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GENDER AND SOCIAL INCLUSION ANALYSIS: UGANDA

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ABBREVIATIONS AND ACRONYMS

ACF	Agricultural Credit Facility
ADS	Automated Directives System
ARV	Antiretroviral (drugs)
CDCS	Country Development Cooperation Strategy
CDD	Community Driven Development
CDO	Community Development Officer
CHEWs	Community Health Extension Workers
CRRF	Comprehensive Refugee Response Framework
DFID	Department for International Development
DO	Development Objective
DPO	Disabled Persons' Organization
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GGGI	Global Gender Gap Index
GII	Gender Inequality Index
GoU	Government of Uganda
GREAT	Gender Roles, Equality and Transformations
IR	Intermediate Result
LED	Local Economic Development
LFPR	Labor Force Participation Rate
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MoGLSD	Ministry of Gender, Labor and Social Development
MoESST	Ministry of Education, Sports, Science and Technology
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
M4P	Markets for the Poor
NDP	National Development Plan
NPA	National Planning Authority
OECD	The Organization for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PAD	Project Appraisal Document
PFM	Public Finance Management
PWD	Person with disability
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health

REAL Fathers	Responsible, Engaged and Loving Fathers
SDSP	Social Development Sector Plan
SGBV	Sexual and Gender-Based Violence
SIGI	Social Institutions and Gender Index
ToC	Theory of Change
UCDA	Uganda Coffee Development Authority
UDHS	Uganda Demographic and Health Survey
UPE	Universal Primary Education
UWA	Uganda Wildlife Authority
VHT	Village Health Team
VSLA	Village Savings and Loans Association
WEF	World Economic Forum
WHO	World Health Organization
YLP	Youth Livelihoods Program

GLOSSARY OF KEY TERMS

- Agency:** The capacity to make decisions about one’s own life and act on them to achieve a desired outcome free of violence, retribution or fear (World Bank 2014).
- Community:** A group of people living in the same defined area sharing the same basic values, organization and interests.
- Empowerment:** Is achieved when women and girls (and other marginalized groups) acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. While empowerment often comes from within, and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine the possibilities for empowerment (USAID, 2012).
- Equity:** Equity is defined in terms of two basic principles. The first is equal opportunities: that a person’s life achievements should be determined primarily by his or her talents and efforts, rather than by pre-determined circumstances such as race, gender, social or family background. The second principle is the avoidance of deprivation in outcomes, particularly in health, education, and consumption levels (World Bank 2006).
- Gender equality:** Gender equality concerns women and men, and it involves working with men and boys, women and girls to bring about changes in attitudes, behaviors, roles and responsibilities at home, in the workplace, and in the community. Genuine equality means more than parity in numbers or laws on the books; it means expanding freedoms and improving overall quality of life so that equality is achieved without sacrificing gains for males or females (USAID 2012).
- Gender:** Socially and culturally shaped roles, attributes and expectations assigned to women, men, girls and boys.
- Household:** A person or group of people who normally cook, eat, and live together irrespective of whether they are related or unrelated (UBOS, 2013).
- Inclusive Development** Inclusive Development explores an array of interventions that remove access to development and participation for any number of marginalized groups. Inclusive development means programming that accounts for and addresses the link between development access and social identities including, but not limited to, gender, disability, ethnicity, and age.
- Social Benefits** Social benefits refer to changes to the social environment, such as changes in social norms or beliefs, economic or legal changes, and to changes in relationships at community and societal levels.
- Social capital:** Networks together with shared norms, values and understandings that facilitate cooperation within or among groups. It includes: i) *Bonds*: Links to people based on a sense of common identity (“people like us”) – such as family, close friends and people who share our culture or ethnicity; ii) *Bridges*: Links that stretch beyond a shared sense of identity, for example to distant friends, colleagues and associates; iii) *Linkages*: Links to people or groups further up or lower down the social ladder (OECD, undated).

Social Development:	A focus on the need to put people first in the development process. It promotes social inclusion of the poor and vulnerable by empowering people, building resilient societies, and making institutions accountable to the people.
Social exclusion:	Process by which individuals or groups of people are systematically denied access to rights, opportunities, and/or services. Based on various axes e.g. age, gender, sexual orientation, geography, disability, etc.
Social inclusion:	The process of improving the terms on which individuals and groups take part in society – improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity.
Social norms:	Social norms can be understood as either “what most people think and do” or, alternatively, “what individuals believe most people think and do.” As such, social norms are about what’s considered normal or ought to be normal in a given context and situation.
Unpaid care work:	Unpaid care work includes all those activities that go towards the well-being of people, including caring for a household such as cooking, cleaning, collecting water and firewood, caring for the ill, elderly and children, and caring for the community when these activities are done for no pay. Note that this does not include unpaid work which is not care such as unpaid labor on family farms or in household enterprises. (USAID, 2016).
Youth:	USAID uses the term youth and young people interchangeably and while youth development programs often focus on youth in the 15 to 24-year age range, USAID programs also are likely to engage individuals aged 10-29 as a broader youth cohort (USAID, 2012).

EXECUTIVE SUMMARY

USAID/Uganda's Country Development Cooperation Strategy (CDCS) 2016 – 2021 aims to work towards ensuring that “Uganda's systems are accelerating inclusive education, health and economic outcomes.” Six integrated projects are planned, to contribute to the achievement of this goal. They are: i) Resilience Project, ii) Demographic Drivers Project, iii) Market Systems Project, iv) Natural Resources Management Systems Project, v) Health Systems Project, and vi) Governance and Citizen Participation Systems Project. The respective projects are elaborated in interrelated Project Appraisal Documents (PADs). For these projects to be effectively implemented, USAID/Uganda recognizes that it is important to integrate gender equality and inclusion of vulnerable groups. USAID therefore commissioned this gender and social inclusion analysis, to identify key gender and inclusive development issues and constraints that need to be addressed within its portfolio and to recommend how USAID/Uganda can achieve greater inclusive development in its programs.

The scope of the analysis covered:

- 1) Key Government of Uganda (GoU) policies and programs related to gender and inclusive development and areas for potential collaboration with USAID.
- 2) Socio-cultural norms and practices and their implications to equitable participation and access in programs of all the five PADs (Natural Resource Systems PAD was analyzed as part of the Resilience PAD).
- 3) Approaches that enhance access and equity for target populations.
- 4) Gender relations that could affect the achievement of sustainable results for all five PADs.
- 5) Potential impacts of the UDAID's proposed strategic approaches on marginalized populations.
- 6) An evidence-based Theory of Change (ToC) for promoting inclusive development.

The analysis used qualitative methods. Focus group discussions were conducted with marginalized groups in Kamwenge and Sironko Districts. Key informant interviews were held with district and national-level officials. National reports were also reviewed for statistical data to validate the qualitative data. International literature was reviewed for examples of best-practice on gender and social inclusion.

The key findings of the analysis are that:

Exclusion happens on the basis of identity. These identities constitute what is described in Uganda's policies as “vulnerable groups.” They include orphans and other vulnerable children (OVCs), persons with disabilities (PWDs), unemployed youth, displaced persons, marginalized women, older persons, and ethnic minorities (MGLSD, 2016). PWDs constitute about 18% of the population (UNHS, 2010). About 46% of girls are married below the age of 18 (UNICEF, 2015), while youth unemployment stands at 18% (MGLSD, 2016). Despite vulnerabilities caused by disability and old age, only 5% of the population have access to government social safety nets (World Bank, 2016).

The above attributes lead to exclusion of these categories of people from services and economic opportunities. For instance, although women constitute 84% of agricultural labor force, they own only 27% of registered land (NPA, 2013). Women are disproportionately represented in unpaid care work – spending over three hours a day on housework compared to less than one hour spent by men (Action Aid, 2014). This and the low number of women in technical and professional jobs limits their incomes. Men earn more than twice (USD 2,535) as much as their female counterparts (USD 1,008) annually (WEF, 2016). Other forms of exclusion from markets include: exclusion of youth, due to limited skills and experience, exclusion of PWDs due to limited labor capacity, and exclusion of LGBTI people due to low social tolerance for their sexual orientation.

While rights determine access to resources and authority, to claim these rights people need access to resources, power, and knowledge. Unequal social relations result in some individuals and groups being more able to claim rights than others. For example, the LGBTI community highlighted its inability to exercise their rights and citizenship due to legalized homophobia. Refugees, for their part, are also limited from claiming their economic rights and citizenship privileges. Women continue to suffer GBV and are constrained in obtaining justice. Excluded groups have apathy towards participating in governance processes because of the perceived lack of direct reward for their participation.

Notwithstanding the above issues, some positive social norms and coping mechanisms exist in communities, to reduce their exclusion. These include: formation of self-help groups to resolve common problems, local mediation of disputes by clan heads to minimize social injustice, community safety nets to support the most vulnerable, and pooling labor and other resources to support asset building. These norms need to be identified and promoted by USAID's projects.

A theory of change (ToC) and an action plan for gender and inclusive development are proposed, to address the above issues. The ToC highlights that USAID's goal of making systems accelerate inclusive education, health, and economic outcomes can be achieved by transforming negative social norms that perpetuate social exclusion. The ToC proposes, that three interlinked strands of interventions need to be embedded in all programs.

- *Changing social norms:* To address communities' own attitudes, beliefs, and practices that perpetuate social exclusion and limit uptake of available services, positive social norms will need to be scaled up, while steps need to be taken to reduce the effects of the negative norms.
- *Building agency:* To empower excluded groups themselves to have the ability to influence change, e.g. by tackling barriers to women's capacity to make choices on their reproductive health and economic wellbeing.
- *Making social capital work for the excluded:* Building agency and transforming social norms needs to build on and work through formal and informal groups of disadvantaged groups. Interventions will, however, need to improve the quality of this social capital by linking these groups to other progressive groups and supportive processes.

The intended outcomes of the ToC are:

- Equitable access to USAID-supported social service programs (health, education, social protection, GBV prevention/response) by excluded groups.
- Equitable access by excluded groups to USAID-supported economic empowerment programs in selected value chains.
- An enabling environment for participation of women and other disadvantaged groups.

Finally, the analysis recommends that USAID/Uganda should:

- 1) Commit to leaving no one behind - maintain a willingness to meet the cost of special targeting and social inclusion, even when the numbers of beneficiaries may not be appealing.
- 2) Ensure support from top leadership (Mission Director, Deputy Mission Director and Office Directors) to maintain commitment and accountability for inclusive development.
- 3) Develop the capacity of project teams and partners to undertake effective inclusive development across the CDCS priorities; through training and "How-to Notes."
- 4) Implement a mix of gender/inclusion-specific programs, and integrate a mainstreaming approach across programs. Where a mainstreaming approach is used, establish quotas for excluded groups e.g. women, PWDs, youth, and LGBTI people to benefit from services and economic opportunities.
- 5) Ensure that interventions do no harm; by mitigating the unintended negative outcomes e.g. perpetuating social exclusion, escalating GBV, etc., that could arise from some of the interventions proposed by the projects.
- 6) Support collection of data on social inclusion indicators for progressive improvement in targeting excluded categories, and tracking impacts of the programs on their development outcomes.

I. INTRODUCTION

I.1 CONTEXT

The 5-year goal of USAID/Uganda’s Country Development Cooperation Strategy (CDCS) 2016 – 2021 is to work towards ensuring that “Uganda’s Systems Are Accelerating Inclusive Education, Health and Economic Outcomes.” It is expected that this goal will be achieved through three integrated and mutually dependent Development Objectives (DOs). DO 1 is “Community and household resilience in select areas and target populations increased.” DO 2 is “Demographic drivers affected to contribute to long term trend shifts.” DO 3 is “Key systems more accountable and responsive to Uganda’s development needs.” Six integrated projects (Project Appraisal Documents/PADs) are planned, to contribute to the achievement of these DOs. They are: i) Resilience Project, ii) Demographic Drivers Project, iii) Market Systems Project, iv) Natural Resources Management Systems Project, v) Health Systems Project, and vi) Governance and Citizen Participation Systems Project.

Based on analysis of the 2014 national census data, the CDCS describes the Ugandan development context from the perspective of the multiple deprivations faced by the average Ugandan – the fourteen-year-old-girl. The CDCS highlights that:

“The average Ugandan is a fourteen-year-old girl. She is one of six children, living in a rural area; her family is poor and it finds itself vulnerable to economic, political, and environmental shocks. She has a one-in-four risk of becoming pregnant during adolescence, is at high risk of being engaged in early marriage, and will likely drop out of school before reaching secondary level. Her status is the result of a combination of factors: poor nutrition, low performance in school, cultural expectations related to early marriage and family size, and systems not supporting her ambitions to thrive. Development in Uganda must address the needs of typical Ugandans the fourteen-year old-girl exemplifies if it is to generate the sustainable, broad-based prosperity, and shared stake in the future that will ensure Uganda’s long-term stability.”

USAID/Uganda recognizes that, for the above multiple deprivations to be addressed, and for the goal of the CDCS to be achieved, it is important to integrate gender equality and inclusion of vulnerable groups across sectors and in its results framework. USAID therefore commissioned this gender and social inclusion analysis to identify key gender and inclusive development issues and constraints that need to be addressed within its portfolio, and to recommend how USAID/Uganda can achieve greater inclusive development in its programs. The gender and social analysis reflects the multiple layers of social exclusion typified by the fourteen-year-old-girl. While USAID remains committed to supporting broad-based development through its investments, the lens of how its programs impact the average Ugandan, a fourteen-year-old girl, is a powerful narrative tool to anchor its work and give context to its goal.

The analysis addresses six key tasks as follows:

- 1) Assess key Government of Uganda (GoU) policies and programs related to gender and inclusive development and identify where USAID can collaborate to improve GoU policies and programs for gender equality.
- 2) Identify the socio-cultural norms and practices and their implications to equitable participation and access of men, women, girls, and boys, persons with disabilities, youth, and gender/sexual minorities in programs of all the five PADs.

- 3) Identify approaches that enhance access and equity for target populations including marginalized populations (persons with disabilities (PWDs), adolescents, youth, lesbians, gay, bisexual, transsexual, and/or intersexual (LGBTI)).
- 4) Analyze how gender relations will affect the achievement of sustainable results for all five PADs.
- 5) Analyze the potential impacts of the Mission’s proposed strategic approaches on the status of men, women, boys, girls, youth, and marginalized populations.
- 6) Based on the analysis and dialogue within the Mission, support USAID/Uganda in developing an evidence-based ToC for promoting gender-based empowerment.

1.2 THE NATURE OF GENDER INEQUALITY AND SOCIAL EXCLUSION IN UGANDA

- Uganda ranks 111 out of 128 countries in the 2017 Social Progress Index (SPI), with a score of 49.59, compared to the global average of 64.85¹ (SPI, 2017).
- Uganda ranked 111 with a score of 36.93 on the inclusion and tolerance sub index of the SPI (SPI, 2017).
- Uganda ranked 121 out of 159 countries in the 2016 Gender Inequality Index (GII), with a score of 0.522, compared to the global average of 0.443.²

There is no commonly agreed framework for categorizing social exclusion. Due to this and the overlapping definitions, i.e. with multidimensional poverty and vulnerability, the magnitude of social exclusion in Uganda is also not well documented. This report adopts two overlapping dimensions of social exclusion and accompanying statistics:

1) *Exclusion based on identity:* This is discrimination along several dimensions, including gender, age, disability, sexual orientation, ethnic identity, etc., which reduce the opportunity for such groups to gain access to social services and limits their participation in labor markets and civic participation. These are commonly described in Uganda’s policies as “vulnerable groups.” They include orphans and other vulnerable children (OVCs), Persons with Disabilities (PWDs), unemployed youth, displaced persons, marginalized women, older persons, and ethnic minorities (MGLSD, 2016). Individuals may belong to more than one group, which compounds their disadvantage.

2) *Exclusion from markets, services and spaces:* Individuals and groups are excluded from three intersecting spheres – markets (land, labor, credit),

services (education, health, information, water, social protection, etc.), and spaces (physical, political, cultural and social spaces). These dimensions are used to highlight gender inequality and social exclusion in each DO of the CDCS (in this section), and in the subsequent analysis of the PADs.

Although social exclusion is driven by factors beyond the control of the individual, some minority groups voluntarily exclude themselves. For example, individuals may choose not to utilize certain services because of their religious or cultural beliefs. Although this may not typically be categorized as social exclusion, its

¹ Scores range between 0 – 100. SPI scores reflect absolute performance from good to bad. The index benchmarks basic human needs, foundations of wellbeing (education, health, access to information, and quality of the environment), and opportunity (rights, freedoms, tolerance, and inclusion). According to the index, an inclusive society is one where every individual can pursue his or her human right to a life of dignity and worth.

² The GII ranges between 0, which represents perfect equality, and 1, which represents inequality. Higher GII values indicate higher inequality and consequently higher loss to human development.

effects on development and uptake of services is the same. Voluntary exclusion will therefore be reflected in the subsequent analysis of the respective PADs.

DO I: Gender Inequality and Social Exclusion in Community and Household Resilience

This DO focuses on addressing key drivers of vulnerability; improving households' and communities' capacity to manage risk; enhancing the prevention of HIV, malaria, and other diseases; and increasing/diversifying community and household assets.

Key Statistics & Figures		
	Male	Female
Labor force participation	88%	84% (ILO, 2016)
Professional & technical workforce	60%	40% (WEF, 2016)
Ownership of registered land		27% (NPA, 2013)
Average earned annual income	USD 2535	USD 1,008 (WEF, 2016)
Youth unemployment rate	18% (MGLSD, 2016)	
HIV prevalence	6.1%	8.3% (UAC, 2015)
Population (aged 5 and above) with a disability	16% (UNHS, 2010)	
Population with access to government safety nets	5% (World Bank, 2016)	
Population below national poverty line	19.7 (UNDP, 2014)	

Gender inequalities in economic participation and opportunity. Despite high labor force participation by men and women, women are more disproportionately represented in unpaid subsistence and domestic work (reproductive gender roles), which is not accounted for in Labor Force Participation Rate (LFPR) and Gross Domestic Product (GDP) computations. Gender inequalities in economic opportunity are also reflected in high (33%) wage inequality for similar work (WEF, 2016). Women occupy less technical and professional positions than men. These economic factors when aggregated make women earn considerably lower annual incomes compared with men. Men earn more than twice (USD 2,535) as much as their female counterparts (USD 1,008) annually (WEF, 2016). These and other forms of gender and social exclusion in economic systems are further explored in the market systems' PAD in [section 2.4](#).

A sizable proportion of the population, particularly women do not own land. Although 83% of the female working population is engaged in agriculture, women own only 27% of registered land (NPA, 2013). Due to entrenched patriarchal norms, women face additional constraints to their productivity – including: limited credit worthiness; limited access to markets; cultural conventions that allocate lower-value subsistence crops to women and cash crops to men; limited access to tools and technology to which men have priority access; and lack of decision making power over sales, prices, and investments.

About 12.4% of the population have a disability. Disability limits physical access to health care, education,

employment, and justice. It also leads to economic, political, and social exclusion of PWDs. Women and girls with disabilities face double discrimination and are more vulnerable to poverty and social exclusion.

DO 2: Gender Inequality and Social Exclusion in Demographic Drivers

Results under this DO are in the spheres of reproductive health, child wellbeing, girls' education, and youth productivity. A number of gender and social exclusion issues however pose a risk to the full achievement of these results.

Key Statistics & Figures		
	Male	Female
Maternal Mortality Ratio.		334 per 100,000 live births (UBOS/UDHS 2016)
Total Fertility Rate.	5.4 children per women (UDHS/UBOS, 2016)	
Adolescent birth rate (births per 1,000 women ages 15 – 19).	179.1 per 1000 (UN Population Division, 2015)	
Proportion of the population aged 15 – 49 who had experienced SGBV in the 12 months preceding the 2016 DHS.	4%	12% (UDHS/UBOS, 2016)
Girls married before the age of 18	46% (UNICEF, 2015)	
Youth unemployment rate.	18% (MGLSD, 2016)	

Gender and social norms drive reproductive health outcomes. Although the Maternal Mortality Ratio (MMR) in Uganda has reduced from 438 deaths per 100,000 live births in the 2011 (UBOS/UDHS, 2011) to 334 in 2016, the rate is still high. About 25% of adolescents age 15-19 in Uganda have begun childbearing (UDHS, 2016). Adolescent girls account for a significant proportion of maternal deaths in Uganda annually. Some drivers of these reproductive health challenges are rooted in gender and social norms that encourage large families, early child marriage, teenage pregnancy, and limited access to youth-friendly reproductive health services, as further discussed in [Section 2.2](#).

Despite improvements in basic school enrollment, gender inequalities persist in educational attainment. Primary school enrollment in 2016 was at 95% for girls, and 92% for boys (WEF, 2016). Gender parity in primary school enrollment is attributed to Uganda's policy of free Universal Primary Education (UPE). However, beneath these impressive enrollment statistics are challenges such as low retention rates, low completion rates, and low quality of learning outcomes for both girls and boys. Transition to secondary school is also still low (22% for girls and 24% for boys), driven by poverty and inability to pay for secondary school education.

Gender-based violence remains a critical human rights, public health and economic concern, with 22% women aged 15-49 having ever experienced sexual violence compared to 8% of men in the same age group (UDHS/UBOS, 2016). The causes of gender-based violence (GBV) are multifaceted but include - unequal power relations between men and women, unequal

control of resources, and patrilineal customary norms such as payment of bride price that create a sense of ownership of women by husbands/men. Gender-based violence has far reaching consequences on health and education, and contributes to a loss in productivity of the victims and loss of income due to high associated costs of medical care and legal aid. The estimated annual costs of intimate partner violence for various providers and duty bearers is Uganda Shillings 56 billion (\$22.4 million) (CEDOVIP, cited by World Bank, 2016).

Unemployment is still a challenge particularly among the youth and women. Although the average unemployment rate in Uganda is 9.4% (PSR, 2014), the bulk of the population (81.5%) is in unpaid subsistence employment. High unemployment and underemployment among the youth particularly results in low incomes and exclusion from markets and a range of social services.

DO 3: Gender Inequality and Social Exclusion in Systems Accountability

Although Uganda ranked 37th out of 144 countries in the political empowerment sub index of the Global Gender Gap Index (GGGI) (WEF, 2016), gender inequality in political participation is still pervasive. Women occupy only 33% of the parliamentary seats and only 30% ministerial positions (WEF, 2016). These statistics mirror women's representation in local councils. Cultural barriers to women's participation in politics, as well as a general apathy by marginalized groups towards political participation, are explored further in the governance system's program area in [Section 2.5](#).

1.3 APPROACH AND METHODOLOGY

This analysis builds on a gender and social inclusion analysis conducted by USAID/Uganda in 2015 to inform the design of the CDCS (2016 – 2021). The report recommended that social inclusion must inform each stage in the project design cycle. As USAID designs its PADs therefore, a more detailed gender and social analysis was commissioned - to make specific recommendations to promote gender and social inclusion in the specific program areas. PAD-specific approach papers were developed to guide the gender and social exclusion analysis, and these are contained in the inception report (Among, 2017).

The analysis was conducted through a five-step process that included:

1. An inception phase: In which the consultant reviewed the CDCS and other documents, developed PAD-specific approach papers and tools for the analysis, and obtained input from PAD teams on areas of focus. The primary questions that guided the design of interview/discussion guides were:
 - What are the socio-cultural norms and practices, and what are their implications to equitable participation and access by all groups of people to programs of all the five PADs.
 - How will gender relations affect the achievement of sustainable results for all five PADs?
 - What are the key GoU policies and programs related to gender and inclusive development (in each of the five PADs), and how can USAID collaborate to improve them for gender equality?
 - What are the evidence-based approaches that enhance access and equity for excluded groups?
 - What are the potential impacts of USAID's proposed strategic approaches on the status of men, women, boys, girls, youth, and marginalized populations?
2. A policy review phase: Involved identification and appraisal of key sector policies/programs. This phase also involved interviews with technocrats in line ministries.
3. Field consultations phase: Involved focus group discussions with excluded groups, and key informant interviews with Local Government Officials in Kamwenge and Sironko Districts.
4. ToC development: Involved a meeting with Mission staff, to discuss a draft ToC.
5. Analysis and report writing: An iterative process was conducted throughout the assignment. The primary information generated was qualitative (as described in step (c) above). The anecdotal information obtained through this approach was compared with statistics from national reports, and, in some instances, with literature from international practice.

The key methods used included:

Review of documents such as: national policy and program documents, USAID/Uganda's CDCS and other gender and social inclusion policy documents, and documents on international best practice on social inclusion.

Key informant interviews with officials in key line ministries with a direct thematic link to the five PADs and with district officials – to understand the status of government policies and programs aimed at addressing gender inequality and social exclusion.

A total of 11 *focus group discussions*: with men, women, youth, people with disabilities, refugees, and fourteen-year old girls in Kamwenge and Sironko Districts, and one with LGBTI people in Kampala. This was aimed at understanding gender and social drivers of social exclusion as experienced by these excluded groups. Groups of men, women, youth, and refugees were randomly selected, while PWDs and LGBTI people were selected from their already existing associations.

Kamwenge District in the Western Corridor was selected for the analysis because it has six economic growth activities, three HIV/Aids and health activities, and one education activity supported by USAID. Kamwenge is also host to 70,000 refugees in the Rwamanja Settlement, which is managed by UNHCR and the Office of the Prime Minister (OPM Uganda). A total of five focus group discussions were held in Kamwenge. One with men and another with women (in Kanara Subcounty), one with PWDs (in Nkoma Subcounty), one with 14-year-old girls in Rwamanja secondary school, and one with refugees in Rwamanaja Settlement.

Sironko District in the Eastern Corridor was selected because it has five economic growth activities, two education activities and two HIV and health activities supported by USAID. It also has land conflicts and a series of disasters from landslides and floods. Sironko is still rooted in cultural practices such as preference of boys. A total of five focus group discussions were held in Sironko. One with men and one with women (in Bukhulo Subcounty), one with PWDs (in Sironko Town Council), one with 14-year-old girls in Salikwa Primary School, and one with youth in Sironko Town Council.

Interviews with 14-year-old girls were focused on three key questions: 1) What do you like/dislike about your home; 2) What do you like/dislike about school? and 3) What do you like/dislike about your community? The responses were then aggregated and are presented in the report as “my ideal home; my ideal school; and my ideal community.”

Limitations

The range of issues to be covered by this gender and social inclusion analysis within the limited time scope necessitated selection of only two districts for community-level analysis. A meaningful assessment of community practices and norms however needs to be context-specific. It may therefore be necessary for USAID to commission more localized social analysis, particularly in areas with the poorest social indicators and where USAID has the highest investment. USAID could alternatively integrate research into the designs of new programs to be awarded under the new strategy. Another limitation is that some of the available national data is old and may not give an accurate reflection of the current situation. In other cases, there is an absence of data to back up the qualitative information provided by excluded groups, e.g. PWDs and LGBTI people because the magnitude of their social exclusion is not consistently documented.

I.4 REPORT STRUCTURE

The report is presented in five parts. Part 1 provides an overview of social exclusion in Uganda, explains the rationale for the social exclusion analysis and highlights the methodology used. For ease of reference by the respective PAD teams, part 2 presents PAD-specific findings, based on an analysis of policies, literature on global best practice, findings derived from focus group discussions held with marginalized groups, and interviews with national and district technical officials. Although some gender and social inclusion issues may seem repetitive across the five PADs, the multidimensional nature of some factors varies their impact on the different PAD themes. For instance, women’s unpaid care work has different impacts on governance, resilience, child wellbeing, market systems, etc. These different perspectives are therefore explained in the respective PADs. This part also provides recommendations for the respective PADs. Part 3 shifts the discussion from social exclusion to social inclusion. It draws the key desirable social development outcomes of each PAD into a common ToC. Part 4 proposes a gender and social inclusion action plan, while Part 5 draws overall conclusions and recommendations.

2. GENDER AND SOCIAL EXCLUSION IN THE PROJECT AREAS

2.1 HOUSEHOLD AND COMMUNITY RESILIENCE PROJECT

Resilience is the ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from economic, environmental, and social shocks and stresses (CDCS, 2016). The aspiration of USAID/Uganda's CDCS for building resilience is contained in the following DO and high-level IRs.

DO 1: Community and household resilience in selected districts and target populations increased.

- IR 1.1: Key drivers of vulnerability addressed, as defined by communities.
- IR 1.2: Capacity to manage risks increased.
- IR 1.3: Enhanced prevention and treatment of HIV, malaria, and other epidemics among the most vulnerable.
- IR 1.4: Community and household assets increased and diversified.

A combination of power structures, intra-household dynamics, community norms, decision-making processes, and inequalities in workloads and incomes play a big part in affecting the ability of individuals, households, and communities to cope with shocks. Building people's resilience therefore requires an understanding of the social norms and other systemic factors that maintain gendered and other forms of exclusion, and that perpetuate the vulnerability of groups of people to shocks.

2.1.1 GENDER AND SOCIAL EXCLUSION IN HOUSEHOLD AND COMMUNITY RESILIENCE

Gender and social drivers of vulnerability

Vulnerability relates to the diminished capacity of individuals, groups, or households to anticipate, cope with, and recover from the impact of a disaster. Individuals, groups and households differ in their exposure to and ability to cope with or recover from disasters. Social characteristics such as gender, ethnic identity, age, disability, sexual orientation, and other factors sometimes expose people to different risks, or affect the nature of coping options available to them. The CDCS has identified climatic shocks, conflict, and disease as the key threats. The CDCS aims to build households' and communities' resilience in these areas. However, gender and social issues may perpetuate vulnerability and limit the capacities of households to mitigate, cope with, and recover from unanticipated events as elaborated in this section.

Uganda experienced a long drought in 2016 and parts of 2017 as described in [Box 2.1](#). Focus group discussions with men and women in Sironko District revealed several gender and social factors that affected the ability of households to cope with the drought and food insecurity – and that need to be addressed to reduce vulnerability and support households and communities to be more resilient.

Gender: Women in Sironko expressed the idea that, to them, food insecurity was not a new phenomenon. They experience food shortage annually. This is partly because they do not have easy access to land. Poor women depend on casual labor on other people's land, while the enterprising ones hire gardens at an average annual price of UGX 200,000 (USD 55). Women in both Sironko and Kamwenge also expressed that they often lack control over proceeds of the harvest. Men control the harvest and women have limited decision-making over the quantities to sell vis-à-vis the quantities to keep as food reserves. The

NDP II estimates that less than 20% of women control the outputs and proceeds from their efforts (NPA, 2013).

In post-disaster situations, women are universally found to be more vulnerable than men. Their maternal care-giving roles expand dramatically after a disaster, while at the same time their access to resources for recovery is constrained. The cumulative effect of these circumstances puts both women and children at a significant risk.

BOX 2.1: THE 2016 DROUGHT AND FOOD INSECURITY SITUATION IN UGANDA

The regional drought of late 2016 led to severe impacts particularly in the eastern and southeastern regions of the country. This was due to persistent dryness that affected these regions first during October and early November into December.

By March 2017, an estimated 10.9 million people were experiencing acute food insecurity (phase 2 and 3), of which 1.6 million (5%) were in a crisis (phase 3). Those in phase 3 were found in Central-I (0.58 million); Karamoja (0.12 million), Teso (0.2 million), East Central (0.38 million) and South Western (0.31 million) regions. All regions in the country had a combined food security stressed population of 9.3 million (26%).

Source: WFP, and Integrated Food Security Phase Classification

Family size: Community members in Sironko noted that the long drought of 2016 had been particularly hard on people with large families. In these families, as any food reserves were quickly depleted, the effects of the food insecurity were felt earlier than others. When there was a food shortage, most families had only one meal a day.

Age: Breastfeeding mothers, children, and the elderly were said to be the most vulnerable, which quickened the onset of the effects of the food insecurity.

Limited livelihood options/diversification: The lack of alternative livelihoods means that most households rely almost entirely on agriculture, which is dependent on unpredictable weather patterns. In addition, the lack of alternative income sources drives the rural farmers to sell their crops even before full maturity. In Sironko, farmers sell sorghum and maize cheaply to middle men from Kenya, at low unregulated prices. The impacts of these practices are felt by entire communities because of the aggregate food shortage caused by distress sales.

Ethnic identity and its effect on access to social safety nets: Some men and women also indicated that during the emergency food distribution by the Office of the Prime Minister (OPM), the food relief was not enough, and access to the rations

depended on nepotism by the officials in charge of the distribution. One man in Sironko (originally from Pallisa District) expressed that:

“when I queued for the emergency food relief, I was told that the food was for Bagisu only, and that I should go back to Pallisa. I have lived in Sironko for very many years now, and I consider this place my home. I presented my National ID to prove I was Ugandan, but that did not help.”

Displacement: This is contributing to changes in gender roles and power relations among refugees. For example, in Rwamanja settlement in Kamwenge, most refugees are women and children – this has led to women assuming new, expanded roles over their own wellbeing and that of their children. On the other hand, some men have given up their role of provider for their families because the trades they were accustomed to are no longer available. Although the magnitude of the disruption of men’s livelihoods is

not documented, it is often the case that refugees have restrictions and take a while to set up viable trades in their host communities. One male refugee in a focus group discussion noted:

“I used to drive trucks for a living to support my family. I can no longer do that here, and so I spend most of the day doing nothing. Men have become useless to their families in this setting.”

Refugee in Rwamanja

Positive social norms/coping strategies used by communities

Community self-help groups pool funds to support establishment of non-farm income generating activities. There are organized groups, particularly of people with disabilities in Kamwenge and Sironko that do collective saving and have set up enterprises such as piggery, poultry, *boda boda* (motor bike taxis), and other projects.

Planting drought tolerant crops, e.g. cassava, millet, or sorghum. Communities in Sironko have been flexible enough to adopt alternatives to the staple *matoke* (green banana).

Engagement in off-farm activities, e.g. petty trade. Women have also diversified their livelihood options and taken up trade in the local markets.

Key recommendations

- 1) Promote the above positive norms used by communities for their own resilience.
- 2) Change social norms that promote large family sizes through behavior change interventions.
- 3) Build community risk awareness by training them to undertake their own vulnerability analysis, to map risk areas, to identify vulnerable groups, and to lead their own action planning. Done well, this will ensure that solutions are locally derived and owned.

Gender and social issues that influence household and community capacity to manage risk

The CDCS notes that for sustainable development to take hold, communities and households must strengthen their capacity to manage or mitigate risk and to recover quickly from the aftermath of shocks and stresses. The causes of shock and stress vary from one excluded group to another and from one context to another. In addition to the drivers of vulnerability to climatic shocks and to conflict, described above, other risks described by communities for instance included:

- *Risk of sudden displacement*: This particularly affected communities with proximity to game and forest reserves, and refugees. Community members in Kanara Subcounty which borders Queen Elizabeth and Kibaale game parks complained of the constant fear of displacement because of changing park boundaries.
- *Uncertainty among refugees about resettlement prospects*: For refugees, moving to new locations dismantles the social capital built in the current location. A Congolese female refugee in Rwamanja settlement for instance was pleading with the authorities to take her back to Kyangwali settlement, where she had been living prior to a short unsuccessful attempt to return to the Democratic Republic of Congo. This form of uncertainty was expressed by other refugees as well.
- *Loss of parents*: Fourteen-year old girls in Sironko and Kamwenge expressed that loss of a parent was the main risk that could immediately make them drop out of school, ending their dream for

a brighter future. Some had peers who had suddenly dropped out of school because of loss of a parent. They also feared that the extended family would not provide support. The State of the Ugandan Child Report (Walakira et al., 2016) estimates that there are over 2.2 million orphans.

- *Victimization due to sexual orientation:* Among the LGBTI people, coming out as gay is a shock, the effect of which can go as far as to affect their ability to complete school and to continue running their enterprises. They reported a constant risk of being ostracized by their families, being expelled from school, being evicted from rented homes, being dismissed from work, and losing business customers. They noted that having skills and a good education did not necessarily protect them from the risk of exclusion and loss of income.
- *Disability comes with reduced labor capacity* of individuals and households and sometimes reduces the resilience of households. This is particularly the case if the household head has a disability, or if household expenditure rises due to the need to look after members with disabilities. The resilience of such households is comparatively lower.

Key recommendations

- 1) Support disaster risk reduction strategies that build on communities' local knowledge and cultural practices. Use local approaches and tools that people can easily adapt with minimum external support.
- 2) Work with communities to develop emergency response plans. The community response plans could then be linked to subcounty, district, and national disaster action plans

Gender and social issues in prevention and treatment of HIV, malaria and other epidemics among the most vulnerable

According to the CDCS (2016), individuals and families affected by infectious diseases are extremely vulnerable to economic shocks as well as social isolation. An estimated 1.5 million Ugandans are living with HIV/AIDS. Although those affected by the epidemic are heterogeneous and geographically dispersed, there are some particularly affected populations, such as youth, PWDs, and the LGBTI communities, which warrant special attention. Malaria is still the leading cause of child death, though considerable progress combatting it has been made through the President's Malaria Initiative (U.S.).

Focus group discussions with youth, men, women, and LGBTI people revealed a number of social and gender drivers of HIV, which are similar to the behavioral drivers highlighted in the 2011 Uganda Aids Indicator Survey. They include:

Limited control over decisions on safe sex: The HIV/AIDS prevalence rates in Uganda show a higher vulnerability of women and girls due to limited control over decisions on safe sex. Among the age group 15-19-year-old, the female prevalence rate increased from 2.6 percent in 2006 to 3 percent in 2011 while male prevalence of the same age group moved from 0.3 percent to 1.7%.

Multiple sexual partnerships: This continues to be a challenge among both men and women. In Kamwenge, men noted that some of them have sexual relationships with sexually active women from Rwanda who seek multiple relationships. On the other hand, youth in Sironko contend that family planning methods reduce the sexual libido of their partners, and, in the case of some men, encourages multiple relationships. For some, HIV through multiple sexual partnerships is the counter intuitive result of family planning.

Perceived exclusive efficacy of male circumcision: Perceptions of immunity from HIV, particularly in traditionally male-circumcising communities such as Sironko, still contribute to HIV infection among the youth. Furthermore, sexual activities surrounding circumcision processions and ceremonies continue to pose a public health challenge. Public messaging on HIV prevention methods is, therefore, still required - particularly in circumcising-communities.

Inability to afford condoms: Youth in Sironko noted that lack of income implies that they hardly ever purchase condoms.

“If I have to pay about 2,000 shillings (USD 0.5) to a sex worker, as well as buy condoms for the same price, I will hardly have any income left to meet my other survival needs. I therefore have sex without a condom. It doesn’t matter if I do not know the status of the sex worker, I have nothing else to do.”

Youth in a focus group discussion in Sironko Town Council.

This tallies with statistics by the UDHS (UBOS, 2016), which indicates that 21% of men age 15-49 reported that they had two or more partners in the past 12 months. Among men who had two or more partners in the 12 months preceding the survey, 22% reported using a condom during their last sexual intercourse. The young respondents reported that free condoms are hard to get these days. Condoms on the market are the government-branded ones which are sold instead of being given out free of charge in government health facilities and other public places. This raises a governance/social accountability concern.

Joblessness among the youth: Related to the above, the youth in Sironko spend most of their day at the “jobless corner,” where they play board games, drink alcohol, and watch local cinema. This tallies with the national statistics that place youth unemployment rate at 18% (MGLSD, 2016). The environment is also rife for unprotected sex.

Sex work: Related to the above, “jobless corners” are also frequented by sex workers. Young women make a living, and, consequently, expose themselves and others to HIV.

Unique challenges faced by LGBTI people: HIV prevalence is estimated at 13% in men with a history of having sex with men (UAC, 2015, NSP). Despite this high prevalence, the LGBTI people face cultural prejudice from health workers, stigma, lack of commodities, e.g. lubricants, and poor adherence to antiretroviral medicines (ARVs) due to lack of money to meet regular transport costs to the health facilities. LGBTI respondents noted that some health workers are outright offensive. There is a low social tolerance for homosexuality in Uganda (33.42%) according to the Social Progress Index, 2017 (Social Progress Imperative 2017)

“When we go to the health center for treatment of HIV or other conditions unique to LGBTI people, health workers ask us irrelevant questions, such as, “why don’t you get married to a woman? How did you get this condition? Are you mentally normal? These stigmatizing questions make us shun health centers, and this affects our adherence to ARVs.”

LGBTI Person in a focus group discussion in Kamwokya, Kampala

Self-exclusion from accessing Long Lasting Insecticide Nets (LLINs): In both Sironko and Kamwenge, there is a religious cult that discourages its followers from accessing services where a registration number or enumeration is required. [Box 2.2](#) elaborates the doctrine and how it has affected uptake of malaria prevention and other services. While the number of people excluded on this basis is not well known, because of the clandestine operations of the cults, cultural and religious doctrine as a driver of voluntary exclusion needs further research and possible legislation.

BOX 2.2: VOLUNTARY SELF EXCLUSION: THE NYANGAKIIBO SECT IN KAMWENGE AND 666 IN SIRONKO DISTRICT

Nyangakiibo cult is said to have followers spread across three sub counties (Kanara, Kabambiro and Nyabani) of Kamwenge District. The 666 cult, on the other hand, operates in Butandiga and Bunyafa Subcounties of Sironko District. The main doctrine of the two cults is that numbers are not good and their followers must reject anything that assigns them numerical identifiers. As a result, the cults have discouraged their followers from accessing programs and services such as: registering for national identification cards, participating in the census, participating in the national insecticide-treated bed nets campaign (against malaria), immunizing children, and accessing other health services. In addition, children of cult members are discouraged from attending school because numeracy is a key education outcome. Although Government Officials in both districts noted that the cults undermined the uptake of government programs, they expressed frustration that efforts to disband them had not been successful. Police and political leaders have arrested members who deny children access to education and immunization. However, the beliefs are engrained in the minds of followers, and influence their choice of development programs. Community Development Officials contend that the most effective approach against the cults is sensitization for attitude change, to prevent further growth of the cults. A social anthropological approach should be considered, as changing such beliefs and norms is a long-term complex process.

Source: Primary interviews with Community Development Officers in Kamwenge and Sironko

Positive social norms/coping strategies used by communities

Peer to peer education: LGBTI people have used this approach of sharing information among members of their community to achieve positive outcomes for health and well-being, e.g. sharing information about rights, health services and adherence to treatment. Their network trains members to do this on a voluntary basis to support each other. This approach can be scaled up to other population groups, but with caution to avoid destroying the self-initiative and creating perverse incentives in the process.

Pooling of resources and rotating responsibility for collecting ARVs: To manage the prohibitive costs of transportation to health facilities to replenish their ARVs, LGBTI people are in initial stages of exploring the option of pooling money and sharing the responsibility of picking up the ARVs from the health centers. This however requires members to live within the proximity of each other. If not well managed, it could also cause for members to miss some doses of their medication as they await a replenishment.

Adherence buddies: This peer support has enabled people living with HIV to adhere to their ARVs. Relatives or friends agree to assist the patient in adhering to the medication. Buddies remind patients to take their medication, encourage them and remind them in keeping hospital appointments. Social support not only assists the patient in adhering to ARVs, but can also provide psychological support to the patient, which helps them to cope with the disease.

Health workers modelling positive attitudes towards LGBTI people and other key populations: MARPI Clinic Mulago was lauded by the LGBTI community for having friendly health staff, who have a good understanding of the unique needs of key populations. The clinic ensures that staff are trained to provide good care. The clinic also follows up patients through home visits when necessary. The clinic provides health support, not only to the most-at-risk individual, but extends the friendly services to family members of the key populations. This approach makes the LGBTI individuals feel useful to their families.

Key recommendations

- 1) Set quotas for women, PWDs, LGBTI people, and youth to access HIV and malaria interventions.
- 2) Support behavioral messaging on HIV prevention to curtail reversal of gains, particularly among youth and in circumcising-communities.
- 3) Support replication of best practice to promote positive health-worker attitudes towards key populations. This could be done through non-monetary recognition and awards of health workers that demonstrate positive client care for marginalized groups.
- 4) Work in partnership with Local Government Community Development Departments to support social anthropology approaches to changing cultural and religious barriers to service uptake.

Gender and social issues in household and community asset accumulation

The CDCS aims to increase and diversify community and household assets by diversifying income sources of households, increasing access to financial services at the grassroots level, and increasing purposeful household savings. The gender and social issues include:

Proximity to game/forest reserves: Although location at the margins of a game/forest reserve is a potential asset to communities, challenges to mutual coexistence, boundary enforcement, and compensation of communities continue to affect such communities. In Kamwenge for instance, Kanara Sub County borders with Queen Elizabeth national park and Kibaale reserve. However, Kanara is the poorest subcounty in the district. This unique location has clearly not translated into better fortunes for households and the community. In Rwamanja settlement, there are concerns about the possible pressure on the land, which may cause the refugee populations to encroach on the forest reserve. In Sironko, there are still conflicts between the communities and the Uganda Forestry Authority over the boundaries of the Mt. Elgon forest reserve. Social safeguards procedures may not have been well enforced to ensure appropriate resettlement of communities. Related to this, tourist areas attract mobile men with money, and associated sexual violations to girls. The Probation Officer of Kamwenge for instance noted that Bigodi trading center, which borders Kibaale National Park, is a hot spot for sexual exploitation of girls.

Women are most affected by poor compensation procedures: In Kanara Subcounty, women complained about the procedures used by the Uganda Wildlife Authority (UWA) in compensating them for damage to crops, caused by wildlife from the respective parks. They indicated that sometimes, there is no direct compensation for loss of crops, and this aggravates household food insecurity. In the past, the money has been shared proportionately among affected households and other members of the community. This fiscal year (2017/18) however, UWA has asked the community to identify a community project to which the funds will be allocated. Although this is a positive move towards strengthening community infrastructure, it needs to be implemented alongside social safeguards and compensation of directly-affected households.

Women have limited access to and control over land for agriculture: The Social Institutions and Gender Index (SIGI) survey by OECD and UBOS (2015) highlights that women in Uganda provide 70% of agricultural labor and yet women represent less than one-third of landowners. Due to this, women lack valuable collateral required to access financial services.

Limited savings and credit for asset accumulation: Although the savings culture through Savings Associations and Credit Cooperatives (SACCOs) has improved, with more than half of the adult population estimated to have an account at a formal financial institution (World Bank, undated), the savings through village savings and loans associations (VSLAs) are usually small and not purposeful. Communities have not been able to translate these savings into meaningful assets. In addition, access to credit is affected by lack of collateral, and this mostly affects women who do not own land. In Uganda, women access only 9% of available credit (World Bank, 2013). Women also lack control over spending decisions on their income. The World Development Report 2012 (World Bank, 2012) indicates that about 13% of women in Uganda are not involved in decisions about their income. This limited control of assets and income by women undermines their ability to plan long term investments to lift them out of poverty

Women's disproportionate representation in unpaid care work: Unpaid care work includes domestic work (cooking, cleaning, washing clothes, and water and fuel collection) and care for household members (including children, older persons, persons with disabilities, and able-bodied adults). The bulk of this work is done by women, and its burden is worse for poor women who do not have access to time/labor-saving technologies. It is estimated that women in Uganda spend three times as many hours (1 hour and 20 minutes) a day on unpaid GDP work such as subsistence agriculture than men who spend only 40 minutes. Women spend over three hours a day on housework compared to less than one hour spent by men (Action Aid, 2014). Although this work is important for maintaining a healthy labor force required for economic development, the over representation of women in this kind of work limits their opportunity to earn and build household assets. According to the SIGI (2015), attitudes towards the division of household chores and caring activities between girls and boys are not translating into changes in practice. While two-thirds of Ugandans agree that girls and boys should have an equal share of caring responsibilities, half of the population reports that, in practice, girls are still performing more housework.

Limited labor capacity for PWDs: Labor is one of the critical requirements for asset accumulation. In rural areas, most of the labor-requirements are manual. People with disabilities are therefore particularly disadvantaged because of a reduced ability to provide manual labor to generate assets.

Exclusion of LGBTI people: Members of the LGBTI community report a reduced ability to accumulate assets. Homophobia in some instances causes landlords to evict them from business premises and rental facilities.

Positive social norms/coping strategies used by communities for asset accumulation

- VSLAs have enabled communities, including vulnerable groups to save. VSLAs also have the added benefit of building social capital for members. People with disabilities, youth, and women are active in VSLAs.
- Pooling labor is a common practice among rural communities to increase agricultural productivity.

Key recommendations

- 1) Support participatory community asset mapping to identify the local resources that can be harnessed to improve community and household wellbeing. This exercise can also support communities to define for themselves how to best utilize assets to improve their wellbeing.
- 2) Adopt women's economic empowerment models that use a family approach and avoid creating the potential backlash of gender-based violence.
- 3) Support programs that increase women's access to land.

2.1.2 POTENTIAL SOCIAL OUTCOMES OF USAID'S PROPOSED INTERVENTIONS

This section examines the likely social benefits and social harm/risks of some of the interventions proposed by the CDCS for the achievement of the IRs under the Resilience PAD, and proposes possible ways to maximize the benefits and minimize possible harm.

IR 1.1: Social benefits/risks of proposed interventions to address key drivers of vulnerability

Diversify assets: While this has the potential to improve incomes and household wellbeing and to increase income stability during periods of unemployment, it may have the possible harm of escalating gender inequality in access to and control of the assets. It could also lead to accumulation of household debt when households can use the assets as collateral. USAID therefore needs to consider integrating a gender approach to promote equal access to and control of assets by women and men. Communities – especially low-income communities – also need to receive financial education to mitigate the risk of debt accumulation.

HIV prevention (e.g. through test and treat): This will result in improved health and productivity of individuals and households. However, stigma that could result from disclosure of positive test results needs to be managed to avoid the risk of reinforcing social exclusion on the basis of HIV status.

Family planning: This has the potential benefit of resulting in manageable family sizes, reduced care roles for women, and other multiplier effects. However, women need to be protected from the likely risk of GBV resulting from their decision to use family planning without spousal consent. In addition, there is need to mitigate the risk of men, especially young men, interpreting family planning as a cause of promiscuous behavior (youth in Sironko expressed that some family planning methods reduce the sexual appetite of their partners, and this drives them into multiple concurrent partnerships to cope). To maximize the benefits of family planning and mitigate harm, there is need to educate both men and women about the benefits of family planning.

Promote the use of sustainable stoves: This has the potential social benefit of reducing the time spent by women looking for wood fuel. However, the stoves may be unaffordable by poor households, and yet it may equally be unsustainable for USAID's implementing partners to keep distributing the stoves at no cost. This risk could be reduced by training local artisans to make them. This will have the added benefit of creating local jobs.

IR 1.2: Social benefits/risks of proposed interventions to increase household and community capacity to manage risks

Early warning systems: This will save lives and property and guard against destabilization of livelihoods. However, there is a risk of community inaction due to the likely occurrence of false alerts. Nevertheless, communities need to be educated about the risks of inaction/not responding to the alerts.

Work with communities to plan for quick recovery: This has the potential to strengthen community participation and social cohesion to address communal problems. However, if not deliberately integrated, generic community action may not pay attention to the impacts of disasters on vulnerable groups, e.g. PWDs, the elderly, women, etc.

Direct support to families to graduate themselves out of vulnerability and build household resilience: This has the potential to increase self-determination among households to make them more resilient. However, resilience interventions also need to address intra-household dynamics, such as those that perpetuate gender inequalities and GBV.

IR 1.3: Social benefits/risks of proposed interventions to enhance prevention and treatment of HIV, malaria and other epidemics among the most vulnerable

Prevention of malaria in pregnancy: Targeting pregnant women introduces social equity. However, it could lead to exclusion of other groups if not complemented with other targeting mechanisms. For its part, the CDCS proposes to use Indoor Residual Spraying (IRS) and mass distribution of mosquito nets.

Indoor residual spraying: This will result in reduced illness for the entire household, and reduced out-of-pocket expenditure for management of malaria. However, community perceptions about the side effects of the chemicals need to be managed through community education prior to spraying.

Outreach for safe voluntary medical male circumcision This will result in reduced risk of HIV infection and associated social impacts of HIV. However, it could also have the risk of leading to complacency by circumcised men, de-emphasizing condom use, and an escalation of risky sexual behavior. There is therefore a need for continued provision of accurate messages on the efficacy of circumcision.

Prevention of mother- to-child transmission (PMTCT): This will result in good health outcomes for infants, and reduce the burden of care for HIV positive mothers. However, there is a risk of GBV resulting from the inevitable disclosure of HIV status. Family-oriented approaches to delivery of PMTCT programs therefore need to be used to complement clinical approaches.

OVC socio-economic community-based packages: This has the potential benefit of improving the wellbeing of OVCs, ensuring they continue their education, and could alleviate the economic burden on families of meeting all the needs of OVCs.

ARV treatment: This will result in improved health and labor capacity of individuals and households. It could also contribute to building social capital, if ARV peer groups are used to support adherence to treatment. However, there is a risk of complacency and harmful sexual practices arising from the normalization of HIV. ARV treatment services therefore need to be complemented by behavioral messaging on positive living and altruism by HIV positive people.

Encouraging behavior change: Negative attitudes, beliefs, and practices that drive HIV will be transformed. However, attention needs to be paid to excluded groups, e.g. PWDs, to promote equitable access to prevention messages.

IR 1.4: Social benefits/risks of proposed interventions to increase and diversify community and household assets

Entrepreneurship, leadership, and workforce readiness: This has the potential to expand non-farm economic activities and improve incomes and household wellbeing. However, it could also reproduce or maintain

gender-based disadvantages for women because enterprises operate in patriarchal economies that are biased against women and constrain their success. There is also a risk of excluding PWDs and youth. USAID therefore needs to either create quotas for marginalized groups to benefit from the programs, or set up special entrepreneurship programs for women, youth, and PWDs. However, special targeting of women for economic empowerment and autonomy needs to be monitored to prevent the risk of triggering GBV.

Access to financial services at the grassroots level: This will result in improved investment and household wellbeing. However, if emphasis is placed on formal viable financial service providers, there is a risk of distorting local community savings initiatives and the associated social capital. There is a deliberate need to support a hybrid of informal community savings and credit mechanisms and formal financial services.

2.1.3 PROMISING APPROACHES FOR ENHANCING GENDER AND INCLUSIVE DEVELOPMENT IN RESILIENCE

More research is needed on what works in promoting gender and social inclusion in resilience, and in reducing vulnerability to risk, managing risks, managing disease, and building household and community assets. Nevertheless, secondary literature proposes the following approaches:

Social safety nets: According to the World Bank, social protection systems help the poor and vulnerable cope with crises and shocks. Providing social assistance through cash transfers to those who need them, especially children, benefits and support for people of working age in case of maternity, disability, work injury, or for those without jobs. Furthermore, pension coverage for the elderly buffers them against risk. Assistance is provided through social insurance, tax-funded social benefits, social assistance services, public works programs, and other schemes guaranteeing basic income security.

Building social capital: Social capital is defined by the OECD as “networks together with shared norms, values and understandings that facilitate co-operation within or among groups.” Social capital is built on trust among members. It creates a sense of belonging and purpose among members. This empowers women and girls and other marginalized groups to have more choice to make decisions about the issues that are important in their lives. It involves working with women’s groups and those of other marginalized groups to demand for rights, plan for collective action to build their resilience, and support each other to address practical challenges.

Building agency: According to the World Bank, agency is about an individual’s (or group’s) ability to make effective choices and to transform those choices into desired outcomes. Agency can be understood as the process through which women and men use their endowments and take advantage of economic opportunities to achieve desired outcomes. The outcomes of agency include:

- Control over resources - measured by women’s ability to earn and control income and to own, use, and dispose of material assets;
- Ability to move freely - measured by women’s freedom to decide their movements and their ability to move outside their homes; decision making over family formation - measured by women’s and girls’ ability to decide when and whom to marry, when and how many children to have, and when to leave a marriage;
- Freedom from the risk of violence - measured by the prevalence of domestic violence and other forms of sexual, physical, or emotional violence; and ability to have a voice in society and influence policy - measured by participation and representation in formal politics and engagement in collective action and associations.

Recognizing, redistributing, and reducing women’s unpaid care work: Recognition means that the unpaid care work done mainly by women is acknowledged as work and production, and is documented in national statistics. UNWomen and UBOS have started this initiative. Reduction involves reducing the burden and freeing up time for women and girls to pursue other activities such as formal jobs or political participation. Unpaid care work can be reduced through the introduction of infrastructure and technology, such as energy-saving stoves, to reduce the amount of time spent collecting firewood. Interventions exist, supported by NGOs in this area, albeit at a limited scale. Work can also be redistributed through engaging men and boys in household responsibilities such as health, nutrition, etc., that are traditionally regarded as women’s work.

2.14 CONCLUSIONS

Gender and social exclusion issues, if not addressed, could undermine the achievement of the intermediate results expected under the resilience PAD. They include: removal of gender barriers to asset ownership; reduction in large family sizes; and an expansion of resilient livelihoods options for excluded groups. Other challenges include: the limited agency of women over safe sex; the unique challenges faced by PWDs and LGBTI people which limit their resilience to HIV; and social norms that encourage early sexual debut and multiple concurrent partnerships by men as a symbol of masculinity, and particularly put youth at risk of HIV infection.

The following actions therefore need to be prioritized:

- 1) Support behavioral change programs to change social norms that promote large family sizes and gender exclusion.
- 2) Set quotas (targets) for men, women, youth, PWDs, and LGBTI people to be reached by HIV prevention services.
- 3) “Do no harm” – by implementing the mitigation measures proposed in the social impact assessment of the interventions proposed by the CDCS under the resilience PAD – to ensure that activities do not perpetuate gender inequality and social exclusion.
- 4) Track gender and social inclusion indicators as proposed in the Action Plan and Implementation Framework in [section 4](#).

2.2 DEMOGRAPHICS PROJECT

The demographics project is about addressing the problem of Uganda’s rapidly growing and disproportionately young population, which exerts pressure on service delivery. According to the CDCS, the demographic drivers of Uganda’s extremely high fertility rate are rooted in cultural, social, and political factors. These drivers are closely linked to the power balance within households and in communities and have both a gender and age dimension (USAID, 2016). The CDCS recognizes that for shifts in these demographic drivers to be realized, social norms, and gender issues must be addressed. USAID’s response to the demographics challenge are contained in the following DO and its high-level IRs.

DO 2: Demographic drivers affected to contribute to long-term trend shifts.

- IR 2.1: Adoption of healthy reproductive behaviors and practices increased
- IR 2.2: Child wellbeing improved
- IR 2.3: Girls’ education improved
- IR 2.4: Increased youth economic productivity

2.2.1 GENDER AND SOCIAL EXCLUSION ISSUES AFFECTING DEMOGRAPHICS

Gender and social exclusion in reproductive health

The gender and social issues affecting the adoption of healthy family planning practices include:

Limited agency over decisions to have children: Although the majority (85%) of married women want to either space their next birth or cease childbearing altogether (UDHS/UBOS, 2016), women have limited agency in relation to their sexual and reproductive health. Over 30% of Uganda's adult population think that a woman cannot choose for herself whether to use contraception (OECD, 2015).

Social preference for large family sizes: The decision on the number of children to have is almost entirely made by the husband. For rural households, this often happens in large families where children are considered a source of farm labor and proof of the husband's sexual prowess. Young men, in a focus group discussion in Sironko for instance, revealed that, when a man has few children, his peers question his masculinity. Men face social pressure to demonstrate that they can have many children. The outcome of this behavior is weakened maternal health, multiple sexual partnerships, and large families.

Men's attitudes about family planning: A study (Johns Hopkins University, 2015) among Ugandan men aged 15 – 54 in 31 districts revealed that 69% believed that a large family reduces quality of life; 76% believed family planning improves a woman's health; 43% thought that side effects associated with family planning outweighed any benefits resulting from its use; and 42% believed that peers would lose respect for them if they decided to have a small family. These attitudes affect family planning adoption and underscore the need to involve both men and women in family planning discussions.

Customary requirements to sustain family lineage: Related to the above, society also expects men to father many children to sustain the family lineage. Cultural norms place a crucial importance on the production of the next generation to family, clan, and tribe. This contributes to resistance by men to permanent family planning methods such as vasectomy for men and tubal ligation for women. Women consent to multiple pregnancies for fear of divorce and domestic violence. Permanent contraception methods are considered damaging to the lineage and are avoided by communities.

Provider attitudes towards excluded groups: Women with disabilities (in Kamwenge and Sironko) complained that sometimes the attitudes of health workers are negative towards them. Exit surveys may however be required to track the magnitude and changes in how women with disabilities are treated.

Recommendation

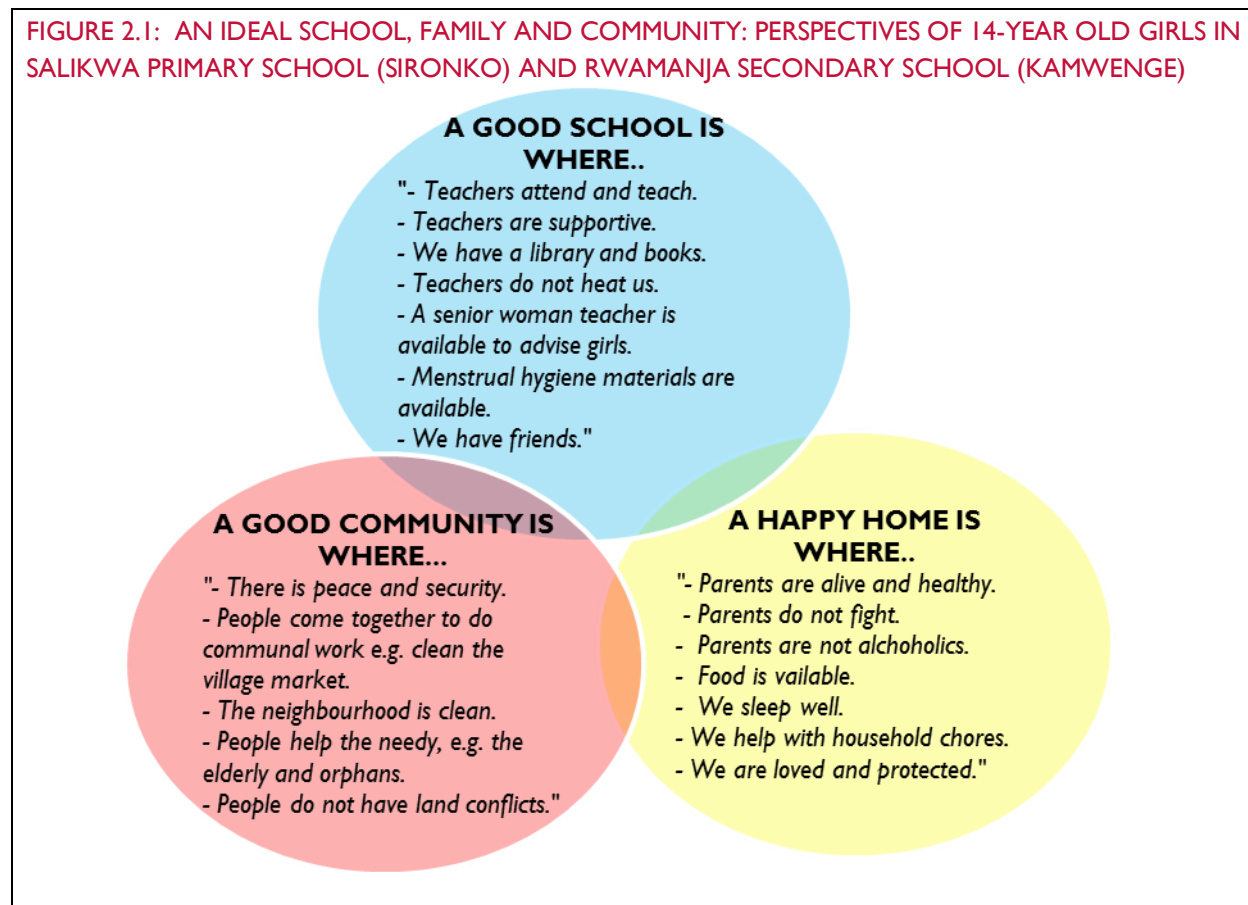
Adapt evidence-based behavior change approaches for diffusing positive norms and promoting uptake of reproductive health services. Options could include: Stepping Stones, SASA, and/or Men Engage.

Gender and social issues affecting child wellbeing

The 2014 census data shows that about half of the Ugandan population (of 34.9 million) is comprised of children under 15 years of age (Walakira et al., 2016). Many children remain vulnerable to abuse, sexual exploitation, and violence. These include: children living in extreme poverty; an estimated 2.2 million orphans; an estimated 310,000 children heading households; estimated 40,000 children living in childcare institutions; children living on the streets with no adult care, an estimated at 10,000; children involved in

hazardous work, an estimated at 507,000; and children murdered through ritual practices (Walakira et al., 2016).

The girl child remains disfavored compared to the boy child – owing to the failure to adequately address the nature of vulnerabilities, and the needs of the girl child – throughout her life cycle. As revealed by the views of 14-year old girls in Sironko and Kamwenge in [Figure 2.1](#), based on their life experiences, systems need to work together to support their wellbeing. These include: availability of teachers and teaching materials; a good school environment for learning and socialization; food, shelter and a violence-free home; household health; peace and security; as well as functional community support systems/safety nets.



In addition, the following gender and social factors affect the wellbeing of children:

Child feeding practices: Sub-optimal infant/child feeding practices are common in Uganda. According to the 2011 UDHS report (cited in State of the Ugandan Child, 2015), almost all children (98%) were breastfed at some point, but 63% of children who were 0–5 months were exclusively breastfed. By 4 - 5 months of age, the percent of exclusively breastfed children dropped to only 41%. The prevalence of exclusive breastfeeding is slightly higher in rural than in urban areas (19.7% vs 16.3%), due to work pressures of urban women. Weaning practices are also mixed – including early weaning and taboos around some foods.

Household feeding practices: General household food shortages affect what children are fed and the number of meals per day they receive. Food insecurity remains a major cause of inadequate dietary intake and malnutrition in Uganda. Diets are extremely unbalanced, energy-deficient, devoid of protein, and chiefly

comprised of starch. Children in most homes are fed on what is available and at the same interval as adults (State of the Ugandan Child, 2016).

Women’s workload and competing roles: Workloads prevent women from providing proper care to their children, especially in households with a single parent. Women are involved in farm work, household chores, and community roles which often leave them with little time to care for their children, to prepare food, and to ensure hygiene and sanitation within their homes (State of the Ugandan Child, 2016). Men in a focus group discussion expressed frustration about the long absence of some women from home.

Weak support systems for orphans and vulnerable children: Most orphaned children continue to live in families – typically with a sibling or members of their extended family. However, a considerable number lack regular family-support networks. Orphans live with caregivers who were typically impoverished and/or elderly. Orphanhood is also associated with multiple deprivations with far reaching implications for child survival (State of the Ugandan Child, 2016).

Non-involvement of men in parenting: Due to gender roles in parenting, the responsibility of caring and nurturing children rests with mothers. According to the Community Development Officer of Kanara Subcounty, Kamwenge, most of the cases handled by her office relate to child neglect by fathers.

Violent environments and violence against children: Corporal punishment of children is nearly universal (98%), with children mainly experiencing punishment at home (39%), or both at school and home (State of the Ugandan Child, 2016). Children also witness violence of parents at home, and this affects their wellbeing.

“The thing I dislike most at home is when my parents fight. Sometimes, when he is drunk, my father beats my mother while my siblings and I are watching.”

14-year old girl in Salikwa Primary School, Sironko

Other harmful practices: Child sacrifice, defilement, child labor, and female genital mutilation (FGM) are the other social and contextual practices affecting the wellbeing of children. Isolated cases of abuses due to religious practices (as illustrated in [Box 2.2](#)) also hinder children’s access to services such as immunization and education.

Recommendations

- 1) Support behavior change communication on effective child-feeding approaches tailored to locally available nutrition options.
- 2) Promote diffusion of positive behavior patterns on parenting by men – through identifying model male parents and promoting their parenting practices. This could be done by adapting lessons from USAID’s Responsible, Engaged and Loving (REAL) fathers project.
- 3) Promote technological innovations and dissemination that reduces women’s care workloads.
- 4) Scale up social protection for OVCs.

Gender and social issues affecting girls’ education

Child marriage: Poverty-stricken families use early marriage to divest themselves of the responsibility of bringing up girls, or as an opportunity to receive bride wealth. According to the SIGI (2015), the prevalence of early marriage therefore remains pervasive. On average one in two Ugandan women is married before turning 18. Early marriage is widely accepted, but only for girls: 45% of respondents in the SIGI survey

declared that girls should be married by 18, while 85% believe that men should be married later. The social and economic drivers for child marriage vary from poverty itself to gendered social norms that place high value on girls' reproductive capabilities.

Teenage pregnancy and high adolescent birth rate: According to the 2011 UDHS, one in every four girls aged 15–19 years begins childbearing - is pregnant with their first child or has had a live birth. Teenagers with no education are three times more likely to start early childbearing than those with a secondary education. Adolescent pregnancy is driven by both a lack of parental guidance and poverty as expressed in the voices of young girls below:

“Some girls get pregnant because they lack parental guidance. Some find men to buy them necessities such as pads. Some girls did not join Primary 7 with us because they got pregnant and dropped out of school.”

14-year old girls in a focus group discussion in Sironko

Menstrual hygiene: Related to the above, girls noted that a good school is where menstrual hygiene management materials are available. For many of them however, this is the responsibility of parents. It is estimated that girls miss up to 24 days a year due to menstrual management challenges (SNV, undated).

Increased vulnerabilities during adolescence: Adolescence is one of the periods in a girl's life when she is most vulnerable to gross and irreparable violation of her human rights, is cut off from civic participation, and is excluded from health, education and other social services (MoESST, 2015). It is the period when girls face a lot of pressure and are more likely than boys to drop out of school, to engage in illegal or unsafe work, or to be subjected to child marriage, transactional sex, and unsafe sexual relationships. The relative “protection” by the school system is often abandoned at the time when the girls are most vulnerable to pressure related to perceptions about their maturity. The vulnerability of adolescent girls is particularly escalated by mobile men with money attracted to the community by new economic activities in the area. Border towns, tourist destinations, trading centers, and road construction sites are hot spots for the abuse of teenage girls.

In Kamwenge for instance, the Probation Officer noted that sexual violence against girls is endemic and ingrained in people's attitudes that put little premium on girls' education. The scale of these challenges, for example, became evident in Kamwenge in 2015 following the suspension by the World Bank of the construction works on the Fort Portal – Kamwenge road. The suspension was, among others, due to sexual abuse of girls (in Bigodi trading center) by road workers.

Institutional challenges for children with disabilities: Girls and boys with disabilities face multiple challenges in accessing education, including inaccessible school terrain, negative societal attitudes towards their education, and limited numbers of teachers trained to teach them. The language barrier for children with hearing impairments is also a challenge - there are no language interpreters to communicate counselling and other life-skills information to them. The safety of children with disabilities, motivates some parents to keep them out of school with the result that fewer girls with disabilities are in school. Girls with disabilities are particularly affected by considerations of their personal security and by fear of sexual exploitation in addition to biases against education of children with disabilities in general. Limited counselling and guidance for parents of children with disabilities further escalates the problem, as revealed by one parent in Kamwenge:

“My ten-year old daughter has multiple disabilities, and I have struggled to get her the right medical care, and to keep her in school. The costs of her treatment are so high, and I am frustrated that she is not making any progress at school. I do not think she is learning anything. I am contemplating taking her out of school, so that I only have to worry about her health and not educational progress.”

Mother of a child with multiple disabilities during a focus group discussion in Nkoma Subcounty, Kamwenge.

Lack of guidance and behavioral modelling for boys: School and community-based guidance on issues of maturity, reproductive health, and appropriate behavior usually focuses on girls. Boys are left to learn from peers, cinemas, and other informal sources. According to the MoESST, the limited attention given to boys to help navigate gender relations serves as a breeding ground for several vices and limits the school system from preventing “masculine” behaviors such as various forms of drug abuse, early sexual debut, and subsequent violence against girls. The promotion of positive masculine identities among boys is essential for reducing high risk behaviors among them. Provision of sustained mentoring can help boys to respect girls’ rights and support their education.

Reduced educational opportunities for LGBTI people: Although the magnitude is not known, and the problem is likely to affect children in secondary schools, LGBTI people noted that homophobia causes some among them to be bullied and expelled from school. They reported that, in addition, many families are likely to end educational support or opportunities to LGBTI individuals after their sexual orientation is revealed.

Recommendations

- 1) Promote SGBV prevention in schools and communities.
- 2) Promote a hybrid of legal enforcement and attitude change against child marriage.
- 3) Explore (within the legal and cultural confines of Uganda), options for contraceptive use among vulnerable adolescent girls, to prevent teenage pregnancy.
- 4) Leverage school-based interventions to provide appropriate modelling for boys. Lessons could be adapted from USAID’s Gender Roles, Equality and Transformations (GREAT) project for behavioral modelling for boys.

Gender and social issues affecting youth economic productivity

“Youth is the time of life full of promise, aspiration, and energy. Between childhood and adulthood, youth is when men and women are most eager to strike out to secure their futures and to contribute to their families, communities and societies. This stage of life is crucial in determining young peoples’ paths to achieving productive employment and decent work.” (ILO, Undated). Nevertheless, gender and social barriers often stifle the ability of youth to meet their aspirations and contribute meaningfully to economic growth, as illustrated by the youth in Sironko ([Box 2.3](#)).

Masculinity and social pressure on male youth to provide for families: While gender stereotypes are mostly skewed against girls and women, societal expectations regarding masculinity also often limit the potential of boys and men. There are social expectations on men to start fending for themselves and their families at an early age. This divides their attention, particularly when they must balance between attaining a good education over many years and finding a job to fulfill their social obligations. Families often divest themselves of their obligation to pay school fees and to look after boys at an early age when, as young men, they are expected to be independent and contribute to the household.

BOX 2.3: “THIS IS OUR WORLD” - MALE YOUTH AT THE “JOBLESS CORNER” IN SIRONKO TOWN COUNCIL

“We come here to the ‘jobless corner’ every afternoon to play *ludo* and cards. Those of us with family gardens go to the gardens in the morning, then come here in the afternoon to spend the rest of the day. We would like to work, but there are no jobs and we do not have capital to start our own enterprises. We have heard about the government’s youth livelihoods fund, but we have not yet received it. We have a few university graduates among us, but their situation is like that of their peers with limited or no education.

“Condoms here are for sale, even the ones branded as ‘not for sale’ by the government. We do not worry much about HIV these days because we cannot afford to buy condoms each time. Sometimes our wives and regular girlfriends deny us sex because some of the family planning methods they use reduce their desire for sex. So, we resort to finding other sexual partners, and using the services of sex workers. Some of us are taking ARVs, but sometimes they are out of stock from the health centers when we need them.

Unpaid work opportunities for female youth: Gender discrimination, cultural traditions, and the lack of opportunities often leave women and girls with traditional unpaid, family-based work, and underpaid domestic work in other people’s households.

Weak social capital: As illustrated in [Box 2.3](#), the social capital available to the youth is unfortunately not suited to reducing their vulnerability to poverty, and improving their productivity. They network with peers who lack information and connections to relevant opportunities. They also lack the guidance and role models among their peers to build their aspirations to be more productive.

Limited labor capacity of youth with disabilities: The exclusion of youth with disabilities from the market is compounded by the lack of skills, as well as reduced labor-capacity owing to disability.

Recommendation

Strengthen the quality of social capital for youth, by linking them to training opportunities, market information and progressive social networks.

2.2.2 GENDER AND INCLUSIVE DEVELOPMENT POLICIES AND PROGRAMS IN THE DEMOGRAPHICS SECTORS

Reproductive health: The Ministry of Health and its partners developed a “sharpened plan and investment case for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) for Uganda.” The plan forms the sector’s overall approach to accelerated progress towards reduction of maternal mortality targets set in the HSDP. The plan states that the high RMNCAH burden is rooted in inequalities within the social determinants of RMNCAH over the life course of women. It advocates an increased focus on primary community-based healthcare that is rooted in prevention. Village Health Teams (VHTs) and the proposed community health extension workers (CHEWs) are to be revamped.

Child wellbeing policies and programs: Uganda has many laws and policies to promote the wellbeing of children. They include: The Children’s Act, the Early Childhood Development (ECD) policy, the national Orphans and Vulnerable Children (OVC)VC policy, the national child labor policy, the Action plan for

Children with Disabilities, etc. A National Action Plan for Child Well-Being, 2016 – 2021 has been developed to provide a framework for the implementation of these policies.

Girls' education policies and programs: Like the policies on child wellbeing, there are many policies and guidelines developed by the MoESST to promote girl's education. They include: The Gender in Education policy aimed at addressing access, enrollment, retention, and completion; the Penal Code (Amendment) Act, which abolished corporal punishments and outlawed defilement; the National Strategic Plan on Violence Against Children in school; the guidelines for menstrual hygiene; etc. Programs have also been put in place, in partnership with USAID (School Health and Reading Program, and Literacy, Achievement and Retention Activity (LARA)), UNICEF, Irish Aid, and other partners to promote girls' education. The Ministry needs to be supported to implement the policies at scale.

Youth economic productivity policies and programs: The Youth Livelihoods Program (YLP) is the main GoU program for tackling youth unemployment and improving productivity. The program, led by the MGLSD, targets poor and unemployed youth in the entire country. YLP is a community, demand-driven, program implemented with guidance from both the central and local governments. Funds are advanced to Youth Interest Groups in form of a revolving fund to increase outreach and enhance sustainability.

Recommendations

- 1) Support implementation of the proposed community-based mechanisms for tackling the social barriers of uptake of reproductive health services.
- 2) Support operational research and innovations on changing social norms, that complement Behavior Change Communication (BCC).
- 3) The YLP, if well implemented, has potential to improve the productivity of youth. USAID should therefore consider partnership with the MGLSD and respective districts to improve its implementation. This could entail providing technical assistance at the district level and working with existing groups of youth to build entrepreneurship skills to generate higher success and profitability of enterprises. However, this should be preceded by a political economy analysis of the Ministry's interest in donor involvement in the project.

2.2.3 POTENTIAL SOCIAL OUTCOMES OF USAID'S PROPOSED DEMOGRAPHICS INTERVENTIONS

This section examines the likely social benefits and social harm/risks of some of the interventions proposed by the CDCS for the achievement of the IRs under the Demographics PAD - and proposes possible ways to maximize the benefits and minimize possible harm.

IR 2.1: Social benefits/risks of interventions to promote adoption of healthy reproductive behaviors and practices

Health communication strategies to empower girls to make healthier reproductive behavior choices: This will lead to improved reproductive health behavior. However, a mix of school-based and community-based health communication need to be used to ensure that out-of-school girls also access the health messages.

Increase the range of contraceptive methods available, including long-acting reversible contraception (LARCs) and permanent methods (PMs): This has the potential to lead to planned pregnancy, smaller family sizes, and improved family wellbeing. However, there is a social risk of excluding adolescent girls, due to cultural

and religious backlash regarding contraceptive use by girls. This requires work with religious/cultural leaders to change attitudes and protect vulnerable girls.

Reduce dependence on clinic-based services and optimize limited human resources: This has the potential to build stronger provider-user relationship through community outreach. However, there is a risk of social stigma to adolescent girls who may turn up for contraceptives. There is also a risk that privacy will be compromised by community-based services, leading to GBV towards women who do not want to disclose use of contraceptives to their partners. Therefore, outreach activities should be complemented by broader systemic community attitude-change on the benefits of contraceptives.

Media socialization and counseling to ensure informed choice, and promote knowledge of contraceptive side effects: This will lead to informed decision making. However, there is likely apprehension by women that the side effects of contraceptives outweigh the benefits – leading to low uptake. Counselling should therefore explore myths and include information on how to manage adverse effects.

Address provider bias: This has the potential benefit of building client-provider trust and greater uptake of services. However, some providers have strong religious/cultural biases that may perpetuate stigma, and affect client uptake of contraceptives. There is need to provide regular evidence-based, accurate information to health workers, support them, and promote a rights approach to service delivery.

Remove/reduce social barriers to healthy reproductive behaviors: This will lead to improved reproductive-health seeking behavior. However, barriers persist due to deep-seated cultural and social norms. There is need for diffusion of new ideas and norms through social networks and individual behavioral change, as this can outlive the short span of project interventions. Other means of minimizing this risk include: use of political and other opinion leaders to communicate and model alternative norms; and enhancing the utilization of family planning services by working with men and boys.

Male involvement for increased uptake of services: This has the potential to minimize GBV resulting from women's uptake of services. However, there is a risk of social stigma towards men who engage, due to culturally constructed masculinities that view contraception as women's responsibility. Therefore, there is need to work through men's networks and social capital to examine gender norms and traditional views of masculinity and how to increase male participation in family planning.

IR 2.2: Social benefits/risks of interventions to improve child wellbeing

Mothers' groups: These have the potential social benefit of building social capital, mutual learning, and support for better parenting practices. However, there is potential stigmatization and exclusion of adolescent mothers. There is also a risk of reinforcing the passive role of fathers in parenting. There is a need therefore to sensitize older mothers to mentor adolescent and first-time mothers and to involve men to model positive parenting skills.

Family-based income generating activities. This has the potential to increase self-determination of households to improve their incomes. However, interventions may ignore/escalate gender and social exclusion dynamics within households. Interventions should therefore assess and address household-level economic exclusion.

Nutrition education: This will lead to improved household nutrition practices. However, social loyalty to traditional feeding norms may limit success, and there is need to integrate positive community nutrition practices into nutrition education.

Village savings and loan associations (VSLA): This will contribute to building social capital, as well as improving savings and food security. It will also lead to improved agency of women, regarding household expenditure. However, it could be burdensome if members are required to attend numerous VSLA meetings. There is a need to encourage promote efficiency - notwithstanding that most VSLAs are self-regulating, so external development workers may have minimum input.

Safe drinking water: This will lead to improved household health and productivity. However, long distances to, and long waiting-time at safe water points may perpetuate the care roles of women. There is need therefore to ensure proximity.

Handwashing with soap: This will result in improved household health. However, poverty and an inability to afford sustainable supplies of soap may lead to exclusion of poor households.

Safe disposal of excreta: This will lead to improved household health. However, there is a risk that negative social norms on the handling of excreta, particularly that of babies, will affect success. There is a continued need for WASH communication campaigns to change negative norms.

Child protection case management: This will result in improved access to justice for child survivors of violence and abuse. However, a case-management approach may not necessarily include appropriate prevention mechanisms. There is therefore need for a holistic approach that includes prevention of violence against children.

Neonatal care and services: This will lead to child survival, less illness and less care burden on mothers. However, social norms, e.g. on managing the baby's umbilical cord, breast feeding, weaning, etc., could undermine uptake of neonatal care services. This requires addressing negative social practices on neonatal care through counselling mothers, and providing education through mothers' groups.

IR 2.3: Social benefits/risks of interventions to improve girls' education

Address school-related GBV: This will lead to an improved learning environment for girls and encourage school completion. However, fear of the consequences of reporting violence may perpetuate silence by girls. In addition, there is a risk that appropriate forms of disciplining children may be classified as GBV and lead to the reluctance of teachers to correct girls. There is need to educate teachers about GBV and ensure that educational institutions are held accountable for their GBV preventive work.

Promote healthy relationships and role models for girls: This will lead to improved agency for girls. However, the exclusion of boys may perpetuate negative gender definitions of masculinity. There is need therefore to promote a similar approach for boys and to build positive attitudes on masculinity.

Engage communities to set clear norms and expectations about schools as a safe space: This will create positive social norms that create safety for children. However, there may be tensions between community expectations and school rules. There is need to work through service (school) user associations and parent-teacher associations to hold schools accountable.

Educate communities on the importance and benefits of education and the empowerment of girls and women: This will lead to improved agency for women and girls. However, backlash on women's empowerment may result in some men taking a passive role. It is important to integrate the topic on masculinities in community education and to avoid approaches that blame men.

Electrification at the household level to help girls to complete homework in the evenings: This will lead to improved home environments for girls and families. However, there is a risk of possible exclusion of hard-to-reach households. If program resources are sufficient, there is need to use a universal targeting-approach in selected communities, so as to ensure that marginalized households are included.

Provide water to households around targeted schools to maximize schooling time and improve the learning environment: This will result in a reduced workload and time saving for girls.

Support the girl to make informed decisions on her future: This will lead to improved agency by girls. However, it could have a potential backlash by escalating violence against girls for their assertiveness. There is need to educate communities about the benefits of empowering girls.

Support vocational training and life skills: This will lead to improved agency and labor productivity. However, it could create a perverse incentive for children (girls) to spend more time on income generating activities, affecting time for school. It is therefore necessary to promote approaches that balance the need for early economic independence with adequate basic education.

IR 2.4: Social benefits/risks of interventions to increase youth economic productivity

Employable skills for youth, with a special focus on female and rural youth, and youth with disabilities: This will result in social inclusion and improved productivity of these groups. However, if not matched with attitude change by employers, there could be employer-bias against female and rural youth, and youth with disabilities.

Soft/life skill development: This will lead to improved personal behavior, attitudes, and social norms. However, if training is not of sufficient duration and frequency, it may not be transformative. It is therefore necessary to adopt participatory learning approaches and follow up.

Technical and financial skills, including climate-smart, adaptive agriculture and agro-processing, necessary to start businesses: This may reduce socio-psychological problems and delinquency that result from unemployment. However, fear of failure may inhibit the translation of skills into actual enterprises. Training models should therefore integrate mentorship approaches and follow up youth trainees.

Support business growth within agriculture and food systems (and additional value chains, e.g. transport): This will result in revitalization of the local community. However, there is a risk of possible exclusion of remote rural areas because businesses tend to concentrate around townships and urban hubs. It is necessary to promote forward and backward linkages of enterprises to inputs from the most remote areas as well.

Conservation enterprises: These have the potential to increase innovation, resilience and incomes for the poor. Conservation of biodiversity which may also have cultural significance to fringe communities. Broader challenges, such as conflicts over resettlement of communities from conservation areas, may however undermine enterprise success. In addition, displaced people may not be the direct beneficiaries

of conservation enterprises. There is need to integrate social safeguards, e.g. resettlement and compensation, into the conservation enterprise approaches.

Create paid and unpaid internships for entry-level positions on USAID projects: This has the potential to give disadvantaged youth the ability to succeed regardless of their background. However, it could lead to psychological pressure to succeed if there is limited space for error. Internships should therefore include periodic job counselling and psychological support for interns.

Invest in youth cooperatives or producer associations: This will result in improved social capital and increased incomes for the youth. However, there is a risk of social exclusion of youth with disabilities, due to their lower productive capacity. Affirmative action for inclusion of youth with disabilities in the cooperatives and producer associations is required.

Economic empowerment of youth and women. Due to market dynamics, businesses will be less inclined to consider social inclusion. Consider monetary and non-monetary incentives for businesses to promote social inclusion.

Develop demand-driven training programs and increase the capacity of youth to take on jobs. This will improve employability of youth. Demand-driven approaches may exclude youth who, due to their poverty, gender, location, disability, and other constraints, may lack access to information on available training opportunities. Take deliberate measures to find and include marginalized youth in the training programs.

Assist businesses to recruit youth for skill-building internships: This will generate more employment and reduced youth delinquency. However, psychological pressure on youth to succeed needs to be managed through periodic job counselling and psychological support for interns.

2.2.4 PROMISING APPROACHES FOR ENHANCING INCLUSIVE DEVELOPMENT IN DEMOGRAPHICS

Working within the context of existing social norms and practices: This requires identifying and promoting the positive social norms and practices that form a community's sense of identity. At the same time, it is important to introduce new positive norms to replace the negative norms that undermine reproductive health, child wellbeing, girls' education, and youth productivity. Creating an environment for behavior change at the local level may encompass the following tools:

- Peer support networks, where behavior change is reinforced from within peer groups and in which information is received and exchanged based on relationships of trust.
- Building social capital through capacity building of the existing informal and formal community-based support networks and organizations. This could cover support to self-help groups of women of reproductive age and support to microcredit schemes to reduce economic vulnerability and improve women's agency.
- Responsiveness of reproductive health services to client needs, including those of people with disabilities.
- Behavior change communication.

Male involvement: While maintaining a focus on adolescent girls, it is important to involve boys and men and encourage them to take steps to support girls and women. One of the ways to do this is to find and develop male advocates for girls' empowerment.

Mentoring youth: It is crucial for young people and girls to have business role models who can help them to navigate markets and grow their enterprises.

Girls as agents of change: Equipping girls with skills (including leadership skills), knowledge, and attitudes (developing their confidence and self-esteem) can transform them into powerful agents of change in their communities. They can start the debate at the community level themselves.

2.2.5 CONCLUSIONS

The size and quality of the population are driven by a number of gender and social issues throughout the life cycle. Notably, the patriarchal norms promote a social preference for high fertility rates, and limit women's agency over family size. The quality of child wellbeing is affected by poor child feeding norms, violence, and weak social protection systems. Despite gender parity in primary school enrollment, gender issues such as child marriage and SGBV in schools affects completion and transition rates for girls. Among the youth, unemployment, and weak social capital affect life prospects. For female youth, unpaid domestic work undermines economic progress. The following recommendations are emphasized. Indicators and outcomes for the demographics PAD are proposed in [section 4](#) in the action plan.

- 1) Support evidence-based behavior change approaches for diffusing positive norms on family sizes, and promoting uptake of reproductive health services. Options could include: Stepping Stones, SASA, Men Engage, etc.
- 2) Promote technological innovations and dissemination that reduces women's care workloads.
- 3) Support interventions to prevent SGBV in schools and communities.
- 4) Strengthen social capital for youth by linking them to cooperatives and other economic networks.

2.3 Health Systems PROJECT

The health-systems project is one of the three key systems that form DO 3 of the CDCS. The other priority systems are: social protection; education; and natural resource management systems. Plans of the CDCS for the health systems project are contained in the DO and high-level IRs below:

DO 3: Key systems more accountable and responsive to Uganda's development needs.

- IR 3.1: Leadership in development supported
- IR 3.2: Citizens actively participate in development
- IR 3.3: Key elements of systems strengthened
- IR 3.4: Enabling environment that supports functional systems improved

The primary focus of the gender and social inclusion analysis of this PAD is: understanding the prevailing cultural norms and gender relations that could influence improvement in leadership and citizen engagement in health systems. Analysis of findings in this PAD is closely linked with the resilience and demographics PADs, which have aspects, e.g. HIV prevention, reproductive health, child health, nutrition, etc. that contribute to and are affected by the health system.

2.3.1 GENDER AND SOCIAL EXCLUSION ISSUES AFFECTING HEALTH SYSTEMS

The World Health Organisation (WHO, 2012) identifies social determinants of health as the conditions in which people are born, grow, live, work, and age. It states that these social determinants are the most

responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries and, indeed, within and between households and communities.

The social determinants of health conditions are addressed through three primary interventions: i) improved governance for health and development; ii) participation in policy-making and implementation; and iii) promoting health and reducing health inequities. This section considers gender and social exclusion within these social determinants of health.

Gender and social exclusion in the health sector are two-fold. On the one hand are social factors that affect health and preclude people from accessing services, and on the other are health system-based factors that limit access to services by some socially excluded groups.

Social factors that impact health and uptake of health services

Health care is a disproportionate responsibility of women: As part of their ascribed reproductive gender roles (child bearing, care for children and other household members), women tend to be the biggest users of health services. They interact with the health system for their own health-care needs, such as treatment of common illnesses and access to reproductive health services. They also interact with the health system to meet the health-care needs of household members. This includes the immunization of children, the treatment of common household illnesses, and sometimes the management of long-term disability or illness of household members. This, coupled with a range of other unpaid domestic and economic work, effectively constrains the ability of women to meet their own health-care needs and those of their families. Furthermore, the actual cost of accessing health services – including transportation costs and the cost of medications – are disproportionately born by women. Effective participation of men in the health affairs of their households could therefore improve access to health services by households and reduce the disproportionate burden on women.

Gender definition of masculinity affects health-seeking behavior of men: Social constructions of gender and masculinity expose men to poor health. For instance, society expects men to be strong and not show weakness. Many men, as a result, see illness as a sign of weakness and are often late in seeking medical help in the event of ill health. In Uganda, for example, this affects men's health-seeking behavior for HIV/Aids treatment services. In addition, men are more likely to engage in risky behavior, such as excessive drinking, smoking and unprotected sex, to assert their masculinity.

Women have limited agency over disease prevention and reproductive health choices: As already discussed (in the Resilience and Demographics PADs), women have limited control over their sexual and reproductive health choices (OECD, 2015). This translates into higher HIV prevalence among women, poor maternal health, high fertility, and early teenage pregnancies among others. Maternal illness leads to loss in time for productive labor and often escalates health expenditure for women.

Gender-based violence has dire consequences for women's health and exerts pressure on the health system: GBV affects women's physical, sexual, reproductive, mental, and behavioral health. The more severe the level of violence, the greater its impact on women's health. Furthermore, exposure to more than one type of violence, e.g. physical and sexual, and/or multiple incidents of violence over time tends to lead to more severe health consequences (WHO 2002). The World Bank estimates that rape and domestic violence account for a loss of 5% of the healthy life years for women age 15 to 44 (World Bank, cited by UNFPA, 2014). The consequences of GBV do not only affect the individual, but put pressure on the health system and its ability to provide treatment for the physical and mental effects of GBV.

The effect of refugee displacement on health status and the health system: Refugees, in Rwamanja settlement, observed that displacement and the resettlement process often cause a disruption in health-care services, particularly for those on life-long treatments for conditions such as HIV. In addition, the growing numbers of refugees in Uganda is exerting pressure on the health system, particularly in host communities where limited human resources are shared between the local community and the refugee population. The number of health workers per 1,000 population in Uganda is still far below the WHO threshold of 2.3 doctors, nurses, and midwives per 1,000 population (MoH, 2016).

Myths about disease undermine health-seeking behavior: Related to the above, disease is often attributed to witchcraft and the first health consultations for an estimated 0.5% of households are with traditional healers (MoH, 2016). This traditional response undermines the ability of the formal health-care facilities to successfully address the patient's health issues and could lead to mortality.

Recommendation

Support behavioral change approaches to transform negative social norms about disease and health care-seeking behavior.

Health system-based factors that limit access to services by some socially excluded groups

Health worker stigma towards LGBTI people, adolescent girls, and PWDs: Community-based interviews with PWDs and members of the LGBTI community revealed that health workers' attitudes are sometimes stigmatizing in nature and make those who are stigmatized reticent to seek health-care services. LGBTI interviewees in particular revealed that negative attitudes by health workers affect their access to HIV prevention and care services. PWDs, on the other hand, reported challenges with accessing antenatal and child-delivery services because some health workers' attitudes are against PWDs having children. Adolescent girls also have challenges accessing reproductive health services because the service providers are not youth friendly. These qualitative reports from communities in Kamwenge and Sironko are supported by the MoH (2016) annual sector review which indicates that the proportion of households reporting that the overall quality of services provided at Government health facility was good and that health staff were responsive was only 46% (MoH 2016).

Infrastructure access challenges affecting access by PWDs: Although there are improvements in physical accessibility of public health facilities, some health centres still do not have ramps and hand rails. In addition, PWDs complained about the lack of sign-language trained health workers. They noted, however, that they cope with this challenge by going to health facilities with their own care-givers to act as language interpreters. The challenge, however, is that care givers are not always available to accompany them to access health care, particularly when they have other domestic and economic activities to tend to.

Prohibitive costs of accessing health services: Despite Government efforts to make public health facilities functional – with human resources, equipment, and drugs – some system gaps preclude some groups of people from accessing services. Some health centres remain without essential staff. Drugs are sometimes sold when they should be free.

Recommendations

- 1) Support health systems strengthening interventions to remove barriers to access by vulnerable groups.
- 2) Train health workers to model positive attitudes and ethics in providing services to women, PWDs, LGBTI, and adolescent girls.

- 3) Prevent corruption in management of the drug supply chain to ensure that patients access government drugs at no cost to them.

Gender and social exclusion in governance and community participation in health

Governance of public health relates to more than just the role of government. It includes the role of family, patriarchy, culture, and community in determining exposure to disease. Health sector governance is a function of multiple interventions, including: i) political accountability; ii) formal oversight institutions; iii) public sector management; iv) civil society and media (including preparing health sector report cards and use-satisfaction surveys); and v) local participation and community empowerment (World Bank, cited by WHO, 2014). The health system in Uganda is structured in a decentralized manner that creates avenues for participation. These include Village Health Teams at the lowest level and health unit management committees at the higher levels. User committees are expected to monitor administration, finances, and supplies of the health facility. However, participation is affected by:

Opportunity cost of voluntarism by community health workers: Until recently, community participation and representation in health governance has been through VHTs. VHTs are served by community volunteers who are selected by communities to provide correct health information, mobilize communities, and link them with the formal health service. The VHTs work on a voluntary basis with varying degrees of motivation and incentive. For most, they are an avenue to fulfil community gender roles, to acquire influence, and to gain better access to health information.

Constraints to women's participation: Related to the above, the voluntary nature of the VHT model affects the participation of women whose participation is constrained by the many other household activities that require their time. The MoH has, however, proposed to replace the VHT approach and with the CHEW Program. CHEW will engage slightly better educated community workers who will be trained and paid to deliver a similar service. However, where monetary incentives are involved, women risk being excluded if deliberate efforts are not put in place to ensure equity in recruitment.

Perceived non-responsiveness of health officials to local needs: Men in Bukhulo Market (Sironko) complained that their (parish-level) Health Centre II has been closed and without health workers or drugs for close to a year. They noted that, despite constant complaints to their local leaders, no action has been taken to open it. They responded by using local clinics or walking long distances to far-off health centres.

Recommendation

Support the health system's ability to respond to issues arising from demand-side accountability. As proposed by the CDCS, this will be done by providing essential commodities and supporting functional health infrastructure.

2.3.2 GENDER AND INCLUSIVE DEVELOPMENT POLICIES AND PROGRAMS IN THE HEALTH SECTOR

Some of the gender and social exclusion issues highlighted in [section 2.3.2](#) are addressed by a range of social inclusion policies and programs in the health sector which, if implemented at scale, could further help eliminate social exclusion in health. They include:

Policies and programs that enhance community participation: The MoH has proposed, through the CHEW's strategy (MoH, 2016) to provide what it considers the most feasible and acceptable link between the

health sector and the community. The CHEW is expected to perform a wide range of functions, which include: home visits; environmental sanitation; safe water usage; first aid and treatment of simple and common ailments; health and nutrition education; disease surveillance; maternal and child health activities; family planning; communicable disease control; community development activities; referrals; record-keeping; and collection of data on vital events. Services provided by CHEWs are expected to be more appropriate to the health needs of populations than those of clinic-based services, to be less expensive, and to foster self-reliance and local participation. It is expected that the CHEWs will also encourage the active participation of women and men in discussing the multiple issues that affect their health with the view of coming up with solutions.

Policies and programs that promote governance and accountability: “mTrac” is the government led national program that focuses on strengthening responsiveness by identifying supply-side bottlenecks, monitoring responses, and improving communication channels among health care providers and users. The MoH has also set up a health service delivery complaints hotline to provide a platform for health workers and community members to report on any issues they face within the health system. However, the time taken to act, the number of “unactionable reports,” and the perceived quality of the action/response continue to perpetuate community perceptions of the non-responsiveness of the health sector.

2.3.3 POTENTIAL SOCIAL OUTCOMES OF USAID’S PROPOSED INTERVENTIONS

This section presents the potential benefits and possible risks of the interventions, and proposes possible ways to maximize the benefits and minimize possible harm. In addition to the health sector interventions proposed by the CDCS to tackle HIV and malaria ([DO 1](#)) and reproductive and child health ([DO 2](#)), the Health Systems PAD proposes the interventions below.

Link village health teams with elected officials through an integrated community development plan: This will lead to increased participation of communities in health, improved responsiveness and accountability by elected officials, and better health outcomes for communities and households. However, there is a risk of non-responsiveness by elected officials to health issues raised by communities due to supply-side issues in the health system beyond the control of local elected representatives. There is also a risk of weakened voluntarism of VHTs. To address the former, there is need to match demand-side accountability with supply-side responsiveness of the health system by educating communities about what is realistically achievable while working with the health sector to address systemic inefficiencies and corruption. To tackle the risk of VHT voluntarism, USAID should consider adopting and working through the MoH’s proposed CHEWs approach that will gradually replace the VHTs with better qualified, trained, and remunerated community health workers.

Systematically target those at highest risk to prevent disease: This will result in social inclusion and improved access to health services by vulnerable groups, e.g. pregnant women, children, adolescents, populations at risk of HIV, etc. However, populations at risk of disease are often context-specific and a standardized national targeting approach could still risk excluding some categories of people. This can be mitigated by working with district health systems to ensure that people at highest risk within local settings access health services.

Adopt a multi-sectoral approach to harness the structural and social determinants of health: This may result in improved health status of individuals and households arising from improved education, rights, and incomes. There is also a likelihood of adoption of positive behavior that leads to positive health outcomes. However,

there is a risk of evaporation of interventions that, if not well coordinated and monitored, will lead to lack of significant changes in the social determinants of health.

Strengthen participation and community linkages to health unit management committees: This could lead to improved participation by communities and improved responsiveness of health workers to user/community needs. However, there is a risk of low representation of women and excluded groups in health unit management committees. The project therefore needs to ensure gender balance in composition of health unit management committees. There is also a risk of apathy by communities towards participation if their needs are not met. Participation could also be incentivized by ensuring that health units reasonably respond to the complaints raised by communities.

Increase the effectiveness, transparency, and accountability of supply chains by providing commodities, capacity-building, and systems support: Availability of essential commodities may result in improved universal access to health care. However, there is a risk that essential commodities for management of conditions suffered by socially excluded groups, e.g. people with mental illness, LGBTI people and PWDs, will continue to be in scarce supply and perpetuate social exclusion of these groups from health care. It is therefore important to promote equity in supply chain management.

2.3.4 PROMISING APPROACHES FOR ENHANCING GENDER AND INCLUSIVE DEVELOPMENT IN HEALTH SYSTEMS

Gender and equity budgeting: This is about a gender-based analysis and an equality-oriented approach to the distribution of public resources. Gender and equity-responsive budgeting provides a means to conduct policy dialogue with respective government institutions about existing gender and other inequalities and the opportunity to undertake transformative sector-based interventions to address them. The GoU in 2015 introduced sections into the Public Financial Management (PFM) Act that mandate all government ministries, departments, and agencies to present a Certificate of Gender and Equity compliance from the Equal Opportunities Commission before its plan, budget, policy statement, bill, or loans are approved by Parliament. Therefore, USAID and other development partners could add relevance to this process by commissioning or using data from the health sector gender and equity analysis. USAID could also support civil society advocacy to ensure that the health sector is accountable for addressing gender and equity concerns in the sector.

A human life-cycle approach to addressing vulnerability: A life-cycle approach to targeting health service provision is effective in identifying special vulnerabilities at various age brackets and tailoring services accordingly – including contingencies and provisions for social groups who may be left out because of disability status, ethnicity, etc. For example, infancy and childhood require interventions, such as immunization and nutrition counseling, to promote survival; adolescent age requires age-appropriate reproductive and sexual health interventions for boys and girls; reproductive age requires interventions to guarantee the choice and health of women; while old age requires special health care for the unique age-related diseases. The MoH in Uganda has already adopted this approach. However, more work is needed to empower communities to undertake health promotion and prevention approaches using the life cycle approach so as to reduce pressure on the health sector's resources for curative health.

Gender-specific targets: The targets are focused on outcomes rather than inputs and create an environment in which health systems are required to deliver specific results. Gender-sensitive indicators are used to provide solid evidence for changes in health outcomes for both men and women. This approach is

especially needed to ensure that men and boys are not excluded from critical health services because of their poor health-service-seeking behavior.

Participation and stakeholder involvement: There is some evidence that consumer involvement in the planning of health care and in the holding health workers and elected representatives accountable contributes to better health outcomes (Björkman & Svensson, 2009). Approaches to increase accountability, however, need to ensure that user-demands are appropriately met by supply-side interventions.

2.3.5 CONCLUSIONS

In addition to systemic challenges that limit access to health services, gender roles and social issues are also involved. For instance, gender ascribes women the responsibility for household health care. This role may sometimes be affected by their workloads and limited agency over decisions. In addition, the gender expectation of men to be strong leads to a poor-health-service-seeking behavior among men. In some unique cases, religious and traditional beliefs lead some groups of people to self-exclude from accessing certain health services. On the other hand, systemic challenges such as health workers' attitudes, barriers to physical access, and prohibitive costs of health care lead to further exclusion of certain groups. Despite these challenges, participation by excluded groups in health system governance is often affected by the perceived non-responsiveness of the health system. The following recommendations are emphasized. These are backed by actions and indicators in the action plan in [section 4](#).

- 1) Support behavioral change approaches to transform negative social norms about disease and health care-seeking behavior.
- 2) Train health workers to model positive attitudes and ethics in providing services to women, PWDs, LGBTI people, and others.
- 3) Support the health system to respond to issues arising from demand-side accountability. As proposed by the CDCS, this will be done by providing essential commodities and supporting functional health infrastructure.

2.4 MARKET SYSTEMS IN KEY VALUE CHAINS PROJECT

As highlighted in [section 2.3.1](#), the market systems project is one of the three systems (along with health systems and governance/citizen participation systems) that form DO 3 of the CDCS. Analysis of this PAD is complemented by the social analysis embedded within PAD 1 (resilience) and PAD 2. Linkages, such as gender relations in natural resource management, in PAD , I and social exclusion in youth employment in PAD 2, are examined.

A market system is a dynamic system - incorporating resources, roles, relationships, rules, and results - in which private and public actors collaborate, coordinate, and compete for the production, distribution, and consumption of goods and services. The behavior and performance of each actor is influenced by other actors' decisions and by the rules, incentives, and the physical environment (ACDI/VOCA, undated).

A well-functioning market system for key agricultural commodities is critical to reducing poverty and expanding economic growth. For focus crops, it includes a system for distributing agricultural production inputs as well as one for marketing agricultural commodities – both of which lead to higher productivity of farmers.

USAID/Uganda has chosen to focus on three priority value chains – coffee, maize, and beans – based upon their widespread production and strong market potential on the international (coffee) and regional (maize and beans) markets, and their potential to reduce poverty among millions of Ugandans. While these value chains represent the “focus” value chains, USAID/Uganda proposes to adopt a flexible approach, seeking to be more opportunistic in how it identifies opportunities. This means the Mission will look beyond coffee, maize, and beans to work in other crops, as needed. Interventions must work at all levels: supporting an enabling environment, technical capacity building, input systems, production and marketing, investment, availability of finance, and youth engagement (USAID, 2016).

2.4.1 GENDER AND SOCIAL EXCLUSION IN MARKET SYSTEMS

Inclusive market systems are those that engage and benefit a range of actors including the poor, women, youth, ethnic minorities, and/or other marginalized groups who are often excluded or even exploited by traditional market systems. In inclusive market systems, marginalized actors can acquire access to the opportunities, the skills and resources to participate in the market, and the capabilities to profit from it.

Markets matter for everyone – but especially for the poor. Markets provide a direct means through which the poor can improve their economic standing, as producers (farmers, investors, business owners), as employees (providers of labor), as traders, and/or as consumers (of goods and services). Markets operating in an inclusive way offer the poor meaningful ways – jobs, opportunities, goods, services – to increase their incomes. Conversely, where markets are working exclusively or inefficiently, poor people have fewer chances to benefit directly from growth, and the benefits of a vibrant economy rest with a select few (SDC, 2008).

Understanding how and why market systems serve women, men, youth, and other marginalized groups differently is therefore crucial for interventions aimed at using markets to reduce poverty and exclusion. Below are some issues to be considered in how gender and social exclusion interface with market systems.

Time spent by women on unpaid care and subsistence work limits their ability to meaningfully gain from markets: Unpaid care work takes up a lot of women’s time, affects their mobility, and affects their power to make market decisions. Women’s daily activities involve many tasks pertaining to domestic care work, subsistence, and unpaid productive work. In Uganda women spend three times as many hours (1 hour and 20 minutes) a day on unpaid productive work such as subsistence agriculture than men who spend only 40 minutes. Women spend over three hours a day on (unpaid) housework and child care compared to less than one hour spent by men (Action Aid, 2014). Socially ascribed roles require women to offer this service to their households and communities without monetary reward. This often precludes their participation in markets. Lowering the fertility rate will help address this constraint in the long term, but exploring community childcare (World Bank 2016), and time-saving technologies may provide some gains in the immediate term.

Limited mobility by women limits their potential to participate in markets: Related to the above, social norms are such that a woman’s responsibility is for home-based activities centered on looking after dependents and preparing meals. These responsibilities, in turn, limit a woman’s mobility and her ability to engage in certain economic activities or to find more stable employment. When women, especially rural women, try to break the norm and venture into distant markets, the repercussions include gender-based violence, family tensions, and sometimes family disintegration. These tensions were addressed by some men in a community discussion in Sironko.

“We are weary of programs that spoil our women. We hear the Government has now introduced a women’s economic fund, which may require women to have business activities in lucrative places as far as Busia border. This is not good because women will abandon their household responsibilities.”

Men in a focus group discussion in Sironko

Limited agency over factors of production constrains women’s efficient participation in markets: Women have low decision-making power over how to access or utilize land, labor, labor-saving technologies, and capital. In Sironko for instance, women complained that even when they have their own money to buy land, there is always social pressure to be accompanied by a man to negotiate the price and terms of payment. The autonomy of women to make decisions to empower them economically is therefore limited.

Value chains are affected by gender attributes: Crops with perceived and actual income-earning potential, e.g. coffee, are often classified as “men’s” crops, while the perceived food crops, e.g. maize, beans, and sorghum, are classified as “women’s” crops. This was evident in both Sironko and Kamwenge where women typically named only food crops when asked about the main crops they grow. However, food crops often cease to be “women’s crops” when they become marketable. In both districts, women complained that men sometimes harvest the crop before it matures and sell it for themselves. The women who grew the crops did not get the market proceeds despite having invested their time, money, and labor. Furthermore, due to the social norms and associated limited mobility and lack of market access, women have limited interaction with value-chain actors, e.g. input suppliers, wholesalers, and consumers. Women who do not participate in value chains are more likely to work with low-technology equipment, e.g. knives and hoes, and have little access to improved capital and property. Men, in contrast, dominate value addition processes through the ownership of higher-cost equipment, such as maize milling facilities, and through access to more profitable markets.

Household approaches of coping with low incomes limits the evolution of associated value chains: As highlighted above, the poor sometimes sell their maize and bean crops before they mature. Men who were interviewed noted that this helps them to contribute to household incomes. In Sironko, maize and beans are often sold to buyers from Kenya, at low prices, and without consideration for household food security. As a result, there is an annual season of food scarcity. Women call this the “black” season because their families must rely on the market to supply the little food (which hardly fills up a small black bag) they can afford to feed the family. During this season, most households only have enough for one meal of porridge a day. The lack of regulation on when to sell is therefore disastrous on two fronts. On the one hand, food security is jeopardized, and on the other, the food (maize and beans) value chains do not evolve in a manner that attracts associated enterprises, e.g. agricultural equipment enterprises, transportation, restaurants, etc., that could help poor people benefit from the crops.

Exclusion of groups with limited productive labor capacity: Labor is often the only tradeable resource for which most of the poor can be remunerated, albeit often in dismal amounts. According to the World Bank (2016), a 10% increase in the number of days of family labor provided by the household is associated with an increase in crop income by 2%. However, due to disability or domestic workloads, people with disabilities and women have limited or no labor to offer to produce goods and services needed by the market. As a result, they lack the resources to purchase technology and market services that could improve their labor capacity or provide them with time-saving opportunities. This physical limitation is

often perpetuated by social norms that overprotect people with disabilities. They are often denied basic education – the technical and life skills – needed to improve their situation and to participate in the market.

Weak social capital excludes people from progressive market opportunities: Marginalized groups often organize in some form of self-help and support groups, which in some instances evolve into VSLAs (as is the case with groups of women and PWDs), or remain as leisure groups (as is often the case with self-evolved youth groups). In addition, some external interventions, e.g. by GoU and other development practitioners have required poor people to organize in groups to benefit from programs such as the Government's Youth Livelihoods Fund, or the Women's Entrepreneurship Fund. While these groups offer social capital, and have helped the poor to build their savings and economic capital, limitations abound. Strong social capital should be outward and upward-looking to other networks that have the potential to link them to opportunities. However, groups of socially excluded people attract people with similar characteristics who have fewer relationships with upwardly mobile and well-networked people and their connections to better market information and opportunities. These groups, therefore, continue to operate within a limited scope of opportunity.

Recommendations

- 1) Set quotas for women, youth, and PWDs to benefit from market systems interventions.
- 2) Conduct context-specific gender and social exclusion analysis of selected value chains to avoid perpetuating social exclusion.
- 3) Promote innovations in time-saving technology that reduces women's unpaid care work load and frees up their time and mobility.
- 4) Support social protection for people with limited labor capacity.
- 5) Reduce gaps in access to productive assets by women, especially land.

2.4.2 GENDER AND INCLUSIVE DEVELOPMENT IN KEY MARKET SYSTEM POLICIES AND PROGRAMS

A gender policy analysis conducted by the Budget Monitoring Unit (BMU) (MoFPED, 2016) indicates that the agriculture sector is gender sensitive and aware. However, gender sensitivity does not translate to gender responsiveness by the key programs in the sector, as demonstrated below:

The Agricultural Credit Facility (ACF), a GoU loaning scheme set up to facilitate provision of subsidized credit to farmers, had by 2015 benefited only 9% female borrowers compared to 64% men (27% were joint ventures by both men and women). The ACF has no mechanisms to address the key constraints limiting women's access to credit including: lack of collateral, long distances to financial institutions, and low literacy.

The Labor Saving Technologies and Mechanization project is aimed at improving farm incomes through efficient farm operations. By 2015, 65% males, 5% females, and 30% institutions had accessed and used the equipment. The project lacks appropriate mechanisms to deal with gender inequalities facing female farmers, e.g. inability to pay the equipment leasing rates and fuel due to low incomes, to small acreage where mechanisation is not possible, and to limited access to information about the opportunity.

The Operation Wealth Creation program focuses on provision of strategic interventions (planting and stocking materials, tractors, value addition) and streamlining output markets. By 2015, over 80% of beneficiaries of the program across the country were male, compared with 20% female. The program lacks appropriate mechanisms for dealing with gender barriers, such as limited access to land and advisory

services by women, male dominance in decision making in the use of family land, long distances to collection centers, and inadequate access to information by women and other vulnerable groups.

The Uganda Coffee Development Authority (UCDA) promotes and oversees the development of the coffee industry in Uganda. This is done both by distributing robusta and arabica coffee seedlings to farmers and nursery operators and by training farmers in coffee production, processing and marketing. However, men dominate in setting up coffee nurseries as a source of income and in accessing training and inputs. The key constraints to female participation include: limited ownership of land to produce perennial crops like coffee; limited incentive to grow coffee commercially as most decisions about marketing, sales and use of proceeds are made by men; and limited access to information about the timing and venues of training sessions.

Recommendation

Partnerships between USAID and the agriculture sector should consider establishing affirmative action activities. Specific measures are also required to tackle the barriers that preclude women and marginalized groups from accessing program benefits and participating effectively in the selected value chains.

2.4.3 POTENTIAL SOCIAL OUTCOMES OF USAID'S PROPOSED INTERVENTIONS

This section examines the likely social benefits and social harm/risks of some of the interventions proposed by the CDCS for strengthening market systems and proposes possible ways to maximize the benefits and minimize possible harm.

Support coffee, maize, and beans value chains: This could result in improved household incomes. However, there is a risk of possible exclusion of women from incomes generated from markets because men control agricultural proceeds. There is also a risk of food insecurity from the sale of maize and beans. In addition, there is a likelihood of limited benefit to women from coffee, which is traditionally controlled by men. Affirmative action to ensure that women's enterprises constitute the value chains selected for USAID's support is therefore crucial. There is also need for continued work with GoU and markets to improve women's access to land in reasonable acreage. It is also necessary to work with farmers to ration their harvest reasonably between household food security and for the market.

Promote private sector-led extension services like the village agent model: This may increase access to inputs by farmers and lead to diffusion of good farming practices. However, there is a risk of excluding female farmers due to their limited agency on the utilization of improved technology and limited ability to pay for it. There is also a likelihood of exclusion of youth from employment opportunities as older farmers are preferred for their experience on the job. Specific quotas are therefore needed to ensure that a significant proportion of women is reached by the village agent model. It is also necessary to consider affirmative action to increase the number of youth employed as village agents.

Work with financial institutions to create incentives for the creation of flexible and innovative products that are mutually beneficial to farmers and the financial sector: This will result in improved household incomes. However, there is a risk that the products developed will not address challenges faced by female farmers, e.g. domestic workloads, limited access to information, limited access to land, etc. There is a need to support the financing of innovations that have the potential to be time/labor-saving for women and to address the multiple limitations faced by female farmers.

Improved access to market information by farmers: This will also increase household incomes, but may exclude women and other marginalized groups who may not have easy access to information technology, particularly where low incomes preclude their ownership of mobile phones. Limited network connectivity may also perpetuate exclusion of people in the remotest geographical locations. The project should therefore consider disseminating market information through a range of other media, e.g. community radio.

Partner with other donors and financial institutions through local guarantees to support small-scale infrastructure needs that are climate smart: This will improve connectivity between households and markets, leading to higher income margins for vulnerable households, particularly where costs of middlemen are reduced. However, financial institutions are driven by profit and less by social inclusion and this creates a risk of further exclusion of some groups of people, particularly women, PWDs, and others who may not have substantial collateral to trade with the financial institutions. It is therefore necessary to support VSLAs to build collective capital for organized groups of women, PWDs, and others, and provide guarantees to link them to formal financial markets.

2.4.4 PROMISING APPROACHES TO ENHANCE GENDER AND SOCIAL INCLUSION IN MARKET SYSTEMS

Making markets work for the poor (M4P): M4P's strategic rationale is based on the recognition that the poor exist within wider market systems. Therefore, the objective of interventions is to stimulate those market systems to work more effectively and sustainably for disadvantaged groups. M4P analyzes why markets don't work for the poor currently and identifies how they might work more effectively in the future. The approach identifies three main sets of functions in any market system:

- i) Core functions - The central set of exchanges between providers (the supply-side) and consumers (demand-side) of goods and services at the heart of any market. The private sector is the main provider;
- ii) Rules - These act to shape market outcomes and govern participation and behavior in markets. They include informal rules or norms, formal rules or laws, and other standards and codes of practice. Formal providers of rules are commonly governments or membership organizations. Informal rules are generally a product of local culture, value systems, and practices and invariably define the extent to which formal rules are accepted;
- iii) Supporting functions - A range of other functions help the market to develop and grow including, for example, consultation processes, research, information, and capacity development. The nature of these, and who provides them, varies from one context to another.

Intervention is needed by development actors to ensure that the core functions, rules, and supporting functions of markets include marginalized groups. However, the approach emphasizes that the role of intervention should be temporary and catalytic. Agencies should avoid performing market roles directly and facilitate market players so they can perform more effectively. Interventions, therefore, need to be sensitive to local market conditions (Swiss Agency for Development and Cooperation (SDC), & The UK Department for International Development (DFID), 2008).

Social protection: Some poor and vulnerable groups lack the basic means to participate as buyers or sellers in the market. As already reflected in the analysis, they lack income, labor capacity, and assets needed to participate effectively in market systems. Social protection, in the form of regular and predictable cash transfers, in-kind transfers, and public works programs, can, however, encourage the poor to invest in

businesses. Cash transfers can provide the poor with the knowledge that their families will maintain a basic level of food security. As a result, they are likely to feel better able to plan for and invest in the future. Even the very poorest recipient families are able to use transfers for investment. Social protection can also be a means for women, youth, and PWDs to access income and assets. Cash transfers can improve local economies and labor markets.

Building economic capital from social capital: The density of social networks and institutions, and the nature of interpersonal interactions that underlie them, significantly affect the efficiency and sustainability of development programs. Social capital represents an asset for development through several related elements, such as information sharing, mutually beneficial collective action, and decision-making. Social capital is economically beneficial because social interaction generates at least one of three externalities. It facilitates the transmission of knowledge about the behavior of others and this reduces the problem of opportunism. It facilitates the transmission of knowledge about technology and markets and this reduces market failures in information. Finally, it facilitates collective action (World Bank, 2001). In USAID's project context, this could translate into community self-help groups, e.g. of women, youth, and PWDs, diffusing valuable information about opportunities in selected value chains and working collectively to build their savings, assets, and linkages to financial markets.

2.4.5 CONCLUSIONS

In addition to other economic drivers of market systems, the effectiveness of the redistributive role of markets is affected by gender and social relations. For instance, gender attribution of unpaid care and subsistence work limits the ability of women to increase their incomes through markets. This is because their work is hardly paid for, and, even when it is, women have limited control over the proceeds. They also have limited access to factors of production, e.g. land, capital, and the ability to hire labor. Besides, markets often exclude poor people with limited labor capacity, e.g. PWDs and the elderly. The market systems PAD should therefore consider these actions, which are further elaborated in the action plan in [section 4](#):

- 1) Set quotas for women, youth, and PWDs to benefit from market systems interventions.
- 2) Conduct context-specific gender and social exclusion analysis of selected value chains to avoid perpetuating social exclusion.
- 3) Support innovations to develop time-saving technology that reduces women's unpaid care work load and to free up their time and mobility.
- 4) Support social protection for people with limited labor capacity.
- 5) Support interventions to reduce gaps in access to productive assets, notably land by women.

2.5 GOVERNANCE SYSTEMS PROJECT

Analysis of the governance situation by the CDCS (USAID, 2016) points out that government services in Uganda are not dysfunctional primarily because they lack the expertise to run an efficient bureaucracy. Rather, governance shortcomings are perceived to serve the interests of a few elites. Furthermore, most Ugandan citizens do not feel empowered to embrace their roles and responsibilities as members of a multi-party democracy. This inhibits the development of a genuinely effective and inclusive political system. The governance systems project addresses this situation by supporting the CDCS DO and high-level IRs below:

DO 3: Key systems more accountable and responsive to Uganda's development needs.

- IR 3.1: Leadership in development supported
- IR 3.2: Citizens actively participate in development
- IR 3.3: Key elements of systems strengthened
- IR 3.4: Enabling environment that supports functional systems improved.

The key focus of analysis is therefore to understand whether and how women, men, youth, PWDs, the LGBTI community, and other marginalized groups participate in governance. It also focuses on how to harness opportunities for the effective participation of these groups.

2.5.1 GENDER AND SOCIAL EXCLUSION IN GOVERNANCE SYSTEMS

Gender and social exclusion in leadership: Although the participation of women and PWDs in the political sphere is high, in part because of mandatory quotas, their capacity to influence policy and affect decisions has remained limited. In addition, when compared against global standards such as the GGGI, political participation of women in leadership in Uganda is low. Uganda ranks 37th on the political participation sub-index, having bridged 26% of its gender gap, which leaves a gender gap of 74% (WEF, 2016). Uganda has bridged 50% of its gap on the women in parliament indicator, with 33% women, compared to 67% men in the 2015 parliament (WEF, 2016). Regarding women in ministerial positions, the gender gap stands at 68%. Only 30% of women occupy ministerial jobs, compared to 70% of men (WEF, 2016). At the local level – from grassroots to national level – women’s, youth, and PWD’s councils have been established to enhance the confidence of women, youth, and PWDs and provide them with opportunities to rise to leadership positions (Republic of Uganda, 2015). The affirmative action provision in the Local Government Act (1997) also provides avenues for women and PWDs to be part of the political leadership of local governments.

Among others, the following factors preclude disadvantaged groups of people from effectively participating in leadership:

Domestic responsibilities limit the mobility of women: Women’s reproductive and domestic roles mostly constrain them at home to care for their families. The opportunity cost of taking up community leadership roles is therefore high and prohibitive. This is further influenced by the social norm that women’s roles require them to be in the home and not in political leadership.

Low literacy and confidence: Elective offices often have some minimum education requirements. The overall lower literacy of women and PWDs affects their eligibility as well as their confidence to vie for leadership positions. Men with low or no education are also excluded from participating.

Violence in elective processes precludes women from vying for elective office: Political processes in Uganda are often riddled with violence and arrests. For most women, the risk is too high, as it could result in bodily harm or arrest and separation from their children.

Low incomes and assets: Electoral campaigns also require a lot of funding and this is often through personal savings (if the political party provides limited or no funding for the candidate). The costs of mobilization, transportation, and publicity among others are often prohibitive to women, PWDs, youth, and men whose incomes and assets are inadequate.

Unintended negative consequences of affirmative action for PWDs: Due to the special constituencies created for PWDs, their access to other leadership positions (and services) is jeopardized. PWDs in Sironko for instance highlighted that when they try to vie for leadership in general positions, others in the community tell them to focus on their special constituencies, e.g. disability councils and special positions earmarked by districts and subcounties for disability councilors.

Limited mobility: Challenges in physical mobility make it particularly difficult for people with physical disabilities to engage in mobilization politics. Some of them lack basic assistive devices to get by, let alone invest in grand mobilization work.

For LGBTI people, homophobia among the general population makes it unsafe to vie for general leadership positions, except within their own secretive civil society spaces.

For many young people, engagement in politics through formal processes, e.g. government and political parties, is mainly used by the elite for patronage – rather than placing youth at the core of reform efforts in governance at national and district levels, as well as in political party affairs. Other barriers to the participation of youth include:

- *A social structure/culture that celebrates governance by elders and shuns the young:* The norm in many parts of Uganda is to respect the wisdom of elders, who are seen as fountains of experience and knowledge on how to govern community affairs. When youth vie for positions – other than those carved out for them through affirmative action and that have traditionally been occupied by older people – they are sometimes shunned as disrespectful.
- *Lack of leadership skills and experience:* There is limited capacity building to groom the youth for leadership. This is in part because it poses a risk to the entrenched leadership of councils and parties by older people.
- *Lack of finances to mobilize for support:* Youth unemployment is high and they lament the lack of capital to make a meaningful living ([box 2.3](#)), let alone grow their savings. The cost of mobilizing for support for leadership positions is therefore equally prohibitive for the youth.

Recommendations

- 1) Train and support women, youth, and PWDs to take up leadership positions at all levels.
- 2) Support advocacy against homophobia.

Gender and social exclusion in citizens' participation: Citizens' participation provides individuals an opportunity to influence public decisions as part of the democratic decision-making process. The Constitution and Local Government Act provides avenues for women, PWDs, and other marginalized groups to participate. However, in reality, systemic challenges as well as socio-cultural norms and practices preclude these groups from participating as elaborated below:

Participation fatigue: Local government officials contend that the requirement (by the Local Government Act) for communities to be consulted annually and to contribute to the subcounty and district level development plans is time-consuming and redundant. One official in Sironko noted that the five-year plans are comprehensive, and developed with adequate community consultation. He noted that there is limited change within the span of one year to necessitate annual community participation. Community members are also weary of participating since many believe that their issues will not be addressed. For elected representatives, the time and cost of convening constituents to participate is prohibitive.

Apathy about non-responsiveness of representatives: Related to the above, marginalized groups perceive that it is futile to participate because their concerns are not addressed. This concern was mostly raised by people with disabilities – in both Kamwenge and Sironko. They noted that their elected representatives only interact with them during the election season and hardly return to consult or provide feedback.

Monetary and opportunity cost of participating: It is common for communities to demand a sitting allowance for participating in local public policy decision-making processes. Coupled with the perceived lack of (monetary) reward from participating in public policy making, youth, women, and PWDs in both districts noted that they would rather spend the time on farm or other household duties. For women, in particular, domestic roles limit their time and mobility - generally precluding them from participating. They therefore prioritize family social structures over political/community social structures.

Patronage and social exclusion: Participation of excluded groups is used to make those in leadership seem altruistic, but with limited benefit to the excluded groups. At the basic local-level, redistributive politics, e.g. determining who benefits from government programs, is driven by kinship connections, political networks, and religious affiliation among others. Men in Sironko, for instance, highlighted that distribution of food rations during the long drought of 2016 was based on kinship and ethnic connections.

Powerlessness of marginalized groups: The defining experiences of excluded people involve highly limited choices, an inability to make themselves heard, and an inability to influence or control what happens to them. The situation is more precarious for LGBTI people whose powerlessness is partly created by the legal regime. Powerlessness results from multiple interlocking disadvantages, including limited resources – which force excluded people to think only of short term survival – and low confidence.

BOX 2.4: PARTICIPATION BY REFUGEES

Refugees complained that they are hardly consulted on matters affecting them. However, recent frameworks such as the Grand Bargain (Relief web edits, 2016) and the Global (and Uganda) Comprehensive Refugee Response Framework (CRRF, 2017) present new opportunities to promote participation by refugees. The Grand Bargain proposes that humanitarian actors should provide accessible information, ensure that an effective process for participation and feedback is in place, and that design and management decisions are responsive to the views of affected communities and people.

Although the focus of USAID's CDCS is on citizen participation, USAID can promote the above approaches in its humanitarian support. Another option would be to deliberately co-locate some governance programs in refugee-settlement districts, so as to leverage best practices from citizen's participation to benefit refugees.

Recommendations

- 1) Promote issue-based participation, using flexible avenues of participation, e.g. through existing networks of excluded groups.
- 2) Provide civic education and empower women, youth, PWDs, and LGBTI people to demand for and take up opportunities for meaningful participation.

Interplay between weak systems and social exclusion: Weak systems generally preclude people from accessing quality health, education, social protection, justice, extension, and other services and economic opportunities. An analysis of government policies indicates that most have attempted to include

responses to gender and social issues. However, inefficiencies in implementation often result in situations, e.g. absentee workers, drug stock outs, shortage of teaching and learning materials, delayed justice, etc., that exclude people from accessing services.

The key questions are therefore broader than the realm of social exclusion. As posed by the World Development Report (2017), the key concerns are:

- Why do best-practice policies to achieve security, growth, and equity so often fail to produce the desired outcomes?
- Why are so many potentially transformative policies not adopted? And what makes some unlikely policies succeed?

The answers to these questions have to do with how policies affect the interests of the actors who have the power to block them, how actors who would benefit from policies are able to influence the decision-making process, and how rules and norms sustain the existing political equilibrium. This necessitates both an understanding of the political economy of systems and policy implementation, and of its intersections with social exclusion.

From a social exclusion perspective, disadvantaged groups and the poor often lack the power to influence decisions or to compel systems to function for their benefit. Corruption undermines implementation of progressive policies by perpetuating a shortage of operational funding and through high absenteeism by front-line service providers. For instance, although broadly categorized as a socially inclusive program, Universal Primary Education (UPE) delivery systems manifest social exclusion in many ways. For example, for teachers to be able to make a difference, an education system needs to recruit high-quality teachers, provide them resources to be effective, and support them in ways that help every child learn.

Social norms that impact the enabling environment for social inclusion: An enabling environment relates to legal, regulatory, and policy frameworks, as well as to political, socio-cultural, and economic factors that impact on the capacity of development actors to engage in development processes in a sustained and effective manner. Socio-cultural norms that affect an enabling environment for systems to function in a socially-inclusive manner include:

Social acceptance of corruption: Uganda ranked 151 out of 176 countries on the 2016 Corruption Perception Index by Transparency International (Transparency International, 2016). There is general resignation by communities as to the endemic nature of corruption. Public workers perpetuate social exclusion by often demanding bribes before offering a service, by diverting public resources for public gain, and by using their office for patronage. Men in Sironko, for instance, noted that sometimes they are required to pay illicit bribes to be enrolled in government programs.

Powerlessness to demand personal rights: While rights determine access to resources and authority, to claim these rights people need access to resources, power, and knowledge. Unequal social relations result in some individuals and groups being more able to claim rights than others. For example, the LGBTI community highlighted its inability to exercise their rights and citizenship due to legalized homophobia. Refugees, for their part, are also prevented from claiming their economic rights and citizenship privileges. Women continue to suffer GBV and are unable to obtain justice.

Subservience: Disadvantaged groups, and communities in Uganda in general, are cultured into respecting, and not questioning, authority. This sometimes leads to undue reticence to demand official accountability. This perpetuates the powerlessness that is common among excluded groups.

Social attribution to men, of the obligation to participate: Communities generally perceive that it is the obligation of men to participate in the affairs concerning the governance of their communities. On the other hand, participation by women, youth, and PWDs is mostly perceived as good but not an obligation. The social distribution of community governance roles therefore often serves to limit the interest of these excluded groups in participating. This is evident in the silence of women in community meetings where men are present – because the norm is that men speak for the family and for the community.

Positive norms and institutions that support justice, accountability, and social inclusion

Opinion leaders speak up against corruption: Opinion leaders emerge based on the collective respect they earn from communities. Sometimes influential elders emerge based on their knowledge derived from age and experience, religious responsibilities, clan hierarchy, and/or education. In some communities, these leaders use their position to speak against social injustices such as corruption and social exclusion. Sometimes, they provide alternative conflict resolution mechanisms, e.g. through “clan courts.” However, sometimes important judgements may be driven by biased patriarchal gender stereotypes.

Self-help initiative to solve community problems: Communities sometimes organize labor and mobilize themselves to address collective needs, e.g. maintaining roads, promoting sanitation, or policy advocacy. This is often a purely self-initiated, community-driven collective-action approach with minimum to no external support.

Excluded groups cooperate with civil society to amplify their voice: A number of civil society initiatives exist to work with women, youth, PWDs, LGBTI people, and communities in general to promote their participation. These initiatives have enabled excluded groups to highlight their issues – where they normally wouldn’t through formal political processes. In turn, civil society organizations have acted as the mouthpiece for these groups to demand for responsiveness by state actors. For instance, LGBTI people mentioned that through their civil society groups, they have continued to advocate against homophobia. PWDs have also had their issues presented by Disabled People’s Organisations (DPOs). In some instances, civil society organizations have also stepped in to meet the service needs of excluded groups, e.g. by among others, improving physical mobility of PWDs through assistive devices, addressing barriers to participation of marginalized groups through training, and representing marginalized groups in court to access justice.

2.5.2 KEY POLICIES AND PROGRAMS FOR GENDER AND INCLUSIVE DEVELOPMENT IN GOVERNANCE

Affirmative action in political representation: Uganda’s constitution (Republic of Uganda, 1995) provides for affirmative action for disadvantaged groups (women and PWDs) to participate in national and local government elective politics. Article 33(5), provides a quota system requiring that a third of parliament shall be constituted by women. Although the quota provides affirmative action for representation of women, sticking to just “a third” perpetuates the gender gap. Gender parity is a more ambitious goal and will require measures to achieve a 50-50 representation of women and men in parliament and other political spaces.

Integrating gender and equity in public financial management: Uganda's Public Finance Management (PFM) Act (2015) now requires every Ministry, Department, and Agency (MDA) to present a certificate of gender and equity compliance to parliament before its budget is approved. The Act proposes that, "the Minister of Finance shall present, with the Budget-Framework-Paper, a certificate issued in consultation with the Ministry of Gender, Labor and Social Development certifying that: a) the Budget-Framework-Paper is gender and equity responsive; and b) specifying measures to equalise opportunities for men, women, persons with disabilities, and other marginalized groups." (Republic of Uganda, 2015b, Section 9(6)). Sector budgets are now required by law to integrate gender-equality financing as well.

2.5.3 POTENTIAL SOCIAL OUTCOMES OF USAID'S PROPOSED GOVERNANCE INTERVENTIONS

This section examines the likely social benefits and social harm/risks of some of the interventions proposed by the CDCS for strengthening governance systems and proposes how to maximize the benefits and minimize possible harm.

Identify and support local solutions to leadership: This will result in evolution of local leadership platforms that are potentially more inclusive. However, there is a risk of friction with existing leadership frameworks prescribed in local governance laws. There is also a risk of elite capture of leadership platforms, perpetuating social exclusion. There is need to undertake a political economy analysis to identify influential allies to support the approach.

Cultivate leadership practices by supporting training, peer-to-peer, and other mentorship to strengthen individual, institutional, and community leadership in the six targeted systems: This will lead to effective leadership for social inclusion in the six systems (education, health, social protection, markets, natural resource management and governance). Synergy across systems may enhance social inclusion. However, weak coordination across systems may reinforce multiple exclusion.

Inclusive participation in decision making processes: This will potentially improve voice and agency. However, there is a risk of non-responsiveness of duty bearers. The CDCS nonetheless plans to support supply-side accountability.

Increase access to and utilization of information: This may result in improved agency and access to services. However, there is a risk of possible exclusion of women and other groups from access to information, due to social barriers that limit mobility and social networks. The activity should therefore consider information dissemination approaches that reach women, youth, and PWDs through their social networks and within their local settings.

Support sector- specific civic education: This could enhance empowerment for issue-based voice and accountability. However, information overload could lead to inaction. This necessitates prioritization and follow up of issues to their most possible conclusion.

Support availability and adequate management of quality commodities: Although this may lead to improved access to services, social exclusion may arise from corruption and mismanagement of commodities. The project could therefore consider integrating rewards and incentives against corruption.

Enhance Domestic Resource Mobilization: This will ultimately result in improved access to services and supply-side accountability. However, tax regimes could further impoverish the poor and perpetuate

inequality. There is need to integrate gender and social analysis in resource mobilization mechanisms to avoid perpetuating inequality and social exclusion.

Support availability and functionality of infrastructure. There is need to integrate physical access standards in infrastructure designs and eliminate barriers created by front-line workers.

Support availability and effective utilization of high-quality data: There is potential for improved planning and access to services. However, there is need to integrate social exclusion data collection and analysis in this intervention.

Advance positive social and cultural norms and practices: Positive norms on justice and accountability will be promoted. However, political barriers could limit the diffusion of positive norms. It is therefore necessary to identify political allies to promote the intervention.

2.5.4 PROMISING APPROACHES FOR ENHANCING GENDER AND INCLUSIVE DEVELOPMENT IN GOVERNANCE SYSTEMS

Community Driven Development (CDD): CDD gives control of decisions and resources to community groups. CDD treats poor people as valuable contributors and partners in the development process, building on their institutions and resources. Support to CDD usually includes strengthening and financing inclusive community groups, facilitating community access to information, and promoting an enabling environment through policy and institutional reform. By directly relying on poor people's interest in driving development activities, CDD has the potential to make poverty reduction efforts more responsive to their demands, more inclusive, more sustainable, and more cost-effective than traditional centrally led programs.

The main argument in favor of CDD is that communities are deemed to have a better knowledge of the prevailing local conditions, such as who is poor and deserves to be helped, and a better ability to enforce rules, monitor behavior, and verify interventions. CDD gives control of decisions and resources to community groups. These groups often work in partnership with demand-responsive support organizations and service providers, including elected local governments, the private sector, NGOs, and central government agencies.

CDD is relevant across many sectors, but its potential is greatest for goods and services that are not complex, are produced by small-scale processes, and require local cooperation, such as common-pool goods (for example, management of common pasture and surface water irrigation systems), public goods (for example, local road maintenance), and civil goods (for example, public advocacy and social monitoring). Public goods that span many communities or that require large, complex systems are often better provided by local or central government. Similarly, private goods or toll goods are often better provided using a market-based approach that relies more on individual enterprises than on collective action. CDD can, however, fill gaps where markets are missing or imperfect, or where public institutions or local governments fail to fulfill their mandates (World Bank, undated).

Democratic Governance: Although democracy is about majority rule, its inherent tenets, such as the rule of law, equality, participation, accountability, etc., are aimed at promoting social inclusion. Inclusive democracy involves more than the formal equality of all individuals and groups to enter the political process, but entails taking specific measures to address the social and economic inequalities of unjust social

structures. Such measures may require forms of group representation, e.g. of women, youth, PWDs, etc., in order that the social perspective of group members gains voice.

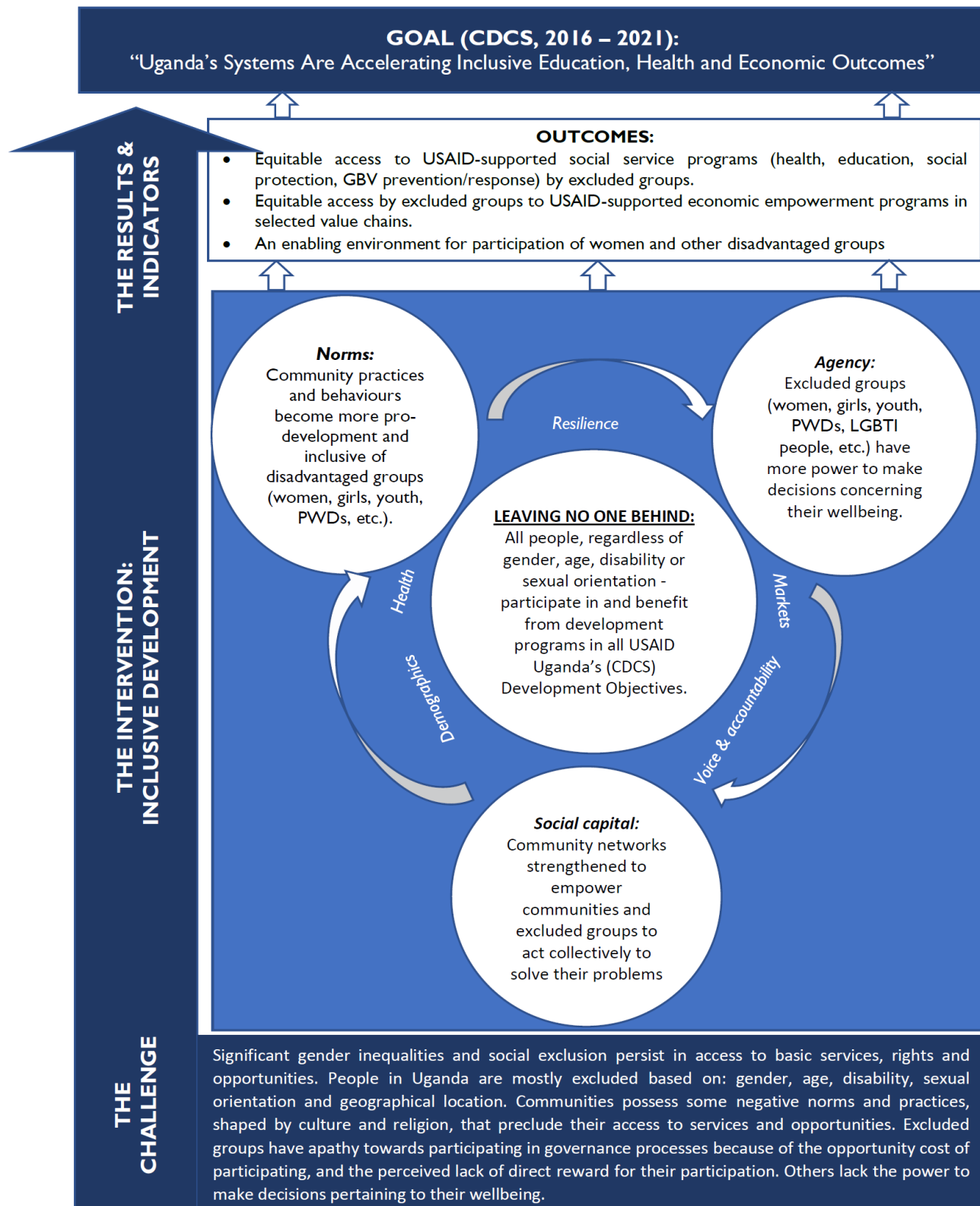
Decentralization: If well implemented, decentralization has the potential to improve local participation, e.g. through participatory planning and budgeting, and to improve inclusion of context-specific socially excluded groups. Decentralization can also promote the accountability of local officials by empowering local-level authorities. Decision making at the local level gives more responsibility, ownership, and thus incentives to local agents. By making local officials more accountable and placing responsibility for decision-making and implementation in the hands of local stakeholders, the quality and efficiency of public services is shown to improve. However, the challenge is in sustaining funding and political interest in decentralization.

2.5.5 CONCLUSIONS

Poverty, gender inequality, and social exclusion limit the ability of certain groups of people to take up leadership positions. For instance, poor men, women, and PWDs are less likely to take up general leadership positions. Social preference for elderly, experienced people precludes youth from taking up leadership positions. Besides, factors like homophobia force LGBTI people to remain invisible, outside of leadership. Citizen participation is also undermined by social factors such as patronage by leaders, non-responsiveness of duty bearers/officials, and the high opportunity cost of participation - particularly to women. The endemic levels of corruption and its normalization have also affected the functioning and responsiveness of systems that could transform the situation of excluded groups. The following recommendations are therefore emphasized and backed up by actions and indicators in the action plan in [section 4](#).

- 1) Provide leadership training to women, youth, and PWDs with potential to take up leadership positions beyond their social networks.
- 2) Promote issue-based participation, using flexible avenues of participation, e.g. through existing networks of excluded groups.
- 3) Support advocacy against homophobia that results in the exclusion of LGBTI people.

3. THEORY OF CHANGE FOR GENDER AND INCLUSIVE DEVELOPMENT



The ToC proposes that, in addition to a systems-strengthening approach, USAID’s goal of “making systems accelerate inclusive education, health, and economic outcomes” can be achieved by transforming negative social norms that perpetuate social exclusion. This will entail working effectively with communities and excluded groups themselves to ensure that they maximize benefits from USAID’s programs, as well as GoU programs. To achieve this, three interlinked strands of interventions need to be embedded in USAID’s programs across the five PADs:

- 1) *Changing social norms*: To address communities’ own attitudes, beliefs, and practices that perpetuate social exclusion and limit uptake of available services, positive social norms will need to be scaled up, while steps need to be taken to reduce the effects of the negative norms. Positive norms, e.g. where communities take personal initiative to solve collective problems, where cultural approaches promote social justice, and where communal assets are used for the benefit of all, will need to be identified and scaled up. Norms that perpetuate patriarchal exclusion of women and deny them access to opportunities and economic resources; and norms that perpetuate homophobia, and exclusion of PWDs - will need to be identified and addressed by USAID’s projects. Approaches to transform social norms will need to be consistent over time, and not solely the result of sporadic BCC messaging.
- 2) *Building agency*: To empower excluded groups themselves to have the ability to influence change, e.g. by tackling barriers to women’s capacity to make choices on their reproductive health and economic wellbeing. This will in part be linked to changing underlying social norms while, at the same time, working through legal provisions to ensure that women and marginalized groups access justice; and to promoting an environment that prohibits social exclusion. This will require empowering excluded groups to not only know their rights, but to be able to effectively demand and defend them without fear of further harm.
- 3) *Making social capital work for the excluded*: Building agency and transforming social norms needs to build on and work through formal and informal groups of disadvantaged groups. Interventions will, however, need to improve the quality of this social capital by linking these groups to other progressive groups and to supportive processes that can improve their connection to information, services, and opportunities beyond their current reach. This may for instance require provision of guarantees to link these groups to markets or special targeting to access USAID’s programs.

The ToC makes the following assumptions:

- Socially excluded groups have the will to change their situation. This assumption is drawn from the self-initiative they have already taken, e.g. through the forming of support groups to pool their resources and amplify their voice. The ToC, therefore, assumes that reasonable external support from USAID’s programs will not destroy their self-determination, but propel them to access services and opportunities currently out of their reach.
- Despite some uniform patterns, social exclusion is context-specific. The ToC assumes that USAID’s implementing partners will understand the importance of undertaking context-specific social exclusion analysis and adapt their programs to the local drivers of social exclusion.
- Communities are more concerned about promoting social justice than maintaining regressive norms. Despite long-term norms, e.g. negative and repressive patriarchy, the ToC assumes that communities will choose progressive norms.
- The ToC assumes a positive commitment from policy makers towards actively responding to social issues and towards removing barriers to progressive policy uptake by excluded groups.

Indicators and activities to achieve the desired outcomes are elaborated in the [action plan](#).

4. FORWARD LOOK: A GENDER AND INCLUSIVE DEVELOPMENT ACTION PLAN

This gender and social inclusion action plan lays out the approach and process for integrating gender and social inclusion in USAID/Uganda's programs during the CDCS implementation period 2016 – 2021. The action plan adapts guidance from the ADS 205 (USAID, 2017), USAID's Gender Equality and Female Empowerment Policy (USAID, 2012), Disability Policy, Youth Policy, and the LGBTI Vision for Action.

I.1 PROGRAM DELIVERY APPROACH

The action plan contributes to the goals of the USAID Gender and Female Empowerment policy by proposing activities that will contribute to the achievement of the following objectives of the policy:

- 1) Reducing gender disparities and social exclusion in public access to, control over, and benefits from societal resources;
- 2) Reducing SGBV and mitigating its harmful effects on individuals and communities; and
- 3) Increasing the capability of women and girls and other socially excluded groups to assure their rights, determine their life outcomes, and influence decision making.

Achieving these goals requires a mainstreaming approach, a special focus on marginalized populations, and a mix of strategic programs as described below. In addition, specific actions are required for program design, solicitation, implementation, and monitoring and evaluation.

Whether to focus on gender equality or on girls and women: While interventions need to focus on women and girls, programs will also need to critically consider and reform gender norms that negatively affect men's development outcomes across the PADs. When compared to boys and men, it is globally recognized that gender discrimination and inequitable gender norms are more likely to limit girls' and women's ability to access services, rights, and opportunities. However, despite the privileged position that gender norms assign males, some norms create vulnerabilities and negative outcomes for boys and men.

Which socially excluded groups to prioritize: The nature of social exclusion varies from one program to another. Therefore, each project/activity will need to determine the categories of people that are most excluded from accessing the specific benefits and put in place measures to ensure social inclusion.

A twin-track approach to social inclusion: This assessment proposes a twin-track approach to addressing gender and social exclusion in USAID Uganda's programs. This involves social-inclusion-mainstreaming in some instances, and special programs for excluded groups in others.

An *inclusion-mainstreaming* approach has a range of benefits. It allows disadvantaged groups, e.g. PWDs, to participate in activities in an environment where disadvantaged groups are co-mingled with mainstream groups. It also provides implementers with experience working with social-inclusion programming and builds their capacity to promote the sustainable inclusion of disadvantaged groups. This approach protects disadvantaged groups from the threat of further exclusion from mainstream benefits which often happens when entire categories of people are separated into special programs.

The approach requires project teams and implementing partners to deliberately identify context and program-specific gender and social exclusion factors that would prevent groups of people from accessing

services. Specific measures should then be identified and adopted to address these issues - to maximize program benefits for disadvantaged groups.

For project teams to be effective in integrating a gender and social inclusion approach into USAID projects, however, the following conditions need to be satisfied:

- *Support from top leadership (Mission Director, Deputy Mission Director, and Office Directors):* This is essential if social inclusion outlined in the CDCS and PADs is to translate into actual program implementation by USAID partners. Furthermore, senior management needs to hold implementing teams accountable for program outcomes.
- *Technical capacity:* It is necessary to equip project teams and implementing partners with the skills and resources to integrate gender and social inclusion into program delivery. Technical capacity development may require customized training and tools for both project teams and implementing partners.
- *Indicators and targets:* Project teams need to establish specific targets to measure the benefits gained from USAID's mainstreaming projects.
- *Budgeting and designing for equality:* Project teams need to allocate staff time and monetary resources to ensuring that gender and inclusive development dynamics are analyzed and incorporated into activity designs, budget planning, portfolio reviews, etc.

An *inclusion-specific approach and special programs for excluded groups* on the other hand recognizes that, despite efforts to maximize benefits for socially excluded groups, some unique challenges they face will require unique interventions. For instance, the challenges faced by the LGBTI community are often invisible to an inclusion-mainstreaming approach. Similarly, in the case of GBV, a stand-alone intervention would have more potential to ensure effective prevention and response than mainstreamed interventions. In the same vein, USAID's Gender and Female Empowerment Policy commits USAID to "strategic investments" that promote inclusion-specific gender equality and female empowerment.

Although GBV prevention and response services, e.g. psychosocial counselling, legal services, economic empowerment, and health services, could be integrated across the five projects, there is a risk that the responses will not be comprehensive. The need for GBV response services, including changing the social norms that perpetuate GBV across the country, is still high, but with limited support from other development partners. USAID could therefore explore setting up a GBV response program or leverage the work of other development partner-supported programs. This will however need to be informed by an appraisal of the evidence to determine the most appropriate model for what works to prevent/respond to GBV. The scope should include USAID's past programs such as GREAT, REAL Fathers, LARA, and other models.

Similarly, PWDs, OVCs, youth, and populations most at risk of contracting HIV face unique challenges that could best be addressed through special programs. Inclusion-specific programs could also be used as a launch pad for effective referrals into mainstream programs. Nonetheless, it is important that inclusion-specific programs not be used to prevent disadvantaged groups from accessing other mainstream services.

Inclusion-specific programs could therefore include: GBV prevention and response; special programming for LGBTI people (for access to health and rights); special programming (especially economic empowerment) for PWDs; health-sector targeting through maternal and child health programs; social protection for OVCs; HIV programming for populations at risk of HIV; and youth empowerment. In addition to the conditions cited for a mainstreaming approach above, inclusion-specific programs require:

- *Resources*: Promoting equality sometimes requires providing disproportionate resources to the group facing exclusion, particularly when attempts to include them in mainstream projects place them in situations of unequal competition for minimal resources. Special solicitations for funds may therefore be required for GBV, LGBTI people, PWD, and youth empowerment programs.
- *Commitment to leaving no one behind*: It is important to recognise that the numbers of beneficiaries of inclusion-specific programs may not be high and commensurate to the resource investment. In some cases, there are no data accurate enough to estimate the number of people in a particular socially excluded group, e.g. the LGBTI community, and the overall impact of the investment on reducing the magnitude of the problem. In other cases, the numbers of beneficiaries may be relatively lower than those of mainstream development programs. Nonetheless, it is essential to maintain a willingness to meet the cost of special targeting and social inclusion, even when the numbers of beneficiaries may be small/un appealing.

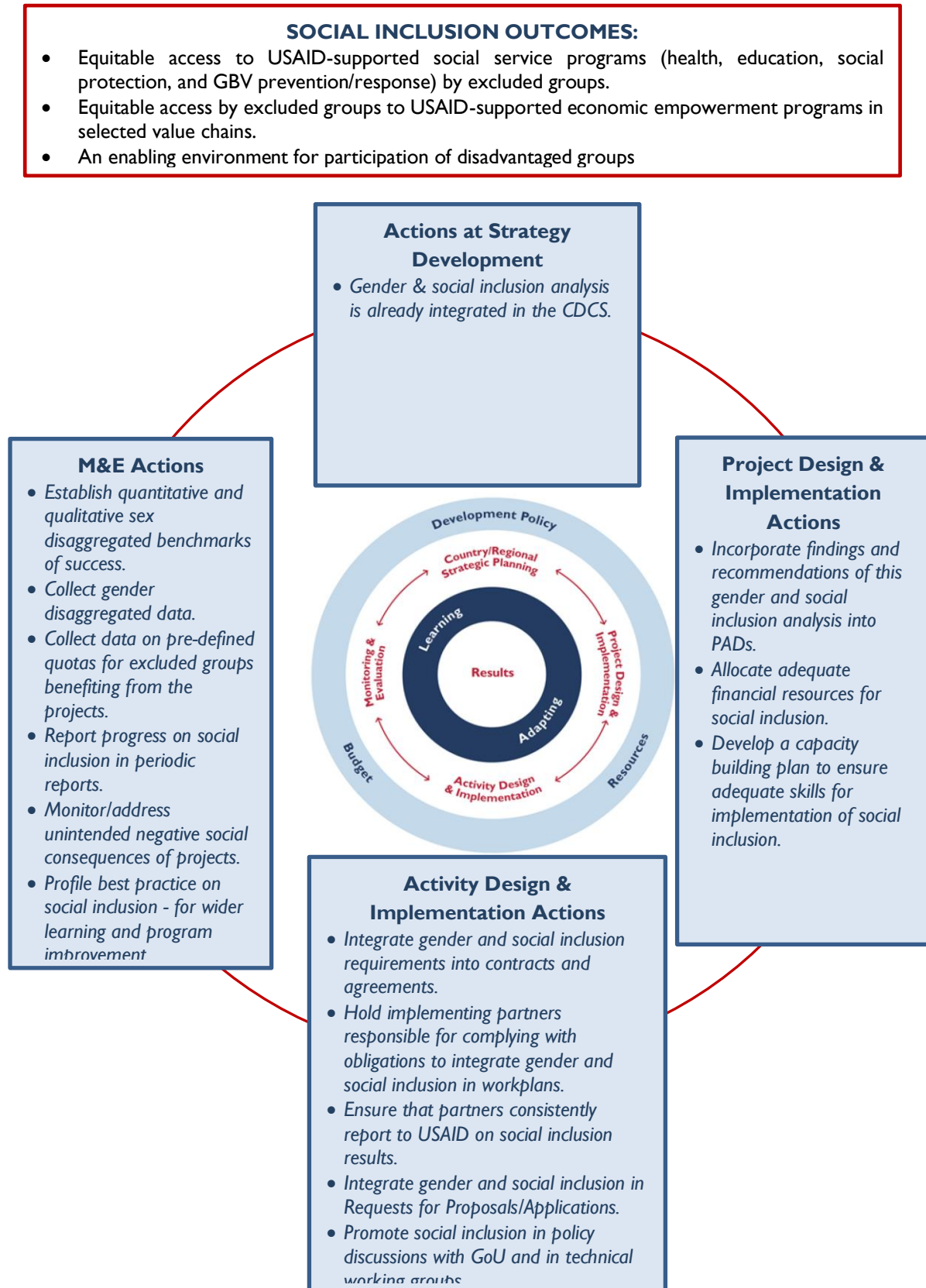
The assessment therefore proposes the following actions for inclusion-specific interventions:

- 1) Expand the technical scope of the LARA program on school-based SGBV to include GBV prevention and response interventions in the communities. Focusing on school-based SGBV without addressing the structural drivers of SGBV in the communities where the school girls live may be effective in protecting the girls while they are in school, but expose them to more risks of SGBV in their communities.
- 2) Continue supporting a specific program for the LGBTI community – focusing on promoting equitable access to health services (especially HIV prevention, care, and treatment) and rights (protection from homophobia). In addition, mindful of the context of Uganda’s current legislation, develop more accurate estimates of the size of the LGBTI population to inform program planning and intervention activities.
- 3) While promoting a mainstreaming approach, continue providing special funding to DPOs to provide specific services to PWDs including: HIV prevention; building household and community assets; providing devices to enable physical access to services; and promoting participation in markets and in governance. This should be accompanied by effective monitoring to ensure that benefits trickle down to PWDs in the most remote areas of the country.
- 4) Continue working through the health system to support programs targeted at promoting maternal and child health.
- 5) Continue to support social protection for OVCs and to address social exclusion of vulnerable children.
- 6) Through PEPFAR, continue supporting HIV prevention and care services to specifically target key populations.
- 7) While ensuring that youth benefit from other mainstream programs in the projects, consider special programming, particularly aimed at the economic empowerment of youth.

4.2 ACTION PLAN FOR GENDER AND INCLUSIVE DEVELOPMENT

This section is presented in two parts. The first part is a process plan (Figure 4.2) providing procedural guidance on how to operationalize the recommendations proposed under the respective PADs. The second part proposes an implementation plan with outcomes, indicators and activities.

FIGURE 4.2 PROPOSED GENDER AND INCLUSIVE DEVELOPMENT ACTIONS IN USAID'S PROGRAM CYCLE



4.3 IMPLEMENTATION PLAN FOR GENDER AND INCLUSIVE DEVELOPMENT

GOAL: UGANDA'S SYSTEMS ARE ACCELERATING INCLUSIVE EDUCATION, HEALTH AND ECONOMIC OUTCOMES.			
OUTCOMES	INDICATORS	ACTIVITIES	RESPONSIBLE PROJECT TEAM
Outcome 1: Equitable access to USAID-supported social service programs (health, education, social protection, GBV prevention/response) by excluded groups.	1.1. Number of women of reproductive age (and by disability type) using family planning services.	<ul style="list-style-type: none"> Support BCC campaigns to change negative norms affecting uptake. Provide accessible services. 	<ul style="list-style-type: none"> Demographics. Health Systems.
	1.2. Proportion of the male population in project areas reporting a positive attitude toward family planning and smaller family sizes.	<ul style="list-style-type: none"> Support behavior change interventions to transform men's attitudes on family planning and family size. 	<ul style="list-style-type: none"> Demographics.
	1.3. Number of women, men, PWDs & LGBTI people accessing HIV prevention and care services.	<ul style="list-style-type: none"> Set special quotas for men, PWDs and LGBTI people to be reached by HIV services. 	<ul style="list-style-type: none"> Resilience. Health Systems.
	1.4. Proportion of the population in project areas, adopting positive child nutrition and wellbeing practices	<ul style="list-style-type: none"> Support community-based education on nutrition and child care. 	<ul style="list-style-type: none"> Demographics.
	1.5. Prevalence of SGBV in schools.	<ul style="list-style-type: none"> Support school and community-based interventions to prevent SGBV in schools. 	<ul style="list-style-type: none"> Demographics.
	1.6. Number of OVCs reached with social protection services.	<ul style="list-style-type: none"> Support external and community-based social protection for OVCs. 	<ul style="list-style-type: none"> Resilience. Demographics (child wellbeing IR).
Outcome 2: Equitable access by excluded groups (particularly women and youth) to USAID-supported economic empowerment programs in selected value chains.	2.1. Proportion of women to men and proportion of disadvantaged groups benefiting from USAID's key value chains.	<ul style="list-style-type: none"> Undertake gender analysis of key value chains. Set quotas for women, and other disadvantaged groups to benefit. 	<ul style="list-style-type: none"> Market Systems. Resilience.
	2.2. Number of youth (disaggregated by gender) supported by USAID's economic empowerment programs.	<ul style="list-style-type: none"> Set quotas for youth to benefit from USAID-economic programs. 	<ul style="list-style-type: none"> Market Systems. Resilience. Demographics.
	2.3. Number of PWDs accessing USAID's economic empowerment programs	<ul style="list-style-type: none"> Set quotas for PWDs to benefit from the economic programs. 	<ul style="list-style-type: none"> Market Systems. Resilience.
Outcome 3: An enabling environment for participation of women and other disadvantaged groups.	3.1. Number of local women, youth and PWDs participating in a substantive leadership role or position in a governance process supported with USAID.	<ul style="list-style-type: none"> Support beneficiary participation. Train women, youth, and PWDs on leadership. 	<ul style="list-style-type: none"> Democracy, Rights & Governance.
	3.2. Number of women, PWDs, and youth participating in health-system demand-side accountability processes.	<ul style="list-style-type: none"> Train women, youth, and PWDs on demand accountability. Support accountability CSOs. 	<ul style="list-style-type: none"> Democracy, Rights & Governance. Health Systems.
	3.3. Number of people reached by a USG-funded intervention providing GBV services, e.g. health, legal, psycho-social counselling, shelters, and hotlines	<ul style="list-style-type: none"> Scale up USAID's GBV program (beyond schools). 	<ul style="list-style-type: none"> Democracy, Rights & Governance. Resilience.
	3.4. Prevalence of homophobia and hate crime. <i>Tolerance for homosexuals in Uganda is 33.42% (Social Progress Index, 2017).</i>	<ul style="list-style-type: none"> Support LGBTI advocacy initiatives. Commission research on prevalence of homophobia. 	<ul style="list-style-type: none"> Democracy, Rights & Governance.

5. CONCLUSIONS AND KEY RECOMMENDATIONS

As revealed by the analysis, gender and social exclusion increase the vulnerability of certain groups to climatic and socio-economic risks. It affects the ability of the households of disadvantaged groups and individuals, e.g. women, PWDs, youth, and some, to cope with disasters. The limited ownership of assets by women, and other excluded groups, and their limited incomes also affects their resilience. Gender barriers, e.g. limited agency of women, social expectations on men to have many children, early sexual debut and teenage pregnancy, etc., affect the quality of life for these groups. Even where basic services are available, some negative community norms affect uptake of the services. For instance, the prevalent social preference for large family sizes undermines the effectiveness of family planning services for managing population growth. The gender attribution of low-income-earning value chains to women and the more lucrative ones to men, and the limited control by women over the proceeds from their labor, makes them more vulnerable to poverty. Powerlessness by excluded groups to influence governance and development processes to improve their wellbeing also perpetuates their further exclusion.

Government policies and programs however exist that could address the gender and social exclusion issues across USAID's PAD thematic areas. Key among them are the National Gender Policy, Disability Policy, Youth Policy, the Social Development Sector Plan, and a range of sector-specific policies in which social inclusion is mainstreamed. Government, e.g. the Youth Livelihoods Program, Women's Entrepreneurship Program, Social Protection, etc., are also in place to respond to some of the gender and social exclusion issues. However, these could be improved by efficient management, targeting, and implementation at scale.

For its part, the CDCS proposes a number of interventions to improve community and household resilience, provide basic services, and strengthen systems to meet its goal of ensuring that "Uganda's systems are accelerating inclusive education, health and economic outcomes." These interventions have the potential to generate equitable access to services and economic opportunities for marginalized groups, if they embed an inclusive development approach. They however have a potential risk of perpetuating exclusion if they remain gender and exclusion-neutral.

Against this background therefore, and in addition to the recommendations made in the respective PADs, the following key recommendations are emphasized:

- 1) Integrate a gender and social inclusion perspective in the projects under the CDCS.
- 2) Where a mainstreaming approach is used, establish quotas for excluded groups to benefit from services and economic opportunities, e.g. special targets for women, PWDs, youth, LGBTI people.
- 3) Where a mainstreaming approach may not be comprehensive, consider supporting special programs to reduce gender and social inequalities, e.g. through special GBV prevention and response programs, disability services and rights programs, and LGBTI advocacy programs.
- 4) Ensure that interventions "do no harm," by mitigating the unintended negative outcomes, e.g. perpetuating social exclusion, escalating GBV, etc., as identified in the social impact assessments under each PAD.
- 5) Support interventions that empower excluded groups to improve their voice and agency.
- 6) Support collection of data on social inclusion indicators for progressive improvement in targeting excluded categories and for tracking impacts of the programs on their development outcomes.
- 7) Develop the capacity of project teams and partners to undertake effective inclusive development across the CDCS priorities – through training and "How-to Notes."

ANNEX I: TERMS OF REFERENCE

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