant given Uganda’s global role in testing new approaches to supporting the needs of refugee populations.

Evaluation assumption	Coverage, coherence and connectedness of humanitarian response to GBV and harmful practices.
Case study evidence	<ul style="list-style-type: none"> • UNFPA supported the MGLSD to contribute to the integration of GBV in the National Contingency Plan for Disaster Preparedness and engendering the Strategic Plan on Disaster of the Office of the Prime Minister. • Although UNFPA has introduced prevention strategies based on a social change model and fostered coordination mechanisms at district level, the agency’s comparative strengths remain in service provision and changing behaviors (and possibly norms) through education and counselling. • UNFPA has established a good working relationship with UNHCR in diverse settings and modalities within Uganda. • That UNHCR is considering encouraging IPs to adopt the SASA! methodology is strong evidence of the value of UNFPA’s contributions beyond immediate response. • Although UNFPA at the global level is facing funding challenges which may limit the agency’s ability to respond in many country contexts, Uganda is likely to have resources dedicated to testing a continuum approach.

Following the Sudanese crisis in 2016, the Uganda CO made initial efforts to build staff capacity and set in place systems, which could help leverage UNFPA’s extensive experience in development settings for a continuum approach. This included a workshop with all staff to increase awareness on humanitarian programming, development of a Minimum Preparedness Plan for the office, support for the training of 26 district health team members and NGO staff from five districts on MISP and one representative each from UNFPA and ACORD to participate with the RH Coordinators on the Norwegian Refugee Council Surge Capacity Initiative. UNFPA supported NGO IPs to hire 12 midwives and 14 GBV project officers while seven district local governments received emergency reproductive health (ERH) kits via the MOH.

With UNFPA’s new global role as coordinator of the GBV AOR, the Uganda CO has a unique opportunity to leverage for global learning a comparative assessment of the lessons learned from inter-sectoral and multi-level interventions to address GBV response and prevention in refugee and post-conflict settings. This will be possible only with rigorous, well documented, and widely disseminated analysis of the impact of such interventions in both the short-term response to survivors and communities in conflict and the longer-term approach to strengthening community building through tools such as the SASA! methodology.

Doing so will require continued cooperation among the government entities responsible for addressing GBV in humanitarian and development settings (the Office of the Prime Minister and the MGLSD), including building robust, coordinated, and accessible data sources to monitor the response and impact.

UNFPA supported the MGLSD to contribute to the integration of GBV in the National Contingency Plan for

Disaster Preparedness and engendering the Strategic Plan on Disaster of the Office of the Prime Minister. In 2015, 25 members of the district disaster management committees in six districts were trained in IDP profiling methodology. Although UNFPA has introduced prevention strategies based on a social change model and fostered coordination mechanisms at district level, the agency's comparative strengths remain in service provision and changing behaviours through education and counselling.

UNFPA has already established a good working relationship with UNHCR in diverse settings and modalities within Uganda. That UNHCR is considering encouraging IPs to adopt the SASA! methodology is strong evidence of the value of UNFPA's contributions beyond immediate response. UNFPA experience is relevant to REHOPE and the CRRF approach as well as longer-term vision for refugees embraced by Uganda.

4. Considerations for the overarching thematic evaluation

Breadth and depth of experience in setting standards, supporting practice, and leveraging partnerships within contexts across the humanitarian-development continuum can inform a global community of practice, provided that UNFPA's comparative strength in population-based data and analysis are reinforced with a focus on intervention research and methodologies which compensate for weak monitoring and data systems.

UNFPA has contributed substantially to the response to the refugees fleeing conflict from countries bordering Uganda, with a significant focus on GBV predominantly on addressing interpersonal and sexual violence. Following the guidelines and tools of the global humanitarian agencies as well as the country programmes' own technical resources and tools, UNFPA is supporting the leading agencies on the ground to address GBV in line with the identified needs and the phase of each emergency situation.

This effort represents a significant proportion of UNFPA's resources given: a) the number and scale of the population settlements, b) the condition of the refugees arriving from failed health systems and c) the violence of the conflicts and the disintegration of protection systems. UNFPA is supporting both the immediate emergency response as well as services for more established camps, such as the refugee camps in the south-west. In addition, Uganda has taken a leadership role in testing new international standards and approaches for addressing the needs of refugee populations, both the global CRRF and Uganda's own adaptation of ReHoPE: this operationalizes Uganda's commitment to providing services to both refugees and the host community, and ensuring that humanitarian support is provided with a long-term objective, as articulated in the Settlement Transformation Agenda of the National Development Plan II.

Based on the evaluation findings, UNFPA may be more effective in later stages of an emergency, although their role is determined largely by UNHCR and the two agencies are working on better coordination. Although acknowledged for contributions of kits, the most noted contributions in the South Sudanese camps were work with service providers in host communities following the 30/70 rule, as well as supporting health personnel from the public system to work in the camps. UNFPA's training on MISP was limited in scope. The rapid and significant influx of South Sudanese refugees in early 2017 caught many off guard and overwhelmed UNFPA's ability to provide key commodities in a timely manner. The tailored mix of emergency kits provided did not necessarily reflect the priorities of the incoming populations, notably with a lack of PEP kits (also linked with need for training on CMR). Even getting non-emergency kits into the country had proven difficult for the agency because of existing procurement requirements.

The key is to match the mix of approaches, and adapt the methods based on the assessed needs along the continuum and the capacity of the agencies serving this population. The REHOPE 30/70 policy, in which the same agencies must invest 30% of their resources to address the needs of the host community, will be an opportunity to adapt approaches for addressing GBV to the host communities, whose experience of and exposure to GBV is likely to be very different from other communities with no such settlements.

The substantial inflow of resources into Uganda on both refugee issues and on GBV may provide the resources for this effort. Because of the overlap of implementing agencies and the reliance on common tools and strategies, UNFPA's non-humanitarian GBV programming can also learn from the initiatives in refugee settings. The content on GBV in the health, security and other curricula can help build capacity for the mainstream health sector and other service providers to address GBV associated with developing crises in their communities.. But given UNFPA's longstanding contributions on health systems and population-based data, it will be important to not lose the development focus. The urgency of the refugee response should be balanced with support for the development and longer-term focus of their GBV work, emphasizing their comparative strengths with respect to the other players in this field. It is possible to some of the key GBV-relevant development initiatives, which are not part of the refugee situation which UNFPA needs to continue to sustain. These include database development and capacity building on the SOPs, integration of content on GBV and HP into the curricula of the health and medical schools, and strengthening the work of the judiciary. The relatively recent work on child marriage should also inform work in humanitarian settings such that the unique needs of young people are taken into consideration.

Operational partnerships and an ability to work across stakeholders and sectors enable UNFPA to leverage its niche expertise, while still contributing to broader strategic outcomes.

Until the advent of UN Women, UNFPA was effectively the UN champion of the human rights-based and integrated strategies to address gender-based discrimination articulated in the global frameworks emerging from the Beijing and Cairo agenda. Fulfilling this responsibility has entailed significantly broadening UNFPA's mandate and engaging allied agencies to address the fundamental drivers of gender inequality through interventions which are outside UNFPA's technical expertise and sphere of influence, thus the agencies acknowledged strength in working across sectors, levels and stakeholders. A trusted partner in Uganda, UNFPA has pursued this in some of the most challenging contexts for women and girls, particularly with respect to violence, including post-conflict, recovery and humanitarian settings.

The Uganda programme successfully mobilized most of the needed expertise, resources, and political support through several different approaches to partnerships with implementing agencies, UN entities, government at national and sub-national levels, and a diverse mix of civil society actors. Lessons learned on partnerships (e.g. the importance of mapping expected contributions based on geography, competence and actual programming to ensure a multi-sectoral approach), flexibility to account for the different *modus operandi* of key sectors, and mutual accountability for sustainability and exit strategies were as valuable as those on the synergies of interventions. This approach to programming contributed significantly to the 2014 gender performance of the UNCT, revisions to the UNDAF, and was cited for demonstrating the rich opportunities for synergistic programming that allow agencies to contribute to a larger goal by working in their niche area in coordination with partner agencies. Joint programming can address women's equality/GE issues by involving a broad base of stakeholders and more holistically targeting root causes of gender inequality. A similar approach was pursued for work on child marriage and teenage pregnancy.

A painful lesson learned from this experience was that rich opportunities do not translate into resources, and that a planned, realistic, exit strategy must be part of the initial development of the joint programme. This lesson was particularly difficult for UNFPA in light of the agencies health and medical services grounding: 'do no harm' in early work on DV included caution regarding creating a demand for services which are not available or sustainable.

Notably, the GBV work specifically was the focus for the 2017 Gender Scorecard Review and has helped to mobilize significant international commitments from multilateral sources. The work can inform UNHCR's CRRF and Uganda's ReHoPE strategies for addressing refugee situations. UNFPA's defining role, experience across the continuum, and global competency in data should inform approaches to partnership, as well as effectively measuring the outcomes and impact of an integrated approach with tools that capture fundamental change in addition to quality services.

Global expertise in leading and negotiating on sensitive issues, including through balancing often divergent partnerships, can advance GE and human rights goals.

Because sex and reproduction are considered sensitive issues, UNFPA has significant diverse experience at all levels in managing controversy, conflict and confrontation and 'holding two truths' while remaining focused on the human rights principles endorsed by the international community on gender, violence, and harmful practices. In accordance with its own modalities approach, at sub-national and services levels, it can address immediate needs while advocating for change to the system.

This strength is evident in UNFPA's concurrent engagements with the human and women's rights community, religious leadership and faith-based implementing agencies, traditional culture leadership and parallel systems, global leaders on progressive social norm change and grassroots mobilization, and the highest levels of leadership in a country very visible on the regional political stage. This ability is particularly valuable when managing the political sensitivities of cross-border conflicts and shared histories and practices such as FGM.

To maintain this delicate balancing act, UNFPA needs to stay true to core messages while finding common ground even with the opposition. This entails guarding against misuse or misconstruing of the core messages, while continuing to work as a respectful partner in the interest of protecting and promoting progress.

Strategic investments and partnerships can be most effective when linked with supporting the development, critical analysis, application and dissemination of diverse sources and types of knowledge, i.e. population-based surveys, administrative data, rapid assessments, multi-method instructional case studies, comparative analysis. The responsibility for data and analysis should be based on a rigorous assessment of technical capacity, access, and ability to effectively disseminate findings, and reliable support for systems should be put in place.

Due in part to the sensitive nature and risks involved in such work, the GBV initiatives have highlighted the importance and significant gaps in the knowledge and data sources needed to effectively design, implement, monitor and evaluate programmes. UNFPA has contributed to adding relevant content to the DHS and requesting GBV-specific analysis; a first effort at building capacity for collecting, managing and applying administrative data on reported cases, which should be well vetted and reliable before launch; standard protocols and training to guide collection of data; new digital tools, which may help to provide more representative data, and efforts to fill in gaps on men and boys and on adolescents.

As the leading agency on population and GBV data, UNFPA is also an important source of capacity building on data. As UNFPA Uganda looks to build technical capacity of its own team, broad-based understanding of the potential and the limitations of these various data sources is critical such that misuse does not undermine the very objectives of the work on GBV. For example, the administrative data source cannot be used to determine prevalence or trends - both because there is no denominator, and because the quality of the data depends on capacity and rigor at the service delivery level.

There is acknowledgement of, and should be plans for addressing the fact that existence and level of familiarity with the rigorous normative guidelines which are a demonstration to the world of Uganda's intent to address these challenges, contribute to not only hiding the behaviour, but also to changing practice and/or definitions of practice in a manner which impacts measurement over time and can have unintended consequences. There is a growing understanding of the limitations of such divergent sources of data which should protect against inadvertently distorting reality on the ground, or using the wrong data to impute findings or serve as a proxy for information which is not available or reliable.

Data collection and analysis must be accompanied by clarity of roles on ownership and management of data and dissemination of findings, and this must reflect a rigorous assessment of comparative technical strengths and capacity for effective collaboration. This is true for the broad-based efforts on a national database for GBV but also for sector-specific collaboration, such as the work with the Ministry of Education on inclusion of SRH outcomes in the education database.

These data resources can complement but do not replace a rigorous evaluation of the outcomes and impacts of interventions and strategic investments. This is a major challenge when the ToC is not clear, multiple sector-specific methods are needed, and synergies are a core principle of the intervention. The partnership approach to the multi-sectoral interventions on GBV brings the added challenge of the relative strengths of each partner on evaluation. This is an area in which all offices, not just regional or global offices, need capacity.

Annexes

A: Reference Group

Betty Kasiko Ikanza	DFID/UKAid	Social Development Advisor
Elsa Bokhre	UNHCR	Community Services Officer
Richard Mukhe	Child Fund International	Child Protection Specialist
Delphine Pinault	Care International	Country Director
Sacha Manov	International Rescue Committee	Deputy Director of Programmes
Mirian Akumu	ACORD	Transitional Justice & Gender
Priscilla Nyarugoye	Uganda Human Rights Commission	Head Vulnerable Persons Unit
Alice Komuhangi	Directorate of Public Prosecutions	Head of Gender, Children and Sexual Offences
Nabwire Joyce Baker	Action Aid Uganda	Project Coordinator Women Protection Shelters
Emmanuel Ochieng	Action Aid Uganda	Project Officer GBV Special Courts
Demeta Namuyobo	Reproductive Health Uganda	Medical Coordinator
Jackson Chekweko	Reproductive Health Uganda	Executive Director
Rita Aciro	Uganda Women's Network	Executive Director
Darlson Kusasira	Office of the Prime Minister	Community Services Officer
Mubaraka Mubuya	Support to Uganda's Response to GE	Team Leader
Susan Oregede	UN Women	Programme Specialist
Tina Musuya	CEDOVIP	Executive Director
Mercy Munduru	FIDA-Uganda	Programme Manager
John Ampeire Kaijuko	National Population Council	National Programme Officer
Miriam Namagere	Ministry of Health	Programme National Officer

B: People interviewed

UNFPA

Alain Sibenaler	Representative
Roselidah Ondeko	Senior GBV and Humanitarian Coordinator
Florence Auma-Apuri	Gender and Human Rights
Peace Acema	Gender and Human Rights
Esther Cherop	Programme Officer FGM
Penninah Kyoyagala	National Programme Officer, Adolescents and Youth
Komuhangi Doreen	Programme Analyst GBV
Florence Mpabulungi Tagoola	Population and Development Programme Officer
Jimmy Dombo	Programme Assistant
Engwau Francis	Head UNFPA, Moroto Sub-Office
Norah Nyeko	GBV and Humanitarian Field Coordinator

Other UNFPA staff who were part of joint meetings

Margaret Birakwate	UNFPA Finance and Admins Associate at MGSLD
John Odaga	National Programme Officer, M&E
Rebecca Nalumansi	UNFPA National Programme Analyst at MGSLD
Judith Amongin	UNFPA Focal Person MOH
Edson Muhwezi	Assistant Representative, Policy and Programme. Coordination & QA.
Rosemary Kindyomunda	HIV/AIDS-Condom Programming Officer
Ogwang Denise	Programme Assistant, Gulu

UN Agencies

Rose Malango	Resident Representative & Head UNDP Country Office, United Nations in Uganda - Delivering as one
Yoon Kyung Shin	Programme Analyst, Gender Equality and Women's Empowerment, UNDP
Anna Mutavati	Deputy Country Representative, UN Women
Akullu Harriet	Chief of Protection, UNICEF
Dr. Olive Sentumbwe-Mugisa	Family Health & Population Advisor, WHO

Kemlin Furley	Deputy Representative, UNHCR
M Panchoe	Senior Field Coordinator, UNHCR-Adjumani
Elsa Bohkre	Senior Community Services Officer, UNHCR

Government of Uganda

Ministry of Gender, Labour & Social Development

Jane Mpagi	Director Gender & Women Affairs
Ida Kigonya	Principal, Women in Development Officer
Kenneth Ayebazibwe	E-Resource Centre Manager/Head IT

Other Government Entities

Alice Komuhangi	Head of Gender, Children and Sexual Offences, Directorate of Public Prosecutions
Darlson Kusasira	Disaster Preparedness, Office of the Prime Minister
Patricia Nduru	Director Monitoring & Inspections, Uganda Human Rights Commission
Maureen Atuhaire	SSP Child and Family Protection Department, Police Headquarters
Naguru, Dr. Betty Nakazzi	Director Family Health, National Population Council
Miriram Namugere	Ministry of Health
Wilberforce Mugwanya	Ministry of Health

Development Partners

Nadia Elouargui	Embassy of Norway
Betty Kasiko Ikanza	Social Development Advisor, DFID
Grace Namata	DFID
Mubaraka Mabuya	Team Leader, Support for Uganda's Response to Gender Equality (SURGE)

Implementing Partners

INGOs

Ellen Bajenja	Country Director, ACORD
Harriet Gombo	Director Programmes, Action Aid
Delphine Penault	Country Director, Care International,

Richard Mukhe	Child Protection Specialist, Child Fund International
Angela Rugambwa	Executive Director, International Rescue Committee
Jackson Chekweko	Executive Director, Reproductive Health Uganda
Laureen Karayi Nabimanya	Programme Coordinator, Uganda Women's Network

National NGOs

Joshua Kitakule	Executive Director, Inter-Religious Council
Tina Musuya	Executive Director, CEDOVIP
Irene Ovonji-Odida	Executive Director, FIDA Uganda
Lori Michau	Executive Director, Raising Voices

Field Visits

Adjumani

DHO, Ministry of Health

SRH, Ministry of Health

SGBV Working Group (15)

District Local Government (10)

Lewa Secondary School/Anti-GBV Group (IRC) (21)

GBV Survivors, ACORD staff (8)

IRC Staff

Gulu

Rose Jane Okilangole	Assistant District Health Officer & Gender Focal Person, District Government, Gulu
Angwech Pamela Judith	Executive Director, Women Economic Development Globalisation
Jennifer Ayot	Project officer/Legal, ActionAid Shelter
Alice Kipwola	Psychosocial Support Officer, ActionAid Shelter
Christopher Ayella	Team Leader, Straight Talk, Gulu Office
Emmanuel Rachkara	Project Coordinator, Straight Talk, Gulu Office

GBV Working Group (14)

Women's Household Group (10)

Peer Educators (16)

Role Model Men (10)

Cultural Leaders (9)

Moroto

Martin Jacan Gwokto	Chief Administrative Office
Andrew Rewes	District Medical Officer
Loru Moses King	Community Development Officer, Topac Sub-county
Joseph Oumo	Assistant Inspector of Police (AIP) Child & Family Protection Unit
David Korang	MOZIDEP
Grace Amaigiro,	Programme Officer, BRAC

BRAC Out of School Adolescent Girls Group (20)

Male Action Group (15)

C: Documents reviewed

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