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Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 28-Apr-2017 | Report No: PIDISDSA21606



BASIC INFORMATION

A. Basic Project Data

Country Uganda	Project ID P160447	Project Name UG - Enhancing Social Risk Management and Gender Equality Project	Parent Project ID (if any)
Region AFRICA	Estimated Appraisal Date 20-Apr-2017	Estimated Board Date 20-Jun-2017	Practice Area (Lead) Social, Urban, Rural and Resilience Global Practice
Financing Instrument Investment Project Financing	Borrower(s) Ministry of Finance, Planning and Economic Development	Implementing Agency Ministry of Gender, Labour and Social Development	

Proposed Development Objective(s)

The Project Development Objectives are to: (i) increase participation in Gender Based Violence (GBV) prevention programs; and (ii) increase utilization of multi-sectoral response services for survivors of GBV in targeted districts.

Components

Gender Based Violence Prevention
Response to Gender Based Violence
Project Management, Training and Monitoring and Evaluation

Financing (in USD Million)

Financing Source	Amount
International Development Association (IDA)	40.00
Total Project Cost	40.00

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue



Note to Task Teams: End of system generated content, document is editable from here.

Other Decision (as needed)

B. Introduction and Context

Country Context

High levels of Gender Based Violence and of acceptability of such violence particularly among youth

1. **Uganda has experienced steady macro-economic growth, poverty reduction, and relative political stability over the last few decades.** The country has been successful in reducing poverty, but a third of the population still lives below the international extreme poverty line. According to the Uganda Country Partnership Framework (FY16-21), the proportion of households living in poverty more than halved from 1993 to 2013, with poverty reducing from 68 percent to 33 percent. However, a large proportion of the population remains vulnerable to falling back into poverty. Overall, 43 percent of Ugandans live in non-poor (but vulnerable) households, illustrating the fragility of the gains realized.
2. **Uganda ranked 88th out of 142 countries¹ and lowest in the East African region, in the 2014 Gender Inequality Index. This index benchmarks national gender gaps using economic, political, education, and health criteria.** One of the key areas where gender inequality persists is economic participation and access to education as well as health services. Attitudes, beliefs, and practices that exclude women from social and economic life are deeply entrenched in society. Discriminatory attitudes towards women as well as high fertility rates create barriers to women's full participation in economic and social life and may limit the extent to which women are able to benefit from poverty reduction gains (World Bank Uganda Poverty Assessment, 2016). Discriminatory attitudes towards women and perceptions of what are gender appropriate economic roles contribute to lower female earnings, partly causing women to go into lower productive sectors (Campo et al. 2015 in World Bank, 2016).

Prevalence rates of Gender Based Violence (GBV) in Uganda are high compared to both global and regional averages. Overall, 62.2 % of all women and 58.8% of all men aged 15-49 in Uganda reported experience of physical or sexual violence (by any perpetrator) at least once since the age of 15 (according to the 2011 Uganda Demographic and Health Survey).² By comparison the global average prevalence rates for violence against women (physical or sexual) aged 15-49 is estimated by the WHO at 35.6% and the regional (Africa) average is 37.7%.³ In most cases (60 percent), perpetrators were intimate partners. Furthermore, the 2011 Uganda Demographic and Health Survey (UDHS) data indicates that beyond Intimate Partner Violence (IPV) Non-Partner Sexual Violence (NPSV) and child sexual abuse are the two most prevalent forms of GBV.⁴

¹ With a score of .6821

² Figures are for men and women aged 15-49 whether never married, married /living together or divorced /separated / widowed.

³ World Health Organization (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva, World Health Organization.



3. **Overall, acceptance of IPV is also high in the Africa Region, on average around 30 percent, which is more than twice the average of the rest of the developing world (at 14 percent). Such accepting attitudes towards IPV are high in Uganda even when compared to other countries in the region (please see Figure 1 below).** The 2011 Uganda Demographic and Health Survey (UDHS) found that 58% of all Ugandan women aged 15-49 believe that wife beating is justified for at least one specified reason. Acceptance varies with age and location and worryingly, women from younger age groups and rural areas appear to be more accepting of abuse. Among men, the acceptability of wife beating is still high but lower than for women. The 2011 UDHS found that 44% of all Ugandan men aged 15-49 believe that wife beating is justified for at least one specified reason with figures being higher for rural men (47%) compared to urban men (29%).
4. **Both the prevalence of and accepting attitudes towards specific forms of GBV⁵ have decreased in Uganda between 2006 and 2011, according to the UDHS data.** These gains have, however, been relatively limited and are not shared by all cohorts of women. The proportion of women who have ever experienced physical violence (age 15-49) declined only by 4 percentage points—from nearly 60% in 2006 to 56% in 2011. The recent 2016 UDHS is currently being analyzed and was is not available to inform project preparation. Initial data released focuses only on the prevalence for sexual violence. It shows a further modest decline in prevalence rates between 2011 and 2016⁶. Preliminary findings from the 2016 UDHS show that the probability of experiencing sexual violence at some point in one's life was at 22% for women aged 15-49 (reduced from 28% in 2011). Sexual violence was only reported by approximately 8 percent of men in 2016. Patterns in terms of prevalence of sexual violence in 2016 are similar to those observed in 2011 (namely higher rates in rural areas, and among women with an education level lower than secondary education).
5. **Key vulnerable groups include adolescent girls.** Early marriages and pregnancy are leading contributors to vulnerability accounting for more than half of all reasons for girls leaving school. The national teenage pregnancy rate is 24.8 percent among girls aged 15-19 years. On average, 40% of women aged 20-40 were married before the age of 18 and 15% before the age 15. Prevalence of physical and sexual violence is highest among younger cohorts of women. Physical violence declined for most age groups, except for women aged 20-24 and 40-49. The highest drop was for those age 30-39. Violence prevalence declined for women with primary and secondary or higher education, but increased for those with no education by one percentage point. Importantly, high levels of acceptability of wife beating remain among women in younger cohorts (61.8% for women aged between 15 and 19).

Social acceptability of GBV can create high risk conditions for violence, further exacerbated by infrastructure investments

⁵ Specifically wife beating which is monitored by the UDHS

⁶ Preliminary results from the 2016 DHS were made available on March 18, 2017. The information currently available is limited to key indicators on sexual violence. Micro-data from the 2016 DHS is expected shortly but will not be available before project approval in June. The background analysis for the project uses the most complete available DHS data, which is currently from 2011. Further analysis of the 2016 DHS data will be carried out by the team before project effectiveness



6. **In a context, where both rates of GBV and levels of social acceptability of GBV are high, the risk of such violence can be exacerbated by development interventions, including investment projects.** Research has shown that while these investments - roads, dams, and railways – can be key for economic development at a macro level, they can also negatively impact communities (USAID 2015, World Bank 2016). For instance, labor influx associated with large investment projects, taking place in a context where social norms and values may include high levels of acceptability of GBV can further expose vulnerable groups living around construction sites to sexual assault, transactional sex, rape, and forced/early marriage. Furthermore, it also has the potential exacerbate chronic vulnerability of children and adolescent girls and increases their risks of experiencing violence at the community level.

7. **The Uganda World Bank Country Portfolio has recently faced numerous challenges in managing and mitigating social risks associated with the influx of labor in infrastructure projects, particularly in Kamwenge and Kabarole districts.** Adverse social impacts experienced during the implementation of the Uganda Transport Sector Development Project (TSDP), included the sexual abuse of minors in communities affected by project implementation. The Government of Uganda (GoU) with the support of the World Bank Group (WBG) has subsequently put in place a series of measures to respond to the immediate needs of child survivors of sexual violence in the project area, through the Emergency Child Protection Response (ECPR) intervention. The ECPR provided emergency support to the survivors and their families in accessing health care, legal aid, as well as livelihoods and education opportunities. Further acknowledging the need to develop a more sustainable and comprehensive approach to addressing GBV as part of infrastructure investments, GoU is currently implementing a Rapid Social Response (RSR) Grant in the two above mentioned districts. The Grant will enable GoU to test out mechanisms to: (i) raise awareness among project affected communities of the potential risks of GBV; and (ii) establish response services in these same communities that can respond to instances of GBV (particularly those related to issues of labor influx). The RSR will be completed by June 2018 and will generate critical lessons-learned for other GoU infrastructure interventions.

Sectoral and Institutional Context

Solid legal and policy framework but significant gaps in terms of its implementation and access to GBV prevention and response programs and response programs

8. **The Government of Uganda recognizes the burden that gender inequality, including GBV, places on social and economic development. This realization is reflected by the consistent progress made by GoU in strengthening the policy and legal framework to address GBV as follows:**
 - i. The National Policy on the Elimination of Gender Based Violence (October 2016). The NPEGBV provides a framework for the implementation of comprehensive GBV prevention measures and provision of multi-sectoral support services for survivors. It also outlines the role of various state and non-state actors at local and national levels, strategic actions, and milestones for measuring progress. The new policy plays a key role in addressing critical gaps in GBV response, such as the lack of functioning referral systems that coordinate health, social, law enforcement, and judicial sectors.



- ii. The Second National Development Plan NDP II (2015/16-2019/20), which emphasizes gender equality as a basis for development and the elimination of GBV as a key strategic action.
 - iii. The National Gender Policy NGP (2007) and associated National Action Plan on Women (2007) which encourages Government, civil society, and UN agencies to put gender equality at the heart of strategies and interventions, including those that address GBV.
 - iv. The Social Development Sector Plan (SDSP) 2015/16-2019/20, which underlines the expansion of GBV prevention and response programs as a priority area of action.
9. **These policies are complemented by a robust legal framework which includes the ratification of major international and regional agreements to promote gender equality. In addition, comprehensive domestic legislation addresses the issues of GBV.** This includes the Constitution (1995), Penal Code Act (2007), Domestic Violence Act (2011), Equal Opportunities Commission Act (2007), and the Prohibition of Female Genital Mutilation Act (2010). However, this legal framework co-exists uneasily with customary laws and practices, which remain the primary determinant of outcomes for most women due to Uganda's dual legal system, especially in domains related to marriage and successions (World Bank 2016).
10. **In terms of GBV in the workplace,** the overall legal framework is provided by the following pieces of legislation: the Occupational Safety and Health Act (2006); the Labour Disputes and Arbitration Act (2006); the Workers' Compensation Act, 2000; the Magistrate Courts Act, Employment Act 2006 and its attendant regulations like the Employment (Sexual Harassment) Regulations No. 15, 2012 among others. The implementation of these acts and regulations has, however, not been adequate. The gaps noted in the existing legal and policy framework result largely from a lack of clear procedures to address issues of GBV in the workplace.
11. **National coordination mechanisms have been put in place by the above mentioned policy framework. However, these platforms lack financial resources as well as strategic planning aligned to the goals of the National Policy on the Elimination of Gender Based Violence.** They include i) the National GBV Reference Group coordinated by the MOGLSD and comprised of government, Civil Society Organizations (CSOs), development partners, and the private sector, and ii) the Gender and Rights Sector Working Group bringing together Gender Focal points from the different Government Ministries and departments. In addition, Uganda has a vibrant community of civil society organizations that contribute significantly to innovative and quality service provision for survivors and those at risk of GBV. Currently, civil society organizations active in this field, lack a national coordination platform and depend primarily on the regional African GBV Prevention Network, as a platform for knowledge exchange on effective approaches.
12. **While Uganda's legal and policy framework is comprehensive, critical gaps in terms of policy implementation remain.** Government agencies at national and local levels experience challenges particularly with the provision of integrated services for survivors of GBV. Specifically, barriers include insufficient resource allocation to fund prevention and response programs across sectors, inadequate human and technical resources, weak law enforcement, limited capacity among social service providers to support and refer traumatized survivors, and limited availability of gender-



disaggregated data to inform GBV programming. Regarding GBV in the workplace, MOGLSD's oversight capacity is limited. Currently there are 84 labor inspectors nationwide, none of which have been trained to address GBV in the workplace.

13. An analysis of the gaps in service provision for GBV survivors at district level was conducted as part of the project preparation process in four purposefully selected sites in both Western (Hoima and Kibaale districts) and Eastern (Kamuli and Bugiri districts) regions of the country. The analysis, conducted between December 2016 and February 2017, using primarily qualitative research methodologies, provided important insights in terms of access to services and in terms of the quality of the services available as follows:

- i. *Access to health services* - The majority of the facilities did not have protocols or guidelines for the clinical management of GBV and no comprehensive training program had been rolled out on the Ministry of Health Guidelines for the management of the GBV cases. Overall, lower level health facilities lacked sufficient equipment and staff to provide the necessary basic services. The analysis conducted indicated gaps in: (a) the availability of Post Exposure Preventive (PEP) treatment; (b) sufficiently trained staff manage GBV cases; (c) gaps in the routine screening for Sexually Transmitted Infections (STIs) beyond HIV; and (d) access to emergency contraception. The vast majority of facilities lacked appropriate space to conduct consultations in a private setting.
- ii. *Counselling services and psycho-social support at community level* – While the analysis highlighted gaps in terms of access to counselling at health facility level, it also noted that survivors often seek informal community-based counselling. The latter was provided by a range of entities such as para-social workers, members of child-protection committees, community activists as well as probation officers and local council authorities. These often do not have the required training, which may result in further harm to GBV survivors.
- iii. *Livelihoods and economic empowerment* – While the analysis highlighted the strong presence of Village Savings and Loans Association (VSLAs) in the targeted districts, the overall absence of structured referral systems and of psycho-social support or counselling meant that among respondents there were no instances of referrals of GBV survivors to existing livelihoods programs. In addition, existing programs reviewed did not include an element of gender transformative training and/or engagement of men and boys in the community. In line with international evidence, this may lead to increased tensions at household level over the additional income earned by women (which in some instances was found to result in increased levels of GBV).
- iv. *Security* – The analysis noted a lack of Standard Operating Procedures (SOPs) to deal with cases of GBV. While the research team observed efforts to train police officers and establish Gender Desks in some stations, there were a number of significant operational limitations in the ability of police to respond adequately to cases of GBV. This included a lack of trained personnel, and funding to cover basic operational costs (including transport). The analysis noted the absence of safe spaces/rooms at police stations that would allow survivors to remain temporarily in secure



conditions. Significantly, respondents indicated a relatively high level of mistrust of the soundness of police investigations into instances of GBV and an important lack of coordination between the health system and the police on the collection of forensic evidence and medico-legal information.

- v. *Access to justice* - Given the significant gaps in access to health and security services noted earlier (particularly in what concerns medico-legal support), only a small proportion of reported GBV cases are ever prosecuted. From the point of view of survivors, however, there are number of obstacles to accessing the formal justice system, which are important to note namely: (a) procedures are insensitive to the needs of survivors who are required to give evidence in open court, under adversarial conditions and potentially facing further stigmatization and re-victimization; (b) access to legal aid is limited and administrative costs can be prohibitive for a significant number or survivors; (c) sentences are often considered too lenient which may discourage survivors from pursuing the costly and challenging process of obtaining legal redress. Importantly, the analysis also covered traditional justice systems. These were overall found to reinforce existing gender norms which are accepting of GBV and often discourage women from accessing formal services/lodging complaints with the police.

15. In terms of prevention initiatives, there are noteworthy examples of community level prevention interventions in Uganda some of which have been rigorously evaluated and have demonstrated impact in reducing GBV among participants. A mapping of existing prevention interventions was conducted during project preparation as part of a secondary review of data on GBV in Uganda (GBV Diagnostic, 2016) to inform project design. These interventions, while promising, are primarily implemented by civil society and therefore face issues of implementation at scale and sustainability once donor funding is fully utilized.

C. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet.

Development Objective(s) (From PAD)

The Project Development Objectives are to: (i) increase participation in Gender Based Violence (GBV) prevention programs; and (ii) increase utilization of multi-sectoral response services for survivors of GBV in targeted districts.

Key Results

The following key indicators will be used to track progress toward the project development objective:

- Numbers of direct project beneficiaries (% women)



- Number of participants in community-based GBV prevention programs in targeted districts
- Percentage reported decrease in accepting attitudes towards GBV in targeted sub-counties
- Percentage of reported cases of GBV that receive at least two multi-disciplinary services (medical, psychosocial, security, legal support, livelihoods support)
- Percentage of reported cases of eligible GBV who receive Post Exposure Preventive (PEP) Treatment within 72 hours

D. Project Description

Overall approach

- 16. Project design acknowledges the fact that GBV is widespread nationwide and accepting attitudes towards GBV play an important part in the high GBV prevalence rates observed in Uganda.** The project takes into account the additional risks of GBV posed by the implementation of large scale infrastructure projects by including a specific focus on GBV in the workplace. However, the proposed intervention is also based on the assumption that GBV in the workplace or instances of GBV directly related to labor influx cannot be addressed in isolation. Addressing these particular manifestations of GBV requires a focus on the underlying social norms and values at community and household level that may create an environment where GBV is condoned. Communities, informal institutions and families can discourage survivors from accessing services and lodging formal complaints. Therefore, the project has included a strong focus on GBV prevention also at community level (beyond its focus on GBV in the workplace) with an emphasis on gender transformative training and behavior change.
- 17. In line with global best practices and based on the overall situation analysis of GBV in Uganda, the project will focus on both preventing GBV and on improving the quality of multi-sectoral response services for survivors in targeted districts.** Global evidence indicates that effective prevention programs encourage GBV survivors to come forward and seek services. It is therefore important that awareness raising and gender transformative training be accompanied by improvements in the availability and quality of response services.
- 18. The proposed approach builds on tried and tested interventions in Uganda particularly in terms of prevention programs.** In order to maximize GoU investments in this area, the project will adapt and take to scale prevention programs which have been developed in Uganda, have been rigorously evaluated and therefore have a proven track record of reducing GBV prevalence⁷.
- 19. Finally, project design has taken into account the constraints in providing high quality services at district and sub-county level.** This includes inadequate staffing levels for police stations, high turn-over of staff at the level of health facilities, significant case backlog in the criminal justice system and existing capacity constraints on the part of Ministry of Gender, Labor and Social Development at district level. In order to put in place a sustainable approach to GBV response, the project has adopted a mainstreaming approach, rather than a center-based

⁷ Abramsky (2014), *Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduced HIV risk in Kampala, Uganda*. The Impact Evaluation of the SASA! GBV prevention intervention (whole of community awareness raising and behavior change) indicates a significant reduction in acceptance of IPV among both women and men. Bandiera et al (2012), Impact Evaluation of livelihoods and life-skills interventions with adolescents implemented by BRAC indicates that the incidence of girls reporting having sex against their will dropped by 76%.



service delivery strategy. Under the overall coordination of the MOGLSD and the high level Steering Committee, the project will support the enhancement and adoption of a clear referral pathway for the management of GBV cases with the involvement of key sectors. This referral pathway will inform the development of further Standard Operating Procedures (SOP) and case management guidelines in the Health Sector, Uganda Police Force and Department of Public Prosecution.

Component 1 – Prevention of Gender Based Violence

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

Sub-component 1 A – Preventing Gender Based Violence in the workplace (US\$ 2.911 million).

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

- (i) **Strengthening the legal framework to address GBV in the workplace**, by: a) conducting a review of existing legislation and supporting the development or amendment of laws and regulations, including the employment act and occupational safety and health act; b) developing a framework to assess risks of GBV in the workplace as part of the labor inspection system. This will also include a focus on the interaction between the labor force in infrastructure investments and the broader community. The assessment will be developed with a focus on the following sectors: roads, oil and gas, energy and water; c) designing and rolling out a training program for labor inspectors at national and district levels on the application of the GBV assessment framework; d) improving the technical inspection tools currently in use, such as the Occupational Health and Safety (OHS) checklist to monitor risks of GBV as well as the mitigation measures put in place (in infrastructure projects).
- (ii) **Supporting MOGLSD to oversee the design and implementation of Grievance Redress Mechanisms (GRMs) in selected sectors to handle issues of GBV in the workplace (including those pertaining to the interaction between workers and the broader community).** The project will fund: the development of guidelines for the design of GRM promoting/encouraging the reporting of cases of GBV in the workplace⁸; b) the development of procedures on how to effectively refer cases of GBV that maybe captured through these enhanced GRM; and c) the training of relevant sectoral agencies on the design and management of

⁸ This will build on the work currently being initiated by MOGLSD and UNRA on the development of GRM specifically for roads projects.



such GRM in coordination with the MOGLSD. The MOGLSD will work closely with the following line agencies to pilot these enhanced GRMs: Ministry of Energy and Mineral Development, Ministry of Water and Environment and the Ministry of Works and Transports.

- (iii) **Increasing public awareness of GBV (with a specific focus on GBV in the workplace).** This will include: (a) the development and dissemination of simplified information on the policy and legal framework to address GBV in the workplace, including referral pathways; (b) the design and implementation of a multi-media campaign on GBV prevention (including but not limited to the workplace); and (c) piloting awareness raising and behavior change intervention addressing GBV in the workplace in strategic sectors. This will be done in collaboration with employers, the private sector, and labor unions. The pilot will include signaling interventions by employers and public commitments to eradicating GBV in the workplace as well as an external monitoring mechanism in partnership with the private sector and civil society.

In addition, the project will support MOGLSD's ability to monitor the implementation of issues pertaining GBV in the workplace.

Sub-Component 1B - – GBV prevention and referral at community level (US\$ 15.5 million)

22. In order to address the underlying causes of GBV and tackle social norms and values that may condone GBV, the project will invest significantly in awareness raising and behavior change at community level in the 13 focus districts highlighted above. The approach to prevention builds on tried and tested models which have been rigorously evaluated in Uganda. Through the proposed project, GoU will develop a national protocol for community based prevention programs bringing together: (i) whole of community awareness behavior change and awareness raising interventions; (ii) specific interventions focusing on adolescent girls and boys and combining gender transformative training with livelihoods support; and (iii) community based referral system and provision of psycho-social support at community level. The national protocol for community based prevention programs described below will be designed by MOGLSD with the support of specialized technical assistance. The MOGLSD will lead the operationalization of community based prevention activities. Interventions will be implemented by the MOGLSD in partnership with service providers to be selected on a competitive basis by MOGLSD at central level. These organizations will have a proven track record of delivering GBV prevention programs at community level. The implementation of GBV prevention activities at community level will draw on a pool of qualified community workers including para-social workers and Village Health teams as well as on community opinion leaders. MOGLSD at district and sub-county level will closely supervise the implementation of the prevention program. MOGLSD staff at district level, in particular will participate actively in community mobilization activities and in the implementation of the community-based referral mechanisms. Resources for the active engagement of MOGLSD staff at district level have been included in the project's detailed budget.

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



as follows:

- (i) *Community mobilization and promotion of behavior change:* The identification, training and mentoring of a team of community facilitators as key agents of change who will implement a community mobilization intervention targeting opinion leaders, key community based organizations as well as older men and women that play a key role in perpetuating accepting attitudes towards GBV (and IPV in particular). This element of the approach is expected to foster changes in social norms, attitudes and behaviors at community level. It will focus specifically on transforming gender relations and power dynamics. The element of the intervention will be implemented by service providers under the overall guidance and with the participation of Community Development Officers and Probation Officers at district and sub-county level.
- (ii) *Livelihood Support Intervention:* Through the initial community mobilization step, facilitators will identify and target a selection of adolescent girls and boys – with priority given to out of school youth- in each community to support their economic empowerment. Based on Uganda best practice interventions that have been rigorously evaluated, livelihood interventions with groups most at risk can play a key role in preventing GBV. The livelihoods component will deliver a mix of market-oriented vocational training and mentorships arrangements, business development and financial literacy skills to girls and boys and then seek to link these adolescents to existing credits and savings schemes. Evidence from Uganda indicates that livelihoods’ support is most effective in preventing GBV when combined with life-skills and gender-transformative interventions targeting both boys and girls.
- (iii) *The third element of this package will be to strengthen community-level response and referral mechanisms for GBV survivors.*⁹ At present, a very small proportion of women and girls who are abused actually report violence to anyone. Women survivors face multiple barriers to speaking out, and in particular, to accessing formal services. This community response and referral intervention will train the community facilitators in close coordination with district level MOGLSD staff that implement community awareness raising activities (see (i)) as well as key community structures (e.g. village health teams, local council, religious institutions, schools) on GBV response. The aim will be to ensure that GBV survivors have trusted individuals and mechanisms to who they can report violence and through whom they can get access to the services – informal and formal – they need and want. Trained community activists, supported under the project will act as victims’ advocates for referral to adequate services and will be also have access to the necessary funding to provide emergency support to destitute survivors of GBV (covering the costs of transport, purchase of clothing and hygiene items as needed). Facilitators will also play a key role in the community reintegration of survivors, who have approached them to request support in accessing services or who have been referred to civil society partners after approaching health or police services directly. This will be done through engagement with the community and key opinion leaders, provision of psycho-social support where appropriate, integration in project supported livelihood interventions for adolescents and referral to existing livelihood program in the case of adult survivors.

The project will invest in developing and rolling out a training module for the provision of psycho-social support at community level. The training will be based on the guidelines for the provision of psycho-social support developed by the MOGLSD in 2016 and will be provided by civil society partners to community

⁹ The community-based level response has been included in Component 1B as it will be part of the package implemented in partnership with specialized service providers, as outlined in paragraph 32 above.



facilitators (and where feasible to trained community activists). Following the training, community facilitators will provide Psycho-Social Support (PSS) to survivors at community level. The training will also equip them with the knowledge to identify and refer more complex cases for follow-up at health center or hospital level. Civil society partners will in addition provide more specialized psycho-social support through their staff at district level based on the initial screening conducted at community level. This approach acknowledges the staffing limitations at both MOGLSD and MoH level to provide this specialized service and the fact that community facilitators and activists are often the first port of call for survivors.

24. Under this sub-component, the MOGLSD will pilot the provision of support for shelter interventions in two selected districts (Kamuli and Kisoro). This would entail the continuation of the support currently provided in Kamuli from 2018 onwards as well as the establishment of a new partnership with a civil society organization in Kisoro for the establishment of a new advisory center and shelter in partnership with MOGLSD. The project will specifically support GoU to pilot cost-effective approaches to shelter interventions based on the lessons-learned and documented in Kamuli. These advisory centers will provide psycho-social support, referral to livelihood opportunities, legal aid and other services as relevant. These shelters shall be established and operationalized in line with national guidelines. Staff at the advisory center will act as victims' advocates and support the GBV survivor to access relevant services (health, police and judiciary). In addition, in both districts, an off-site shelter in an undisclosed location and linked to the advisory center will provide temporary accommodation to survivors who are not able to immediately return to their households and communities. Finally, the project will support analytical work on the expansion of GoU support to further advisory centers and shelters currently being funded by civil society organizations in critical districts.

Component 2 – Gender Based Violence Response

25. Overall this component will strengthen the responsiveness of front-line service providers: Health Sector, Uganda Police Force and the Department of Public Prosecution to cases of GBV and improve their ability to provide quality care to survivors. This component will: (i) strengthen national coordination systems, (ii) support the enhancement and adoption of comprehensive guidelines for referrals¹⁰; (iii) the review and updating of Standard Operating Procedures (SOP) for the Justice Law and Order Sectors (JLOS) and; (iv) national training curricula. In addition, dedicated resources will be allocated to these core services in the 13 focus districts to directly improve the quality of the service provided. This will be key to ensure that these critical sectors are able to effectively provide quality services to GBV survivors. Strengthening the key sectors will in addition support them to deal with a potential increase in reporting and in demand for services stemming from the implementation of awareness raising and GBV prevention activities implemented under Component 1. Given the significant social barriers to reporting GBV, it is expected that the majority of cases in the targeted areas will reach formal services through the community-based referral system put in place in partnership with civil society. However, when survivors approach health centers/ hospital or police stations directly, staff at these service points will equally liaise closely with the civil society partner at district level and refer survivors of violence for: (i) additional support that may be required at community level; and (ii) further guidance on how to access other response services that may be needed. Monthly technical meetings held at district level with key service providers and civil society partners will be the main mechanism to ensure effective case management and coordination between prevention and response interventions.

26. Sub-Component 2A – Strengthening the Health Sector Response to GBV (US\$9.3 million). The main objective of

¹⁰ This will be based on the 2013 Guidelines for Referral of GBV cases developed by the Ministry of Gender Labor and Social Development



this sub-component will be to strengthen the Uganda health sector responsiveness to gender based violence with a focus on (a) strengthening sector leadership and governance; and (b) strengthening provider capacity to respond to GBV.

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

- (i) *Strengthening sector leadership and governance* by supporting MoH to establish a technical working group on GBV and developing a sector specific strategy for mainstreaming GBV¹¹. This sub-component will also support the mapping of health sector GBV actors and service providers to enable better coordination of these stakeholders by MoH. Institutional capacity will be further strengthened by establishing a network of GBV focal points at national and subnational levels and at the level health facilities in the targeted districts. Coordination with UPF and DPP will take place at national and district levels.¹² Particular attention will be paid to the collection and recording of forensic/medico-legal data by health service providers and its sharing with UPF for subsequent investigation.¹³
- (ii) *strengthening provider capacity to respond to GBV*. Key activities under this sub-component will focus on: (a) Re- printing GBV training manuals developed by MoH, (b) training Health Care Providers (HCP) including community health workers in targeted districts using the above materials. The training will focus on GBV case screening, medical case management including the correct collection of forensic evidence and accurate record keeping and reporting¹⁴; (c) updating and disseminating management protocols and guidance notes for practitioners (job aides) developed specifically by the health system in Uganda. These materials will be distributed countrywide starting with the project target district. In addition, the project will fund an assessment of the current capacity to provide mental health services for survivors of GBV and prepare an options paper for MoH on how best to strengthen such services in targeted districts.

In addition, the project will also aim to build medico-legal response capacity of HCP. The project will support the adoption printing and distribution of the draft medical - legal manual.¹⁵ The manual will be used to train HCP's as well as experts from police and judiciary with a focus on handling forensics, preparing for court hearings and filling of police and medico-legal forms.¹⁶The project will further strengthen forensic evidence collection by procuring sexual assault evidence kits for targeted districts¹⁷. The project will aim to integrate the kit into the national essential medical supplies list.

In order to improve the quality of services provided to survivors of GBV the project will institutionalize integrated GBV case management at different service points in targeted health facilities (e.g. Maternal, Newborn and Child Health (MNCH), HIV Youth Friendly Services, Family Planning Casualty units). This is expected to ensure that sufficient numbers of adequately trained staff are available to manage GBV cases. In order to improve the quality of front-line services the project will also ensure the availability of medical

¹¹ This will include the adoption of the WHO Global Standards on Gender Based Violence Management

¹² This is in line with the Kampala declaration 2012 signed during the IGAD conference

¹³ Based on the demand for such follow-up on the part of the survivor

¹⁴ Building on existing training modules in Uganda, HCP will also be supported to better identify and manage their own biases when dealing with instances of GBV.

¹⁵ The medical- legal manual was jointly developed by MoH, WHO, Judiciary and FIDA-Uganda with the support of the Democratic Governance Facility

¹⁶ Forms 3, 3A, 24 and 24A. Form 3 is critical for the recording of forensic/medico-legal information enabling further investigation and potential prosecution of cases.



equipment and essential commodities at health facilities for effective management of SGBV cases (with a focus on PEP kits and emergency contraceptives). Finally, this sub-component will fund small scale rehabilitation of health facilities (painting, small internal repairs and provision of screens or partitions as well as lockable cupboards) to create adequate conditions for consultations and counselling where those don't currently exist.

28. Sub-Component 2 B - Strengthening the Justice Law and Order Sector (JLOS) Response to GBV¹⁸ (US\$ 3.45 million). This sub-component supports the operationalization of the GBV policy within the mandates of the participating JLOS institutions (i.e. JLOS Secretariat, Judicial Studies Institute (JSI), Directorate of Public Prosecution and Uganda Police Force). The sub-components will focus on the following interventions

- (i) *Strengthening the coordination role of the JLOS Secretariat (with a specific focus on engaging UPF, DPP and Courts)* through the provision of technical assistance at national level and support to reach out to the District Chained Linked Committees (DCC) that bring together critical JLOS institutions in targeted districts for their engagement in the activities set out below.
- (ii) *Reviewing and updating Standard Operating Procedures (SOP) for the UPF and DPP to support the standardized management of cases and monitoring of the effective implementation of the GBV policy.* In addition, the project will support the monitoring of how GBV cases are handled in line with the updated SOP and guidelines to be put in place in both institutions.
- (iii) *Skilling the human resources in the UPF, DPP and courts to adequately address GBV cases* through (a) the development of a tri-partite officially adopted curriculum for pre-service and in-service training; (b) supporting the initial training of trainers for the roll-out of these new curricula; and (c) supporting the delivery of the training curriculum with a focus on targeted districts.
- (iv) *Supporting the development of analytical work outlining options and cost implications to address the current backlog of GBV cases by the JLOS-Secretariat and JSI.* As of March 2017 there are reportedly between 26,000 and 40,000 backlogged criminal justice cases. A report commissioned by the Chief Justice, is expected to provide recommendations on how to systematically address case backlog issues across the sector. Further analytical work to be supported by the project will build on these initial recommendations and focus specifically on options to address barriers to the timely prosecution of GBV cases. This analysis will inform the development of a comprehensive, strategic and costed plan of action for the sector outlining options for the fast tracking of GBV cases.
- (v) *Support small scale internal rehabilitation of police stations in targeted districts – to ensure minimum conditions of privacy for interviews with survivors of GBV (these will be unmarked rooms to avoid further stigmatization).* No expansion of existing facilities will be supported through this activity but rather the repair and rehabilitation of existing facilities.

29. Component 3 - Project Management, Training and Monitoring and Evaluation (US\$8.839 million)

- (i) *This component will cover overall project management costs to ensure efficient and effective coordination, fiduciary management, monitoring and evaluation at national and local levels.* This will be

¹⁸ It is important to note that access to justice for survivors of GBV is provided free of charge under Ugandan legislation.



done through dedicated technical assistance to the implementing agencies, institutional strengthening, purchase of critical equipment and small scale rehabilitation of the district offices for Probation Officers, Labor Officers and Community Development Officers. This component will include support for strengthening existing coordination structures the sustainability of project activities and the training of critical staff at national and sub-national level.

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

- (iii) *Implementation of an analytical work-program on GBV with a focus on:* (i) conducting an Impact Evaluation (IE) focusing specifically on the proposed GBV prevention activities. Given the design of GBV prevention interventions and the focus on specific sub-counties (particularly for the more intensive whole of community awareness raising activities as well as activities to be implemented with adolescents), the project expects to put in place a Randomized Control Trial (RCT). The detailed design of the impact evaluation will be completed during the project's start-up phase (initial six months of implementation); and (ii) supporting the implementation of additional critical studies in the area of GBV including: (i) working with the Uganda Bureau of Statistics (UBOS) to improve data collection on GBV in the workplace; and (ii) preparing an operational options paper on the funding of advisory centers and shelters by GoU in critical districts.



E. Implementation Arrangements

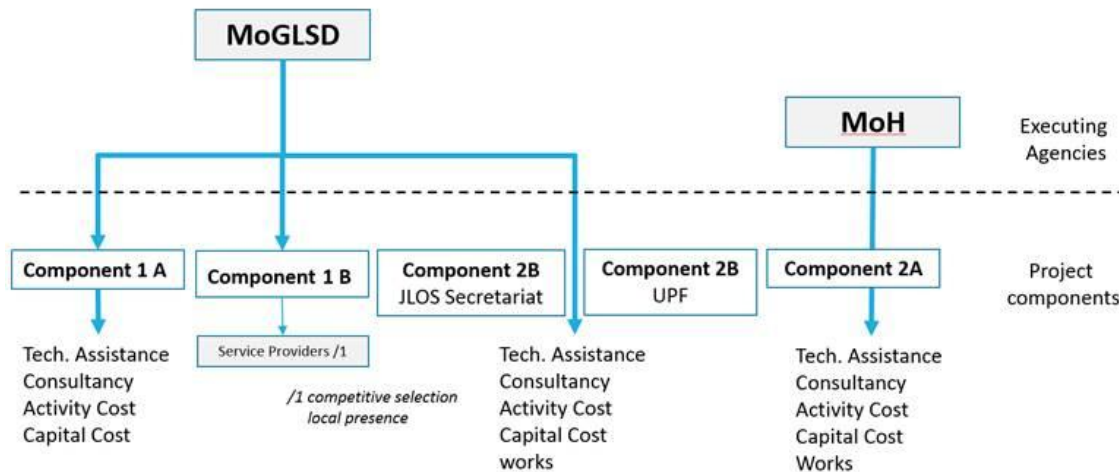
- 30. The project will be implemented by the Ministry of Gender Labor and Social Development (MOGLSD) and the Ministry of Health (MoH) using a multi-sectoral approach.** The MOGLSD as the main recipient will be responsible for overall project coordination and consolidation of Annual Work Programs and Budgets. MOH will be responsible for component 2A including its Financial Management (FM) and procurement. MOGLSD will be responsible for FM and procurement for activities under Component 1, Component 2B and Component 3. MoH will submit technical and financial work plans and reports for component 2A to the PS MGLSD for approval and onward submission to the World Bank for release of funds to their designated accounts. The MOGLSD as the main recipient will be responsible for overall project coordination and consolidation of Annual Work Programs and Budgets. MOGLSD will competitively select Non-Government Organization (NGOs) for the implementation of Component 1B. The Uganda Police Force and JLOS Secretariat will be sub-recipients under the MOGLSD. MOGLSD will sign Memorandums of Understanding with MOH, Uganda Police Force and JLOS stipulating details of implementation of this modality.
- 31. The Permanent Secretary (PS) of the MOGLSD, as the “Accounting Officer” of the Project, is responsible for overseeing overall project implementation.** The PS will delegate the day-to-day management of the Project to a full-time Project Coordinator (PC) supported by a team of officers specifically hired to provide technical support for project implementation. This will include: (i) a Deputy Coordinator for the Project Support Team (PST); (ii) a Gender Based Violence Specialist; (ii) Partnership Specialist; (iii) Legal Officer; (iii) Monitoring and Evaluation Specialist and (iv) Communications Officer at MOGLSD. In addition, based on the procurement and financial management assessments carried out, a Financial Management Specialist and a Procurement Specialist will support the MOGLSD team. Senior officers at the rank of Commissioner will coordinate closely with the PST to ensure consistency between project support supported activities and the core functions and interventions of critical departments (namely the Department of Gender, Department of Children and Youth, Department of Labor and Department of Occupational Health and Safety (Additional details on the composition of the PST are provided in Annex 2). The Permanent Secretary (PS) of the MoH will be responsible for overseeing the implementation of activities under Component 2A. Project activities will be mainstreamed within the MoH Reproductive Health Division to ensure sustainability of the interventions. A dedicated project officer will be recruited to provide additional technical support. He/she will work under the overall guidance and supervision of the Assistant Commissioner for Reproductive Health, work closely the project coordinator based at MOGLSD and coordinate activities with the PST in MOGLSD. The need for additional support from a Monitoring and Evaluation Specialist at MoH level will be confirmed following the assessment of data collection systems to be undertaken during Year 1 of project implementation. Finally, dedicated technical assistance will be provided to the Uganda Police Force and to JLOS for the development of the respective training programs. The MOGLSD team and these technical experts will work under the overall coordination of two focal points to be nominated by the UPF and JLOS and who will have the technical lead of activities under Component 2B.
- 32. The GoU will establish a Project Steering Committee chaired by the PS, MOGLSD. Its membership will comprise;** PS (MoH), Inspector General of Police, Director for Public Prosecution, Solicitor General, Principal Registrar and relevant MOGLSD senior staff. A Project steering committee will be responsible for multi-sectoral coordination, policy guidance and oversight to the overall performance of the project implementation. This committee will meet twice a year or when need arises. The Project Implementation working group comprising of project coordinator (chair), focal persons from MoH, Police, JLOS will conduct quarterly review meetings with the



involvement of service providers selected for the implementation of Component 1 B and coordinate day-to-day project activities.

33. District Level Coordination – A District Level Steering Committee will be the main mechanism for the coordination of project activities at district level. The Chief Administrative Officer (CAO) will nominate a district level official to oversee the overall implementation of project activities. Mirroring the structure developed at national level, the District Steering Committee will be convened semi-annually to review critical issues with project implementation and identify concerns/issues with implementation that should be discussed and addressed at the level of the National Steering Committee. A technical sub-committee on Gender Based Violence will be convened on a quarterly basis to oversee the implementation of prevention and response activities. The sub-committee will be convened on a quarterly basis with the support of the Community Development Officer and include: (i) Probation Officers, (ii) District Health Officers as well as GBV focal persons at health facility level; (iii) civil society organizations responsible for the implementation of Component 1B in selected districts; (iii) Senior District Police staff; (iv) District Magistrate and other relevant senior staff. The Project Operations Manual will include the detailed description of the functions of the District Level Coordination mechanism.

34. Role of Service Providers/Civil Society Organizations (CSOs) – The MGLSD shall competitively select service providers which will be contracted to provide GBV prevention intervention at household and community levels in areas of community mobilization, livelihood support, and referral using evidence based GBV prevention and response approaches. Service providers shall submit quarterly progress activity reports to the District project focal persons based on their respective work plans and budgets. Service providers shall submit biannual project technical and financial reports to the MGLSD for harmonization into National project report.



Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.



F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

Wakiso, Masaka, Mukono, Mbale, Sironko, Kamuli, Alebtong, Apac, Zombo, Hoima, Kisoro, Kamwenge and Kabarole districts. OP 4.10 has been triggered given the presence of IP communities in Kisoro district. The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities and police stations (limited to small internal repairs, painting, and installation of screen or partitions for further privacy). Project activities will contribute to improved health services; they will also lead to increased generation of medical waste by the health facilities. Small scale rehabilitation works may pose minor health and safety risks, while health care waste may pose health risks to the patients, attendants, health workers and the public in the event of poor management practices.

G. Environmental and Social Safeguards Specialists on the Team

Catherine Asekenye Barasa, Herbert Oule

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities and police stations (limited to small internal repairs, painting, installation of screen or partitions for further privacy). Project activities will contribute to improved health services, they will also lead to increased generation of medical waste by the health facilities. Small scale rehabilitation works may pose minor health and safety risks, while health care waste may pose health risks to the patients, attendants, health workers and the public in the event of poor management practices. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. Due to the overall limited likelihood of environmental and social impacts, the Project is rated as Environmental Assessment Category B. Environmental Management Framework (EMF) has



		been prepared through a consultative process to guide the handling of project environmental aspects during implementation. The EMF provides basic guidance on environmental screening and where necessary development of Environmental Management Plans during implementation.
Natural Habitats OP/BP 4.04	No	The project will not affect any natural habitat.
Forests OP/BP 4.36	No	The project will not involve degradation of any forest.
Pest Management OP 4.09	No	The project will not support use or purchase of any pesticides.
Physical Cultural Resources OP/BP 4.11	No	All rehabilitation works will be internal to existing buildings and facilities. There will be no increase of the footprint of existing structures.
Indigenous Peoples OP/BP 4.10	Yes	The Project's geographical coverage includes Kisoro district with presence of the Batwa Indigenous Peoples' (IP). To ensure social inclusion of this IP group, the project has triggered safeguard policy OP/BP 4.10. An Indigenous People's Policy Framework (IPPF) will be prepared for the Batwa. Free, prior and informed consultations will be carried out with Batwa communities. Some of the identified potential positive effects of project implementation on Indigenous Peoples include increased use of available health care services, delivery of culturally appropriate GBV response services and improved access to health services through outreach activities. The project will promote socio-cultural interaction, coordination and consultation with traditional leaders prior and during implementation. For this, it is essential that districts and civil society partners selected to work in Kisoro employ staff who speak the local dialects and are compliant with local socio-cultural interaction norms and belief systems of the IPs.
Involuntary Resettlement OP/BP 4.12	No	The project will not involve land acquisition or resettlement. All rehabilitation works will be internal to existing buildings and facilities.
Safety of Dams OP/BP 4.37	No	The Project does not support or involve use of any dam structure.
Projects on International Waterways OP/BP 7.50	No	The project will not be implemented in and/or affect any international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project shall not be implemented in disputed areas.



KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The Project's geographical coverage includes Kisoro district with presence of the Batwa Indigenous Peoples' (IP). To ensure social inclusion of this IP group, the project has triggered safeguard policy OP/BP 4.10. An Indigenous People's Plan (IPP) was prepared for the Batwa. Free, prior and informed consultations will be carried out with Batwa communities. Some of the identified potential positive effects of project implementation on Indigenous Peoples include increased use of available health care services, delivery of culturally appropriate GBV response services and improved access to health services through outreach activities. The project will promote socio-cultural interaction, coordination and consultation with traditional leaders prior and during implementation. For this, it is essential that districts and civil society partners selected to work in Kisoro employ staff who speak the local dialects and are compliant with local socio-cultural interaction norms and belief systems of the IPs.

The interventions under the project involve improvement in the provision of health services, handling of medical products as well as small scale rehabilitation of health facilities, police stations and District Offices for the Ministry of Gender Labor and Social Development (limited to small internal repairs, painting, installation of screen or partitions for further privacy). Project activities will contribute to improved health services, they will also lead to increased generation of medical waste by the health facilities. Small scale rehabilitation works may pose minor health and safety risks, while health care waste may pose health risks to the patients, attendants, health workers and the public in the event of poor management practices. The potential environmental impacts can be adequately managed by integrating environmental due diligence into the Project cycle. There are no potential large scale, significant and/or irreversible impacts associated with the project since they can be managed and readily mitigated on site.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Beyond the continued generation of medical waste in the health facilities, there are no anticipated long term or irreversible impacts by the project.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
The project will use a combination of approaches to handle medical waste as per the guidelines issued by the Ministry of Health.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

Environment - An Environmental Management Framework (EMF) was prepared to guide handling of project environmental aspects during implementation. The EMF includes environmental management tools (screening procedures for sub projects, assessment checklists, generic environmental management plan). Environmental compliance will be the responsibility of the Occupational Safety and Health Department of the MoGLSD which is headed by a Commissioner. The department also has two Assistant Commissioners, and is staffed by Inspectors and Hygiene Officers. The Officers shall undergo refresher training on implementation of Environmental Safeguard requirements of the project, having already had an induction as part of project preparation. At the health facilities, centers to handle infection control shall be established, where non-existent. The District Environment Officers and



District Health inspectors shall be involved in monitoring and supervision of project activities in their respective areas.

Social - The borrower has prepared an Indigenous Peoples Plan (IPP) to address the specific needs of the Batwa community in Kisoro district. The measures in the IPP will: (i) ensure that the additional barriers faced by the Batwa in accessing prevention and response services on Gender Based Violence (GBV) are effectively addressed; and (ii) put in place additional measures to mitigate the potential re-victimization of Batwa survivors of GBV given the high levels of stigmatization and cultural bias against the Batwa on the part of other ethnic groups at district level. The IPP is aligned with the existing project components. It includes additional activities to be carried out in terms of GBV prevention by the civil society organization to be contracted by MOGLSD to implementation community-based GBV prevention activities in Kisoro district. The MOGLSD will be responsible for the implementation of the IPP. MOGLSD has limited capacity to implement these measures and will therefore contract the services of a specialized civil society organization for this purpose. A dedicated GBV Specialist at PMU level will be responsible for overseeing IPP implementation and will receive additional orientation/training.

The EMF, SIA and IPP were cleared by the RSA on April 21, 2017 for the EMF and SIA , and April 26, 2017 for the IPP. The instruments were disclosed in country through the WB website (21 April, 2017 for EMF/SIA and 26 for IPP).

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

Environment - Local consultations were done as part of the preparation of the ESMF. The consultations included the full spectrum of directly affected local stakeholders, including selected District Local Governments of Kisoro, Kamuli, Kamwenge and Kabarole out of the 13 participating Districts. The following institutions were also consulted during project preparation: Ministry of Health, Uganda Police Force, Ministry of Education and Sports, Ministry of Justice and Constitutional Affairs, Ministry of Local Government, National Environment Management Authority, and CSOs including UWONET, Action Aid and FIDA.

Social - For the preparation of the IPP consultations were undertaken with: Mikingo, Kisoro town council and the following Batwa communities: (i) Rubuguri; (ii) Biraara; (iii) Mukungu; (iv) Gatera and Mabuyemeru; (v) Nyakabande; and (vi) Murora. Stakeholder analysis was carried out with the support of the MOGLSD District Community Development Officers (CDOs) and the above communities identified in partnership with Batwa community leaders and key informants. A total of 162 respondents were consulted through a series of five community meetings, Focus Group Discussions and Key Informant Interviews. Consultations were held in Rufumbira and Rukiga languages which are commonly used and understood in the targeted Batwa community. Further interviews were carried out with civil society organizations working with the Batwa and a mapping of ongoing support and an analysis of the key barriers in accessing services developed for the IPP. The full details of the consultations are included in the IPP. The IPP preparation process included the provision of information to the consulted communities on the project scope and proposed measures to enhance outreach to the Batwa. The IPP was disclosed in country and further shared with the targeted communities through the Kisoro CDO and civil society organization working with the Batwa in local languages.



B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission to InfoShop	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
03-Apr-2017	21-Apr-2017	

"In country" Disclosure

Uganda
17-Apr-2017

Comments

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission to InfoShop
03-Apr-2017	26-Apr-2017

"In country" Disclosure

Uganda
17-Apr-2017

Comments

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?



Yes

If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

Yes

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

NA

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank's Infoshop?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

CONTACT POINT

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Borrower/Client/Recipient



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APPROVAL

Task Team Leader(s):	Patricia Maria Fernandes Peter Okwero
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Approved By

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Practice Manager/Manager:	Robin Mearns	26-Apr-2017
Country Director:	Christina Malmberg Calvo	30-Apr-2017

Note to Task Teams: End of system generated content, document is editable from here.