Ministry of Gender, Labour and Social Development

Irish Aid
Department of Foreign Affairs
An Roinn Gnóthaí Eachtracha

Uganda Women's Network
UWONET
Gender Transformation & Empowerment

CEDOVIP
Center for Domestic Violence Prevention

Joint Programme To Address Gender Based Violence

FINAL EVALUATION OF THE GoU–IRISH AID JOINT PROGRAMME TO ADDRESS GENDER BASED VIOLENCE IN BUSOGA REGION

3rd August, 2016

The findings and opinions expressed in this report are the sole responsibility of the authors. They do not necessarily reflect the views of the GoU/ Irish Aid Joint Programme on GBV or any of the other parties involved in the implementation of the Programme.

FINAL EVALUATION OF THE GoU–IRISH AID JOINT PROGRAMME TO ADDRESS GENDER BASED VIOLENCE IN BUSOGA REGION

3rd August, 2016

Acknowledgements

We would like to acknowledge and extend thanks to the following persons who have made this evaluation and completion of this report possible:

GoU–Irish Aid Joint Programme to address GBV in Busoga region Programme Management Team (PMT) including the Ministry of Gender Labour and Social Development (MGLSD), Irish Aid, Center for Domestic Violence Prevention (CEDOVIP) and Uganda Women Network (UWONET) for providing all the prerequisite logistical support that enabled us to accomplish this assignment.

Members of the Technical team including Ms Maggie Kyomukama (Asst Commissioner, MGLSD), Mr. Noel Komunda (JP M&E Officer, MGLSD) Ms Caroline K. Laker (Programmes Officer, Irish Aid), Ms Tina Musuya (ED, CEDOVIP), Mr. Richard Makumbi (Programme Officer, CEDOVIP), Ms. Rita.H. Aciro–Lakor (Executive Director, UWONET), Ms. Laureen Kalayi (Programme Officer, UWONET), Mr Alfred Rwamirego (Communications Officer, UWONET) and Mr. Edwin Kayuki (Programme Officer, IRCU) for their overall supervision and invaluable input in the entire process of the evaluation.

Respondents at Central Government, District, Sub–county and Community levels for sparing their valuable time to participate in the evaluation.

Councilors, the NGO networks on GBV and the districts' technical teams representing the departments of Community Development, Education, Gender, Health, Magistrates Courts, Police, for giving us invaluable information to inform this evaluation.

Last but not least, the research assistants who worked tirelessly to collect data for this evaluation.

MAP OF UGANDA SHOWING COVERAGE (SHADED) OF THE GOU/ IRISH AID JOINT PROGRAMME ON GBV IN BUSOGA REGION.

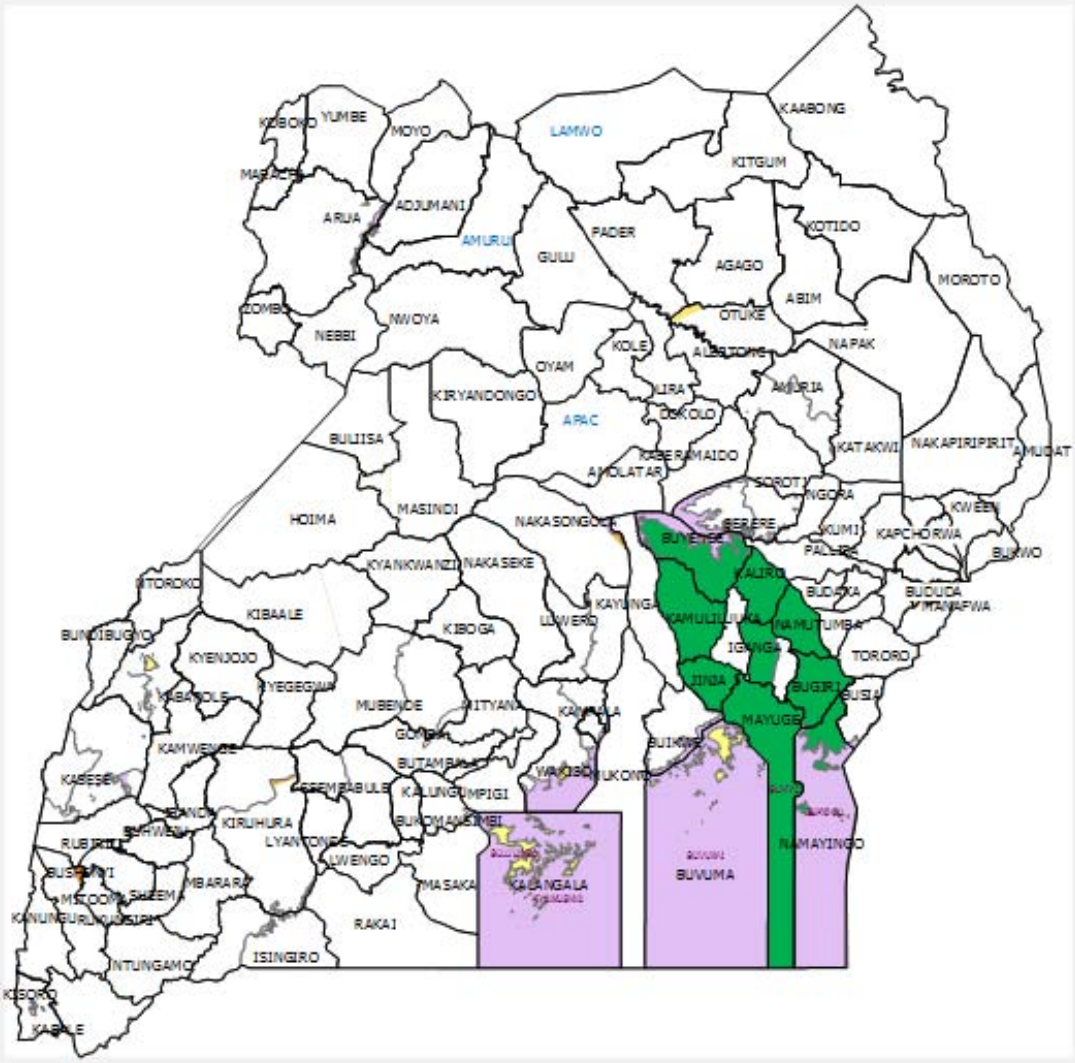


Table of Contents

Acknowledgements ---------- ii
List of Acronyms ---------- vi
Executive Summary ---------- ix

Section 1: Introduction 1

1.1 Background ---------- 1
1.2 Purpose of the Evaluation ---------- 2

Section 2: Evaluation Methodology 4

2.1 Evaluation Design ---------- 4
2.2 Sample size / Respondents ---------- 6
2.3 Limitations of the Evaluation ---------- 7

Section 3: Major Findings of the Evaluation 9

3.1 Introduction ---------- 9
3.2 Relevance ---------- 10
3.3 Effectiveness ---------- 13
3.4 Efficiency ---------- 34
3.5 Outcomes and Impact ---------- 36
1.6 Sustainability ---------- 45

Section 4: Implementation of Midterm Review Recommendations 47

Section 5: Lessons Learned 51

Conclusions and Recommendations 53

6.1 Conclusion ---------- 53
6.2 Recommendations ---------- 54

References 59

Annexes 61

List of Tables

Table 1: Programme Implementing Partners - - - 2

Table 2: Key features of the Quantitative and Qualitative approaches used in the evaluation - - - 4

Table 3: Evaluation Limitations and how addressed - - - 7

Table 4: Evaluaton Criteria - - - 9

Table 5: Link between the Programme and the national and international GBV priorities 13

Table 6: GBV cases reported in Kamuli District in 2012 and 2013 - - - 19

Table 7: Knowledge on what constitutes GBV (% of responses) - - - 27

Table 9: Allocation of funds to partners for the 5 year Period (€) - - - 35

Table 10: Responses on Attitude towards Wife Beating (Assault) (% of responses) - - - 37

Table 11: Help–seeking behavior for Females (% of responses) - - - 39

Table 12: Help–seeking preferred options for Males (% of responses) - - - 40

Table 13: Opinion on tolerance of different forms of GBV (% of responses) - - - 41

Table 14: Status of implementation of MTR recommendations - - - 47

List of Figures

Figure 1: Respondents' knowledge of referral pathway for GBV cases - - - 19

Figure 2: Respondents who have met or talked to a community activist - - - 25

Figure 3: Preferred choice of support when faced with violence - - - 29

Figure 4: Responses on whether a husband has a right to slap his wife if angry with her 37

Figure 5: Whether a woman should tolerate violence in order to keep her family - - - 42

Figure 6: Whether Women should be blamed for violence against them - - - 43

Figure 7: Whether Men should be blamed for violence against them - - - 43

Figure 8: Responses related to decision making and gender equality - - - 44

List of Acronyms

ACDO	Assistant Community Development Officer
BCC	Behaviour Change Communication
CA	Community Activist
CAGs	Community Action Groups
CAO	Chief Administrative Officer
CBO	Community Based Organization
CDO	Community Development Officer
CEDOVIP	Center for Domestic Violence Prevention
CID	Criminal Investigation Department
CLO	Community Liaison Officer
CPFU	Child & Family Protection Unit
CSOs	Civil Society Organizations
CSW	Commission of Status of Women
DAC	Development Assistance Committee
DCDO	District Community Development Officer
DIO	District Information Officer
DISO	District Internal Security Officer
DPC	District Police Commander
DPP	Directorate of Public Prosecution
DPTC	District Technical Planning Committee
DVA	
EQs	Evaluation Questions
FAL	Functional Adult Literacy
FGD	Focus Group Discussion

FI	Financial Institution
FIDA–U	Federation of Uganda Women Lawyers in Uganda
FY	Financial Year
GBV	Gender Based Violence
GoU	Government of Uganda
HC	Health Centre
HIV & AIDS	Human Immune Virus & Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
IEC	Information Education Communication
IRCU	Inter Religious Council of Uganda
JLOS	Justice, Law and Order Sector
JP	Joint Programme
KII	Key Informant Interview
LC	Local Council
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSC	Most Significant Change
MTR	Mid–Term Review
NACWOLA	National Community of Women Living With Aids
NDP	National Development Plan
NGBVD	
NGO	Non–Governmental Organization
OC	Officer in Charge
OECD	Organization for Cooperation and Development
PMT	Programme Management Team

RDC	Resident District Commissioner
RFW	
SASA	Start Awareness Support and Action
SGBV	Sexual and Gender Based Violence
TC	Town Council
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demography Health Survey
UGP	Uganda Gender Policy
UN	United Nations
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UWONET	Uganda Women's Network
VHTs	Village Health Team

Executive Summary

The GoU–Irish Aid Joint Programme (JP) to address Gender Based Violence (GBV) in Busoga region was implemented from 2010 –2015 with financial and technical support of Irish Aid. The region was targeted based on Uganda Demography Health Survey (2006) findings which established that Busoga region in Eastern Uganda had the highest incidences of sexual violence cases against women (53%). The programme was designed to contribute to improved quality of life and enjoyment of rights for all through reduced vulnerability and social tolerance to GBV in the community particularly among girls and women. The programme targeted the eight districts of Bugiri, Buyende, Jinja, Kaliro, Kamuli, Iganga, Mayuge and Namutumba. The programme was implemented by: Ministry of Gender, Labor and Social Development (MGLSD), Uganda Women's Network UWONET, Center for Domestic Violence Prevention (CEDOVIP) and Mystic Multimedia working in collaboration with local governments.

This evaluation covered the period December 2010–June 2015 and assessed the JP's performance in addressing GBV in Busoga Region based on the OECD–DAC evaluation criteria that focuses on relevance, efficiency, effectiveness, impact and sustainability. Five districts –Bugiri, Jinja, Kamuli, Mayuge and Namutumba were sampled. The Evaluation employed both quantitative and qualitative methods of data collection. While the quantitative methods involved data collection at household level, the qualitative methods included: document reviews, Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and observation. The evaluation respondents were: KII–100 people (41 females and 51 males), FGDs–534 people (274 females and 260males), Household survey–529 people (269 females and 260 Males).

Relevance

The evaluation found strengths in the programme design such as addressing real development challenges of the region and Uganda; having well focused and coherent objectives assigned to partners with comparative advantage; using relevant existing structures; employing a suitable mix of strategies and using a multi–sectoral approach to respond to GBV. However, programme missed some opportunities in the design which included: limited coverage and not having an advocacy component targeting local political leaders.

Efficiency

The programme had a total budget of UGX 5,648,055,000 (€1,805,231) for the 5 years and MGLSD got the biggest share of funds due to its central role of programme coordination. Funds for the programme were released once a year to the IPs who would provide accountability annually and directly to Irish Aid. This was contrary to what was provided for in the programme document which required all financial and management reports to be submitted to Irish Aid through the Permanent Secretary MGLSD quarterly.

Effectiveness

MGLSD took lead in the coordination of the programme. The overall coordination was through the GBV reference Group at the national level while at the district level it was through the District GBV Coordination committee. The GBV reference group and the Programme Management Team were instrumental in maintaining the cohesion between the partners. The district GBV coordination meetings helped in sharing information, building synergies and tackling bottlenecks. The coordination mechanism however, faced challenges which included: stalled activity implementation during the one year when the MGLSD had no programme funding; high staff attrition among some of the duty bearers at district level and high monetary expectations from some participants.

The MGLSD also lead partners on generating and disseminating GBV information for district and national level policy, programming and advocacy. As a result of this intervention, an M&E Officer was recruited; M&E strategy developed and operational zed; Functional GBV Data base is in place and accessed under www.ngbvd.mglsd.go.ug; local government manage the GBV database in their districts and are linked to the NGBVD; GBV BCC multimedia campaign was developed and implemented though short–lived; and data on GBV is collected, analyzed and disseminated for planning and policy at international, national and district levels. However, there were challenges related to: the programme M&E was not undertaken as one system linking all Implementing Partners (IPs) and districts; baseline was conducted before the M&E FW and could not link with programme objectives and their indicators, and data quality was wanting.

The Uganda Women's Network (UWONET) was the lead partner on building capacity of duty bearers in Local Governments to prevent and respond to gender–based violence. The duty bearers' were equipped with knowledge and skills on GBV which helped improve the quality of service delivery and fostered close collaboration and support of each other. GBV shelters were built to provide temporary home for GBV survivors that are unable to return home immediately after reporting and some civil society GBV actors were strengthened to for better action in prevention and response. Duty bearers have integrated GBV in their work and operationalized the referral pathway. However, there were challenges that included: high staff attrition requiring continuous training; high cost of management of GBV shelters; and high cost of supplies and logistics.

The Center for Domestic Violence Prevention (CEDOVIP) was the lead partner on mobilizing communities with a particular focus on strengthening male involvement as agents of change to prevent and respond to GBV. To achieve this, the SASA! Model was utilized. As a result of this intervention, the DCDOs, CDOs/ACDOs and CAs attained knowledge and skills and motivation for application of SASA! Model. The Community Activists (CAs) were instrumental in awareness creation on GBV and guiding reporting of cases and their role is appreciated by the community. Community Action Groups (CAGs) contributed to expanding GBV awareness especially among the male folks and increasing understanding of GBV and its different forms and encouraging their pears to use peaceful means of resolving misunderstandings in their homes. Women were empowered to negotiate and participate in decision making at household level.

Impact

The evaluation established some impacts of the programme such as positive change relating to attitudes towards wife beating; improved help–seeking behavior, especially among men, and, reduced community tolerance to GBV. The most significant change attributed to the programme is the breaking of the silence on GBV in Busoga region evidenced by increased reporting of GBV incidences and the activism among community members.

Sustainability

The evaluation established opportunities for sustainability such as: programme having worked through existing government institutions and structures; duty bearers with the knowledge and skills that they will continue to use; community activism through the annual commemoration of the 16 days of activism against GBV; and work of community activists and community action groups. However, low revenue base of local governments, high cost of management of shelters and expectation of monetary facilitation for participation in activities pose a challenge to sustainability of the programme.

Some of the lessons learnt included: To ensure successful implementation requires engage multiple partners including Government, CSOs, Private sector since GBV is a multifaceted phenomenon which requires a multipronged approach. The use of existing structures at all levels (national, district, sub–county and community) makes programme implementation cost effective and sustainable. Engagement of local Leaders through lobbying and advocacy increases programme ownership leading to contributions to interventions. Getting the community to take lead to initiate changes in their own social cultural set–up yields positive progress than using outsiders. SASA! Model is an effective method for getting the community understand their social–cultural practices and enables them to come up with ways of solving identified problems.

Recommendations

Based on the findings, the evaluation recommends the following:

a. *Broaden the scope of programme design***.** There is need to broaden the scope the tackle some of the underpinning causes of GBV such as HIV and AIDS, food security and Nutrition, income poverty.

b. *Ensure consistency in organization of quarterly meetings of District GBV Coordination Committee.* This could be done by making the quarterly meeting a key pre–requisite and trigger for disbursement of funds.

c. *Strengthen the role of District GBV Coordination Committee* chaired by the CAO and comprised of the RDCs office, technical departments and CSOs to ensure that quarterly meetings are held.

d. *Strengthen Sub–county coordination.* The programme design did not provide for sub–county coordination yet this is the closest level to targeted communities where action needs to be well coordinated and impactful.

e. *Increase coverage of the programme to target the entire Busoga region including all parishes and villages through strengthening Government structures.* Possibilities of co–funding from districts could be explored if there are funding limitations to the expansion.

f. *Integrate GBV in Health and JLOS training.* There is need for advocacy for Health and JLOS training institutions to include GBV in their curricula to enhance their capacity to provide a holistic response to prevention of GBV.

g. *Review model of construction of GBV shelters with a view to shifting focus towards prevention and legal support to victims.* Investing in prevention, through CAs and CAGs and working with faith based institutions while providing the legal support to victims seem more plausible mechanisms for GBV survivor support than GBV shelters.

h. *Make the DVA Popular among the duty bearers especially police and judicial system.* More sensitization about DVA be conducted targeting especially the Police and Judicial Officers.

i. *Continued use of SASA methodology as an effective method for* use in GBV prevention interventions and scale up to other districts as a model in GBV programming, response and prevention.

j. *Improve the National GBV Data base* to make it more reliable and functional.

k. *Strengthen skills exchange, recruitment and graduation of volunteers through s*etting a clearly defined timeframe in which one will be a Community Activist and thereafter handover their responsibilities to the next group of volunteers in a formal way.

l. *Continued GBV BCC multimedia campaign.* One way for media support would be for LGs to request their local media houses for concessional air time for airing GBV related messages and radio programmes.

m. *Continue support for commemoration and participation in the 16 days of activism* at district and sub–county levels supported through district budgets.

n. The evaluation suggests that the following areas of work be prioritized and strengthened in the next 2 years:

   i. *National Level:*
      - ⇨ Improve the NGBV data system; and
      - ⇨ M&E System revitalization.

   ii. *District Level*
      - ⇨ Support District GBV Coordination Committee.
      - ⇨ Explore phasing out construction of GBV Shelters Program with a move to shift towards prevention and provision of legal support after the programme closure.
      - ⇨ Training and sensitization of CAOs and Political leaders.
      - ⇨ Sensitization and training of Police and Judiciary on DVA.

   ii. *Community Level*
      - ⇨ Strengthen sub–county involvement by orienting Sub–county chiefs and Parish chiefs.
      - ⇨ Replication of SASA Model.
      - ⇨ Use of Radio for BCC.
      - ⇨ Commemoration of 16 days of activism.

1

SECTION 1:
Introduction

Section 1: Introduction

1.1 Background

Incidences of Gender Based Violence in Uganda remain high despite Uganda signing and ratifying a number of international human rights treaties which expressly prohibit sexual and gender–based violence. According to the Uganda Demographic and Health Survey (2011), 63% of the women in Uganda had experienced physical or sexual violence or both in their lives. The study findings further indicated that Gender Based Violence ranked highest in Busoga sub–region compared to any other region in Uganda.

The GOU Irish Aid Joint Programme to address GBV in Busoga was a 5 year programme implemented with financial and technical support of Irish Aid as a response to the high GBV incidences in Busoga sub–region. The programme was implemented from 2010–2015 and covered eight districts of Busoga region [districts created by 2010] including Bugiri, Buyende, Jinja, Kaliro, Kamuli, Iganga, Mayuge and Namutumba.

1.1.1 Programme Goal and Objectives

The overall goal of the Joint Programme was to contribute to improved quality of life and enjoyment of rights for all through reduced vulnerability and social tolerance to Gender Based Violence in the community particularly among girls and women in Busoga region.

The specific objectives of the Joint Programme included the following;

a. Strengthen coordination among key actors at national and local government level for effective prevention and response to GBV

b. Build capacity of duty bearers in Local Governments in Busoga Sub region to prevent and respond to Gender Based violence;

c. To mobilize communities with a particular focus on strengthening male involvement as agents of change to prevent and respond to GBV".

d. generate and disseminate information on GBV in Busoga Sub–region to inform policy, programming and advocacy

1.1.2 Implementation Mechanisms of the Joint Programme

The Joint Programme was implemented by various partners as indicated in Table 1.
Table 1: Programme Implementing Partners

Implementing Partner	Roles and Responsibilities under the Joint Programme
Ministry of Gender, Labour and Social Development (MGLSD)	Lead partner for the implementation of objective 1 [coordination among key actors] and objective 4 [generation and dissemination of information on GBV.
District Local Governments	Coordinated the implementation of the programme through their established structures for service delivery
Centre for Domestic Violence Prevention [CEDOVIP]	Lead implementing partner under objective 3, [To mobilize communities with a particular focus on strengthening male involvement as agents of change to prevent and respond to GBV]
Uganda Women's Network [UWONET]	Lead implementing partner under Objective 2:[To build capacity of duty bearers in Local Governments in Busoga Sub–region to prevent and respond to GBV]
Mystic Multi–Media	This was a private sector partner contracted to develop an effective IEC strategy to facilitate the dissemination of information to communities at all levels.

1.2 Purpose of the Evaluation

Following the expiry of the 5 year Joint Programme, the steering committee of the GOU Irish Aid Joint Programme to address GBV in Busoga commissioned an evaluation of the programme, to help inform the development of a 2 year transition strategy [of up to 2018] when Irish Aid financial support to the programme is expected to end.

The broad purpose of the evaluation was to assess the impact of implementation of the Joint Programme towards reduction of vulnerability to GBV in the target districts. Secondly, the evaluation would also provide evidence of lessons and good practices that can improve design, planning, management, monitoring and evaluation of future GBV prevention and response interventions in the region and elsewhere.

1.2.1 Objectives of the Evaluation

The Evaluation had four objectives which were set out in the Terms of Reference (ToR). These included:

a. Take stock of programme achievements, challenges and opportunities.

b. Assess the continued relevance of the programme as well as the related sustainability of benefits in the region.

c. Assess the programme design, objectives, strategies and implementation arrangements in light of changes in the current GBV prevention and response context in Uganda.

d. Identify key lessons and make recommendations on innovative strategies to improve GBV prevention and response in the context of Busoga region.

1.2.2 Scope of the Evaluation

The evaluation covered the period; December 2010–June 2015

SECTION 2:
Evaluation Methodology

2

Section 2: Evaluation Methodology

2.1 Evaluation Design

A mixed method design was employed to undertake the evaluation. This involved the collection and analysis of quantitative and qualitative data from the perspective of key stakeholders and those involved in the delivery of the programme. A detailed description of how the 2 approaches were employed is provided under Table 2.

Table 2: Key features of the Quantitative and Qualitative approaches used in the evaluation

Key features of methods used	Quantitative	Qualitative
What and How (collected)	Primary data was collected through a structured questionnaire at household level.	Data collection methods included review of documents, key informant interviews, focus group discussions, and to some extent, observation.

Key features of methods used	Quantitative	Qualitative
	The questionnaire comprised of pre–coded items and covered background variables, knowledge of GBV, socio–cultural GBV practices and progress made towards reducing community tolerance to GBV and behavioral change. The questionnaire was administered by a team of research assistants who were trained before fieldwork and were involved in pre–testing and refinement of the survey tool.	Tools/guides such as document review checklist, a key informant interview guide, a focus group discussion guide, a health center checklist were developed and used to inform data collection 100 Key Informant interviews of key stakeholders (41 female and 51 males) were conducted 8 Focus Group Discussions (FGDs) 6–12 persons covering 534 respondents [274 females and 260 males] was undertaken at village level. Details are reflected in Annex1 The observation method was used in different areas such as the Police stations, shelters, communities and health centres. The evaluation team took particular interest in observing the availability and display of GBV BCC/IEC materials and privacy for service provision. In order to capture significant–critical positive and negative changes, the most significant change method was employed. This involved asking programme implementers and beneficiaries to mention what they considered the most significant changes that had been brought about by the programme. Testimonies of individuals during interviews and FGDs were documented as case studies to provide insights about what had changed for some participants in the programme.

Key features of methods used	Quantitative	Qualitative
How (sampled)	Respondents for the household survey were randomly sampled A sample size of 412 was selected at 5% margin of error to represent a population of 623,771 households [Based on Krejcie and Morgan's (1970)]	Purposive sampling was used for selecting key informants based on relevant departments and offices that the programme had collaborated with In case of Focus Group Discussions (FGDs), participants were selected from villages different from those where the household survey had been undertaken, to avoid double participation
How (analysed)	The results of the household survey were analysed using the Statistical Program for Social Scientists (SPSS) to generate logical checks, frequency and cross tabulations	Data analysed using content and thematic analysis which involved classifying responses into meaningful categories so as to bring out patterns in line with the evaluation objectives

2.2 Sample size / Respondents

The evaluation respondents included different stakeholders and participants in the programme at national, district, sub–county and community levels. At National level, respondents included the officials of the MGLSD, Irish Aid, CEDOVIP, UWONET and the Inter–religious Council of Uganda (IRCU). At district level, respondents included the RDCs, CAOs, Town Clerks and technical officers of relevant departments, Councillors in charge of Social Services, Police, Magistrates office, and Religious and Cultural leaders. Respondents at the Sub–county level included the Sub–County Local Council Chairpersons (LCIII), the Sub–county Chiefs, the Community Development Officers (CDO), health centre in charges, and religious leaders. At community level, members of the community–women and men, Community Activists and Community Action Groups, Local Council Chairpersons (LCI).

2.2.1 Selection of Districts

Five districts out of the 8 implementing districts were selected for the evaluation, namely: Bugiri, Jinja, Kamuli, Mayuge and Namutumba. The districts were selected purposively to ensure comprehensive coverage of programme components and services and geographical location taking into consideration the urban and rural locations.

2.2.2 Selection of Sub–Counties, Parishes and Villages

The evaluation employed the random sampling method to select sub–counties, parishes and villages for the field visits. In this regard, in each district, only 2 sub–counties were selected. Similarly, in each of the sub–counties selected, 2 parishes and 2 villages were selected randomly from those covered by the programme.

2.2.3 Characteristics of the Respondents

In order to gain a better understanding of evaluation, the following demographic and socio–economic characteristics of the respondents for the survey were captured.

- *Gender:* Of the total population sampled, women comprised 51% while Men were 49%.
- *Ag:* 52% were above 35 years of age, 14.6% were between 30–34 years, 15.5% between 25–29 years and 13.6% between 20–24 years of age.
- *Marital status:* 76% were married, 12.7% were single, 5.9% were widowed and 1.5% were divorced and 4 % were separated.
- *Levels of education:* 42.4% females and 36.5% Males had completed primary education while at least 1.1% females and 5.8% Males had completed University education. Analysis of education levels is critical in assessing Gender Based Violence as it is believed that the chances of one getting involved in GBV reduces with attainment of high levels of education.
- *Religion:* Most respondents were Protestants (34.8%) followed by Muslims at 34.2%. The least were Bahai at 4%.

2.3 Limitations of the Evaluation

Table 3 shows the limitations of the evaluation and how they were addressed.

Table 3: Evaluation Limitations and how addressed

Limitation	How addressed
Lack of data on GBV cases; GBV case recording was not consistently done over the years and among data collection centers as such it was difficult to establish trends	The evaluation relied on data from literature review
Lack of reliable baseline data; the baseline could not be relied upon to measure programme progress as it was not tailored to programme objectives and UDHS impact indicators	The evaluation compared with Mid–Term Review report

Limitation	How addressed
It was not possible to do in–depth analysis of GBV interventions by other GBV actors as such it was not possible to delineate the sole contribution of the programme regarding impact (attribution).	The evaluation measured programme performance up to outcome level and construed MSC and impact from data collected.
High attrition of duty bearers especially police made it difficult to acquire accurate historical information about the programme as some were new and did not know much about the programme.	The evaluation used a group approach with new ones being interviewed with old to support each other in information provision i.e. Jinja the Ag DCDO with team and in Mayuge the Child and Family Protection Unit was interviewed in a FGD.
The programme key out puts as shown in the Results Framework in the M&E Plan had no targets. As such it was not possible to measure the programme performance against targets. In addition, there was no standard reporting format that was consistently followed in the 5 years. For instance the Annual Report FY 2013/2014 had a summary of results indicating Activities, targets and results while others did not. It was therefore not possible to measure annual and overall programme performance based on preset targets.	The evaluation analyzed performance based on activity implementation and fieldwork findings.
Baseline and MTR Data not sex disaggregated rendering it difficult for comparison.	Evaluation only compared the totals.

3

SECTION 3:

Major Findings of the Evaluation

Section 3: Major Findings of the Evaluation

3.1 Introduction

The evaluation was based on the Organisation for Economic Co–operation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria of: Relevance, Efficiency, Effectiveness, Sustainability and Impact. The evaluation focuses for each of the criteria are explained in Table 4.

Table 4: Evaluaton Criteria

Criteria	Evaluation Focus
Relevance	The extent to which the objectives of the Joint Program are consistent with the evolving needs and priorities of the beneficiaries, partners, and stakeholders particularly in Busoga sub–region.
Efficiency	A measure of how economically resources / inputs (funds, expertise, time, etc.) were converted to results
Effectiveness	The extent to which the Joint Program's objectives were achieved. The basis for this inquiry will be the programme results framework and the following questions will guide analysis:
Impact	Positive and negative, primary and secondary long–term effects produced by the Joint Program, directly or indirectly, intended or unintended
Sustainability	The likelihood of a continuation of benefits from implementation or the probability of continued long–term benefits.

3.2 Relevance

3.2.1 Relevance to the needs and priorities of beneficiaries

The Joint Programme was designed to respond to high GBV incidence that was identified in Busoga sub–region during the UDHS 2006 and the Irish Aid scoping study Scoping study (Assessment on coverage of GBV programs in Uganda) in 2008 which examined the prevalence of Gender Based Violence (GBV) in Uganda and found that GBV was highly prevalent in Busoga region and yet was left out by other GBV prevention and response related programmes.

The programme design was consistent with the needs and priorities of the beneficiaries and had made substantial progress towards meetings its goals and objectives. This was measured through the use of a multi–sectoral approach, involving Government (MGLSD, MOH, JLOS and Local government), Civil Society Organizations, Development Partners and Private sector (Mystic Media) to GBV prevention and response in Busoga region. This approach was critical because Gender based violence is a multifaceted problem which required tackling from different angles.

Similarly, the programme employed a good mix of strategies for tackling GBV in Busoga region including: Capacity development, the SASA approach, Behavior Change Communication (BCC) and Coordination to harmonize efforts and build synergy. These ensured that knowledge and skills among duty bearers would be enhanced so as to be able to provide the services needed to prevent and respond to GBV. BCC was meant to deliver behavior change among men and women through activities and messages well–tailored for the purpose.

Coordination was deemed necessary as there were many players in government, civil society and private sector that needed to be brought together to make a combined effort to address GBV in the region. The SASA Model was appropriate as there was dire need to change socio–cultural norms and attitudes that were fueling GBV. The programme involved men in GBV prevention and targeted them to address male abuse of power in family relations. The programme also used local structures of LCs and identified Community Activists as agents of change.

Cooperation and working through the cultural institution of the Kyabazinga and the Interreligious Council of Uganda (IRCU) was crucial and made it possible to engage with the cultural and religious aspects around GBV. These structures were also vital in the mobilization of communities.

Despite the existing linkages, this evaluation found that programme had fallen short of meeting the needs and priorities of beneficiaries in 2 critical areas which included the following:

a. Link between other development concerns with GBV

The programme design did not make explicit the connection of GBV to food security and Nutrition, poverty and child marriage all of which exacerbate GBV. The programme missed out economic empowerment as a key intervention strategy as one leader commented:

> *"…there needed to be an objective on livelihood right from the start, production is key, when homes have food and can have surplus, the money will flow and hence GBV is an effect yet the underlying causes were not duly addressed by the programme" KI District Political Leader.*

A deliberate focus on enhancing food security and nutrition at household level would thus go a long way in building household resilience which would increase harmony, income and general feeling of success within the family. These would in turn have a ripple effect on reducing incidences of GBV.

b. No direct focus on Children and Youth

Involvement of children and youth is important in tackling GBV. This is because of various reasons including; they are victims of GBV, in some instances, they are the perpetuators and involvement at an early stage provides an opportunity for the programme to influence their attitudes towards GBV at an early age. Despite this however, the design of the programme did not include children and youth both in and out of school as direct beneficiaries. However, children were found to be indirect beneficiaries through the GBV shelter model approach and the temporary shelter facilities with their mothers. It was also hoped that where capacity and services were improved, the children and youth would benefit. Similarly, the evaluation found high incidence of early marriages where children were victims of GBV such as in the case below:

> *After one of the interviewers had just concluded with a female respondent, "husband" (aged 17 years) arrived and started quarreling with his "wife" of 13 years who had a child of 6 months. The 'wife' complained to the interviewer that the 'husband' has another 'wife' aged 15 years, in town and that he had*

mortgaged the house they live in to a financial institution (FI) to get money to marry the second wife and that now the FI was selling the house. The young man on his part claimed the wife has childish behavior and does not even care for the baby. The man said "this silly woman is always playing 'Kwepena" (Translated into "dodge ball" game) instead of cooking and looking after the baby". The interviewer however cooled down the tempers of the two before she left". Household respondent Mayuge district.

3.2.2 Alignment with the national and international frameworks

The evaluation found that the programme was well aligned to national and international frameworks on tackling GBV. At national level, the programme was aligned to the National Development Plan (NDP1 2010/11–2014/15) which prescribed actions for women empowerment as well as reforms prohibiting discriminatory practices based on gender. For instance, the Amendments to the Penal Code prohibiting defilement of girls and boys (2007); The Domestic Violence Act (2010); The Anti–Female Genital Mutilation Act (2010); The Prevention of Trafficking in Persons Act (2010) and the International Criminal Court Act (2010) criminalizing sexual exploitation of women and children during conflict situations, the National Gender Policy 2007 and the National Action Plan on GBV.

On the international arena, the programme was aligned to relevant international and regional legal frameworks such as the UN Resolution 1325, 1820 and 1889, the Maputo Protocol, the Convention on the elimination of all forms of discrimination against Women (CEDAW), Goma Declaration and Kampala Declaration/ICGLR), the African Union (AU) Resolution on Gender Equality and Common Wealth Gender Protocol. The UN SCR 1325 focuses on ensuring access to justice and rule of law for women and girls in conflict prevention, early recovery, relief and peace building processes. The UNSCR 1820 on its part condemns the use of systematic practice of rape and other forms of inhumane and degrading treatment of women as a deliberate instrument of war and ethnic cleansing.

During the MDG period (2005–2015) the MGLSD was responsible for MDG 3 which was ***"Gender equality and empowerment of women".*** The programme therefore was a timely contribution to achievement of this mandate.

The linkages between the programme and the national and international GBV priorities are shown in Table 5.

Table 5: Link between the Programme and the national and international GBV priorities

National Development Plan Priority Objective	National Development Plan, GBV Strategic area of action	The Uganda Action Plan on UN SCR 1325, 1820 and the Goma Declaration	The JP Outcome
Increasing access to quality social services and enhancing Human capital development	Reduce Gender Based Violence and Promote Women's Rights	Strategic Objective 2: Improved Performance of the different actors involved in combating GBV. Strategic Objective 1 under 4.4: Build community and Institutional capacity to ensure the prevention of GBV in society.	Reduced vulnerability to GBV in the community especially amongst girls and women in Busoga Sub region by 2015.

Source: Programme Document FY 2010/11–2014/15

On the overall, the evaluation found evidence to show that the programme was relevant and was tailored to respond to GBV as a development challenge facing the people of Busoga despite the various interventions that several other players have put in place. The GBV problem was found to be multifaceted, portraying itself as a cause and effect of extreme poverty.

3.3 Effectiveness

The Programme Goal was: "to contribute to improved quality of life and enjoyment of rights for all" and had its outcome as "reduced vulnerability to GBV in the community especially amongst girls and women in Busoga Sub region by 2015". The specific objectives of the programme included the following;

a. To strengthen coordination among key actors at national and local government level for effective prevention and response to GBV

b. To build capacity of duty bearers in Local Governments in Busoga to prevent and respond to gender–based violence

c. Mobilizing communities with a particular focus on strengthening male involvement as agents of change to prevent and respond to GBV

This section analyses and presents the extent to which the programme performed regarding achieving the set objectives.

3.3.1 Strengthening coordination among key actors at national and LG level for effective prevention and response to GBV

This was achieved as described below:

National Level Coordination

The overall coordination of the programme was by the GBV Reference Group chaired by MGLSD. This was responsible for providing oversight to the some of the roles of the GBV Reference Group included approval plans, budgets and reports, review and approval of guidelines on GBV such as; the national guidelines for the implementation of the referral pathway, national guidelines for provision of psychosocial support for GBV survivors, national guidelines for –elimination of GBV tabled in Cabinet for final approval of the national GBV Policy. The GBV Reference Group also ensured there was more collaboration among GBV actors, sharing experiences and lessons from their respective interventions/ programmes.

District level coordination

At the district level, the programme was coordinated through a District GBV Coordination Committee except for Kamuli which preferred to have a GBV Shelter Steering committee in addition to the GBV Coordination Committee. The District GBV Coordination committee brought together different GBV actors in the district including local government and Civil Society to discuss plans and actions for addressing GBV in the district. The Committee is chaired by the district CAO and is composed of representatives of the Technical Planning Committee (TPC), duty bearers, and CSOs such as: UWONET, Action Aid, NACWOLA, PLAN Uganda and FIDA.

The GBV DCC meetings which were held quarterly were quite useful as they deliberated on a wide range of issues including: sharing information, progress made, challenges stakeholders were facing, stakeholder activities and referral while identifying who can best handle what, budgeting and planning, possible synergies, solving bottlenecks and following up on actions agreed upon in previous meetings. The GBV DCC meetings helped to harmonize positions and iron out possible conflict areas among service providers while strengthening a joint approach among duty bearers to address GBV.

The GBV reference group and the Programme Management Team were instrumental in maintaining the cohesion between the unique partners. The district GBV coordination meetings helped in sharing information, building synergies and tackling bottlenecks.

"In one of DCC meetings UWONET brought out the issue of health workers charging some money from GBV survivors, it was resolved that this stops and it did"–KI District Level

The district level coordination was done as all districts convened the GBV DCC meetings albeit with different frequencies. As a result of coordination at district level, there was more collaboration among duty bearers which streamlined and improved GBV service provision. For instance the probation and social welfare officer refers GBV cases to Child and Family Protection unit.

"In the past health workers would be invited to testify in court and the judges would keep them waiting for even a whole day at the expense of service provision back at their health facilities, they would not even have transport and the case could be postponed several times but when we engaged the Judiciary this improved"–KI District level.

The evaluation however observed that despite the good performance, the district GBV coordination faced some challenges due to the frequent transfers of staff members especially in the JLOS and Health sectors. Newly transferred officers within the police and health departments did not immediately understand and feel to be part of programme. In addition, there was a lot of delegation of junior officers to the GBV coordination meetings as senior officials claimed were too busy with other duties which undermined the quality of the deliberations during such meetings.

Sub–county level coordination

The programme design did not provide for coordination meetings at sub–county similar to the one at the district level. However, the CDOs ensured programme coordination through holding monthly meetings with CAs.

3.3.2 Building the capacity of duty bearers in LGs in Busoga to prevent and respond to gender–based violence

Building capacity of duty bearers is critical in ensuring effective prevention and response to GBV. Under the programme, progress in this area was to be measured by: a) Number and category of duty bearers identified to prevent and respond to GBV; b) Number of capacity building interventions by category for duty bearers to prevent and respond to GBV and c) Number of Public and CSO actors trained by sex and category in targeted districts. Some of the programme achievements include:

a. Bearers on GBV identified

The evaluation found that a number of duty bearers were sensitized to appreciate the challenge of GBV in Busoga region. The duty bearers targeted for capacity building included Chief Administrative Officers (CAOs), District Community Development Officers (DCDOs), Probation and Welfare Officers (PWOs) and Gender Officers (GOs). Other duty bearers critical to GBV response that were targeted included the Police, Staff of health centers (HC IV, III, and II,), and to some extent, the Magistrates'

Courts. Civil Society Organizations (particularly women's organizations), Local Council Chairpersons, Councilors and Resident Districts Commissioners (RDCs), Sub–county Chiefs and CDOs were also targeted although the focus was more on CDOs. At community level, the targeted duty bearers included the Local Council Chairpersons at Village level (LC1).

b. Duty bearers equipped with knowledge and skills to prevent and respond to GBV

Responses from interviews with the duty bearers revealed that the programme had ably equipped them with knowledge and skills on GBV. Of instance, Police Officers interviewed indicated that although they knew that some aspects of GBV like domestic violence, rape and defilement were crimes, they did not understand the circumstances and challenges that survivors went through. As a result, they treated perpetrators as suspects and survivors just as cases. On the other hand, health workers mentioned that they were now able to identify GBV cases from general health cases received. They are able to appreciate the urgency of handling such cases and carrying out the examinations

required and filling the forms so that survivors can proceed if they wished to pursue cases to court.

Trainings of duty bearers and knowledge sharing on GBV were conducted through Duty Bearers Forums held at national and in Busoga region. The evaluation established that forums were mentioned as key events that galvanized the energy and commitment of duty bearers to work to reduce GBV in the region. Duty bearers on GBV work in close collaboration and support each other in providing response services. They are able to handle cases within their capacity and refer others as appropriate. The existence of shelters had also greatly improved management of cases

and more cases are handled and disposed of faster than before. This is illustrated by what one of the health centre staff said:

> *"Now we have a close relationship with other actors on GBV. For instance when there is need to examine an urgent case of rape or defilement, the Police bring the survivor and we help them without asking to be paid. Sometimes UWONET calls the health centre and we support the survivors accordingly"– KI, Health Centre III.*

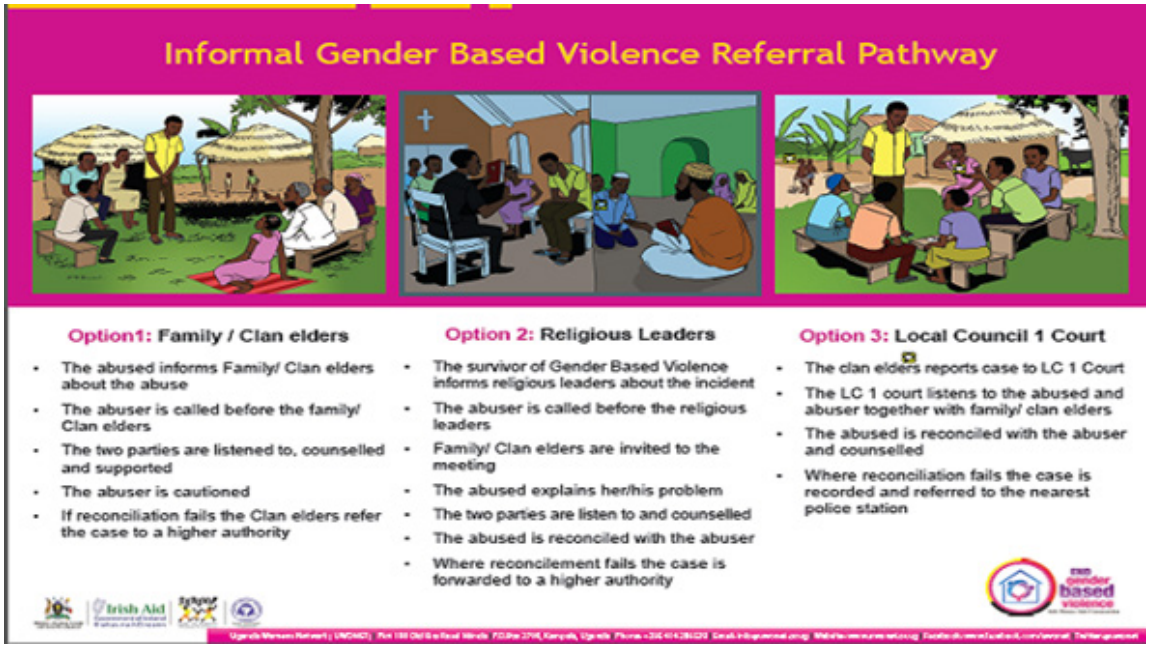
Provision of Stationery to Police

Capacity building also involved provision of essential stationery and supplies to police. Each district was provided with materials which included: typing papers, file covers, box files, punching machines, stapling machines/wires pins, clips, Police tool 6, Form PF3A appendix for medical exam for the victims. The Police appreciated the provision of stationery and mentioned that the materials received had helped them improve in service delivery. This was noted by a Police Officer, who noted that *"the support from UWONET has brought a lot of change. We now have materials and there are no more complaints about police relating to lack of materials like Police Form 3A. Because of increased sensitization, there is increased reporting. So the cases may not have reduced as such. What is important is that when cases are reported, we are now better equipped to handle them."*

Casebooks provided to the LC1 Chairpersons were said to be very useful in keeping a record of all the cases and how they have been handled. This notwithstanding, the evaluation did not find evidence that the data being collected was being utilized. Some respondents complained that no one monitors what they do or looks at the data of cases they have collected.

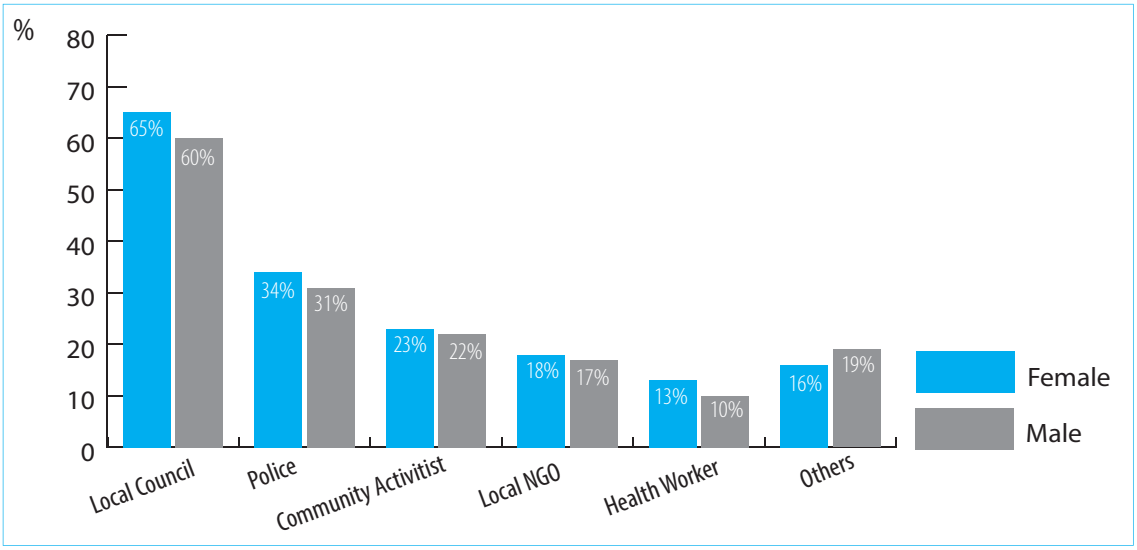
Referral Pathways established and functional

The duty bearers understand and execute their mandates with respect to the referral pathway which is clear to all and has been internalized. Some of the duty bearers interviewed by the Evaluation Team mentioned that the referral pathway were now functional and had been reinforced by the existence of survivor shelters in the districts. Local Council Chairpersons interviewed indicated that they were now conversant with the referral pathway and were able to refer victims/survivors appropriately without attempting to handle cases which are not within their mandate. They indicated that they were now able to separate GBV cases from other general cases and understood that cases like rape and defilement were beyond their jurisdiction and required to be referred appropriately.



Both the formal and the informal pathways have been instrumental in increasing awareness of GBV and communities' understanding of where they can go for help when they experience GBV. Survey results from communities indicate that most people understand the referral pathway. Figure 1 illustrates respondents' knowledge of referral pathway with respect to where to report cases of GBV. The responses indicate that local councils were the most preferred service point for reporting of GBV issues (60% Male, 65% Female), this was followed by Police (31% Male, 34% Female), and Community Activist (22% Male, 23% Female). These findings were collaborated by information from FGDs and KIIs. Participants in FGDs indicated that they knew where to report GBV cases.

Figure 1: Respondents' knowledge of referral pathway for GBV cases (% of responses)



Source: Survey data

GBV survivors utilizing GBV response services

Respondents indicated that the increased awareness at community level resulted in increasing numbers of GBV survivors seeking help at various response points. This increase is demonstrated by the increase in numbers of cases reported to various service points. Table 7 shows cases reported in 2012 and 2013 in Kamuli District. The figures indicate an increasing trend in most of the categories of cases reported except for defilement and child neglect which appear to have remained almost the same. The figures indicate that domestic violence cases reported increased from 124 to 165 in 2013; indecent assault from 12 to 21 and rape from 5 to 15.

Table 6: GBV cases reported in Kamuli District in 2012 and 2013

Nature of Cases	Number of Cases reported	
	2012	2013
Defilement	466	465
Rape	5	15
Indecent Assault	12	21
Missing/abandoned children	60	85
Child neglect	69	68
Domestic Violence	124	165
Child abuse and torture	10	14
Child desertion	19	27

Source:

Increased utilization of GBV service points was confirmed by KIIs and FGD participants as the reason for the high existence of reporting. One of the key informants mentioned:

> *"Before the GBV programme came to the District, GBV was very high in the district, especially domestic violence, however, many people were not reporting. But as a result of the programme, Communities are reporting to UWONET, DCDO, Probation and Police. Other cases are reported to local councils. For instance, recently a step–father defiled a girl child. The mother reported the matter to Police and the perpetrator was arrested and charged. The relatives started threatening the woman for having reported. She also reported the threats and the RDC went to the family and warned the relatives. Now the man is in prison and the woman is at home and no one is threatening her anymore."*

GBV Survivor Shelters established and functional

Provision of temporary shelters to accommodate survivors of GBV was not in the initial programme design. However, early in the implementation of the programme, it was realized that as awareness on GBV increased in the community, more cases were being reported to CAs, LCs and Police. It was increasingly becoming difficult to handle GBV cases at these service points because some GBV survivors would not be able to go back to their homes after reporting for fear of repercussions. The increased numbers of cases reported generated the need to create shelters where survivors could be accommodated temporarily when their issues were being sorted out.

After consultations and learning visits to different countries, Survivor shelters were established in Kamuli and Namutumba districts. The two districts provided land and resources were secured to construct the shelters. The shelter in Kamuli was opened in 2013 and launched in 2014 and was the first of its kind in Busoga region. During the opening ceremony, the Inspector General of Police made a pronouncement to establish special desks in all police stations and police posts country wide to handle cases of Sexual Gender Based Violence (SGBV). This was an outstanding achievement of the programme. Advisory Centers in Kamuli and Namutumba were opened by UWONET to support survivors. Each of the Advisory Centers employs a coordinator and a lawyer. The survivors admitted at the shelters are under the care of a shelter matron who ensures that the survivors are kept safe. The shelters are under tight security and men are not allowed to visit the shelters.

Evaluation found that the shelters have been useful in facilitating the duty bearers to provide services to survivors. They now have a place to accommodate survivors while their cases are being attended to. The presence of a lawyer to follow–up on cases has facilitated the handling of cases in courts of law. This arrangement has helped to have cases followed up much faster and disposed of. In addition, the GBV survivors are counseled and provided with livelihood skills such as making handcrafts for sale. On discharge, they are given start up kits to enable them get started upon reaching home and re–integrated in the community.

The Police appreciate the shelters since before; they used to put survivors in police cells or sometimes at the homes of the officer in charge of the cases at police. This presented a burden to the police, keeping survivors in cells with suspects some of whom were criminals. In addition, the Advisory Centers are

There is increased awareness of GBV and institutional mechanisms for redress of GBV amongst community members. There is also increased reporting of GBV cases while the 16 days of activism event is a successful platform for awareness creation and advocacy

useful in pushing the cases through Court or concluding them through mediation. They mentioned the advisory center staff follows up to ensure that files are produced when they are needed in court.

The shelters are equally appreciated by other duty bearers including health personnel at health centers where survivors are taken for examination. The Local Government officials in Kamuli and Namutumba are happy that they now have a place to put the survivors and an office to handle and follow–up cases. They mentioned that this has stimulated interest and motivated other duty bearers to address GBV issues because of the support provided through the shelter arrangement.

Community members in the two districts also appreciated the presence of the shelters. The Community Activists explained that the shelters were important in their work because, now they had a place where survivors could be accommodated and supported. This encouraged more survivors to report cases of GBV. They mentioned that because of the presence of the shelters more GBV cases were reported. Evaluation found that management of shelters had challenges relating to the high cost of establishment and maintenance casting a shadow on their sustainability

In districts where there are no shelters, the challenge of handling GBV survivors remains. For instance in Jinja, the NGO handling GBV cases mentioned that they keep the victims/survivors in police cells or send them back home. A similar situation exists in Bugiri and Mayuge where the Evaluation team visited.

Coalition and CBO/NGOs capacity strengthened

Capacity development for CBOs/NGOs aimed at strengthening the district level advocacy and coalition building around GBV prevention and response. As such a number of CBOs were targeted and their representatives were trained. According to programme reports, about 80% of those trained have been able to integrate GBV issues in their work. The Evaluation team met some of these networks and it was evident that they had become a sustainable part of the GBV prevention and response mechanisms in the different districts. Some of them had also become referral points for GBV survivors. In each district, there is a coordinating organization for the CBOs/NGOs in that district.

However, the intention to support and strengthen district women's networks seems not to have been very successful. This evaluation did not find any information relating to formation of District Women's networks. Most of the coordinating organizations were already existing networks working different areas like HIV/AIDS, OVC and other areas of service provision.

3.3.3 Mobilizing communities with focus on strengthening male involvement in prevention and response to GBV

A number of outputs and several activities were implemented utilizing the SASA! Model. The model inspires individuals and communities to use their power appropriately to promote justice and equity for both women and men. The intervention aimed at influencing change in attitudes and behavior that perpetuate GBV and particularly violence against women. The activities carried out by CEDOVIP during period are summarized in Annex 3.

To foster collaboration with other stakeholders working on GBV in Busoga region, CEDOVIP established a close working relationship with IRCU and provided support to their staff in knowledge and skills development for GBV prevention using the SASA! Model. IRCU aligned their work to that of the Joint Programme which was an important step in enhancing collaborative efforts towards achieving the objectives of the programme (CEDOVIP Annual report 2011).

DCDOs and CDO equipped with knowledge and skills in the application of SASA!

The program invested a lot of resources in equipping of DCDOs and CDOs in the eight districts on the application of SASA! model. This was done through training sessions and a series of on–site learning and mentoring processes. This increased their knowledge of the application of the SASA! model and stimulated enthusiasm to participate in GBV prevention and response.

The CDOs interviewed, pointed out that they are now aware of the DVA and its regulations and their roles in implementing the Act. They are also very familiar with the SASA! Tool kit and are using it to implement GBV activities in the sub–counties where they work. The DCDOs and CDOs recognize that SASA! work has helped them to do their work with communities better. They have been able to increase their presence in communities and to build stronger relationships with community members. The CDOs reported that the knowledge and skills gained through the use of SASA! model helps them to efficiently perform their work in communities beyond the GBV issues, as one CDO noted:

> *"…it's no longer a hustle for me to mobilize community members for an activity like raising awareness on sanitation; it's easier for me to find them where they are like we do in SASA! work than calling for a village meeting which would be expensive."*

The CDOs have the knowledge and skills to on providing support to women and men experiencing violence; men trying to change not to use violence in their relationships and activists speaking out against violence. They are able to implement activities of the three phases of SASA!–Start, Awareness and Support. They would need to move to the Action phase in the next phase of the programme.

A key challenge to the GBV prevention and response at sub county level is the frequent transfers and turnovers of CDOs which affects program implementation, especially in the districts of Jinja and Namutumba. As a stop gap measure, CEDOVIP worked with DCDOs of districts affected to provide regular orientation to bring the new CDOs on board.

Community Activists (CAs) and Community Action Groups (CAGs) established and functional

Community Activists (CAs) to support the programme were recruited and trained. These community members who have committed and volunteered some of their time to work as resource persons from within their respective communities to inspire others to create change in attitudes, perceptions and practices to prevent violence against women. For each sub–county, six (6) CAs were recruited making a total of 192, comprising of 50% women and 50% men in the 8 districts.

The CAs were instrumental in awareness creation on GBV and guiding reporting of cases as prescribed in the referral pathway. The CAs reached out to communities through household visits and water collection points. This created understanding of GBV and its effects and fostered joint administration of homes by encouraging communication between spouses to promote justice and equity. Community members interviewed during the evaluation appreciated the role of CAs as expressed in the quotes below:

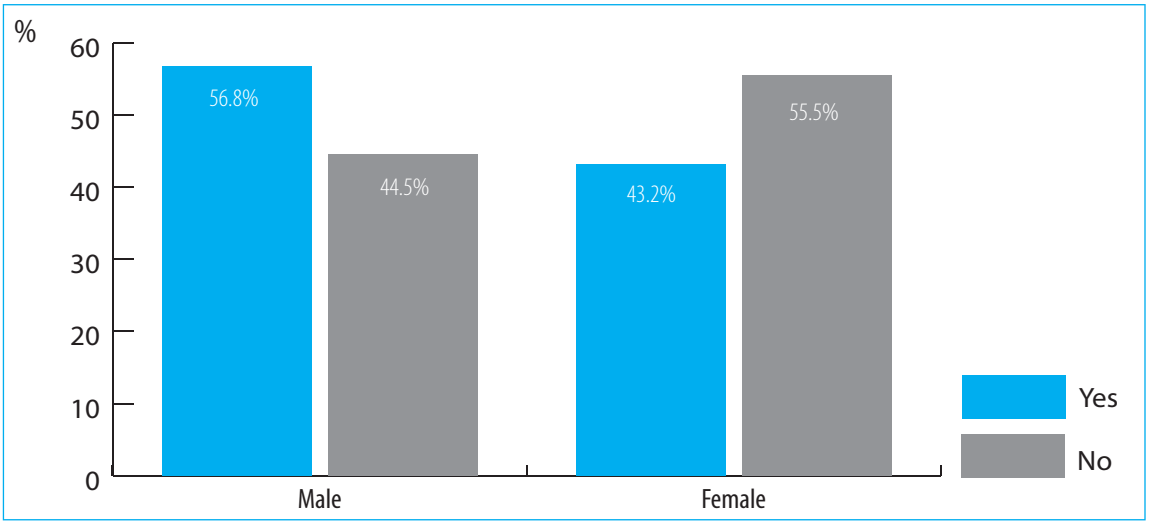
> *"In the beginning, GBV cases used to go to LC but with the coming of CAs, more cases on the table. Many offenders have been brought to book compared to what used to happen before"–KII LC I Chairperson*

> *"I had a problem with my husband. He used to beat me all the time but I addressed the matter to the CA who sat us down and now the situation is okay"–Woman FGD Participant, Ivukula, Namutumba district.*

The programme facilitated CAs with bicycles through the MGLSD for easy mobility and data collection. This was highly appreciated and motivated the CAs. However at the time of the evaluation, many of the bicycles were reported not to be functional due to wear and tear and needed replacement.

However, a relatively small number of community members interviewed had met or talked to a CA. As shown in Figure 4, only 57% Males and 43% Females had met or talked to a CA. This is understandable since there the CAs was very few and only worked in the communities where they lived. Among those who had met or talked to CAs, some met them once (42% Females, 39% Males) while some had met the CA between 2–5 times (42% Males, 31% Females). Those who had met CAs more than 5 times were (19% Males and 27% Females).

Figure 2: Respondents who have met or talked to a community activist (% of responses)



Source: Survey Data

Community Activists are now looked at as agents of change or resource persons not only on issues of GBV prevention but also holding duty bearers accountable to deliver services towards preventing and responding to GBV. CAs are also seen as referral points within their communities on issues of GBV and HIV. Engagement of a wider spectrum of stake holders in community activities by CAs, especially during the 16 days of activism has scaled up activism enabling community members (both men and women) speaking out against GBV and at the same time taking care to avoid victim blame as they provide support to survivors of violence. CAs' work has inspired community members to recognize that GBV negatively affects them and started joining CAs to reach out to other community members with messages on GBV prevention through their different social interaction spaces such as churches and mosques. As a result many community members are steadily beginning to play a watch dog role in their communities by reaching out to those experiencing GBV and reporting cases to the CAs, CDOs, Police and LCs in all the programme districts. This has greatly inspired many people to join the work of CAs and expand the activism within communities.

Community Action Groups (CAGs)

Community action groups (CAGs) were identified within their respective localities and included Boda–Boda riders (Passenger Motor cycle), Ludo (Dice game)[1] players, Malwa (A type of local brew made from fermented millet) drinkers and drama groups. They used GBV information materials to sensitize these groups on GBV and referral pathway and how to reach out to their peers.

Community Action Groups contributed to expanding GBV awareness especially among the male folks. For instance Boda–Boda riders would interact with their customers and talk to them on GBV, the Ludo players would alternately involve different individuals playing while discussing GBV thus increasing awareness among their peers. They would further discuss the messages with their spouses and this helped improve relations in their homes.

> *"We also hold Ludo games with the help of the CA where one of the players acts as the counselor to the affected.The game is usually paused for a minute to allow and give time for the counseling session to the affected individual"– Ludo Group, Mayuge district.*

Drama groups packaged information on different GBV related themes for entertainment and learning of the communities. They acted in different places both in their communities and beyond. The drama groups interviewed informed the evaluation team that they are on high demand in the neighbouring villages and parishes. This is an indication that their activities are effective and likely to be sustainable.

Most community action groups are reported to have taken lead in ensuring that the members of the groups and the communities around them are proactive at preventing GBV. It was reported for example that in the weekly meetings some CAGs start by

1 Ludo game is a board game where players take turns to throw a dice. Boards branded with SASA! Ideas of love, happiness and respect are used in the game. For one to start the game questions like what actions show that you respect your partner? What are the three things you will do to make your relationship happier?; what actions show that you are faithful to your partner?; and, what are the three things you will do to treat your partner fairly?

discussing benefits of non–violent relationships, consequences of violence to men, women and their communities. These meetings are facilitated either by the area CA or a member of the groups on the in addition, they have made codes of conduct that to promote balancing power in relationships and ensure that the members are guided by these codes of conduct which are extended to cover other aspects such as accessing group loans. Interviews with some members of CAGs indicated that some of their members ensure that they reach out to their male colleagues who have received loans and counsel them about joint decision making in regard to the family income and follow–up to ensure that the funds accessed are used for the benefit of the entire family.

A number of CDOs, CAs and CAGs interviewed were proud of the programme and some of them shared personal experiences of how the programme had improved their own lives. Some mentioned that they had used the skills gained through the programme to improve communication with their spouses, joint decision making, received support from their spouses, and gained respect from community.

Increased awareness of GBV amongst community members

Communities interviewed during the evaluation demonstrated a high level of understanding of GBV and its different forms. 95.8% of Males and 96.7% of Females (see Table 7) compared to 88% of Males and 90% of Females at the Baseline reported to know GBV and its different forms. This translates into an increase of 7.8% and 6.7% for Males and Females respectively.

Table 7: Knowledge on what constitutes GBV (% of responses)

Forms of GBV	Males		Females	
	Yes	No	Yes	No
A man beating his wife	95.8	4.2	96.7	3.3
A woman beating her husband	91.9	8.1	93.7	6.3
Emotional Violence	90.4	9.6	91.8	8.2
Rape	90.4	9.6	91.4	8.6
Defilement	90.4	9.6	89.2	10.8
Indecent assault	85.0	15.0	83.3	16.7
Neglect by a spouse	93.5	6.5	95.9	4.1
Verbal Abuse	93.8	6.2	95.2	4.8
Early Marriage	90.4	9.6	92.6	7.4
Forced marriage	93.8	6.2	93.3	6.7
Socio–economic deprivation of women by men	86.5	13.5	87.0	13.0
Socio–economic deprivation of men by women	80.8	19.2	81.8	18.2

Forms of GBV	Males		Females	
	Yes	No	Yes	No
Child neglect by parent/guardian	93.1	6.9	94.1	5.9
Spousal sexual deprivation	87.3	12.7	87.0	13.0

Source: Survey Data

The evaluation found that the most common forms of GBV are Verbal abuse (87.7% of Males, 85.9% of Females); Man beating wife (75.8% of Males, 67.7% of Females); Emotional violence (73.1% of Males, 69.5% of Females) and Neglect by Spouse (70.8% of Males, 71.7% of Females) [See Table 8]. This notwithstanding, the findings also revealed that there is a strong perception that GBV can only be committed against women for example, majority of the women (78.1%) did not think a woman beating her husband is a form of violence.

Table 8: most common forms of violence in the community (% of responses)

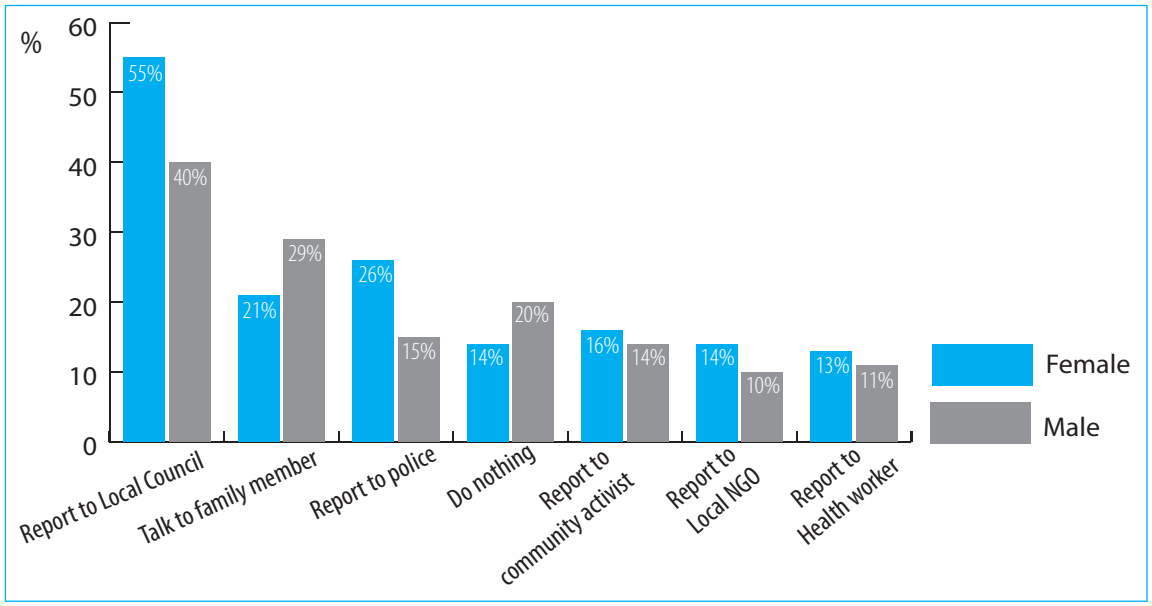
Forms of GVB	Males		Females	
	Yes	No	Yes	No
A man beating his wife	75.8	24.2	67.7	32.3
A woman beating her husband	34.6	65.4	21.9	78.1
Emotional Violence	73.1	26.9	69.5	30.5
Rape	25.0	75.0	20.1	79.9
Defilement	38.5	61.5	30.9	69.1
Indecent assault	43.8	56.2	37.9	62.1
Neglect by a spouse	70.8	29.2	71.7	28.3
Verbal Abuse	87.7	12.3	85.9	14.1
Early Marriage	42.7	57.3	38.7	61.3
Forced marriage	22.3	77.7	21.6	78.4
Socio–economic deprivation of women by men	51.2	48.8	59.5	40.5
Socio–economic deprivation of men by women	25.4	74.6	23.4	76.6
Child neglect by parent/guardian	65.8	34.2	67.3	32.7
Spousal sexual deprivation	35.4	64.6	34.9	65.1

Source: Survey Data

Increased community awareness of institutional mechanisms for redress

The evaluation sought to establish whether the community members were aware of the institutional mechanisms in place for addressing GBV and where they would prefer to go if they experienced violence. Findings indicate that Local councils were the first preference for both women and men (55% of Females and 40% of Males). This was followed by Police (26% of Females and 15% of Males) [see Figure 3]

Figure 3: Preferred choice of support when faced with violence (% of responses)



Source: Survey Data

Majority of the Males however preferred talking to family members, suggesting that most women would rather go to Police than talk to a family member about GBV. This is probably because family members would most likely follow cultural norms which are not in favour of women when it comes to violence against them. Usually family members do not encourage domestic issues going beyond the family and women are sometimes seen as having provoked violence against them by men. This is a significant shift for women to choose to report to police and could suggest that women are becoming increasingly aware that GBV is an abuse of their rights that should to be reported to authorities. It also suggests that women having more faith in Police to address their problems related GBV cases.

Reporting to CAs was given low preference (16% of females, 14% of males) probably because the community knows that CAs are not a formal structure for reporting and when they report to the CA, they would still need to go ahead and report to LCs or Police. This notwithstanding, the findings indicated that CAs are the first point of reference in the areas where they work and may not be accessible to some communities. These also make follow–up on the cases they have referred to ensure that survivors are helped. As a result, it is reported that many survivors feel supported and protected and this has also increased collaboration with the Police, LCs and other referral points within the community (*CEDOVIP report Jan–June 2014*).

Days of activism commemorated and utilized as a platform for awareness creation and advocacy

The 16 days of Activism against Gender Based Violence Campaign is a global annual event that commences on 25th November and ends on 10th December with the International Human Rights Day. The campaign is held during this period to emphasize that GBV is an abuse of human rights of the individuals affected. The evaluation found that the programme annually provided support through CEDOVIP to Sub–counties in the all programme districts to conduct the 16 days of activism against GBV campaigns. The CDOs and CAs (sometimes referred to as SASA! Teams) organized various activities including; intensified door to door visits to households to discuss GBV issues, public events, power post discussions, sporting events and stakeholder meetings. The heightened activities galvanized many stakeholders and community members to participate in the campaigns. At community level, many people signed commitment boards to signify their pledge to prevent GBV in their households and communities.

The SASA! Team (CDOs and CAs) also took leadership to organize and conduct 16 days of activism campaign activities within the communities of their respective sub–counties and also committed themselves to prevent GBV, starting with their households and to continue reaching out to members of the communities through sharing their power with partners.

The 16 days of activism against GBV were so popular among the communities interviewed. They mentioned that they always looked forward to such events which had helped them reach many people with messages against GBV. District and Sub–county leaders interviewed mentioned that this was an event that was very important and appreciated the programme for supporting

the events over the five year period. For instance, Bugembe Town Council provided resources for commemoration of the 16 days of activism in 2015.

During the 16 days of activism campaign some prominent men publicly spoke out against GBV and encouraged community members to participate in GBV prevention activities.

> *"…last year's 16 days of activism campaign theme on power reminded me of how I used to use my power negatively thinking that it was the right thing because I grew up seeing the same things done by our parents e.g. how could a woman make a decision on financial issues in a home…but now am a better husband and father who negotiates with my wife on anything"–Male CA from Bulopa Sub–County, Kamuli district; CEDOVIP report Jan–June 2014.*

3.3.4 Generate and Disseminate GBV information at local and national levels

M&E strategy developed

The evaluation found that the programme developed and operationalized an M&E Plan, including a Results Framework. The M&E function was performed by the M&E Officer at the Programme Coordination Unit at the MGLSD and had registered success in: Development of an M&E System, conducting Programme support supervision visits, and compiling of Programme reports. However noted that while the programme had developed a robust M&E system, the programme M&E was not undertaken as one system linking all IPs, districts and lower local governments focusing on programme log frame. Secondly, the M&E plan was developed in the middle of the programme and the Results Matrix did not correspond with the Baseline that was conducted before. As such the Baseline was general and didn't link with program objectives. This was a very unusual practice as baseline usually provides the benchmarks of the identified programme performance indicators.

Consequently, a number of programme indicators were left without baseline values which constrained targeting as well as tracking programme progress based on the indicators. The programme also did not develop an M&E data base where data collected on programme indicators would have been stored and analyzed such that programme progress could be tracked in "real time" and management decisions guided by data analysis. The evaluation found that only in a few districts such as Namutumba, data was appreciated as a tool for evidence based decision making and influencing policy and resource allocation. The reporting did not follow the programme objectives and outputs except in later years which constrains summing up total programme output performance.

It was found that annual reporting was not standardized and had no consistent reporting format as such it was not easy to compare programme performance throughout the 5 years. Whereas some reports indicated activities, outputs and their targets and the level of performance in the reporting period, a number did not follow such a format.

The M&E work was centralized and not designated and functionalized at the district level. As such the M&E system suffered a blow when it reached the district level where there was no responsible

entity for programme M&E. No wonder that M&E system functionality was left to district ingenuity with some doing it in bits but not as coherent and well–coordinated system.

Functional GBV Data base in place

The MGLSD is running a GBV database which was established under a previous GOU/UNFPA Programme. The data base which is web based and accessed under www.ngbvd.mglsd.go.ug is designed to automatically update GBV data as soon as it is entered and saved into the system. The database was improved through a process that included refining the software.

The IT Assistant in the MGLSD is responsible for maintaining the database and producing the quarterly reports. The Data entry clerk at the district level is responsible for transmitting data from the district direct to the National GBV data base. The data base helps to show statistical trends in forms of GBV and level of incidence for each form. This is useful for monitoring and evaluating performance in terms of GBV prevention and response.

There is increased awareness of GBV and institutional mechanisms for redress of GBV amongst community members. There is also increased reporting of GBV cases while the 16 days of activism event is a successful platform for awareness creation and advocacy.

However, the NGBV data base management faces challenges of inadequate data quality coming from districts and delays in transmission of data. Other challenges facing the smooth and quality functionality of the NGBV include poor internet connection in the districts, making data entry very slow. As a result, data forms are kept in files in different places, others incompletely filled with apparent poor storage and care. It was also noted that Health Centers do not collect GBV data as the types are not reflected in HMIS and efforts by the programme to harmonize have not yet materialized.

Local Government tooled to Manage GBV database

The MGLSD facilitated Local Governments to manage the GBV Data base at their level. The process included training of Local Government staff in use of the software, deployment of the database software program, training of data entrants and providing the necessary financial and technical support. The Local Governments were also equipped with computers and requisite software and facilitated to provide periodic maintenance of computers. Lower Local Government staff (Sub–county CDOs) were oriented on GBV data collection and facilitated to collect the data and forward it to the District Community Development Officer (DCDO) for data entry into the system.

The evaluation found that all districts had a functioning GBV data base as reported:

"Yes the system is working well; we receive data from the CDOs both from where the program is and is not. The System shows you which sub–county

is doing badly. You get the incidences, numbers, types and keeps privacy"–KI District level

The data generated was used for identification of areas with high GBV incidences and advocating for extra resources to tackle the problem as noted by one of the respondents:

"Analysis of data indicates that Magada Sub–County has high levels of GBV and yet was not targeted under the Programme. As a result funds to conduct GBV interventions there were requested and allocated by the district"–KI District level.

The evaluation however found a number of challenges regarding GBV data management at district level including: There is no clear linkage and coordination of GBV service Points (Police, CDOs, HCs, Probation and Social Welfare, CAs, LCs) regarding recording of GBV incidents. Each of them was attempting to collect data on their own with some such as LCs and CAs reporting that no one has ever asked for it and police collecting general crime data and not necessarily GBV data. Secondly, key institutions were not aware they are part of the GBV Data Base system and Programme efforts to link them were not successful. This was confirmed by KIs who noted that:

"Those people came here and said they wanted to connect GBV Data Base to HMIS but have never come back. This is like 2 years ago"–KI District level.

GBV BCC multimedia campaign developed and implemented

The evaluation found that the GBV BCC multimedia campaign was developed but only effectively implemented for two years. The firm spearheading the campaign–Mystic Multimedia closed shop in year 2012 which effectively marked the end of the multi–media campaign. However, prior to the close of Mystic Multimedia, formal and informal referral pathway posters were developed, printing and distribution of materials including T–shirts, info sheets, posters, Community Conversation cards, SASA brochures and Banners was also conducted. The company also conducted brand identity development for the Joint programme including development of a logo, and conducted media training involving four radio stations; KBS in Kamuli, Eastern Voice in Bugiri, Eye FM in Iganga and Victoria FM in Jinja. Other multi media campaign activities conducted included, airing Infomercials, radio talk shows, Taxi Branding, Bill boards and documentation of programme activities.

The evaluation found that the strategy worked well in influencing change of community attitudes and practices but stopped too early to create lasting change in social cultural attitudes and practices that promote GBV. In addition, a video documenting 16 Days of activism, training of Health Workers on clinical management of GBV and the Training of CDOs on SASA was not yet complete.

Data and Information on GBV collected, analyzed and disseminated

At National level, the database is providing useful information for the GBV programme designs and for advocacy. For instance data compiled from the database was presented during the 59th CSW. A

Fact sheet on GBV incidence was also produced and disseminated based on the GBV incidence data generated through the online system. The MGLSD produced District GBV Shelter Guidelines which is expected to yield a well coordinated and harmonized approach to GBV Shelter service provision.

At district level, some districts use GBV data to monitor the trends of GBV and to mobilize resources such as Namutumba which got land and UGX 5 million from Community Driven Development Grants for supporting GBV responses services at the Shelter.

3.4 Efficiency

The Evaluation explored how the programme was managed to ascertain the degree to which efficiency factors were handled so as to deliver programme results with minimum input. Particular focus was placed on how productively the resources were used to realize the results paying particular attention to programme management, budgeting and disbursements and financial resource management

3.4.1 Programme Management

The general management of the programme was found to be efficient as the programme put together a Programme Management Team (PMT) that comprised a representative of MGLSD, UWONET, CEDOVIP, and Mystic Multimedia and a representative of the development partner –Irish Aid. The PMT held quarterly meetings with key roles of : Joint Planning, review of implementation progress, approval of budgets and plans, procurement decisions and approval of content of messages for the media. The PMT meeting proceedings also fed into National GBV Reference Group meetings held quarterly.

In addition to pooling knowledge and experiences, the respective members of the PMT at national level and District GBV Coordination Committee provided the necessary staff for the implementation of the programme. Integration of the programme within the existing government structures at national and local level helped to save on costs for personnel remuneration as the programme only provided a top–up on salaries of participating staff who were already on the government salary structure.

At the district level, a District GBV Coordination Committee was established and this was chaired by the CAO and comprised of the technical departments and CSOs working on GBV. In Districts where shelters existed; there was a GBV Steering Committee such as in Kamuli while in Namutumba the District GBV Coordination Committee also handled GBV Shelter issues in addition to the usual coordination matters.

At the sub–county level, there were monthly meetings between the CDOs and the CAs. The evaluation found that while there was evidence of regular meetings at national level, the same could not be said of district GBV Coordination Committee and sub–county meetings.

It is important to note that the programme provided adequate facilitation of its activities. All community activists were given bicycles, while some districts were given motor cycles for GBV data collection. The Police was supplied with the necessary forms and case books for GBV recording and a large amount of IEC materials were produced.

3.4.2 Budgeting and Disbursements

Budget

The programme had a total budget of UGX 5,648,055,000 for the 5 years (equivalent to € 1,805,231). In addition, to UGX1, 065,300,000 (about €318,000) was specifically allocated to UWONET for the establishment of GBV shelters in Kamuli and Namutumba districts with UGX 227,800,000 (about €68,000) for 2013 and UGX 837,500,000 (about €250,000) for 2014. The funds allocated to each partner as indicated in Table 9.

Table 9: Allocation of funds to partners for the 5 year Period (€)

Partner	2011	2012	2013	2014	2015	Total	% Share
MGLSD	206,290	144,812	159,466	150,529	173,727	834,824	46.2%
UWONET	95,939	151,904	88,113	72,617	55,243	463,816	25.7%
CEDOVIP	96,887	103,252	97,861	110,730	97,861	506,591	28.1%
Total	399,116	399,968	345,440	333,876	326,831	1,805,231	100%

Source: Programme Document FY 2010/11–2014/15

As seen from Table 9, the MGLSD was allocated the biggest share of funds due to its central role of programme coordination, funding districts GBV prevention and response related activities, media financing and spearheading the development and management of a national database for GBV monitoring in the country.

Disbursements

The entire (5 year) programme budget was approved by Irish Aid at the beginning of the programme and annual funds disbursed to implementing partners at the beginning of the year of implementation without any changes. Whereas this eased implementation as funds would be available right in time, it brought out vagaries in total amount available due to variations in exchange rate. At times it yielded exchange gains but at other times it created shortages. Additionally, fixing prices for 5 years also sometimes occasioned shortages due to price increases for some budgeted items.

3.4.3 Financial Resources and management:

There was inconsistence in currency given to partners. While the budget was in Euros, disbursement was a few times in Uganda Shillings, which resulted in exchange gains / loss to the different partners. Financial statements from UWONET indicate exchange gains for the years 2012 (UGX 6,660,336) and 2014 (UGX 7,247,987). However, this does not correspond to the amount of exchange gain requested to be utilized (UGX 84,065,707). On the other hand, CEDOVIP financial statements for 2014 indicate UGX 75, 831, 835 as exchange gain not apportioned. This suggests that this amount may have been accumulated over time and not reported and not utilized.

On the other hand, reports from the implementing partners had no mention of the budgeted funds in Euros which meant that relating the budgeted, disbursed and utilized funds was not easily ascertained from the annual financial reports. Each implementing partner had a separate Memorandum of Understanding with the donor with clear the financial and technical arrangements between the donor and the IP averting any potential misunderstandings in the course of implementation.

Funds for the programme were released once a year to the IPs who would provide accountability annually and directly to Irish Aid which would release funding for the entire year. This was contrary to what is indicated in the programme document section 8.1 and M&E Plan section 5.5 which required all financial and management reports to be submitted to Irish Aid through the Permanent Secretary MGLSD. This diluted the MGLSD in exercising its role of coordination and supervision as there was no link between financial and technical reporting. The evaluation established that while technical reporting was done semi–annually and annually, financial reporting was undertaken only annually.

The programme was right from infancy supposed to procure an accounting system for all partners. By the time of the evaluation, there was no evidence of an accounting system procured for the programme. This resulted into partners reporting in different formats arising from their individual accounting programmes and as such comparison of the financial reports was not feasible.

3.4.4 Human Resources

In terms of Human Resources, the programme had adequate staff with commensurate skills for implementation of its activities both at the national level and in the region. The programme saved costs on personnel remuneration through providing only a top up on salaries of participating CSOs staff and using established government structures where government was already meeting the personnel emoluments. As such CSOs made a significant contribution to programme staff costs through payment of the other bit of staff remuneration. The programme only hired critical staff such as Data Entry Clerks a position not included in government structures.

3.5 Outcomes and Impact

The outcomes and impact of the programme were evaluated with a focus on assessing the changes that have occurred as a result of the programme in terms of the following:

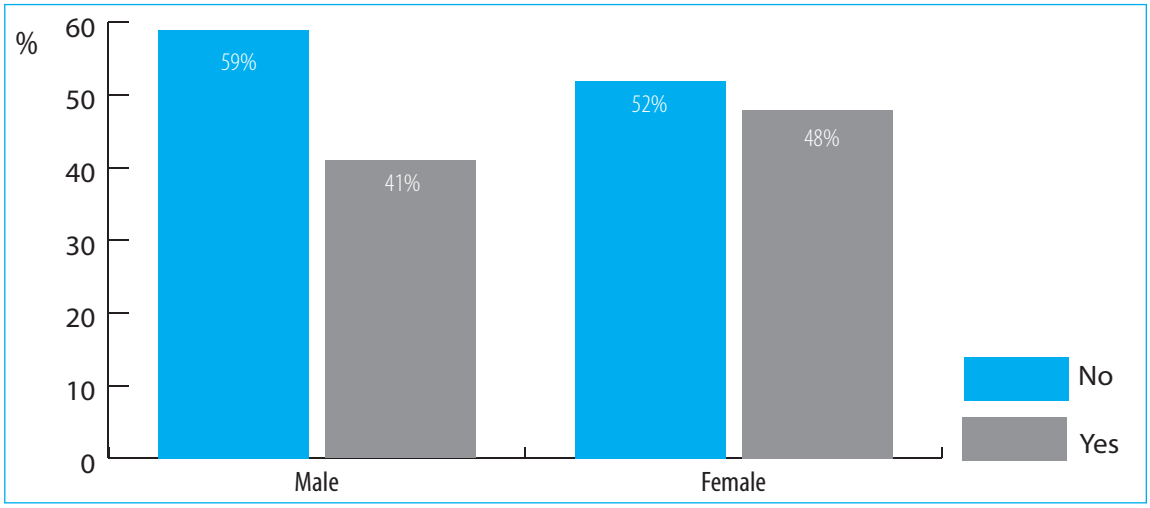
- *Changes in attitudes towards wife beating (assault)*
- *Changes in help–seeking behavior among the GBV survivors*
- *Changes in the levels of community intolerance to GBV*
- *Attitudes towards women's participation in decision making at household level as joint decision making partners*

Evaluation findings on each of these indicators are presented below:

3.5.1 Change in attitudes towards wife beating

Respondents were asked whether a husband has a right to slap his wife if he is angry with her. Figure 4 shows the responses indicating that the majority of the respondents (59% of females and 52% of males said that a husband does not have a right to slap his wife if he is angry with her. On the other hand, a good number of both women (48%) and men (41%) believe that a husband has the right to slap his wife if he is angry with her. This indicates that some respondents still believe that wife beating is justified in certain circumstances.

Figure 4: Responses on whether a husband has a right to slap his wife if angry with her(% of responses)



Source: Survey Data

The survey findings in Table 10 indicate that the average majority of both Male (68.7%) and Female (66.9%) respondents find it unacceptable for a man to beat his wife for different reasons. However, in relation to the reason of a women being unfaithful, the majority of women (56.9%) and a good number of men (43.1%) said that it is acceptable for a man to beat his wife.

Table 10: Responses on Attitude towards Wife Beating (Assault) (% of responses)

A man has a good reason to beat his wife if:	Males				Females			
	Acceptable	Sometimes	Unacceptable	Not sure	Acceptable	Sometimes	Unacceptable	Not sure
She does not complete her household work to his satisfaction	13.5	14.2	71.9	0.4	15.6	11.5	71.7	1.1

A man has a good reason to beat his wife if:	Males				Females			
	Acceptable	Sometimes	Unacceptable	Not sure	Acceptable	Sometimes	Unacceptable	Not sure
She disobeys him	21.2	22.3	55.8	0.8	26.0	20.1	52.0	1.9
She refuses to have sex with him	11.2	10.0	75.8	3.1	14.5	11.5	71.0	3.0
She asks him whether he has other girlfriends	5.8	4.6	87.7	1.9	4.1	3.0	91.1	1.9
He suspects that she is unfaithful	8.1	10.4	78.8	2.7	5.9	5.2	87.4	1.5
He finds out that she has been unfaithful	43.1	10.0	41.9	5.0	56.9	12.3	27.9	3.0
Average	17.2	71.5	68.7	2.31	20.5	10.6	66.9	2.1

Source: Survey Data

The survey findings indicating acceptability of wife beating are corroborated by findings through FGDs in the different districts visited where some women and men still find it acceptable for a man to beat his wife:

> *"The man has no right to slap the wife but because he is annoyed, he does it. A woman deserves it if she has committed adultery, is a drunkard, engages in gossip, mistreats the children she finds in the home or is disobedient to her husband"–Female FGD Participant, Jinja district.*

> *"Yes, it is very much proper to slap her. We are here at the landing site where women drink beer, come back home in the night, they are adulterous, some cannot do household chores and others refuse children to go to school even after the husband has paid school fees."–Male FGD Participant*

This suggests that much more work still needs to be done to sensitize both women and men that wife beating is not acceptable under any circumstances and that there are better ways of resolving misunderstandings and conflicts in the household. However, it is pleasing to note that there were more positive responses at community level against wife beating in all the districts visited as indicated in Table xxx.

In comparison with the baseline and the Mid Term Review (MTR) findings, the evaluation findings seem to indicate that attitudes towards wife beating are retrogressing. At baseline, attitudes towards wife beating were at 85% unacceptable and had increased to 87.5% at MTR. However the evaluation found that wife beating was reported at an average of 68.7% those who reported that it is unacceptable for a man to beat his wife under any circumstances. This is represents a 20.8 percentage decrease from the MTR of which would appear that more people are saying wife beating under certain circumstances is justified.

This negative finding notwithstanding, the evaluation findings compared with UDHS indicates that the attitudes are higher than the national average which was at 62.45% in 2011. Busoga region having had very high GBV prevalence in 2006, it appears that the programme has contributed to increasing the degree of intolerance to GBV. What is common in the UDHS surveys, the MTR and this evaluation is that more women tend to find wife–beating acceptable than men. Men are increasingly appreciating that wife beating is not acceptable.

The divergent figures of the evaluation findings and MTR may be explained by the differences in the communities and individuals selected in the two surveys. However, from the FGDs and KIIs, it was clear that more respondents were against wife beating than those who were of the view that wife beating is justified in some cases.

3.5.2 Improved help–seeking Behaviour among the GBV survivors

With regard to whether women and men seek help when they suffer GBV, the evaluation sought to find out what respondents thought was the best way to handle the situation. The majority of respondents as indicated in Table 11, (83.5% of Males and 86.6% of Females) said that it would be better to talk it over with a family member. Other preferred options were seeking religious counseling, seeking traditional justice and seeking legal advice. For women, the order of preference was: family member, GBV intervention networks, religious counseling, traditional justice, legal advice and talking it over with friends. Going to Police was not among the most preferred options for both women and men. However, more females (56.5%) than males (45.8%) indicated seeking group support as an option. On the other hand, more females (78.8%) than males (68.1%) preferred seeking help from GBV interventions networks, an indication that GBV networks were not only known but reliable as well. Table 12 shows status of help seeking behavior for women

Table 11: Help–seeking behavior for Females (% of responses)

If a woman has been mistreated in the family, the best way to handle the situation would be:	**Male**		**Female**	
	Yes	**No**	**Yes**	**No**
Seek group support	44.2	55.8	50.6	49.4
Talk it over with friends	52.7	47.3	61.3	38.7
Talk it over with family member	83.5	16.5	86.6	13.4

If a woman has been mistreated in the family, the best way to handle the situation would be:	Male		Female	
	Yes	No	Yes	No
Seek assistance from the GBV intervention networks	68.1	31.9	78.8	21.2
Seek legal advice	50.4	49.6	65.1	34.9
Seek traditional justice	72.7	27.3	76.6	23.4
Go to Police	45.8	54.2	56.5	43.5
Seek religious counseling	76.5	23.5	78.4	21.6
Ignore the man	22.3	77.7	26.0	74.0
Average	57.4	42.6	64.4	35.6

Source: Survey Data

In relation to men seeking help when faced with violence in their lives, more women than men indicate that men can seek assistance from various institutions as indicated in Table 12 suggesting that women (65.8%) believe more in seeking help in relation to GBV than men (55.8%). However it is important to note that higher percentages of men indicated that if a man has been mistreated in the family the best way to handle the situation would be to talk to family members, seek religious counseling or seek traditional justice rather than seeking formal channels for legal redress. More women than men indicate seeking formal channels of redress.

Table 12: Help–seeking preferred options for Males (% of responses)

If a man has been mistreated in the family, the best way to handle the situation would be:	Male		Female	
	Yes	No	Yes	No
Seek group support	33.1	66.9	35.7	64.3
Talk it over with friends	46.2	53.8	46.5	53.5
Talk it over with family member	71.2	28.8	79.2	20.8
Seek assistance from the GBV intervention networks	55.8	44.2	65.8	34.2
Seek legal advice	44.2	55.8	57.6	42.4
Seek traditional justice	60.0	40.0	71.0	29.0
Go to Police	36.9	63.1	43.1	56.9
Seek religious counseling	77.7	22.3	78.8	21.2
Ignore the woman	25.4	74.6	24.9	75.1
Average	50.0	49.5	55.8	

Source: Survey Data

What is important to note is that both women and men are more inclined to seeking help when faced with GBV than not going so. The average for health seeking behavior for both women and men is at 56.9% for the evaluation while the MTR was 56.8%. UDHS 2011 did not include "help seeking behavior" in relation to GBV. The MTR and this evaluation results relating to help seeking behavior are almost the same.

3.5.3 Reduced Community Torrance to GBV

Community intolerance to GBV is demonstrated by the attitudes of community members towards whether certain forms of GBV are acceptable or not and whether there are certain circumstances where GBV is justified. To ascertain the extent of community tolerance of GBV, a number of questions were put to the respondents. Table 13 indicates responses to different forms of GBV and the level of tolerance. The survey found high levels of intolerance to GBV.

Table 13: Opinion on tolerance of different forms of GBV (% of responses)

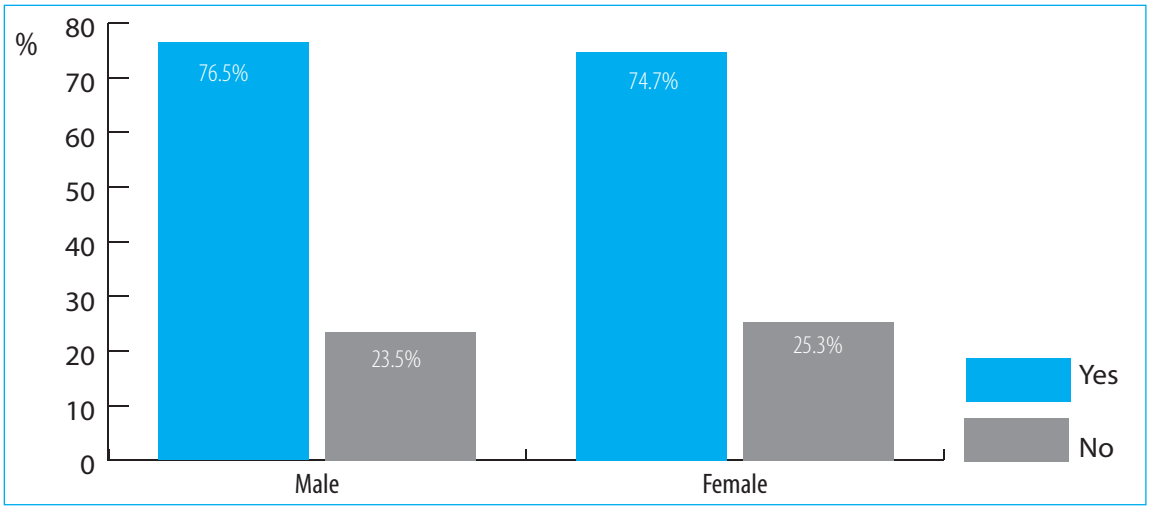
Statement relating to tolerance of GBV	Male				Female			
	Acceptable	Sometimes	Unacceptable	Not sure	Acceptable	Sometimes	Unacceptable	Not sure
Man beating his wife for not respecting him	20.0	21.2	55.8	3.1	21.9	23.4	52.0	2.6
Woman beating her co–wife for abusing her	10.8	13.1	71.9	4.2	25.7	14.1	56.5	3.7
Woman beating her husband for not respecting her	2.3	3.5	92.7	1.5	5.6	5.9	87.7	0.7
Woman beating her husband for not providing for the family	5.0	4.2	87.7	3.1	11.9	5.9	81.0	1.1
Man abandoning his wife due to conflicts	22.3	14.2	60.4	3.1	13.0	7.1	78.4	1.5
Woman abandoning her husband due to conflicts	22.3	16.5	57.7	3.5	24.2	19.7	55.4	0.7
Total	92.0	90.8	69.3	24.7	107.5	82.8	697	12.5
Average	10.2	10.1	77.0	2.7	11.9	9.2	74.4	1.39

Source: Survey Data

The findings indicated in Table 13 suggest that on average, the majority of community members (77% of Males and 74.4% of Females) do not tolerate GBV indicating that violence of all forms is unacceptable. However, there is a lower level of intolerance of physical violence by women against them with 52% of females saying that a man beating his wife is unacceptable while 55.8% of males saying that it is unacceptable. This finding is not surprising. Some other studies (UDHS 2006 and 2011) indicated that a good number of women believe that a woman should be beaten by her husband if she is in the wrong. It should be noted that this perception is ingrained through socialization where girls and women are seen as inferior and sometimes deserving to be punished by males (brothers, husbands) if they are believed to be in the wrong.

Survey findings indicate that majority (77% of Males and 75% of Females) believe that a woman should tolerate violence in order to keep her family. This is a general belief in communities that women should be able to withstand any abuse for the sake of their families, especially for the children. However, media reports are awash with real life stories of women who have been killed while trying to 'tolerate violence in order to keep their families'. Tolerating violence for any reason should not be acceptable.

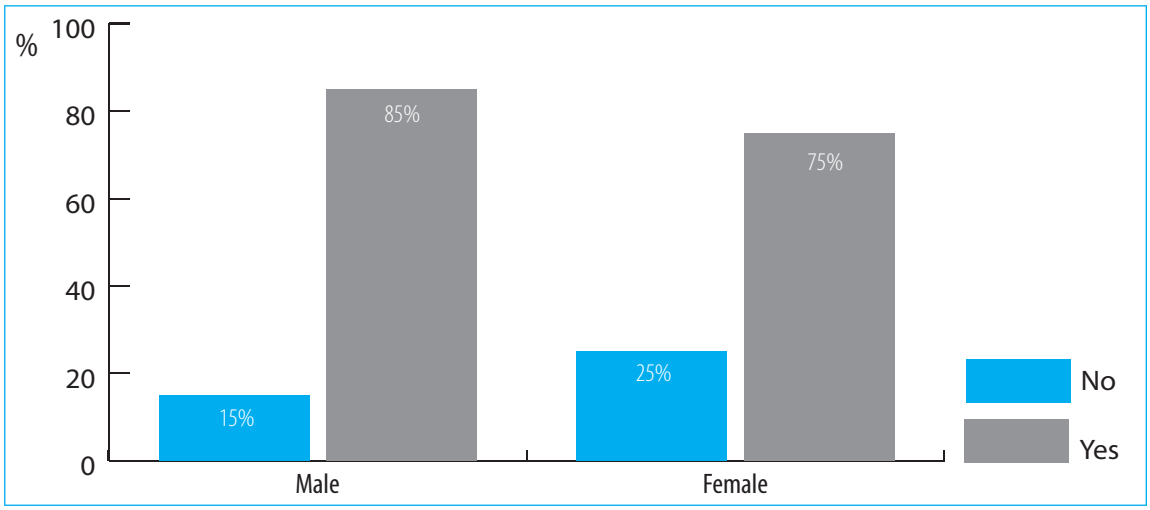
Figure 5: Whether a woman should tolerate violence in order to keep her family (% of responses)



Source: Survey Data

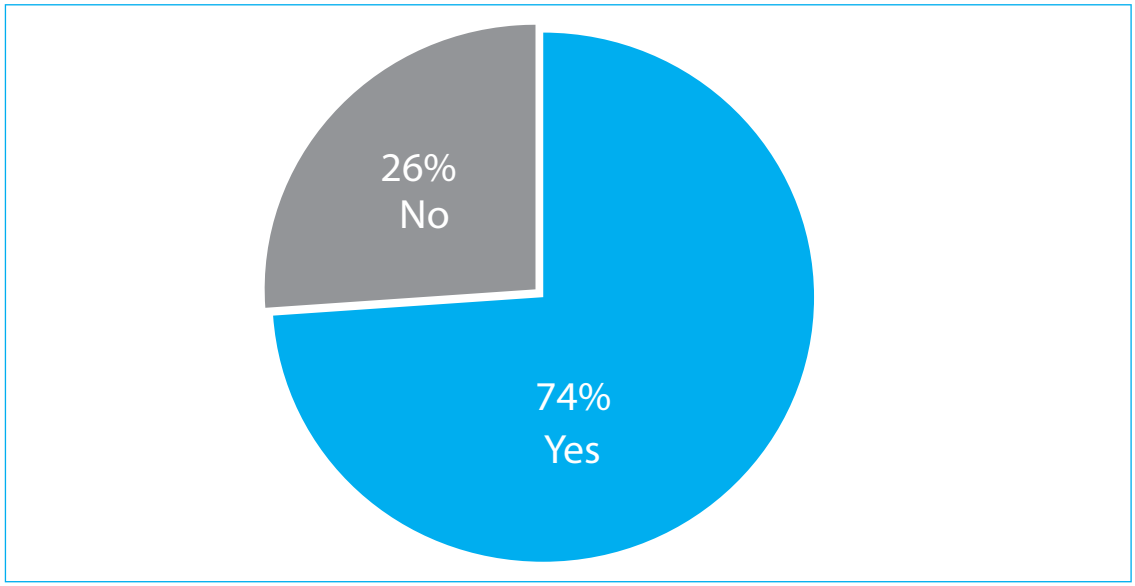
The figures 6 and 7 indicate whether women and men should be blamed for violence against them. The responses indicate that both women and men believe that those who experience violence, whether women or men are to blame for the violence meted against them. This is indicates that generally people believe that those who suffer violence may have done something that provoked the violence.

Figure 6: Whether Women should be blamed for violence against them (% of responses)



Source: Survey Data

Figure 7: Whether Men should be blamed for violence against them (% of responses)



Source: Survey Data

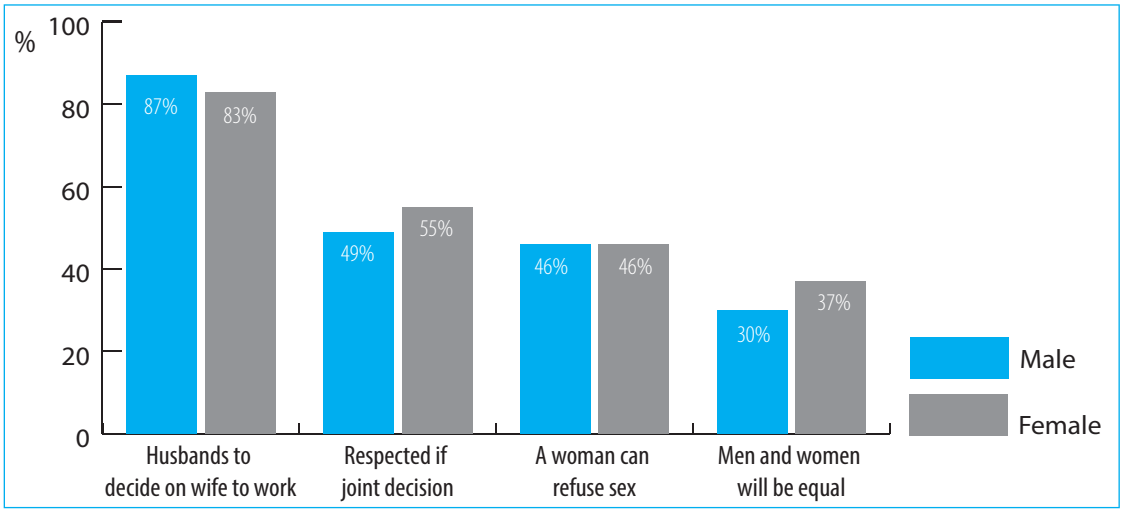
3.5.4 Attitudes towards women's participation in decision making at household level

Influencing decision making processes at household level is important for reducing GBV. When women and men make decisions together and agree on how to handle issues like how to spend the income in the family, then there is likelihood that there will be less quarrels and physical violence. The survey found that women and men have nearly similar view about the husband's role in deciding

whether or not his wife can work outside the home. Majority of respondents (87% of Females and 83% of Males) said that it is the role of the husband to decide.

In relation to whether a man would be respected by his friends if he told them that he made decisions jointly with his wife, male respondents (55%) said 'Yes' while 49% females said 'Yes' indicating that more men felt they would still be respected if they made decisions together with their wives. About whether a woman should refuse sex, 54% of both women and men said 'No' suggesting that it is unacceptable for a woman to refuse sex with her husband, even if she does not feel like having it. On whether women and men will one day be considered equal, only 37% of males and 30% of females believe that equality will one day be a reality. Figure 8 shows survey responses related to decision making and gender equality.

Figure 8: Responses related to decision making and gender equality (% of responses)



Source: Survey Data

3.5.5 Overall Impact

The most significant change attributed to the programme is the breaking of the silence on GBV in Busoga region evidenced by increased reporting of GBV incidences. For a long time, GBV at household level was treated as a family matter requiring no outside interference. However, this has gradually changed and from the findings of this evaluation, many more men and women are now willing to move out to local councils, Police and Community Activists to seek help with faced with an incident of GBV. Similarly, through the programme, there has been increased awareness of GBV at different levels. At the district level, local government leaders are now aware that GBV is a problem and indicated determination to ensure that GBV issues are addressed in all departments. At community level, there is a willingness through CAs and CAGs to support those in need of help.

1.6 Sustainability

The sustainability of the Joint programme and its implementation was reviewed in the following context:

- *The extent to which the programme interventions and benefits are likely to continue long after the programme has ended;*
- *The extent to which the community activities such as GBV shelters, CAs and CAGs are likely to continue providing GBV information awareness and support even without direct support from the implementing partners.*

The evaluation findings indicate that the sustainability of the programme shall be enhanced by the following factors:

Coordination: The programme worked through existing government institutions at the national and district levels within their mandates of addressing GBV as provided in the GBV National Action Plan and the DVA. These structures will continue to exist and to do their work beyond the programme. The programme implementation had an element of integrating GBV in all programmes at local government levels. This strategy ensures that GBV can continue to be addressed within the resources available at these levels. District leaders demonstrated commitment setting aside resources within their means to address GBV. For instance a number of districts have incorporated the 16 Days of activism in their budgets and will be able to continue to commemorate them with or without external funding. A number of districts have committed resources from their local revenues to ensure continuity of some of the interventions started the case of Namutumba district that committed resources (UGX. 5,000,000) from its own local revenue and land for the construction of a GBV shelter is a classic example. This means that even when the programme closes the local governments will continue to address GBV, albeit on a lower scale due to limited local resources.

The GBV database maintained by the MGLSD is a national resource which would provide the much needed information for GBV programming not only in Busoga region but countrywide. It is available to other stakeholders that need to collect and use community based information on GBV and other related programmes.

At NGO level, the programme identified GBV NGOs/CBOs already working on social development issues and some were already working on GBV. Most have been able to integrate GBV in their activities and the evaluation team believes this shall continue. In addition, networking with religious and cultural institutions though not so pronounced in the programme has the potential for continuity through their messages on GBV to their audiences.

Enhanced capacity of Duty Bearers: The programme provided knowledge and skills to duty bearers who continue to operate without additional resources. Some of the structures will continue to provide services within their mandates. JLOS, DCDOs/CDOs Health workers are Government employees who have been empowered and shall continue to execute their roles using the skills and knowledge acquired during the programme.

Communities mobilized to prevent and respond to GBV: The programme used community activism involving CAs. These being community based volunteers with a commitment to the wellbeing of their communities, it is hoped that they will continue to serve them. The evaluation found that some of the CAs had become political leaders thereby increasing the cadre base of GBV activists in the political leadership who have the opportunity to influence decision making in support of GBV related work. They are also expected to integrate GBV prevention in their speeches at various functions such as burial ceremonies and wedding functions normally attended by large numbers of the community.

The programme mobilized communities through various initiatives and involved men through action groups of existing social and economic groups such as Malwa, drama groups and boda–boda riders. These groups will continue to exist after the programm and the discussions on GBV are likely to continue. Involving men in the campaigns to reach out to their fellow men and incorporating GBV messages in local drama and entertainment including games such as Ludo. Capacity building of GBV NGO/CBOs and networking with institutions are initiatives that are expected to transcend the programme lifespan.

Factors that might hinder the sustainability of the programme

The main test of sustainability will however come under the GBV Database and whether districts will continue to collect the necessary information and use it to inform policy and planning. This is because as already noted, there is a lack of clear linkage and coordination of GBV service Points: Police, CDOs, HCs, Probation and Social Welfare, CAs (Client registers), LCs regarding recording of GBV incidents. While each of these units is collecting some data, the usage, analysis and awareness of how this is linked to GBV Data Base system operated at the MGLSD is weak which means that without direct support, the initiative of data collection within the various units shall as well die out.

Similarly, the low revenue base of local governments and lower local governments means that with programme funding, these may be unable to facilitate some components of the programme such as shelters, facilitation of CDOs for community mobilization, payment of salary to the data clerks for data collection thus eventually leading to the collapse of the interventions.

The deeply entrenched social–cultural attitudes and beliefs that gives superior positioning of men in society and relegates women to inferior positions in terms decision making and consideration remains a challenge for programme sustainability. As is evident in the evaluation findings, the retrogressing in terms of attitudes towards wife beating from the Baseline, to the MTR and this evaluation indicates that negative cultural practices unless tackled could prove a huge stumbling block towards gains on tackling GBV.

Lastly, like in any other programme especially donor funded programmes, an expectation of monetary facilitation to attend meetings and participate in programme activities may affect morale and ability of members to continue on their own such as in holding meetings without any facilitation.

4 SECTION 4: Implementation of Midterm Review Recommendations

Section 4: Implementation of Midterm Review Recommendations

The programme conducted a Mid Term Review (MTR) with the main purpose of assessing the progress of implementation of the Joint Programme vis–à–vis the goal and objectives. The exercise was also meant to assess the strategies being employed in the implementation as well as integrate new learning for the remaining period of implementation. The Review accordingly came up with a number of recommendations. The Final Evaluation thus assessed the extent to which the recommendations were implemented. The findings indicate a low level (31%) of implementation of the MTR recommendations as reflected inTable 10

Table 14: Status of implementation of MTR recommendations

JP Objective/MTR Recommendation	Status of Implementation	Remarks
To strengthen coordination among key actors at national and local government level for effective prevention and response to GBV		
Broaden the partnership for GBV programming: 1. MGLSD as a coordination entity in the JP should bring on board more CSOs i.e. National Association of Women Organizations in Uganda (NAWOU) and Inter Religious Council of Uganda (IRCU) and cultural institutions to complement the efforts of other IPs in the region.	Not Done	NAWOU was not brought on board because they do the same work as UWONET which is a partner on this Programme.

JP Objective/MTR Recommendation	Status of Implementation	Remarks
2. The Programme considers supporting sub–county level coordination to bring onboard various stakeholders at that level.	Not done	Sub–county level coordination is still weak with no deliberate actions for its enhancement.
3. The JP develops and implements a Programme Implementation Manual (PIM) with clear mechanisms for ensuring adherence to its guidelines.	Not done	
To build capacity of duty bearers in Local governments in Busoga Sub–region to prevent and respond to GBV.		
Intensify continuous training of duty bearers: 1. Refresher trainings are conducted to fill the staffing gaps so as not interrupt service delivery.	Done	
2. Increase investment in services provision	Done	Establishment of Shelters and strengthening referrals to improve service provision
3. The shelters in Namutumba and Kamuli are an excellent idea if fully implemented that should be extended to the rest of the JP districts.	Not done	Limited funding
Incorporate sustainability mechanism in the JP: 1. Districts should integrate GBV in their annual plans and budgets	Partially done	Partially done as a few districts have done so but with very little funds
2. MGLSD to lobby districts to co–fund GBV activities	Done	
3. IPs to conduct continuous trainings to address attrition challenges.	Done	

JP Objective/MTR Recommendation	Status of Implementation	Remarks
To mobilize communities with a particular focus on men's involvement as agents of change to prevent and respond to GB.		
Scale up GBV interventions: 1. The JP should consider scaling up GBV intervention to all sub–counties in the programme districts	Not done	Funding would not allow covering all sub–counties
2. The JP partners dedicate sometime to draw and consolidate results and revisit the implementation plan (with appropriate objectives, activities, targets and indicators) to guide its operations. It is difficult to gauge performance without planned targets and indicators.	Not done	Reporting was not following the RFW and Outputs were not the main focus of implementation rather it was activity based without targets
Service provision focus: 3. The Joint Programme needs to design innovative measures which will integrate service provision interventions that address causes and provide possible remedies to these issues.	Not done	There was minimal integration of GBV with other service provision structures such as Production, health and Education.
Generating and disseminating information on GBV in the Busoga Sub–region for policy, Programming and Advocacy.		
GBV data management system: The success of the GBV data management system is used to influence other programs to have a uniform mechanism of managing GBV data nationally.	Not done	There is no clear mechanism for influencing other programs to have a uniform mechanism of managing GBV data nationally.

JP Objective/MTR Recommendation	Status of Implementation	Remarks
Strengthen the implementation of a solid M&E System with clear Programme targets, reporting mechanisms and schedules adhered to by all implementing partners.	Not done	In the course of programme implementation, M&E Plan was not followed as there were no clear Programme targets, reporting mechanisms and schedules not adhered to. At the district level, M&E was almost inexistent. This is a programme that had a good M&E System developed but largely not implemented.
Each of the IPs orients staff in M&E aspects of programming.	Not done	CEDOVIP and UWONET did not have designated M&E Officers
The implementing partners should revisit the Monitoring and Evaluation Plan and set annual targets to ease tracking implementation and reporting against these targets.	Not Done	
Summary	Done = 6 (31%) Not Done = 11 (69%)	
Overall view of the evaluation: There was minimal implementation of the recommendations of the MTR as such the programme was not driven back on course.		

5

SECTION 5:

Lessons Learned

Section 5: Lessons Learned

a. GBV is a multifaceted phenomenon which requires a multipronged approach requiring coordination of different actors, improved capacity of duty bearers and community engagement. To ensure successful implementation, there is therefore need to engage multiple partners including Government, CSOs, Private sector.

b. Use of existing structures at all levels (national, district, sub–county and community) makes programme implementation cost effective and sustainable.

c. Working with police to include GBV training in the Police curriculum is critical and would go a long way in enhancing their ability to respond to GBV cases.

d. Engagement of local Leaders through lobbying and advocacy increases programme ownership leading to contributions to interventions. For instance Kamuli and Namutumba LGs donated pieces of land for putting up shelters for GBV survivors.

e. Cultural and religious institutions provide an effective means to sensitize the masses as they wield a lot of influence in the community as they have a variety of platforms for reaching out to the masses with messages. (Such as worshipping services, funeral services and wedding functions).

f. Getting the community to take lead to initiate changes in their own social cultural set–up yields positive progress than using outsiders. For instance use of CAs who are part of the community and CAGs has been more effective and sustainable.

g. SASA! is an effective method for getting the community understand their social–cultural practices and enables them to come up with ways of solving identified problems.

h. Community Development initiatives need to target youth in and out of school to influence them at an early age and make the initiatives more sustainable.

i. All GBV programmes need to include livelihood interventions.

ii. Women empowerment interventions need to target men so as to minimize the perception that men are sidelined yet their complementary role is of paramount importance.

iii. Special events such as the 16 days of activism need to be taken advantage of to intensify community awareness.

iv. The desired end result of a well functioning M&E System is evidence based decision making and advocacy. However, for this to take place, all components of the system i.e. putting in place necessary capacities and conditions including M&E Plan, human, logistical, and financial provisions, data gathering, analysis and communicating data/information, critical reflection, Reporting and feedback provision all need to be adequately functional.

6 SECTION 6: Conclusions and Recommendations

Conclusions and Recommendations

6.1 Conclusion

Overall, the evaluation finds that the JP was very relevant in tackling GBV in the Busoga sub–region. According to UDHS [2011], GBV remains one of the critical challenges at household level and indeed the JP contributed well in complementing other national efforts to curb its effects. Indeed, its alignment to the Vision 2040 and NDP 11 ensures consistency in planning and coordination of development interventions.

The evaluation also notes that the programme was effective in achieving its intended objectives. Findings from the evaluation indicate that the programme has enhanced the capacity of local government staff to respond to GBV issues in their communities. The programme introduced a model [SASA! model], which to date informs mobilization of communities especially men against GBV. Similarly, the programme mobilized communities to prevent and respond to GBV. This was done through Community Activists and Community Action Groups [6 in each sub–county] who were equipped with knowledge and information and have since become change agents within their communities. As this was a community wide intervention, it is bound to have ripple effects.

At national and district level, the JP was well coordinated and involved participation of all stakeholders (government, CSOs and Private sector). Through quarterly coordination meetings there was easy sharing of information, experiences, build synergies, avoid duplication and create joint ownership for the programme. From the coordination, the various organizations have mainstreamed tackling GBV in their work and have even provided additional financial support to continue implementation of programme activities such as Namutumba district that provided UGX. 5,000,000 from its local revenue and land for the construction of GBV shelters. Such levels of cooperation and coordination have since paved way for possibilities of continued sustainability of the programme.

The programme put in place a functional GBV data with a clear process of information generation from village to national level. This has since been critical in informing GBV policy planning at national level.

This evaluation concludes that this programme has largely been successful and has generated good lessons that can be replicated with some adjustments to optimize impact.

6.2 Recommendations

The evaluation suggests the following recommendations:

6.2.1 General Recommendation

Considering that GBV is a deeply rooted socio–cultural problem there is need for such programmes to be implemented over a much longer period (5–10 years) to realize optimum impact. In addition, government institutions involved in the implementation of the programme require a lot of support to continue contributing to GBV prevention and response in their respective areas. Specifically, the office of the DCDO as the coordinating unity for GBV prevention and response at district should be strengthened and adequately supported with both financial and physical resources such as provision of motorcycles to effectively play this function.

6.2.1 Specific Recommendations

Relevance

i. Broaden the scope of programme design

GBV is a multi–pronged phenomenon that requires a number of inter–linked approaches. The programme focus on strengthening coordination, capacity building, awareness creation and community mobilization is valid but needs to broaden the scope the tackle some of the underpinning causes of GBV such as HIV and AIDS, food security and Nutrition, income poverty. As a result, JP is encouraged to do the following;

a. Broaden the scope of the national and district level coordination committee to bring on board other Ministries such as Health, Agriculture and Justice and Constitutional Affairs.

b. Deliberately target children especially from 10 years with children focused/tailored messages about GBV. This is not only because these are sometimes the victims of GBV but targeting them at an early stage provides an opportunity to tackle some of the attitudes, cultural and traditional practices which are reinforced by older community members may deny creation and sustenance of an enabling environment for tackling GBV.

c. Consider building the capacity of children, youth, boys and girls on how to use participatory decision making and how they can communicate issues affecting them to different audiences. This will help in building in creating more awareness and understanding on how to prevent GBV.

Efficiency

i. Ensure consistency in organization of quarterly meetings of District GBV Coordination Committee

Quarterly coordination meetings have played a key role in ensuring proper implementation of programme activities. There is therefore need to ensure these meetings are held quarterly as planned. This could be done by making the quarterly meeting a key pre–requisite and trigger for disbursement of funds.

ii. Disbursements be done quarterly based on delivery of outputs

The programme disbursed funds annually and reporting was semi–annually without placing conditionalities on delivery of outputs. The evaluation recommends that disbursement of funds be changed to quarterly and based on delivery of outputs (after submission of quarterly reports).

iii. Strengthen the role of District GBV Coordination Committee

At District level, the District GBV Coordination Committee chaired by the CAO and comprised of the RDCs office, technical departments and CSOs working on GBV needs to be strengthened to ensure that quarterly meetings are held. This should as well serve as a GBV shelter Steering Committee for districts that have shelters i.e. Kamuli and Namutumba

iv. Strengthen Sub–county coordination

The programme design did not provide for sub–county coordination yet this is the closest level to targeted communities where action needs to be well coordinated and impactful. As such it is recommended that a sub–county GBV Coordination Committee be instituted and functionalized.

Effectiveness

i. Increase coverage of the programme to target the entire Busoga region including all parishes and villages through strengthening Government structures

The GOU–Irish Aid JP coverage was at 80% with 8 out of 10 districts and 32% with 32 sub–counties out of 101. Considering the performance so far, the evaluation recommends that the programme be expanded to cover all the districts and sub–counties in the Busoga region. Possibilities of co–funding from districts drawing from the Namutumba experience could be explored if there are funding limitations to the expansion

ii. Integrate GBV in Health and JLOS training

Evaluation found that the programme fostered close collaboration and support among duty bearers regarding provision of GBV response services. There is therefore need to continue inculcating a sense of togetherness and synergy building for a common purpose among duty bearers. Particularly,

there is need for advocacy for Health and JLOS training institutions to include GBV in their curricula to enhance their capacity to provide a holistic response to prevention of GBV.

iii. Review model of construction of GBV shelters with a view to shifting focus towards prevention and legal support to victims

Evaluation found that GBV shelters were important in providing a response to GBV, the costs associated with it (setting up each shelter, cost of maintenance in terms of; feeding, utilities, medical care, security and of recent provision of skills) makes sustainability of the intervention questionable. Besides, evaluation also found out that some community members were simply being lured to the shelters by sheer comfort and provisions made at the facility and not necessarily that they were in deep danger. Investing in prevention, through CAs and CAGs and working with faith based institutions while providing the legal support to victims seem more plausible mechanisms for GBV survivor support than GBV shelters

iv. Make the DVA Popular among the duty bearers especially police and Judicial system

The evaluation found out that while the JLOS is very useful in GBV response and prevention, is not yet popular especially among the Police and Judicial Officers who as a result are still applying the Penal Code while handling GBV cases. It is therefore recommended that more sensitization about DVA be conducted targeting especially the Police and Judicial Officers. The programme could do the following on popularizing the DVA

a. Partner with the Judiciary to sensitize Magistrates and Judges on the application of the DVA model

b. Reach out to Uganda Law Society to sensitize them about DVA and how it can be used to extent support to victims of GBV

c. Engage universities and National Council for Higher Education on integrating new “practices” such as DVA in the training curriculum for law students

d. Reach out to Police especially Family and Children’s Division to sensitize them on DVA

v. Continued use of SASA methodology as an effective method for BCC

The SASA! behavioral change approach designed to motivate, facilitate and structure effective reflection on the use of power as a root cause of violence has approved an effective methods for correcting the imbalance of power between women and men. It also advocates for the need to replace norms around power that are hurtful, damaging, oppressive and unjust with norms that are healthy, safe, liberating and just. As such this evaluation recommends its continued use in GBV prevention interventions and scale up to other districts as a model in GBV programming, response and prevention.

vi. Ensure the programme does more advocacy targeting leaders at various levels.

Advocacy involves lobbying people with influence to change policies, programmes and resources for an intervention to be more effective. The JP design missed focusing on Political leaders especially

Parliamentarians from the region, who are so influential at national and local levels although it focused on LC1s.

vii. Improve the National GBV Data base

The evaluation found the National GBV data base is in place and accessible but with limited functionality due to inadequate quality of the data. However, the NGBV data base management faces challenges of inadequate data quality coming from districts and delays in transmission of data. The system also uses a bottom–up approach with no feedback mechanism for data sponsoring entities. This evaluation recommends that for the National GBV Data base be improved to make it more reliable and functional.

Sustainability

i. Strengthen skills exchange, recruitment and graduation of volunteers

The JP relied heavily on Community Activists (CAs) who are volunteers and are prone to attrition which can adversely affect the continuity of the programme. Similarly, experience from similar progammes that use community volunteers indicates that steam and dedication tends to drop as one spends more years as a volunteer. As such, the programme could explore the following;

a. Set a clearly defined timeframe in which one will be a Community Activist and thereafter handover their responsibilities to the next group of volunteers in a formal way.

b. Put in place a system that enables trained Community Activists to transfer similar skills to the new group so as to ensure continuity and participation of all members of society.

i. Continued GBV BCC multimedia campaign

Addressing social cultural issues surrounding GBV calls for continued use of media as partners in GBV prevention and response interventions. One way for media support would be for LGs to request their local media houses for concessional air time for airing GBV related messages and radio programmes.

ii. Strengthen the M&E Function

This evaluation recommends that the JP M&E be integrated within government structures at MGLSD level and strengthened to ensure among others: coordinated data collection, enhanced data quality, use of data for evidence based management decision making and advocacy, continuous assessment of programme progress using outputs and outcomes with their corresponding targets and harmonization with other data collection mechanisms such as HMIS.

iii. Continue support for commemoration and participation in the 16 Days of activism

The 16 days of activism held every year at sub–county level energized community mobilization and advocacy against GBV. This served as an event to recognize the efforts of CAs, CAGs and CDOs. The event has been found useful in raising awareness and promotion of behavior change. As such this evaluation recommends its continued commemoration and support for participation at district and sub–county levels supported through district budgets.

iv. More involvement of Cultural and religious institutions

Cultural and religious institutions are an effective way to sensitize the masses as they wield a lot of influence in the community since they have a variety of platforms for reaching out to the masses with messages. These include worshipping services, funeral services, traditional marriage engagements and wedding functions.

v. Priorities for Next 2 Years

The evaluation suggests that the following areas of work be prioritized and strengthened:

National Level

- *Improvement of NGBV Data system.*
- *M&E System revitalization.*

District Level

- *Support the DCDO to put in place a costed post JP transition plan for District funding.*
- *Support District GBV Coordination Committee.*
- *Support of DCDOs, Probation and CDOs.*
- *Explore phasing out construction of GBV Shelters Program with a move to shift towards prevention and provision of legal support after the programme closure.*
- *Training and sensitization of CAOs and Political leaders.*
- *Sensitization and training of Police and Judiciary on DVA.*
- *Support to Police.*

Community Level

- *Strengthen sub–county involvement by orienting Sub–county chiefs and Parish chiefs.*
- *Replication of SASA Model.*
- *Use of Radio for BCC.*
- *Commemoration of 16 days of activism.*

7 References

References

Capacity Building Strategy, April 2011

CEDOVIP, Annual Report 2011

CEDOVIP, Semi–annual Report, January–June 2013

CEDOVIP, Semi–annual Report, January–June 2014

CEDOVIP, Semi–annual Report, January–June 2015

CEDOVIP, Semi–annual Report, July–December 2013

CEDOVIP, Semi–annual Report, July–December 2014

Gou –Irish Aid Joint Programme to address GBV in Busoga Region

GoU–Irish Aid Joint Programme to Address Gender Based Violence (GBV) IN Busoga Region: Programme Document FY 2010/11–FY 2014/15

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Annual Report, Year III (FY 2012/2013)

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Annual Report, Year II (FY 2011/2012)

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Annual Report, Year IV (FY 2013/2014)

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Annual Report, Year V (FY 2014/2015)

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Annual Report, Year III (FY 2012/2013)

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga; Year II (FY 2011/2012) Quarter II Monitoring and Supervision Report, February 2012

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga, Monitoring and Support Supervision Report, December, 2012

Government of Uganda–Irish Aid Joint Programme to address GBV in Busoga Region, Semi–Annual Report, Year III (2012/2013), February 2013

Government of Uganda: Uganda Demographic and Health Survey 2011

Government of Uganda: Uganda Demographic and Health Survey 2006

Kamuli Annual Report 2014

Ministry of Gender, Labour and Social Development GoU–Irish Aid Joint Programme to address GBV in Busoga Region, "Data Collection on Programme Indicators, Activity Report, July 2012.

UWONET, Progress Report January–June 2012

UWONET, Progress Report January–June 2013

UWONET, Progress Report January–June 2014

UWONET, Progress Report January–June 2015

UWONET, Progress Report July–December 2011

UWONET, Progress Report July–December 2011

UWONET, Progress Report July–December 2012

UWONET, Progress Report July–December 2013

UWONET, Progress Report July–December 2014

UWONET, Progress Report, July 2010–June 2011

8 Annexes

Annexes

Annex 1: Respondents per district, category and method of data collection

Respondent Category	Method				Districts					Total
	KIIs	FGDs	Questionnaire	Observation	Jinja	Kamuli	Mayuge	Namutumba	Bugiri	
Resident District Commissioners	√				√	√	√	√	–	4
Chief Administrative Officers (CAOs)	√					√		√	√	3
District Security Officers (DISOs)						√				1
District Community Dev. Officers (DCDOs)	√				√	√	√	–	√	4
District Probation and Social Welfare Officers	√				√	√	√	√	√	5
Gender Officers (GOs)	√				√	√	√		√	4
Police (CFPU, SGBV Desk Officers)	√	√			√	√	√	√	√	5
Police (DPC, OC CID, CLO)	√				√	√	√	√	√	5
Councillors in charge of Social Services/ Gender issues	√				√	√		√	√	4

Respondent Category	Method				Districts					Total
	KIIs	FGDs	Questionnaire	Observation	Jinja	Kamuli	Mayuge	Namutumba	Bugiri	
Health Departments		√			√	√	√	–	√	4
Magistrates	√					√	√	–	√	3
Prime Minister Kingdom of Busoga	√				√					1
Faith Based Leaders	√				√	√	√	√	√	4
Media People	√				√	√	√	–	–	
Women's Agency/ CBOs Groups	√				√	–	–	√	√	4
Sub–county Levels										
LC III Chairpersons	√				√	√	√		√	5
Sub–County Chiefs	√				√	√	√		√	5
CDOs		√			√	√	√	√	√	6
Health Centre III–in Charge/Facility	√			√	√	√	√	√	√	9
Community level										
Women		√			√	√	√	√	√	20
Men		√			√	√	√			20
Community Activists		√			√	√	√	√	√	28
LC1 Chairpersons		√		√		√	√	√	√	4
GBV Survivor Support Groups		√				√		√		2 groups
Community Action Groups									√	10 groups
Household level				√						269 Men & 260 Women
GBV Shelter Steering Committee in Kamuli held on 5th May 2016										1
GBV Shelters						√		√		2
Total										692

Annex 2: List of Respondents

S/N	Name	Organisation /District	Designation	Contact
	National Level			
	Aine Denise Doody	Irish Aid	Deputy Head of Cooperation	0772–744403 aine.doody@dfa.ie
	Caroline Kego Laker		Social Development Advisor	0772–744344 carolinekego.laker@dfa.ie
	Tina Musuya	CEDOVIP	Executive Director	0712240694 tina.musuya@cedovip.org
	Richard Makumbi	CEDOVIP	Programme Officer	0782763761 richard.makumbi@cedovip.org
	Edwin Kayuki	IRCU	Programme Officer	0772365951
	Maggie Kyomukama	MGLSD	Asst Commissioner Gender And Women Affairs	0772516778 mmkyomukama@yahoo.com
	Laureen Karayi	UWONET	Programme Officer	0759330009 laureenk@uwonet.or.ug
	Alfred Rwamirego	UWONET	Communications Officer	0750440046 alfred.rwamirego@uwonet.or.ug
	Noel Komunda	MGLSD	M&E Officer Gou–Irish Aid JP	0751027127 noel.komunda@gmail.com

S/N	Name	Organisation /District	Designation	Contact
	Rachael Muteesi	MGLSD	Administrative Assistant Gou–Irish Aid Jp	0774439944/ 0700860312 muterache@yahoo.com
	Amira Diallo	UNFPA	Gbv And Humanitarian Response Programme Analyst	amidiallo@unfpa.org
	Doreen Komuhangi	UNFPA	Gbv And Humanitarian Response Programme Analyst	0772592873
	District Level			
	Moses Dumba	Kamuli	RDC	0701419611 dmoses@gmail.com
	Ben Ogwette	Kamuli	CAO	0772410633
	Merewoma Leo	Kamuli	DCDO	0772–614540 mmere2@yahoo.com
	Mboizi Joshua	Kamuli	District Probation Officer	0772–374243 mboizij@yahoo.com
	Mukasa Monica		Woman Councillor Butansi S/C	0752478420
	Olweny Aloysius Peter	Kamuli	Gender Officer	0712 306 721 / 0756 762 596
	Lyagoba Moses	Kamuli	Adho Mch	0782466220 0754466220 lyagobamoses@gmail.com

S/N	Name	Organisation /District	Designation	Contact
	Kercan Peter Prosper	Kamuli	Magistrate Grade 11	0772 628 276/0753 628 276/0392 300 042 kerchan2007@yahoo.com
	Patrick Kachope	Kamuli	DISO	0772 623 518 kachpat@yahoo.com
	Grace Mawerere		CDO Bulawori	0771896540 grmawe@gmail.com
	Tidhomu Moses		CDO Bulopa	0751522425
	Nabuye Zowen		CDO	0772388
	Moses Mitala		CDO Namwendwa	0752250079
	Eric Kantale		CDO	0704008155
	Simon Kabaale		CDO	0774293599
	Rogers Mulyazawo		CDO	0776130543
	Richard Lugada		CDO Bulopa	
	Fatuma Kitamirike		Secretary	
	Nabirye Harriet	Kamuli	Matron: GBV Shelter	0757 066 332
	Ajilong Pamella	Kamuli	Police OC–CID	
	Asp Ninsiima Doreen	Kamuli	Police OC Station In–Charge (Stood In For DPC)	
	Sgt. Agnes Apolot	Kamuli	Police GBV Desk In Charge	
	Judith Nakalembe	Kamuli	Coordinator, GBV Shelter Project, Kamuli & Lawyer UWONET	

S/N	Name	Organisation /District	Designation	Contact
	Nyende Aloysious Religious Leader Advent Church	KAMULI	Religious Leader Advent	0750001630
	Chalrse	Kamuli	Manager KBS Radio	
	Namukasa Erinah	Kamuli	SCDO	0782680136 namukasa.ruth@yahoo.com
	Religious Leader Kamuli Mosque	Kamuli	Religious Leader Moslem	
	Mukooli Paul	Mayuge	DCDO	0772–960953 pmukooli2009@yahoo.com
	Naigaga Hadija		CDO Buwaya	0704593441 naigagahadija@gmail.com
	Aggrey Sajjabi		CDO Bukatube	0782891741
	Peter Kwagaba		CDO Mayuge TC	0717320973 kwagabapeter@gmail.com
	Sgbv Desk In–Charge	Mayuge	Police	
	Oc–Cid Mayuge Cps	Mayuge	Police	
	Milly Kayaga	Mayuge	SPSWO	0774761100 milliepretty@yahoo.com
	D/Aip Salamula Sarah	Mayuge	D/AIP	078247207
	Sgt Munyana Margaret	Mayuge	Sgt	0774442913
	D/C Nanteza Zamu	Mayuge	S.G.B.V	0756343578

S/N	Name	Organisation /District	Designation	Contact
	D/C Bazanya Aggrey	Mayuge	S.G.B.V	0773901885
	D/C Kasango Shabani	Mayuge	S.G.B.V	0775088494
	D/C Katanengo Sabasi	Mayuge	S.G.B.V	0758365952
	D/C Nambasi Gerald	Mayuge	S.G.B.V	0777771799
	D/ASP Mulinira A.N	Mayuge	OC/CID	0714668007
	D/C Kintu Milton	Mayuge	Records	0753602531
	SP Denis Odoch	Mayuge	DPC	071466800
	Madoi Elijah	Namutumba	Resident District Commissioner	0776 960 634
	Hajji Muslimu Mugoya Butotooba	Namutumba	Vice Chairperson, Lc V, Secretary For Gender Labour And Social Development	0752 981 788
	Kauma Rose Kaumakagere	Namutumba	Assistant Chief Administrative Officer, Namutumba	0783 3934 080 0704 792 319
	Magoma Henry Stephen	Namutumba	District Education Officer, Namutumba DLG	0772 866 591 0701 866 591
	Kalisengawa Fred	Namutumba	District Inspector Of Schools	0702 164 223 0772 869 588
	Esther Nandase	Namutumba	Senior Probation Officer	0779 488 420
	Julian Naluwoza	UWONET	Social Worker/ Ag Coordinator–UWONET GBV Shelter, Namutumba	0752 701 120/0778 424 330

S/N	Name	Organisation /District	Designation	Contact
	Harriet Namukenge	UWONET	Legal Assistant– Uwonet Gbv Shelter, Namutumba	0701 156 777 0759 807 308
	Kabakubya Samuel	Namutumba	Town Clerk, Namutumba	0772972779/ 07O3533302 samuelkabakubya@gmail.com namutumbaurban@gmail.com
	Asp Wafula Charles Richard	Namutumba	OC Station, Namutumba	0714 668 059 (Official) /0772493604} Personal 0701 493 604}
	D/Sp Gimei Topher	Namutumba	District CID Officer, Namutumba	0772 666 837
	D/SGT Lubaale Prossy		I/C GBV/Sexual Offences	0782 405 794/ 0701 919 228
	Sarah Bayiga	Namutumba	OC, Child And Family Protection Unit (CFPU)	0772 353 928
	Juliet Mutesi	Namutumba	Community Development Officer, Namutumba TC	
	Baganda Joseph	Namutumba	Catechist, Namutumba Town Catholic Church	0782568143

S/N	Name	Organisation /District	Designation	Contact
	Kyebajja Goretti	Namutumba	Senior Clinical Officer In–charge, Namutumba H/C3	0774 971 198 0704 630 897
	Nabugoma Ellen Tracy	Namutumba	Matron, Namutumba GBV Shelter	
	Kasule Noah Pasha	Namutumba	Assistant Programme Officer Nsinse Sub–County HIV/Aids Workers Association (NSHAWA)	0779 536 791
	Stephen Mageo	Bugiri	DCDO, Bugiri DLG	0772 418 417
	Swabaya Magid	Bugiri	Clinical Officers At Bugiri Hospital	0705009055
	Aip Akello Margaret	Bugiri	In–charge, Sexual Gender Based Violence Desk, Bugiri Police Station	0776 563 532 0702 304 231
	Ip Egesa Denis	Bugiri	Community Liaison Officer	0788882404
	Mulongo Muhammed	Bugiri	CPFU, Bugiri Police Station	
	Desire Mooli	Bugiri	M&E Officer, Community Participation For Improved Service Delivery (COPISED)	0700241883
	PC Nairanga Christine	Bugiri	CPPU, Bugiri Cps	
	Hami Mulongo Muhamad	Bugiri	Vice Chairperson LCIII, Kapyango Sub–County	0784 987 755 0701 895 996

S/N	Name	Organisation /District	Designation	Contact
	Kisubi Kagoma Meddy	Bugiri	Community Development Officer, Kapyanga S/C	0701 510051; 0772 552947.
	Nakato Fariday	Bugiri	CDO, Bugiri Town Council	0752 837 962
	Walusimbi	Jinja	ADCDO	0772436971
	Tamubula Olivia	Jinja	CDO	0782084399 oliviatamubula@ gmail.
	Simon Lubaale	Jinja	SCDO Gender	0704028322 simonlubale@gmail. com
	Kyenda Rachael	Jinja	CDO–Butagaya	0772904783 kyendarachael@ gmail.com
	Jinja Police Sgbv Desk	Jinja	Investigator	
	Aip Nabirye Milly (Maama Police)	Jinja	Investigator	
	Detective Asp Ochola George William	Jinja	Police CFPU In–Charge	
	Police Officer Akello Mary (Senga Police)	Jinja	Police OC–CID Jinja Cps	

S/N	Name	Organisation /District	Designation	Contact
	Sub–County Level			
	Mukasa Monica–	Butarisi S/C	Women Councilor	
	Isa Basalirwa Walumukaki	Jinja Tc	LC I Chairman Mafubira Zone B	0752816886/ 0788360794
	Health Centre Staff	Namwendwa	Namwendwa Health Centre III	
	Erisa David Gawune	Bulopa	Chairman LCIII	
	Senior Health Educator	Mayuge TC	Mayuge Health Centre III–Senior Health Educator	
	Senior Health Educator	Mayuge TC	Senior Health Educator	
	Erisa David Gawune	Bulopa	Chairman LC111	
	Immaculate	Namutumba TC	In–charge, Namutumba HC III	

Annex 3: List of Activities by Objective

Activities Under Objective 1	Activities Under Objective 2
➪ *GBV Coordination Meetings conducted at district level* ➪ *Planning and review meetings conducted for Programme partners* ➪ *GBV reference Group Meeting held at national level* ➪ *Orientation on JP M&E Tools and GBV data collection* ➪ *Training on Clinical Management and response of SGBV survivors* ➪ *Attending the 56th CSW* ➪ *Support for International Women's Day in Nebbi District* ➪ *Development of Programme Annual Report FY 2011/2012* ➪ *Conduct Joint Annual Planning Meeting* ➪ *Consultative meeting on GBV draft Policy and guidelines for establishment of GBV safety shelters* ➪ *Programme Logo designed for identity and visibility* ➪ *Conducted Baseline* ➪ *Media training for media practitioners and DCDOs CDOs and DIOs* ➪ *Develop GBV Policy brief* ➪ *Annual commemoration of 16 Days of activism*	➪ *Mapping of key GBV actors (service providers) to establish GBV Referral Pathway* ➪ *Developed a stakeholder's capacity needs strategy to direct the capacity building component. Reviewed and adapted existing GBV training materials to the context of Busoga* ➪ *Developed a handbook for duty bearers on handling GBV cases and survivors* ➪ *National Level Training of trainers (TOT)* ➪ *GBV skills development and knowledge building for key duty bearers (officers of Child and Family Protection Unit, Criminal Investigation Department, Community Development, probation and Welfare and Gender, Health workers and Local council courts).* ➪ *Equipping Police stations with stationery and supplies and LCs with record books* ➪ *Development of IEC materials on the referral pathways* ➪ *Duty Bearers Forum (one at national level and others at regional and district levels)*

	➪ *Capacity Building of district CBO'S and NGO'S on gender, GBV, legal frameworks, Human Rights and organizational development to enhance their capacity to response and prevent GBV)* ➪ *National Launch to commemorate 16days of activism and participation of the events throughout the period of the programme* ➪ *Facilitated quarterly data collection on GBV among service provider (referrals, case management and challenges being faced at the different service point* ➪ *Development of Policy Briefs for advocacy and hosting of high level round table dialogues for national level lobby and advocacy on GBV in relation to the Marriage and Divorce Bill* ➪ *Bi–Annual sector specific mentorship sessions for Police, PSWO and LC's* ➪ *Monitoring visits and support supervision to the duty bearers* ➪ *Management committee, Planning and coordination meetings* ➪ *Participation in the National women's week*

Activities Under Objective 3	Activities Under Objective 4
➪ *Mapping exercise to identify resources and assets to support program implementation* ➪ *Equip Community Development Officers (CDOs) /assistant Community Development Officers (ACDOs) on application of SASA! model for GBV prevention & response* ➪ *Learning center visit to Kampala (for DCDO/ CDOs/ACDOs)* ➪ *Printing & distribution of I.E.C SASA! materials* ➪ *Facilitate sub county GBV action plans* ➪ *On site skill development of CDOs/ACDOs in each district* ➪ *Mentoring of CDOs for GBV activism/ Learning Center visits for CDOs* ➪ *16 days of activism campaign* ➪ *Collaboration and coordination with JP partners* ➪ *Monitoring & evaluation*	➪ *Conduct programme Midterm Evaluation* ➪ *Collection of GBV data and maintenance of GBV Database system* ➪ *Facilitate and strengthen community activism by providing bicycles to CAs (for data collection)* ➪ *Production of Video documentation* ➪ *Print and disseminate IEC Materials* ➪ *Running Radio Adverts and spot messages* ➪ *Participation in 59 CSW March 2015* ➪ *GBV database upgraded* ➪ *Districts re–oriented on GBV data collection* ➪ *Fact sheet on GBV incidence produced and disseminated* ➪ *Programme Monitoring and evaluation Plan developed* ➪ *GBV data base established in all programme districts* ➪ *Management of GBV database system* ➪ *Monitoring and support supervision visits conducted*

Contact

Ministry of Gender Labour and Social Development (MGLSD)
Plot 2, Simbamanyo House
P. O.Box 7136, Kampala
George St, Kampala, Uganda
Phone: +256 41 4347854

Irish Aid
Department of Foreign Affairs
Riverstone House, 23 - 27 Henry Street
Limerick
irishaid@dfa.ie
www.irishaid.gov.ie