THE REPUBLIC OF UGANDA

GENDER AND EQUITY PLANNING AND BUDGETING IN UGANDA

HEALTH SUB-PROGRAMME TRAINING GUIDE

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Budget Monitoring and Accountability Unit (BMAU)
Ministry of Finance, Planning and Economic Development
P. O. Box 8147, Kampala
www.finance.go.ug

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ACRONYMS

ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
BCC	Budget Call Circular
BPfA	Beijing Platform for Action and Declaration
BFP	Budget Framework Papers
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
EmONC	Emergency Obstetric and New-born Care
FOWODE	Forum for Women in Democracy
FP	Family Planning
FY	Financial Year
G&E	Gender and Equity
GEB	Gender and Equity Budgeting
GBV	Gender Based Violence
GDP	Gross Domestic Products
GEWE	Gender Equality and Women's Empowerment
GRB	Gender Responsive Budgeting
HC	Health Centre
HR	Human Rights
HRBA	Human Rights Based Approach
HSDP	Health Sector Development Plan
ILO	International Labour Organisation
LG	Local Government
LGBFP	Local Government Framework Paper
MDAs	Ministries Departments and Agencies
MPS	Ministerial Policy Statement
MTEF	Medium Term Expenditure Framework
MDA	Ministries, Departments, and Agencies
MOH	Ministry of Health
NBFP	National Budget Framework Paper
NCD	Non-Communicable Disease
NDP	National Development Plan
NPA	National Planning Authority
PFMA	Public Finance Management Act
PHC	Primary Health Care
PWD	People with Disabilities
STD	Sexually Transmitted Diseases
SDG	Sustainable Development Goals
UDHS	Uganda Demographic Healthy Survey
UN	United Nations
UWOPA	Uganda Women Parliamentarian Association

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FOREWORD

The Government is committed to ensuring inclusive growth and development through gender and equity planning and budgeting. With the enactment of the Public Finance Management Act (2015), it is now a legal requirement for Ministries, Departments, Agencies (MDAs) and Local Government (LGs) to address gender and equity issues during formulation of Budget Framework Papers and Ministerial Policy Statements.

However, the compliance assessments over the last six financial years show slow improvements with national average increasing from 57% in FY2016/17 to 70% in FY 2021/22. This has been partly attributed to the limited capacity within MDAs and LGs to discern gender and equity issues. To that effect, the Ministry of Finance, Planning and Economic Development, with support from the European Union, has developed tools to support capacity development of Central and Local Governments. This entailed development of specific training materials for the sub-programmes of Agriculture; Education and Sports; Health; and Works and Transport.

I urge all officials engaged in planning, budgeting, implementation as well as monitoring and evaluation, to use these packages with a view to enhancing the gender and equity compliance of our programmes. This is one of the sure ways of promoting inclusive growth and development.

Ramathan Ggoobi

Permanent Secretary/Secretary to the Treasury

1.0 INTRODUCTION

Studies have shown that gender and equity-based inequality limits economic growth (UN-Women 2020, World Bank 2018). A study conducted by the Ministry of Finance, Planning and Economic Development (Ministry of Finance, May 2009) showed that overall, addressing issues of gender inequality would increase GDP growth rates by 1.2% annually. This would boost the economy and accelerate pro-poor economic growth and development. Therefore, for development of the country to take place, the budget should deliver goods and services for everyone and not leave anyone behind.

There are several benefits to addressing gender and equity health issues in planning and budgeting. This promotes the equitable distribution of and access to health services for disadvantaged groups and locations, and improves health indicators. It unleashes the enormous productive potential of women, youth, and Persons with Disability (PWDs) as well as that of remote and disadvantaged locations of the country.

There are consequences to not addressing Gender and Equity (G&E) issues in health delivery. There are poor health indicators when a large section of society is left behind in the delivery of public health services. These include high maternal mortality; inability of Persons with Disability (PWDs) to access health facilities hence these services; poor health service delivery for islands, mountainous and distant locations; an inability of older persons to access geriatric services; and the exclusion of youth from reproductive health services leading to high teenage pregnancies and mortality. This affects development as Uganda might not achieve Vision 2040, the third National Development Plan (NDPIII); and the middle-income status with a per capita income of US$1,033 as proposed by the second National Development Plan.

Further, there are several health-related Sustainable Development Goals (SDGs) that cannot be achieved without addressing G&E issues in the health planning and budgeting process. These include:

Goal 1: End poverty;
Goal 2: Zero hunger;
Goal 3: Ensure healthy lives and promote well-being for all, at all ages;
Goal 5: Achieve gender equality and empower all women and girls;
Goal 10: Reduce inequality within countries.

Gender equality and equity in health is therefore, a prerequisite for the achievement of the national development aspirations as well as fulfilling the international obligations such as the SDGs.

The Public Finance Management Act (PFMA), 2015 obliges Ministries, Departments, and Agencies (MDAs), and Local Governments (LGs) to address gender and equity issues in budget formulation. Section 9 (6) states that, the Minister shall, in consultation with the Equal Opportunities Commission, issue a certificate; (a) certifying that the Budget Framework Paper (BFP) is gender and equity responsive; and (b) specifying measures taken to equalise opportunities for women, men, persons with disabilities and other marginalised groups.

Section 13 (11) (e) states that a certificate shall be issued by the Minister responsible for Finance in consultation with the Equal Opportunities Commission (i) certifying that the budget is gender and equity responsive; and (ii) Specifying the measures taken to equalise opportunities for men, women, persons with disabilities and other marginalised groups.

Section 13 (15) (g) states that a certificate shall be issued by the Minister responsible for Finance in consultation with the Equal Opportunities Commission; (i) certifying that the policy statement is gender and equity responsive; and (ii) specifying measures taken to equalise opportunities for men, women, persons with disabilities and other marginalised groups.

The Act makes it mandatory for Ministries, Departments, Agencies (MDAs), and Local Government (LGs) to address gender and equity issues in formulation of Budget Framework Papers (BFPs) and Ministerial Policy Statements (MPSs). Compliance with the Act requires knowledge and skills to discern the relevant sector gender and equity issues and to address them in planning and budgeting. However, there is limited capacity within institutions to conduct gender and equity analysis, and to mainstream appropriate interventions into the Budget Framework Papers and Ministerial Policy Statements. With support from the United Kingdom's Department for International Development (DFID), a five-year Gender and Equity Budgeting Capacity Development Plan 2017/18-2021/22, was formulated. The Plan presents a road map for building the capacity of gender and equity budgeting trainers, assessors and officials from Ministries, Departments, Agencies and Local Governments.

To implement the Capacity Development Plan, a National Gender and Equity Budgeting Training Curriculum and Manual was developed. The Curriculum is structured into nine modules, in line with the training needs identified in the Capacity Development Plan. The curriculum intends to train officials in gender and equity analysis, gender and equity responsive planning and budgeting, monitoring and evaluation, gender statistics as well as assessing gender and equity compliance. These are the areas that were identified as the fundamentals for officials to conduct practical gender responsive planning and budgeting. The national curriculum however, is generic in nature and does not highlight sector specific gender and equity issues.

1.1 Rationale/justification for the specific materials

The training and certification of Trainers for National Gender and Equity Budgeting indicated a need to have a uniform approach to training of government and other officials, in addressing gender and equity in planning and budgeting. This requires the development of sector specific training packages in-order to have standardised training content for the Trainers to deliver. Training packages make it easier for the Trainers to adopt a uniform approach to training. In addition, as each sub-programme has specific gender and equity issues to address in budgeting, there is need for training packages that address specific issues related to the sub-programmes. It should be noted that, every sub-programme, field and area subject to legislation, policies, programmes or individual planned measures contain a gender dimension that needs to be taken into consideration.

This training package therefore, consists of standardised training content with health sub-programme specific examples. The following topics are covered in the training package: Gender and Equity Budgeting (GEB) Concepts; Evolution of GEB in Uganda; Policy and Legal Frameworks; Approaches to GEB; Gender Analysis and Identification of GEB Issues; Mainstreaming G&E in Planning; Mainstreaming GE in Budgeting: Budget Cycle, Budget Framework Paper (BFP) and Ministerial Policy Statements (MPS); Gender and Equity Responsive Monitoring and Evaluation (M&E): National Gender and Equity Priority Indicators; SDGs; Gender and Equity Responsive Reporting.

2.0 GENDER AND EQUITY BUDGETING CONCEPTS

There are various concepts used in gender and equity budgeting. These include gender; gender roles; gender sensitive; gender responsive; gender mainstreaming; gender equality; equity; discrimination; inclusion; unfavourable inclusion and exclusion.

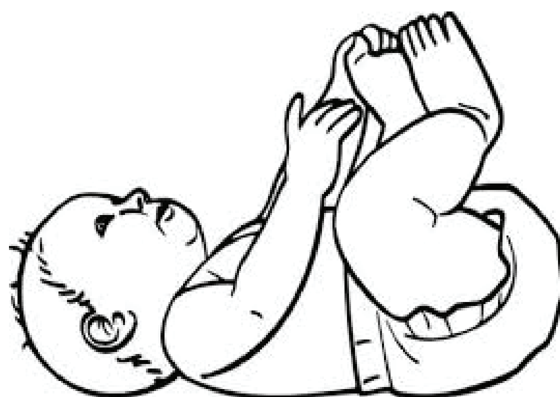
Gender

The term 'gender' refers to the range of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, and relative power and influence that are ascribed to women and men on the basis of their sex (ILO, 2009). It is the social characteristics used to define women or men and defines the boundaries of what women and men can and should be, and what they should do.

'Gender differs from '**sex**', which refers to the genetically determined biological and anatomical characteristics of women and men. Whereas sex differences are determined before birth and cannot be modified by environmental or cultural influences, gender is an acquired identity that is learned, which therefore changes over time, within and across cultures. Table 2.1 shows the difference between sex and gender.

Table 2.1: Differences between Sex and Gender

SEX	GENDER
Biological differences between men and women	Socially constructed roles and responsibilities of males and females
Universal	Varies across and within cultures
Inborn	Acquired
Basic fact of nature.	Differentiates between the sexes in terms of legal, economic, social, political rights and privileges.



You cannot assign the gender of the baby unless you know the sex

Gender as a social construction: Perceived as feminine

Gender as a social construction: Perceived as masculine

Gender perceived as a breadwinner

Gender - Perceived as a source of dowry

Gender - Perceived as a mother

Gender roles

Gender roles denote activities ascribed to women and men based on their perceived differences. Gender roles are formed during the socialisation phases of childhood, adolescence and adulthood. They are socially determined, change overtime or by location, and are influenced by the social, cultural and environmental factors characterising a certain society, community or historical period.

Examples of gender roles in health for women

- Child care, care for the elderly and PWDs in the family
- Provide home care for sick family members
- Sanitation at household and community level

Examples of gender roles in health for men

- Provide transport for the sick
- Pay for health expenses
- Make decisions on health matters including family planning/ granting permission for going to the health facility

Gender sensitivity

It is being consciously aware that boys/men and girls/women are different. For example, privacy for women/girls and men/boys is very important, absence of which can discourage patients from seeking treatment at the health facilities. The waiting rooms at health facilities should not serve as a consultation room with the Clinical Officer's or Doctor's Table in one corner of the waiting room. Boys should not be mixed with girls at the youth friendly corners to keep confidentiality. Men and women should not use the same bathrooms and toilets. The maternity wing should not be next to the Outpatients Department.

Gender responsiveness

This is taking deliberate action to address gender issues in society to eliminate the inequalities. Using the example above of privacy for patients, consultation rooms should be fitted with doors and these should be closed when a patient is consulting a Doctor or Clinical Officer. This is to ensure those in the waiting room do not listen in to what is going on in the consultation room. There should be separate bathrooms and toilets designed to suit each sex, for example having a urinal in the men's' toilet. The maternity wing should not be next to the Outpatients Department.

Gender mainstreaming

It is a globally accepted strategy, process, approach, and a means to achieve gender equality. Gender mainstreaming seeks to ensure that gender equality concerns are considered in all actions and programs throughout program development, implementation, and evaluation. For example, designing a Family Planning Programme without male involvement. Often the husband makes the decisions for whether his wife should use family planning methods or not. Women who use family planning without the husband's consent are always battered. Therefore, a successful Family Planning Programme should include a strategy for male involvement.

Gender mainstreaming contributes to transforming policies, practices, ideas, and beliefs that perpetuate discrimination and prevent women and men from realising their rights.

Gender mainstreaming – a UN definition

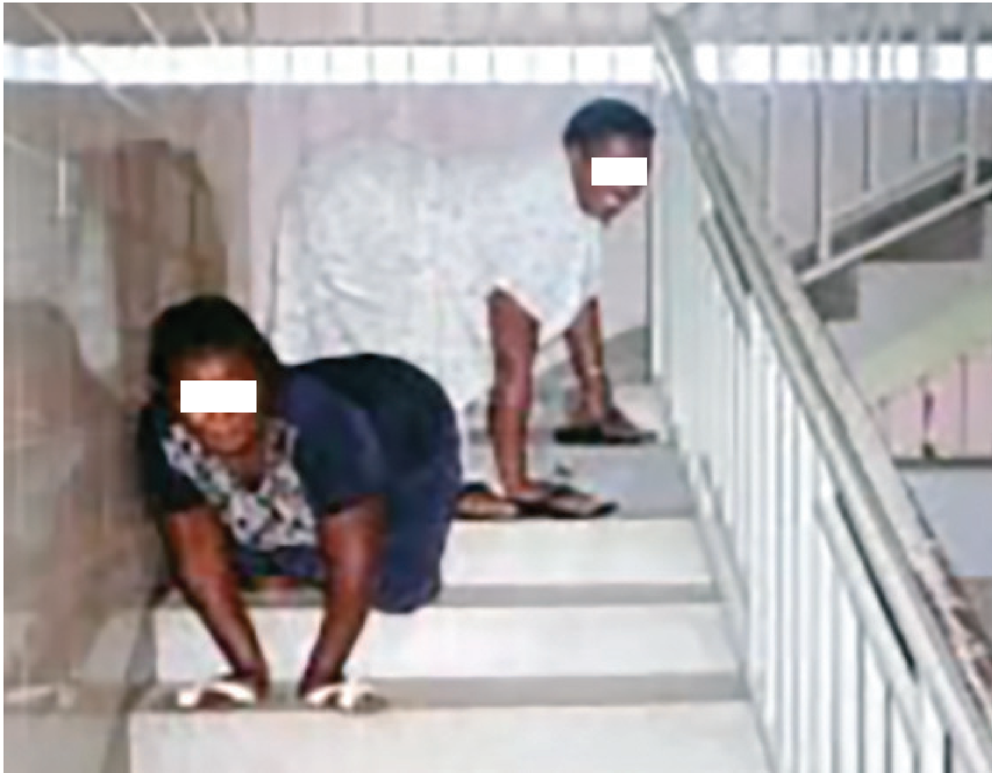
"Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated."

Gender equality

Gender equality refers to provision of equal opportunities for women and men, as well as girls and boys in all spheres of life. Gender equality is the absence of discrimination on the basis of gender roles, biases, stereotypes, norms. For example, women and men, girls and boys should be given equal access to health services as enshrined in Uganda's 1995 Constitution. Also, women and men, should be given equal opportunities for employment in the health sector.

Equity

Equity refers to fairness in provision and distribution of resources and services to all categories of the population considering sex; age; physical ability and geographical location. Other categories that can also be considered are ethnicity, social economic status, and religion. Therefore, obstacles that prevent some categories from accessing the public health services must be identified and addressed. For example, health facilities without ramps, make it difficult for PWDs to access buildings hence health services.



PWD find it difficult to access health facilities without ramps

Similarly, women with disabilities will be afraid to have their deliveries in labour suites if adjustable beds are not available. They would therefore miss out on being attended to by skilled personnel and risk complications from having a home birth. If drugs for chronic illnesses are not available at a Health Centre IIIs, older persons suffering from diseases such as diabetes and hypertension will not access health services. In the absence of staff accommodation, health workers will resist deployment in hard-to-reach and hard-to-stay areas. This denies access to health services for the population living in the difficult areas.

Social Inclusion

The World Bank Report (2013) defines inclusion as the process of improving the terms of individuals to take part in society. Social inclusion as the process of improving ability, opportunity, and dignity of people disadvantaged based on their identity, to take part in the development process in society. People take part in society through markets, services, and spaces.

Examples of Inclusion

- Free health services for all
- Immunisation
- Family Planning
- Ante-natal Care
- District Hospitals and Regional Referral Hospitals

Unfavourable inclusion

Unfavourable inclusion manifests in form of deep "unequal terms" of social participation in each aspect like access to/utilisation of health services. Females, poor men, PWDs, youth, older persons are often denied rights and access to resources and information vital for addressing the challenges of poor health. They are excluded or unfavourably included because of their identity (gender, age, disability, geographical location, or a combination of some these identities).

Examples of Unfavourable Inclusion

- Requirement to go to the health facility with mama kits at the time of delivery
- Unmet needs in family planning
- Absence of youth friendly corners at health facilities for provision of services to adolescents
- Limited availability of sign languages, orthopedic services for PWDs, and geriatrics for the elderly

Social exclusion

Involves denial of resources, rights, good and services, and the inability to participate in normal relationship and activity available to the majority of people in a society. Common dimensions of exclusion include those based on identities of gender, race, ethnicity, socio-economic status, age, disability and regional disparities. Excluded groups are consistently denied opportunities.

Examples of social exclusion

- Long distance to health facilities so people in distant villages do not access services
- People on some islands or in mountainous areas like the Elgon lack access to health services
- Some counties/sub-counties do not have HCIVs or HCIIIs respectively
- Some districts have no district hospitals
- Absence of ramps at health facilities so PWDs cannot access the services

Discrimination

Discrimination is defined as any distinction, exclusion or preference based on race, colour, sex, religion, political opinion, national extraction, or social origins which impairs or nullifies equality of opportunity or treatment in access to services. There are two types of discrimination: direct and indirect.

Discrimination is direct when rules and practices explicitly exclude or give preference to certain individuals solely based on their membership of a particular group. For example, HIV/AIDS patients tend to be discriminated against at health facilities and in community health programmes. The system for the national procurement of drugs and distribution of the same to health facilities is sometimes discriminatory when various drugs, required at different levels of care, are not being procured or if they are procured, are inadequate. This directly discriminates those in need of such drugs.

Indirect discrimination consists of norms, procedures and practices that appear to be neutral, but whose application disproportionately affects the members of certain groups. For example, when adolescents are made to receive reproductive health services alongside adults. If there is only one Family Planning Clinic catering to both adults and the youth, most of the youth will not go there for fear of meeting adults who know them, or are friends to their parents who are likely to report them to the parents. If there are no youth friendly corners where youth can meet and open up, they will not seek reproductive health services.

Another example is the Health Services Commission (HSC) promotional recruitment which is merit based. Women are often disadvantaged during these merit-based promotion as these

do not consider the effect of the role of motherhood when assessing women's productivity and on-job training opportunities. The system marginalises women limiting them to lower positions in the health service sector and denies them opportunities for promotion to management and decision-making positions.

Gender and Equity Budgeting

Gender and Equity Budgeting (GEB) is the process of addressing gender and equity concerns in the budget arising out of inequalities and inequities amongst women and men, boys and girls, PWDs, older persons and other social economic groups as well as disadvantaged locations/ regions. GEB addresses the needs of different people including: women, men, boys and girls, PWDs, children, youth, older persons and disadvantaged locations (e.g. islands) when planning and budgeting for the provision of public health services.

For example, when planning and budgeting for the delivery of health services at sub-county level, the following are supposed to be catered for so that all social categories benefit: there should be an adequate recruitment of midwives to assist women to deliver and conduct antenatal care, family planning and immunisation services; there should be a youth friendly corner at the health facility to enable adolescents access reproductive health services; the facility should have a ramp to enable access to the building by people with physical disability; there should be adjustable delivery beds to enable women with disability deliver from the health facility; there should be community outreaches to enable those in distant villages access health services especially reproductive health services; there must be drugs for chronic illnesses as required by the older people.

3.0 EVOLUTION OF GENDER AND EQUITY BUDGETING IN UGANDA

Gender and Equity Budgeting was embraced by the Government of Uganda as a tool for inclusive economic growth and sustainable development. The budget is the vehicle for implementation of development policies through provision of public goods and services for all categories of the population. Unfortunately, this is not always the case as implementation of the budget results in differentiated impact on different segments of the population with some benefiting more than others.

Gender Responsive Budgeting (GRB) in Uganda was started in 1998 by Forum for Women in Democracy (FOWODE) a Non-Governmental Organisation. The initial project aimed at advocating for gender sensitive national and district budgets that equitably address the needs of poor women and men, boys and girls, and give full attention to the needs and interests of other marginalised groups such as Persons with Disabilities (PWDs). The project was implemented in three sectors; Health, Education, and Agriculture.

FOWODE's approach to GRB focused on ex-post analysis of budget expenditure allocations. This involved analysis of the Budget after it had been passed to establish the extent to which it reflected the identified gender sensitive policies and addressed the prevailing gender gaps and issues. The analysis established who had benefited and who had been left out in the budget. The revenue side of the budget was also analysed but with less rigour. The analysis was used for advocacy to increase budget allocation for the needs of poor women and men, boys and girls, PWDs, and other vulnerable groups. FOWODE's work was expanded into the Village Budget Clubs (VBCs) to allow rights holders or citizens to demand for services, thus promoting grassroots activism and budget advocacy. To successfully implement its GRB initiative, FOWODE built partnerships with civil society (women's organisations), researchers, and government technical staff from the central and local governments, academia especially from Makerere University School of Women and Gender Studies, the media, grassroots communities and donors.

Building upon FOWODE's GRB work, government adopted GEB in Financial Year (FY) 2004/05. The Ministry of Finance, Planning, and Economic Development issued an Annex with gender and equity budgeting guidelines attached to the Budget Call Circular FY 2004/05, on how to address gender-related goals in the Budget Framework Papers for sectors and local governments. The guidelines directed sectors to ensure that gender and equity issues are integrated into the Budget Framework Papers, with special focus on the needs of vulnerable women and men, boys and girls, children, youth, older persons, PWDs and disadvantaged locations like islands and mountainous regions.

Government's expansion of the social categories was a result of advocacy and lobbying by different groups and organisations who also wanted their issues to be addressed through the budget. These included civil society organisations and groups handling disability issues, children and youth. The politicians wanted to see equitable development of the country, so those from disadvantaged or resource-poor districts advocated for equalisation grants.

Government adopted an ex-ante analysis of the budget. This was a proactive way of addressing gender and equity issues during Budget formulation, implementation, and evaluation. Despite guiding sectors on how to address gender and equity issues in annual Budget Framework Papers (BFPs), the analysis revealed that many sectors were just giving statements of how they planned to address gender and equity issues. Where a budget was indicated, it was too small to accomplish the planned activity. This led to a combined campaign to lobby and advocate for inclusion of penalties for the non-compliance to GEB in the draft Public Finance Management Act (PFMA), which was being debated in Parliament. The advocacy team consisted of the Uganda Women Parliamentarian Association (UWOPA), Ministry of Finance officials who were passionate about gender, civil society organisations including FOWODE, academia and the media.

In 2015, the Public Finance Management Act (PFMA) was enacted with gender and equity provisions. The Act requires MDAs to address gender and equity issues in their BFPs and Ministerial Policy Statements (MPS). The MDAs have to specify measures and allocate budgets to address the different needs of men and women, children, youth, older persons, People with Disabilities, and other marginalised groups and locations.

The BFPs and MPSs are assessed by the Equal Opportunities Commission (EOC) using a pre-defined scoring criteria to assess the extent to which they address gender and equity issues and budget for them accordingly. MDAs, which get a Pass Mark of 50% are issued a Gender and Equity Certificate by the Minister of Finance, Planning and Economic Development in consultation with the Equal Opportunities Commission. On failure to get the Pass Mark, the GEB Certificate is not issued and hence the BFP or MPS is not approved by Parliament.

3.1 Rationale for GEB in Health

In Uganda, women, PWDs, children, youth, older persons and people in disadvantaged regions tend to be excluded from health services due to various structural issues. The issues that limit their access, participation and benefit should be identified and addressed. For example, where health facilities are distant, it is important to budget for community outreaches or mobile clinics for distant villages to facilitate access to health services such as the immunisation of children and reproductive health services especially Antenatal Care (ANC) and Family Planning

(FP). If these outreaches are not planned then a considerable number of children in distant villages will not be immunised, and many will get ill or die from immunisable diseases.

Similarly, if women don't have easy access to ANC their pregnancies will not be monitored, and any risk factors associated with the pregnancies will not be diagnosed nor will the women be referred for appropriate levels of care. In addition, failure to access FP services leads to an increase in unwanted pregnancies and other health complications. There are some islands that lack health facilities as such special measures have to be planned and budgeted for to enable the people in these communities to access health services. For instance, the provision of regular marine transport to connect the islands without facilities to those with or to the mainland and or conducting medical outreaches to these remote areas.

Similarly, for health facilities that are inaccessible to PWDs, it is important to budget for the construction of ramps in the existing buildings and to incorporate ramps in the designs for new buildings. There are health facilities without youth friendly corners to allow youth to seek services in privacy –without adults knowing what they are suffering from for instance in the case of Sexually Transmitted Diseases (STDs) or if they want to access FP services. It is important to budget for youth friendly corners so that adolescents can access health services to avoid teenage pregnancies and/or the spread of diseases like STDs.

Addressing G&E issues in the sub-programme will improve the health outcomes, for example, maternal and child health.

4.0 LEGAL AND POLICY FRAMEWORKS

There are various international, regional, and national instruments on the promotion of Gender Equality and Women's Empowerment (GEWE), and Human Rights (HRs) which the Government of Uganda is signatory to. The normative frameworks create an obligation on the part of government to implement the agreed actions hence making GEB obligatory for the health sector. These normative frameworks, therefore, guide the identification of gender and equity issues in health care and the measures to address the same for the benefit of all.

4.1 The International instruments

These include:

i. Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) 1981;
ii. International Covenant on Economic, Social and Cultural Rights,1976;
iii. Convention on the Rights of Persons with Disabilities, 2006;
iv. UN Convention on the Rights of the Child, 1990;
v. Beijing Platform for Action and Declaration, 1995;
vi. Commonwealth Plan of Action for Gender Equality 2005-2015;
vii. United Nations Security Council Resolution 1820 &1325;
viii. Sustainable Development Goals (SDGs) Goal 3 and 5.

1) Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) 1981

The Convention provides for women's equal access to and equal opportunities in health care. It eliminates discrimination against women in the field of health care. The convention addresses maternity leave and protection against harmful work during pregnancy.

2) International Covenant on Economic, Social and Cultural Rights, 1976

Under Article 12 of the Covenant , state parties recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. State parties are required to take steps to achieve the realization of this right through provision for the reduction of still birth rate and infant mortality and health development of the child, improvement of all aspects of environmental and industrial hygiene, prevention, treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would assure all medical services and medical attention in the event of sickness.

3) Convention on the Rights of Persons with Disabilities, 2006

Under Article 25, state parties recognise that PWDs have the right to enjoyment of the highest standard of health without discrimination on the basis of disability. State parties are required to take all appropriate measures to ensure access for PWDs to health services that are gender sensitive including health related rehabilitation.

4) Beijing Platform for Action and Declaration (BPfA), 1995

The BPfA makes it obligatory for state parties to put in place gender responsive interventions, policies, plans, services, and information on women's health.

5) Commonwealth Plan of Action for Gender Equality 2005-2015

This Commonwealth Plan highlights that HIV/AIDS should be considered within the framework of sexual and reproductive health rights. This should be an integrated approach that recognises boarder issues and goes beyond health interventions to reduce gender inequality.

6) The UN Convention on the Rights of the Child (CRC), 1990

Under Article 24 of the CRC, state parties recognise the right of the child to enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall; strive to ensure that no child is deprived of his or her right of access to such health care services.

7) Sustainable Development Goals (SDGs) Goal Number 3 and Number 5

Goal Number 3 seeks, between 2015 and 2030, to ensure healthy lives and promote the well-being for all, at all ages. It commits to end the pandemics of AIDS, Tuberculosis, Malaria and other communicable diseases by 2030.

Goal Number 5 seeks to achieve gender equality and to empower all women and girls. It commits to eliminate all forms of violence against all women and girls in the public and private spheres, including sexual and other types of exploitation, and trafficking; eliminate all harmful practices such as child, early or forced marriage, and female genital mutilation and to ensure universal access to sexual and reproductive health and to reproductive rights.

4.2 Regional Legal and Policy Frameworks

1) African Charter on Woman and Health Rights, 1981

Article 16 provides for the right of every individual to enjoy the best attainable state of physical and mental health. State parties are required to take necessary measures to protect health of their people and to ensure that they receive medical attention when they are sick.

2) The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa - Maputo Protocol

The Maputo Protocol is the main regional instrument. It guarantees comprehensive rights to women including the right to:

- Control their reproductive health
- End female genital mutilation
- Accelerate the implementation of gender specific economic, social, and legal measures aimed at combating the HIV/AIDS pandemic, and to effectively implement both the Abuja and Maputo Declarations on Malaria, HIV/AIDS, Tuberculosis and other related infectious diseases.

3) East African Community (EAC) Youth Policy (2013)

The EAC Youth Policy provides for the wellbeing of youths in East Africa to enable them perform to their maximum potential. It requires all partner states to promote and support youth campaigns aimed at encouraging a change in sexual behaviour and discouraging teenage and early pregnancies, drug and substance abuse, and negative peer influence; Promote and establish home and community-based welfare programmes to help youth orphaned by HIV/AIDS. The policy also requires partner states to incorporate representatives of the youth in efforts to fight the spread of HIV/AIDS, Malaria, Tuberculosis and other communicable and non-communicable diseases.

4) East African Community (EAC) Gender Policy (2016)

The EAC is committed to achieve the highest attainable, sustainable and affordable standards of health for men and women, boys and girls through addressing gender inequalities in access and control over basic healthcare services and facilities and in particular reducing Maternal and Child Mortality. All partner States are thus required to institutionalise gender mainstreaming into planning, budgeting, implementation, monitoring and evaluation of health programmes projects and all health sectoral policies;

The EAC is committed to the achievement of zero new infections on HIV and AIDS and care for all the infected through addressing gender inequalities in access and control over basic healthcare services and facilities. Thus partner states are required to strengthen Primary Healthcare (PHC) in general, and reproductive health services including access to family planning, improving antenatal care, skilled delivery in health facilities, maternal nutrition, and post-natal care including management of Prevention of Mother-to-Child Transmission (PMTCT).

4.3 National Legal and Policy Frameworks

These include:

i. The Constitution of the Republic of Uganda
ii. The Public Finance Management Act, 2015
iii. Second Health Policy, 2010
iv. The Medical and Dental Practitioners Cap 262
v. The Nurses Act
vi. Uganda National Health Laboratory Services Policy 2009
vii. The Allied Health Professionals Cap 268
viii. The Uganda National Policy on HIV/AIDS and the World of Work, 2007
ix. The National Drugs Policy and Authority
x. The Environment Health Policy, 2005
xi. The Third National Development Plan 2020/21-2024/25
xii. The Uganda Gender Policy, 2007
xiii. National Action Plan for Women (NAPW), 2007
xiv. The National Policy on Disability, 2006
xv. The Children's Act
xvi. The Workers Compensation Act
xvii. The National Population Policy
xviii. The National Youth Policy, 2001
xix. The National Policy on Older Persons, 2009
xx. The Third National Development Plan 2020/21-2024/25

1) The Constitution of the Republic of Uganda, 1995

The Constitution provides for equality of men, women, boys, girls, PWDs and older persons. The Constitution also mandates the State to take affirmative action in favour of groups marginalised on the basis of gender, age, disability or on any other reason created by history, tradition, or custom, for the purpose of redressing imbalances which exist against them. This considers affirmative action for provision of health services to disadvantaged groups.

2) The Public Finance Management Act, 2015

The Public Finance Management Act (PFMA, 2015), obliges Ministries, Departments and Agencies, and Local Governments to address gender and equity issues in the formulation of Budget Framework Papers (BFPs) and Ministerial Policy Statements (MPSs).

a) Section 9 (6) (a) and (b);
b) Section 13 (11) e (i) and (ii)

c) Section 13 (15) g (i) and (ii)

Under the PFMA, 2015, it is mandatory for MDAs to address gender and equity issues in their BFPs & MPSs. MDAs have to specify measures and allocate budgets to address the different needs of men and women, People with Disabilities and other marginalised groups before the budget is approved by Parliament. The PFMA provides for addressing of gender and equity issues in the provision of public health services to disadvantaged groups and locations.

3) Second Health Policy 2010

The goal of the policy is to attain a good standard of health for all people in Uganda to promote healthy and productive lives. The Policy recognises that the private sector shall be complementary to the public sector in terms of increasing geographical access to health services, and the scope and scale of services provided.

4) The Medical and Dental Practitioners Act Cap 272

An Act to consolidate the law relating to the medical and dental practice and for other connected purposes. It establishes the Medical and Dental Practitioners Council that's mandated to monitor and exercise general supervision, control, and maintenance of professional medical and dental educational standards including continuing education; to promote the maintenance and enforcement of professional medical and dental ethics; to exercise general supervision of medical and dental practice at all levels; and to exercise disciplinary control over medical and dental practitioners.

5) The Nurses and Midwives Act 274

The Act makes provisions for the training, registration of enrollment and discipline of nurses and midwives of all categories.

6) Uganda National Health Laboratory Services Policy 2009

A policy to develop, recruit, deploy, motivate, and retain adequate numbers of human resources for laboratory services. In addition, the Act provides for the mobilisation of financial and logistical resources required to support the delivery of quality laboratory services.

7) The Allied Health Professionals Act Cap 268

The Act provides for the regulation, supervision and control of the allied health professionals, and establishes the establishment of a council to register and license the allied health professionals.

8) The Uganda National Policy on HIV/AIDS and the World of Work, 2007

Scale up HIV efforts at the work place and integration of all health promotion services.

9) The National Drug Policy and Authority Act Cap 206

The Act establishes a National Drug Policy, and a National Drug Authority as a regulatory body. This is responsible for regulation of drugs in the country to ensure the availability, at all times, of essential, efficacious and cost effective drugs to the entire population of Uganda, as a means of providing satisfactory health care and to safeguard the appropriate use of drugs.

10) The Environment Health Policy (2005)

The policy promotes women's participation in community sanitation activities.

11) The Third National Development Plan 2020/21-2024/25

The NDPIII commits to promote optimal maternal, infant, young child and adolescent nutrition practices; increase access to immunisation against childhood diseases; as well as promotion of youth friendly Sexual and Reproductive Health services. In addition, NDPIII, seeks to reduce the burden of communicable diseases using the Health Primary Care approach; promote delivery of disability friendly health services including physical accessibility and use of appropriate equipment and to improve the functionality of the health system to deliver quality and affordable preventive, promotive, curative and palliative health care services. Further NDPIII commits to improve maternal, adolescent and child health services at all levels of care; increase access to Sexual Reproductive Health and Rights with special focus on FP services, and to increase financial risk protection or a National Health Insurance Scheme.

12) Uganda Gender Policy (2007)

The Uganda Gender Policy 2007 aims to increase knowledge and understanding of Human Rights among women and men so that they access, seek redress and enjoy their rights. The gender and equity issues in the Policy to be addressed by the Health Sub-Programme include gender based violence, high maternal and child mortality and morbidity, and high levels of fertility.

13) National Action Plan for Women (2007)

The National Action Plan for Women promotes reproductive health and provision of HIV/AIDS services and health care to sexual violence victims, conflict resolution and freedom from violence.

14) The Children's Act, Cap 59 as amended

The rights of a child include access to immunisation and medical attention; mandatory request for the medical examination of children under emergency protection e.g. in remand homes and foster care; and protection against violence.

15) The Workers Compensation Act Cap 225

Compensation for injuries whether fatal, temporary incapacity, disability or disease that are certified by a medical practitioner.

16) The National Population Policy, 2008

To improve the quality of life of the people of Uganda through policies and programs that address population trends and patterns. Among the strategies, the Policy advocates for child spacing for the health of mothers and children. In addition, it promotes the strengthening of youth friendly sexual and reproductive health services.

17) The National Youth Policy, 2016

The policy urges the health sector to provide youth friendly health services; protect young people from all forms of violence, and improve life skills and access to information for the youth.

18) The National Policy on Older Persons (2009) and its Action Plan (2012)

The overall objective is to empower older persons with information, knowledge and skills for increased participation in development programs for improved standard of living. Among the specific objectives, three are health related namely:

i. To achieve 50% active access, preventive, promotive, curative and rehabilitative care for older persons.
ii. To increase access to and utilisation of HIV/AIDS services by older persons.
iii. To promote hygiene and sanitation practices in older persons' households.

19) African Charter on the Rights and Welfare of the Child OAU Doc. CAB/LEG/24.9/49 (1990)

Article 14 provides for the right to health. It provides for the right of every child to enjoy the best attainable state of physical, mental and spiritual health. State Parties are required to undertake to pursue the full implementation of this right and in particular shall take measures: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) to ensure the provision of adequate nutrition and safe drinking water; (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventive health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans;

(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents; (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of basic service programmes for children; (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.

20) The National Integrated Early Childhood Development Policy (NIECD) 2016

The major goal of the policy is to provide direction and guidance to all sectors for quality, inclusive, coordinated and well-funded ECD services and programs.

The NIECD Policy of Uganda has three major objectives are to; harmonise existing ECD policy related goals, objectives, strategies and initiatives within and across all sectors; set , improve and align standards for ensuring access to well- coordinated, quality, equitable and inclusive ECD services within and across sectors; build and strengthen capacity of systems and structures to deliver integrated quality and inclusive ECD programs.

5.0 APPROACHES TO GENDER AND EQUITY BUDGETING

There are various approaches for addressing gender and equity issues in health planning and budgeting. These include affirmative action; mainstreaming a gender equality perspective in policies, programmes, projects, and other initiatives; and a Human Rights-Based Approach to programming.

5.1 Affirmative Action

This involves undertaking specific or targeted measures to address existing inequalities in the provision of health services for disadvantaged social groups. The socially disadvantaged mostly include:

- Women and girls
- Youth
- Persons with disability
- Older persons
- People in hard-to-reach areas, remote places, islands, mountainous and poorly resourced regions.

The inequalities could be caused by cultural norms, values, omission, structural bottlenecks and or beliefs, which may exclude women's participation or limit their access to health services. For example, the belief that science subjects are not for girls deters them from becoming doctors. While the belief that the nursing and midwifery profession is for women discourages male applicants from pursuing nursing courses.

Location is another cause of inequality of access to health services. The remote, mountainous or islands regions are disadvantaged in their accessibility to health services provision. These regions are usually hard-to-reach, stay, and leave. For example, the absence of staff accommodation coupled with poor accessibility discourages health workers from working in the islands areas. This is compounded by the lack of reliable transport, for example, marine transport which is very important to connect the islands to the mainland for referral health services. While the poor road infrastructure in mountainous places is another cause of inequality in access to health services. A number of hilly and mountainous regions are almost cut off during the rainy season which hinders provision of health services to these regions such as Ntoroko and Bududa districts.

Inequality in access to health services could be caused by physical disability, hearing impairment, or sight impairment. For example, in the absence of sign language interpreters at the health facility, a patient with a hearing impairment will find it difficult to access health care.

Therefore, affirmative action should be undertaken to address service provision for the socially disadvantaged groups such as equalisation grants, accommodation for health workers, marine transport, and special needs services.

Low representation of women for critical cadres in health care provision (Doctors - 435 (26%); Clinical Officers - 742 (25%); Pharmacists - 15 (25%); Dispensers - 43 (24%) (*MOH, Annual Health Sector Performance Report, FY2018/19*)

Measures:

- Special bursaries for girls
- Admission quotas into universities

Limited availability of specialised health services for PWDs & elderly (equity issue)

Measures include:

- Purchase of orthopaedic equipment
- Recruitment of sign language interpreters
- Provision of drugs for chronic illnesses

Disparities in geographical distribution and accessibility to health services (Percentage of women aged 15-49 who reported serious problems in accessing health care when sick due to distance: 64% Acholi; 62% Lango; 48.2% Bunyoro (UDHS 2016)

Measures: Community outreach programmes

5.2 Mainstreaming Gender Equality in Policies

The mainstreaming approach requires G&E needs or issues to be addressed at all stages of the health programme cycle including:

- Planning
- Budgeting
- Implementation
- Monitoring
- Evaluation

Key tools for mainstreaming include:

Gender analysis

Systematic examination of roles and responsibilities concerning men and women, and boys and girls, with the aim of identifying gaps, raising concerns, assessing implications and proposing relevant interventions in the health sector. For example, although childbearing is the role of women, it's observed that men make independent decisions regarding women's health seeking behavior. A woman must seek permission from the husband to go to the health facility. This is evident in the 2006 UDHS and 2011 UDHS that reveals that about four (4) in every ten 10 (39%) married women aged 15 to 49 years had their husbands make independent decisions for their own health care compared to three (3) in ten (10) in 2016 UDHS.

Secondly, the 2016 UDHS, reveals that 31% of the married women aged 15-49 years make independent decision to use contraception. This shows a gap of inadequate involvement of men in the reproductive health programs. If this power dynamic at household level is ignored, it can affect the program performance. Therefore, a strategy for male involvement in both productive and reproductive health should be reinforced into the reproductive health programme.

Use of sex disaggregated data

Sex disaggregated data is the classification of statistical information by sex. It allows for comparisons to be made between females and males. It identifies the magnitude of the gaps between women and men, girls and boys in terms of needs, constraints and opportunities. For example, the UDHS 2016 showed that 9.9% of women aged 15-49 had experienced sexual violence compared to 4.6% men of the same age. In addition, 28.2% of women aged 40-49 had experienced sexual violence in the 12 months preceding the survey compared to 4.6% men of the same age. 50% of women aged 20-22 had comprehensive knowledge about HIV prevention compared to 53.4% men of the same age.

5.3 Human Rights Based Approach

The Human Rights Based Approach (HRBA) is a conceptual framework for achieving human development through promoting and protecting human rights based on international standards. HRBA identifies *rights holders,* their entitlements, and corresponding *duty-bearers* and their obligations. It works towards strengthening the capacities of rights-holders to make their claims and of duty-bearers to meet their obligations. There are various health human rights, for example, the right of everyone to enjoy the highest attainable standard of physical and mental health; the right to free basic health care; the right to maternal and child-health services; the right to family planning methods; the right to choose a husband; and the right to live a life free from gender and sexual based violence.

HRBA seeks to analyse the inequalities that lie at the heart of development problems in a bid to redress the discriminatory practices and unjust distributions of power that impede the development progress. For example, HRBA will try to establish why there are differences in access to health care for different categories of the population particularly for women and girls, children, youth, PWDs, older persons and remote regions; why there are differences in health care services coverage among districts or local governments; why some locations are avoided by health care workers; why the maternal mortality is high in the country, and why HIV/AIDS is more prevalent in women than men.

Under a HRBA, the plans, policies and processes of development are anchored in a system of rights and corresponding obligations established by international law. This helps to promote the sustainability of development work, empowering people especially the most marginalised to participate in policy formulation and to hold those who have a duty to act accountable.

Table 5.1: Summary of GEB Approaches

Affirmative Action	Mainstreaming	Human Rights Based Approach
Focuses on specifically excluded groups or marginalised persons e.g. people living on islands that don't have any health facility.	General exclusion based on gender inequality e.g. women who are unable to use family planning due to power dynamics at household level.	Focuses on the poorest, most vulnerable and underserved segments of society e.g. PWDs without/with limited access to specialised health services.
Targeted interventions to redress specific imbalances or vulnerabilities. For example: - Construct a health facility - Conduct outreach programmes Improve infrastructure on the island.	Deliberate effort to address gender and equity issues/ mainstream a gender perspective in sector plans, budgets, implementation, monitoring and evaluation. For example: - Design a strategy for male involvement in family planning.	Implementation of obligations under the international human rights standards that Uganda has signed to. Example: - Equip health facilities with orthopaedic equipment and adjustable examination/ delivery beds. - Recruit sign language interpreters to enable PWDs access specialised health services.
Mechanism of positive discrimination. It is deliberately excluding those with access to health services. It focuses on those who are excluded from health service provision so that they can catch up with the rest.	Use of sex disaggregated data to tackle root causes of existing gender disparities in society, For example, gender inequality in household decision making for women's health care. According to UDHS 2011, 23.3% of married women made decisions for their health care; 36.9% of married women made decisions for their health care together with the husband; and 39.1% of married women had decisions for their health care made mainly by the husband.	Anchored in a system of rights and corresponding obligations established by international law. Every individual is entitled to the highest standard of physical and mental health and every individual has a right to access basic care. It is the duty of the health sub-programme to meet these obligations by providing universal access to health care.

Source: Author's Compilation

6.0 GENDER ANALYSIS AND IDENTIFICATION OF GENDER AND EQUITY BUDGETING ISSUES

6.1 Gender Analysis in the Health Sub-Programme

Gender analysis in the health sub-programme is the systematic approach to examining factors related to gender such as access to, participation in and who the beneficiaries are in the provision of public health services. The analysis is aimed at identifying issues or gaps between men and women, or boys and girls in access to health services, raising the concerns, assessing implications, and proposing relevant interventions to address the gaps or inequalities therein. It therefore, examines the differences in the conditions, needs, and participation rates in health; access to and control over resources for health; and the power dynamics between men and women at household level and the influence of these dynamics on health seeking behaviour. Gender analysis raises questions such as;

- Why are some people not accessing health services?
- Why do some people receive poor quality services?
- Why are some women not able to access and use family planning?
- Gender analysis therefore, involves wearing a 'gender lens' in order to view a given health situation from the perspective of both women and men, girls and boys.

6.2 Equity Analysis in the Health Sub-Programme

Equity analysis in the health sub-programme examines the level of justice and fairness for all categories of people in access to health services so as to adhere to the human rights principles as well as social inclusion. Equity analysis exposes the interlocking and multi-dimensional nature of social exclusion as well as the adverse incorporation or unfavourable inclusion which lead to poverty and ill health.

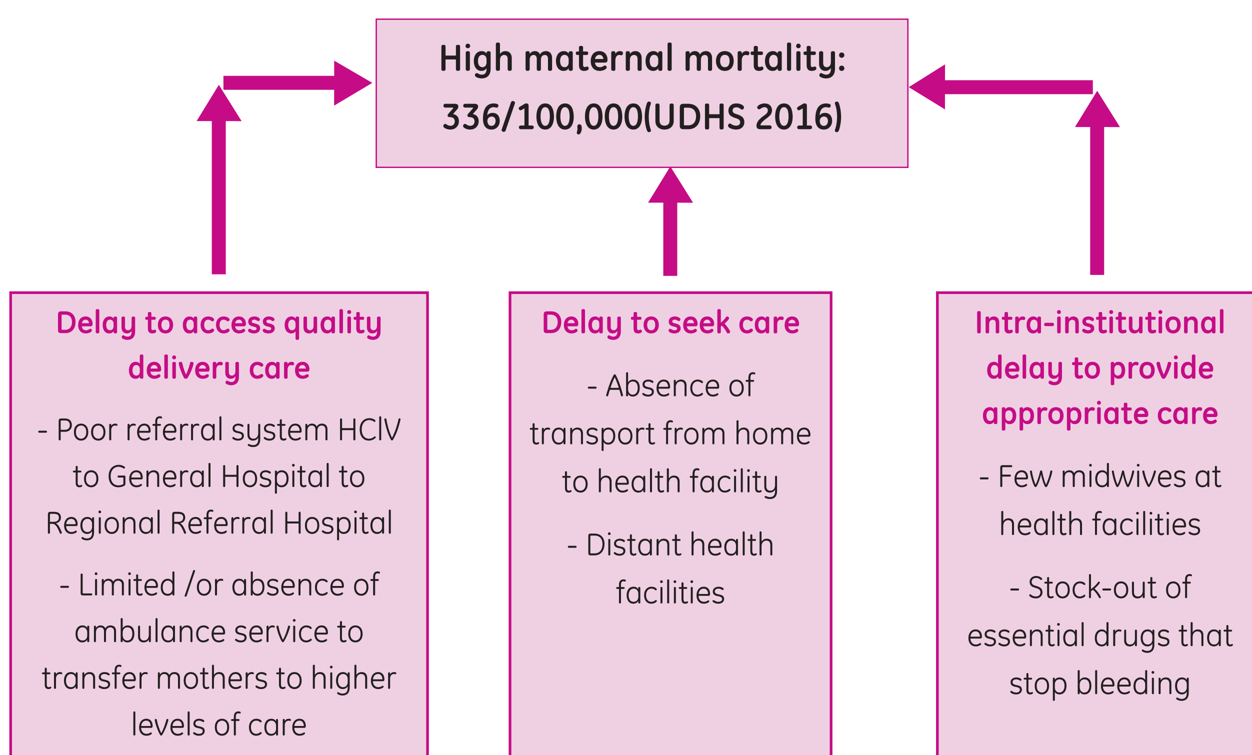
For example,
Why do islands have poorer access to health services?
Why some women with disabilities do not deliver from health facilities?

Rationale for G&E Analysis in the Health Sub-Programme

To understand how the population is benefiting from government investments in health. Gender analysis reveals why certain groups are over or underrepresented in sub-programme undertakings. For example, according to the Annual Health Sector Performance Report, FY 2018/19 (MOH, 2019), there are few female medical staff represented in the critical health cadre: Doctors (26%), Pharmaceutical Cadres (25%); Clinical (25%), Laboratory (26%), while men are underrepresented in the Nursing and Midwifery Cadres, 30% and 6% respectively. Refer to section on identifying gender and equity issues using statistics.

To identify G&E gaps in health service delivery, raising concerns and proposing relevant health interventions. For example, limited availability of specialised health services for PWDs and the elderly (sign language, orthopedic services and geriatrics care). According to the Annual Report on the State of Equal Opportunities in Uganda (FY 2016/17), 69% of the health facilities did not provide specialised health services. A recommendation was made to the health sub-programme to bridge the gaps.

To identify the G&E health phenomena and analyse underlying causes. For example, the high maternal mortality ratio: 336/100,000 live birth. This is caused by three delays: delays in access to quality delivery care; delays in seeking care; and intra-institutional delays in the provision of appropriate care.



6.3 Overview of approaches to Gender and Equity Analysis in the Health Sub-Programme

There are various analytical frameworks that can be used to conduct gender and equity analysis in the health sub-programme. The most common include: Harvard Analytical Framework, Moser Gender Planning Framework, and the Women's Empowerment Framework. These frameworks are important not only for highlighting gender and equity issues during the design of health programmes but can also be used to assess and improve existing interventions. It is important to note that no single framework is effective in the analysis of gender and equity issues in the health sub-programme, hence the need to use a combination of the frameworks to undertake G&E analysis.

6.3.1 The Harvard Analytical Framework

The Harvard Analytical Framework has two of the most relevant tools for the gender and equity analysis of the health sub-programme, these are: The Activity Profile Tool, and Access and Control Tool.

The Activity Profile Tool examines who does what and who makes decisions at the household level. The tool records the daily activities of men and women, boys and girls, and time spent on the tasks within a given location. This highlights women's workload such as caring for children, household chores, farming, which is important for designing strategies for delivering services closer to the community such as community outreach clinics for immunisation and FP.

The Access and Control Tool can be used to analyse access and control of resources required for health such as: money, time, bicycles, skills, etc. The analysis reveals the power imbalance between men and women at the household level that may negatively impact women's access to and utilisation of health services. For example, a woman needs a bicycle or money for a motorcycle to go to the health facility, three kilometres away for ANC. However, women do not control money nor assets like bicycles in their household. They have to rely on their husbands to take them to the health facility which may cause delays in seeking health care. The health facility, therefore must design additional interventions to enable the women from distant villages to access services. For example, expectant mothers are financially supported to meet their transport costs.

6.3.2 The Moser Gender Planning Analytical Framework

The Moser's Planning Analytical Framework provides six tools that can be used to undertake gender analysis. The Practical and Strategic Gender needs tool is most relevant for conducting gender and equity analysis in the health sub-programme as it examines the health needs of women and men in their current roles. The practical gender health needs are those —if met would assist women and men in their current activities. For example, it highlights the women's health care burden in the family –home care for the sick especially HIV/AIDS patients, older persons and taking sick family members to the health facilities. The care burden of women at household level could be relieved through provision of easily accessible health services.

In addition, the framework can be used to transform the existing power imbalance between men and women. For example, women's lack of control over their own bodies that is, their inability to decide when to have children and or the number of children to have, could be addressed by providing them access to family planning services. This would enable women to have control over their reproductive health and sexuality.

6.3.3 The Women's Empowerment Framework (Sara Longwe)

Sara's tool for participation is very important for the involvement of women, men, PWDs, youth and older persons in situation analysis, design, implementation, and monitoring and evaluation of health services. The framework is used to identify and address gender and equity issues of participation in the decision-making, policy making, planning and administration processes of health services. For example, although women, PWDs, youth, and older persons are members of the Health Management Committees, their effectiveness is affected by a lack of, or the limited capacity to articulate gender and equity issues in the health sub-programme. Thus the need to build the capacity of community leaders and various social groups for participation and involvement in health service delivery.

6.4: Identifying Gender and Equity Issues

Gender and equity issues can be identified using statistics, pictures, and normative frameworks and compacts.

6.4.1 Use of Statistics

1) To identify gender issues

To identify gender and equity issues using statistics requires data disaggregated along gender or equity dimensions. Data can be disaggregated on basis of gender that is, according to males and females with regard to their different experiences. Data disaggregation can also be with regards to equity, that is classified along age (children, Infants, youth, adults, older persons); disability type (hearing, seeing, talking, walking, concentration); Geographical location (district, sub-county, rural/urban, hard-to-reach areas, islands, mountainous areas); or other relevant attributes as demanded by user or a combination of the above. Table 6.1 provides an example on how to identify and analyse gender issues using statistics.

Table 6.1: Staffing Levels for Critical Cadres in the Public Health Sector, 2017/18

Cadre	Number			Percent (%)		
	Male	Female	Total	Male	Female	Total
Clinical Officers	2,203	742	2,945	75	25	100
Doctors	1,213	435	1,648	74	26	100
Laboratory staff	2,200	838	3,038	72	28	100
Midwifery staff	364	5,606	5,970	6	94	100
Nursing staff	4,001	9,163	13,164	30	70	100
Pharmacists staff	45	15	60	75	25	100

Source: MOH. Annual Health Sector Performance Report, FY 2018/19

Table 6.1, reveals inequalities by sex in selected staffing level in the public health sector. Although, male staffing levels are noticeably low in nursing positions at 30% and midwifery positions at only six (6) %, female staffing level, are lower across the health job spectrum. For example, less women occupy 25% of the clinical officers and Pharmacists staff each, 26% of the doctors, and 28% of laboratory staff. For example, Table 6.1 shows that there are inequalities in staffing between men and women for the more specialised jobs in the public health sector. There are also inequalities between men and women in the nursing and midwifery positions.

Secondly, it is important to identify the causes of the inequalities. For example, in accordance with the gender division of labour or the roles and responsibilities assigned to men and women by society, women are assigned the care-giving role. This includes taking care of the sick members of the family and assisting in deliveries. Therefore, girls are encouraged to take up nursing and midwifery jobs which are a natural extension of their household roles. In contrast only a few men take on nursing and midwifery courses or qualify as nurses or midwives because this is not their socially-assigned role. Further still girls, are discouraged from taking science subjects —considered masculine subjects thus few girls take science subjects up to high school. This results in fewer girls being admitted for the specialised courses such as Medicine, hence few female Doctors and Pharmacists.

Third, it is important to identify possible interventions to alleviate the situation. For example, putting in place special bursaries to encourage an increase in the number of girls taking science subjects at high school and universities. The other is to allocate quotas to girls joining Medicine courses at university and to the boys joining nursing and midwifery courses in training colleges. Further, professional nurses and midwives could be given special bursaries to undertake more specialised courses at universities. There could be special bursaries for men to join Midwifery and Nursing courses.

Table 6.2: Deliveries at Health Facility, FY 2018/19: Best Performing Districts, and Bottom Performing Districts

Best performing districts – above HSDP target of 85%			
District	**Deliveries**	**District**	**Deliveries**
Kampala	117%	Nebbi	91.7%
Butambala	110%	Masaka	91.1%
Moyo	105%	Bushen B	89.9%
Gulu	104.8%	Hoima	88.1%
Kabarole	103.4%	Kitgum	87.4%
Adjumani	99.3%	Jinja	86.4%
Lyantonde	92.9%		

Best performing districts – above HSDP target of 85%			
Bottom performing districts – Lowest deliveries at health facilities, below the HSDP target of 85%			
Luuka	34.5%	Kaliro	31.9%
Kyankwanzi	34.3%	Namutumba	30.5%
Bududa	34.1%	Buhweju	30.2%
Bukomansimbi	33.8%	Buvuma	23.3%
Ssembabule	31.3%		

Source: Ministry of Health, Annual Health Sector Performance Report, FY 2018/19

Step one: Analysis of the data to identify gaps

There are few deliveries (20 – 35%) at health facilities in Luuka, Kyankwanzi, Bududa, Bukomansimbi, Sembabule, Kaliro, Namutumba, Buhweju, Buvuma, which are the nine bottom performing districts. The top 10 performing districts achieved 86.4 – 117%. The results of the bottom districts are below the HSDP target of 85%, FY 2018/19.

Step two: Identification of causes for fewer deliveries at health facilities in the bottom nine districts.

For example:

- There are few midwives therefore fewer deliveries in the health facilities.
- Distant health facilities making it difficult for women to access delivery services in time. Thus they opt to have the deliveries at home or through Traditional Birth Attendants (TBAs).
- Unavailability of transport to take pregnant mothers to the health facilities.
- The hard-to-reach districts like Buvuma find it difficult to retain health workers e.g. due to a lack of or limited number of staff houses.

Step three: Identify interventions to address the issues

It is important to identify corrective measures for pulling up the districts lagging behind that is - performing below the national average. For example:

- Recruit more midwives for the underperforming districts.
- Construct more facilities especially ensuring that all sub-counties have a HCIIIs.
- Procure an ambulance or any other appropriate transport option to transport women to health facilities.
- Construct staff accommodation.

2) To identify equity issues

Step one: Analysis of data and identification of equity gaps

Example 2: Regional disparities in access to Family Planning.

Table 6. 3: Regions with Lowest Usage of Family Planning below the National Average

Region	FP usage (any method)
Islands	35.5%
Teso	33.9%
Busoga	31.5%
Bunyoro	31.2%
West Nile	21.8%
Acholi	21.3%
Karamoja	7.9%

Source: Ministry of Health Annual Health Sector Performance Report, 2018/19

Low contraceptive prevalence rate below national average of 39% in Islands, Teso, Busoga, Bunyoro, West Nile, Acholi, Karamoja.

Step two: Causes of equity issues in enrolment

- Distant health facilities.
- Lack of male involvement.
- Absence of youth friendly health services.

Step three: Identify interventions to address the equity issues

It is important to identify corrective measures to pull up districts that are performing below the national average. For example:

- Organise community outreaches for FP clinics.
- Design and implement a male involvement strategy in FP.
- Create youth friendly corners at health facilities or sub-counties.

6.4.2 Use of pictures to Identify Gender and Equity Issues

Gender and equity issues can be identified using pictures. This involves studying pictures and identifying issues revealed by the picture; and justifying why these are issues.

Step one: Identify equity issues

- Limited availability of gears for persons with disability.
- Unfriendly gears given to persons with disability. The above picture shows a person with physical disability being assisted off the wheelchair. It also shows steps to the building and the absence of a ramp for the PWD to use to access the building. As a result, he must be lifted up by two men. Without a ramp it is difficult for people with disabilities to access buildings at the health facilities, to get health services.

Step three: Identify interventions to address the equity issues

- Construct appropriate ramps at all health facilities, so that the PWDs can access services easily.

The above picture highlights the challenge of lack of appropriate transport for pregnant women to access a health facility. If there is no transport women, will not access health services when in labour. They will therefore have deliveries at home without the supervision of a trained midwife, or delay to reach health facilities putting them at risk of dying in case of complications.

Step one: Identify equity issues

- Poor accessibility
- Long distance to access social services

Step three: Identify interventions to address the equity issues

- Have appropriate transport like ambulances to transport expectant mothers in distant villages to the nearest health facilities.

Step one: Identify equity issues

The issue identified in the picture above is a queue at the maternity ward. This discourages pregnant women from coming for ANC as this means spending long hours at the clinics. Women have a heavy workload at home and some come from distant villages. They would therefore prefer to spend as little time as possible at the clinic, which may not be possible.

The second issue depicted in the picture is the absence of privacy/confidentiality for pregnant women. Those in labour are mixed with those coming for ANC; the two groups are not separated. The woman in a small green cloth and green headgear is in labour. When the health services are not responsive to the need for privacy/confidentiality of expectant mothers they are discouraged from delivering at the health facilities.

Step two: Causes of equity issues

This could be due to differences in age where life cycle needs change, geographical locations that are at different levels of development, and disability.

Step three: Identify interventions to address the equity issues

- Partition the maternity centre into various spaces.
- Increase the number of health workers.

Step one: Identify equity issues

There are two issues depicted in the picture above: Overcrowding at the health facility – refer to previous picture for further details on that; and few health workers attending to the needs of a large number of patients. Few health workers lead to poor service delivery at health facilities.

Step two: Causes of equity issues

- Few medical workers
- High teenage pregnancy
- Long distance

Step three: Identify interventions to address the equity issues

- It is imperative to recruit more health workers in health facilities.
- Construct more health facilities.
- Promote male involvement in health care seeking.

Step one: Identify equity issues

The issue depicted in the picture above is a lack of youth friendly health services. The adults and adolescents are all mixed together seeking family planning services. This discourages adolescents from accessing FP services for fear of meeting parents, neighbours or teachers at the clinic. Which leads to unintended pregnancies, unsafe abortions and high maternal deaths.

Step two: Causes of equity issues

- Lack of unfriendly youth corners
- Limited access to services

Step three: Identify interventions to address the equity issues

It is vital to establish youth friendly corners at health facilities or sub-counties with age-appropriate information and education materials.

Using observation

Observation involves the collection of data by observing people, processes and culture or use of video/films to document what is going on in a setting. The phenomenon under observation is analysed to establish gaps/issues of concern. For example, the observer can position himself/herself at the Antenatal Clinic and observe what is going at the clinic. This involves observing the opening and closing time of the ANC, the number of midwives running the clinic, mode of transport used by the pregnant women, the length of the queues, registration process, examination of the pregnant women includes: measuring height and weight, taking blood pressure, palpitation of the pregnancy, clients care etc.

Issues of concern: The observer is likely to observe issues referred to in the previous two pictures above.

Using audio and visual materials

Gender and equity issues can be identified using audios and videos, for example a Video on "Why Mrs. X died" https://www.youtube.com/watch?v=qNFrGxEp-UU

The investigator listens to the video and highlights reasons why Mrs. X died. Whereas the above factors reveal causes of the three delays, the gender and equity analysis reveal the underlying causes of the identified factors. For example, the gender analysis of the delays in seeking care interrogates women's and men's access and control of household resources required to facilitate access to health such as: money, time, bicycles, skills, etc. The gender analysis poses questions on the power imbalances between men and women at the household level that may

negatively impact women's access to and utilisation of health services. Whereas, absence of transport from home to health facilities explains the delay in seeking care, the gender inequalities in decision making on when and how to use the available household transport means such as bicycles further affects women's women seeking behaviour. Gender analysis reveals the implications of social norms on health seeking behaviour for men and women.

The issues can be categorised into three

1. Delay to seek care: Mrs X left her home when she was in advanced labour.
2. Delay to access quality delivery care: Mrs X took several hours to reach the health facility.
3. Intra-institutional delay to provide appropriate care: The health facility was not well prepared to handle emergencies such as Mrs X's situation.

Causes of delay to seek care:

- Culture or patriarchy: A woman has to get permission from the husband to seek health care.
- Heavy work load for the women.
- Ignorance and illiteracy

Causes of delay to access quality delivery care:

- Long distance to the health facility.
- Absence of an ambulance in the community.

Causes of intra-institutional delays to provide appropriate care:

- Few health workers.
- Poor attitude of health workers.
- Insufficient blood at the health facility.

Interventions

- Involve men in reproductive health services delivery.
- Mobilise and sensitise community on maternal health.
- Construct health facilities in underserved areas.
- Provide an ambulance for transportation of women for delivery.
- Recruit more health workers.
- Increase financing for health services

6.4.3 Using Normative frameworks and the Health gender and equity compact

1) **International, Regional and National Instruments**

Uganda is signatory to various International and Regional instruments, promoting gender equality, women's empowerment and that of children, youth, PWDs, Older Persons, Indigenous People, and their human rights. These have been domesticated into national laws and policies. These frameworks can be used to identify gender and equity issues. Table 6.4 gives examples.

Table 6.4: Using Normative Frameworks in Identification of Gender and Equity Issues

Instrument	Provision	Identified Gender and Equity Concerns	Required Intervention
International instruments			
Example: Sustainable Development Goals	**Health Sector** **Goal 3.** Ensure health lives and promote well-being for all at all ages **Goal 5.** Achieve gender equality and empower all women and girls	Limited access to universal health care (44% coverage) - High maternal mortality ratio 336/100,000 - High teenage pregnancy rate 25% - Low Contraceptive Prevalence Rate (35%) Unmet need for FP 28% - Gender based violence and violence against children.	-Improve functionality of the health systems Improve maternal, adolescents and child health services -Ensure universal access to sexual and reproductive health and reproductive rights.
Regional instruments			
Example: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa- Maputo Protocol. Protocol	Guarantees comprehensive rights to women including the right to: control their reproductive health and end female genital mutilation and child marriages	Same as above	Same as above'
National Instruments	Refer to Section on GEB Legal and Policy Frameworks for Gender and Equity issues under the national legal and policy framework.		

Source: Author's Compilation

2) **Gender and Equity Compact for the Health Sector**

The Compact is intended to guide the MDAs/LGs and stakeholders while making plans and budgets on the Programme specific gender and equity issues and interventions. It also guides the Programme on other programming initiatives, resource mobilisation and allocation, budget execution and accountability. Table 6.5 gives examples.

Table 6.5: Identification of Gender and Equity Issues

Instrument	Provision	Identified Gender and Equity Concerns	Required Intervention
Gender and Equity Health Compact			
		Similar issues to those identified above, with additions including: • Disparities in geographical distribution and accessibility to health services. • Limited availability of specialised health services for PWDs. • Limited orthopedic services for PWDs, adjustable delivery beds, and artificial limbs. • Limited number of critical health human resource in the country.	Same as above • Increase access to health services to underserved areas e.g. islands and mountainous places. • Provide specialised services for PWDs. • Recruit more health workers.

Source: Health Gender and Equity Compact

7.0 MAINSTREAMING GENDER AND EQUITY IN DEVELOPMENT PLANNING

The National Planning Authority (NPA) Act 2002, section 7(2) h; requires NPA to produce comprehensive and integrated development plans for the country that are gender and disability sensitive. Therefore, gender and equity issues are addressed at all stages of the health sub-programme planning process: preparation, implementation, monitoring & evaluation. It is 'wearing a gender lens' in the process of formulation of the health sub-programme plan.

7.1 Plan Formulation

Consultation Process

The Health Plan is formulated in a consultative and participatory manner to build consensus on the national health priorities to be addressed in the Plan. It involves various stakeholders at every stage of the planning cycle. The consultations present opportunities to raise gender and equity issues for inclusion in the Plan by engaging the civil society organisations working on the health issues of special interest groups that represent women, youth, children, PWDs, older persons and other marginalised groups.

During the formulation of the Health Sector Development Plan (HSDP) 2015/16 - 2019/20, consultations covered a wide range of stakeholders at national and sub-national levels including private and public sectors. The consultations covered government Ministries, Agencies and Departments, UN Agencies, Development Partners, Local Governments, Civil Society Organisations, the Academia, Professional Associations, renowned local consultancy firms, and researchers in health, cultural and religious institutions among others.

Situational Analysis

In conducting a situation analysis in the health sub-programme, it is imperative to pay attention to the emerging and prevailing gender and equity issues. A gender and equity analysis of the health sub-programme is undertaken to identify the G&E health issues. There is need to provide information/disaggregated data on the magnitude of the issue, most affected population, affected areas, incidence, prevalence, and any other issues. It is important to show how the issues are relevant to the sector performance. Examples of Gender and Equity health issues to be included in the situation analysis. (*Refer to Section on Gender and Equity Analysis and Identification of G&E issues*). For relevance to sector performance, *(refer to Section on Introduction)*.

Examples of some of the gender and equity issues highlighted by the HSDP 2015/16-2019/20:

- Low attendance of ANC with mothers attending all four expected ANC visits significantly low.
- Gender Based Violence (GBV).
- Inadequate human resource for the health sector, for example nurses and midwives are staffed at 83% and 76% respectively.
- Inequalities in accessing the services, with rural populations more disadvantaged.
- Low service provision for the elderly with 48%, 44%, and 34% of facilities providing services for chronic respiratory, cardiovascular, and diabetes conditions respectively.
- Only 66% of HC IVs with anesthesia services.

Setting goals and objectives

The goals and objectives should be set in line with gender equality and equity aspirations, and overall NDP objectives. The objectives should address the health needs of men and women, children, youth, PWDs, older persons, and disadvantaged locations. The objective could target a specific category of the population for example, youth or be all-inclusive.

Examples of The HSDP objectives: *Specific Objective 1: To contribute to the production of a healthy human capital for wealth creation.*

This objective aims to improve women's and children's health outcomes; and to improve the quality of life in old age by preventing and treating diseases and disabilities in older persons. *Specific objective 2: To address the key determinants of health.* This objective aims at promoting human rights and gender in the health sub-programme among others.

Identifying strategies

The strategies should aim at achieving the objectives in order to address the gender and equity issues and the causes identified under the situation analysis. Examples include:

i. Improve maternal, adolescent and child health services at all levels of care.
ii. Increase age-appropriate information on, access to, and use of family planning amongst young people, ages 10–24 years.
iii. Increase human resource for the health sector.
iv. Improve functionality of the health facilities.

Outcome and outcome indicators

It is important for the Health Plan to show how gender equality and equity will be increased during the planning period and to formulate indicators to monitor progress. Examples of HSDP outcome and outcome indicators: reducing the Infant Mortality Rate per 1,000 live births from 54 to 44 and the Maternal Mortality Ratio per 100,000 live births from 438 to 320; reducing fertility to 5.1 children per woman; reducing child stunting of under-fives from 33% to 29%; increasing measles vaccination coverage for under one years' from 87% to 95%; increasing the TB case detection rate from 80% to 95%; increasing ART coverage from 42% to 80%; increasing deliveries in health facilities from 44% to 64%; and increasing HC IVs offering CEmOC services from 37% to 50%.

Interventions

The Health Plan interventions should include interventions designed to implement the gender and equity strategies identified above and address the underlying causes of the gender and equity issues and gaps.

HSDP examples:

- Provide comprehensive ANC services that include malaria prevention, HCT, EMTCT and nutrition supplementation. To provide standardised quality Basic Obstetric and nutrition supplementation.
- Sustain universal coverage of available routine immunisation services, with a focus on identifying high risk populations and hard-to-reach (exposed, or uncovered areas). To scale up and sustain effective coverage.
- Implement the costed Plan for family planning services at all levels of care.
- Establish/functionalise adolescent friendly corners at all levels of care.
- Develop and implement a comprehensive set of interventions to reduce teenage pregnancies, with a special focus on hot spot districts.
- Ensure adequate human resources for health at all levels with special focus on specialised and super-specialised human resources.
- Strengthen an emergency medical service and referral system.
- Ensure universal access to all preventive, promotive, curative and rehabilitative services while ensuring quality.
- Ensure availability of NCDs drugs.
- Ensure availability of rehabilitative appliances (orthopedic, visual and hearing devices).
- Build capacity of health workers in elderly care/geriatric medicine.
- Develop a Gender and Human Rights Policy and guidelines in the health sector.

Monitoring and Evaluation

The Monitoring and Evaluation system should capture both outcome indicators as indicated above as well as output indicators.

Examples of output monitoring indicators:

- Proportion of birth attended by skilled personnel by level of care, and district.
- Percentage of approved health posts filled (%) by level of care, and district.
- Number of Regional Ambulance Hubs established.
- Percentage of young people outside school accessing RH services.
- Percentage of Health Centre IVs and district hospitals with youth-friendly services corners.
- Percentage of sub-counties with Health Centre IIIs.

7.2 Plan Implementation

It is important to enable establish the following when mainstreaming gender and equity in plan implementation arrangements:

- Who has access and who does not?
- Who benefits and who does not benefit from the service being provided?
- Who participates/who does not in the delivery of the health services and why?

Examples

- If the FP services are generally distant, many women will be discouraged from getting FP services.
- If health facilities are constructed without ramps, people with physical disability will not be able to access them. Older persons may not benefit from a Health Centre III in their sub-county if it does not have drugs for diseases like diabetes and heart conditions, which affects mostly the elderly.
- If health facilities do not have youth friendly corners, the adolescents will not benefit from the health services especially FP as they will shun the facilities. The lack of participation and involvement of men in FP services negatively impacts women's FP seeking behaviour, because decisions on use of FP are mostly made by men.

8.0 MAINSTREAMING GENDER AND EQUITY INTO THE BUDGET

The Public Finance Management Act, 2015, requires Ministries, Agencies and Local Governments to address gender and equity in the Budget Framework Papers and the Ministerial Policy Statements. The Central and Local Government Budget cycle and processes offer opportunities for or entry points to address Gender and Equity in the budget.

The Entry Points for Gender and Equity in the Budget Cycle in Uganda

- The budgeting cycle is a lengthy process that runs for three quarters of the year (nine months).
- While it is a participatory process, the level of participation depends on the readiness of a given institution/stakeholder.

There are various entry points for influence as long as one has the requisite empirical evidence.

Table 8.1: Key Timelines under the PFMA

(Key Timelines under the PFMA 2015)

Activity/Statutory Documents	Proposed Deadline
Submission of Sector Budget Framework Papers to MoFPED	By 15th November
Submission of National Budget Framework Paper (NBFP) to Parliament	By 31st December
Approval of the National Budget Framework Paper by Parliament	By 1st February
Presentation of the Ministerial Policy Statements to Parliament	By 15th March
Presentation of the Annual Budget and Tax Bills to Parliament	By 1st April
Approval of Annual Budget	By 31st May

8.1 The 5 Stages of the Budget Cycle

1. Fiscal Framework
2. Budget Preparation
3. Budget Execution
4. Accounting and Reporting
5. Control and Audit

8.1.1: Fiscal Framework

The Fiscal Framework, that determines the resource envelope for the year is the responsibility of the Directorate of Economic Affairs in the Ministry of Finance, Planning and Economic Development. The mainstreaming of gender and equity by Ministries, Departments and Agencies takes place largely in stage II up to V of the Budget cycle above. These are the entry points for mainstreaming gender and equity in budgeting for the health sub-programme.

8.1.2 Budget Preparation

There are 4 critical stages that are all good entry points for gender and equity budgeting for the health sub-programme:

1. Fiscal Framework
2. Setting national priorities and sector ceilings
3. Budget consultation meetings
4. Preparation of budget estimates
5. Approval and Presentation of the budget

Setting national priorities and sector ceilings

National Priorities are selected depending on:

a) Interventions with a direct impact on growth and/or poverty
b) The ruling party Manifesto
c) Implementation constraints being faced

Most of the critical gender and equity issues have an impact on growth and poverty and are prioritised within the ruling party Manifesto, therefore, should appear in the national health priorities. The NDP III highlights some critical gender and equity issues, some of which ought to be highlighted in the National Priorities.

These include:

a) High population growth rate of three percent and high fertility rate of 5.4 percent.
b) Limited access to health care services with only 44% of the population accessing health care.
c) Poor access to reproductive health services including access by youth. Poor access to prenatal, antenatal, postnatal, and youth friendly services.
d) Gender-based violence and violence against children

Budget consultative meetings

There are various consultative meetings:

1. Cabinet Retreat
2. National Budget Conference
3. Regional Consultative Workshops
4. Programme/Sub-Programme Working Groups
5. Inter-Ministerial Consultative Meetings
6. Parliament – Sessional committees and budget committees

All these meetings provide an opportunity to advocate for addressing gender and equity issues in health for inclusion in the budget.

In addition, there are various meetings organised by the Ministry of Health which feed into the budget process and are good entry points for highlighting gender and equity issues. These include:

Ministry of Health Budget related Meetings

- Meeting of the Referral Hospital Directors to discuss the Budget Call Circular.
- Quarterly Performance Reviews: Each department presents performance reports.
- Meeting of Ministers, Permanent Secretary and Directors to scrutinise the budget.
- Meeting with donors in the health sub-programme.
- Annual Health Sub-Programme Performance Reviews.

First Budget Consultative workshop – All stakeholders (September)

This Meeting communicates the economic outlook for the country and the challenges to the execution of the budget; discusses budget strategy and priorities; Medium Term Expenditure Framework (MTEF) and disseminates the guidelines for the preparation of the budget for the coming Financial Year. This follows the Government Annual Performance Reviews and gender/ equity issues can be raised as a concern during this, and communicated through the Budget Call Circular (BCC).

Importance of the Budget Call Circular

- Communicate the goals and processes for gender and equity budgeting for the preparation of budget submissions
- Requirement for budgetary units to provide justification and/or planned results on men and women and/or gender equality of the following:
  - Existing programmes
  - Proposed new spending initiatives, and
  - Proposed reductions in expenditures
  - Different forms of gender budget call circulars, they can also include the requirement to include sex disaggregated data to present the results achieved or expected results.

- **Local Government Workshops (October)** disseminate priorities, Indicative Planning Figures, and discuss policy issues affecting Local Government (LG) operations. Usually touches on equity issues although gender can also be critically discussed.
- **Programme/Sub-Programme Working Group Discussions (November)** include Programme MDAs, Ministry of Finance, Planning and Economic Development (MFPED), LGs, private sector, Development Partners and CSOs.

Addressing Gender and Equity Budgeting in BFPs and MPS

It is a legal requirement in accordance with the Public Finance Management Act (PFMA, 2015). *Refer to Section on Introduction and Section on Evolution of GEB in Uganda.*

The Equal Opportunities Commission assesses the BFPs and MPSs for GEB compliance using a pre-determined scoring criteria. All the Sections of the BFPs and MPSs are assessed and scored for gender and equity responsiveness. The total score for all Sections must be at-least 50%, for the BFP or MPS to qualify for the Gender and Equity Certificate and approval by Parliament.

In addition, the health sub-programme is required to demonstrate how it contributes to the attainment of the Sustainable Development Goals (SDGs). The SDG 3 is: "Ensure healthy lives and promote well-being for all at all ages," with 13 targets. Four of the targets specifically focus on gender and equity in health provision: reduce the global maternal mortality ratio; end preventable deaths of newborns and children under 5 years of age; ensure universal access to sexual and reproductive health-care services; and achieve universal health coverage.

The NDPIII identified the following gender and equity issues, which should be considered in budgeting and implemented over the Plan period. These include:

i. Completion rate of immunisation before 1 year remains low at 78%
ii. High maternal mortality.
iii. Limited child and maternal nutrition education.
iv. Non-functionality of some health facilities.
v. Unmet need for family planning at 28 percent of Ugandan women.
vi. HIV infection among babies - 7,500 infected annually.
vii. Gender Based Violence – 56% experiencing spousal violence and 22% sexual violence.
viii. Violence against children is high with 59 percent of females and 68 percent of males reporting experiencing physical violence during childhood.
ix. Exposure to harmful cultural practices including Female Genital Mutilation (FGM).
x. Disability prevalence rate of population aged 5 years and above is high at 12.5 percent for any form of disabilities.
xi. High teenage pregnancies at 25%.
xii. Low staffing levels of critical cadres: midwives and doctors.

If these issues were to be handled over the Plan period, this would substantially contribute to gender equality and equity. Therefore, it is important that before any budgeting exercise the health sub-programme agrees on those particular gender and equity issues is like to affect their performance and the attainment of SDGs, to have measures identified and allocated resources to implement them.

Mainstreaming Gender and Equity into Sections of BFP

Section 1: Programme Overview

This Section illustrates how the health sub-programme relates to the National Development Planlll, and how the sub-programme objective addresses gender and equity concerns. It also includes indicators for measuring progress towards achievement of gender and equity. National Development Plan lll Human Capital Development Objective 4**:** To enhance the productivity and social well-being of the population.

Health Sub-Programme Objective 4: To improve population health, safety and management. The objective is all inclusive, that is, it caters for the different categories of the population including vulnerable groups. The health sub-programme strategic results contribution to NDPIII bring out responsiveness to gender and equity.

i. Increased life expectancy
ii. Reduced neonatal, infant, under 5 and maternal mortality rates
iii. Reduced fertility rate

Outcomes and Outcome indicators

This Section illustrates the linkages between health sub-programme outcomes/indicators and gender equality as well as equity. It illustrates how health outcomes and outcome indicators are gender and equity responsive.

Gender Indicator - Reduced Maternal Mortality Ratio from 336/100,000 (FY 2017/18) to 311 in FY 2021/22

Equity: Children - Reduced under 5 mortalities from 64/1000 live births (FY 2017/18) to 59/1000 for FY 2021/2022

Youth - Reduce teenage pregnancy rate from 25 percent (FY 2017/18) to 22 percent FY 2021/22

Older persons – Reduce NCDs Diabetic rate from 3.4% (2017/18) to 3 in FY 2021/22

Section 2: Medium Term Budget Projections

The section highlights budgetary commitments for addressing health priorities including gender and equity priorities for the Plan period, 2020/21-24/25 and performance targets.
Most of the gender and equity priorities fall under Public Health, Curative and Rehabilitation Health Services, under the Ministry of Health. The example excludes other Votes like National and Regional Referral Hospitals.

Table 8.2: Gender and Equity Medium-Term Budget Projections

	Approved Budget 2020/21	Proposed Budget 2021/22	Medium Term Budget Projections		
			FY 2022/23	FY 2023/24	FY 2024/25
Public Health Services	16.65	11.4	11.4	11.4	11.4
Curative Health Services	1,228.16	1,020.86	1,020.86	1,020.86	1,020.86

Source: NDPIII 2020/21-2025/26

These are block figures with no **breakdown but address gender and equity.**

Table 8. 3: Gender and Equity Responsive Performance Targets for the Medium-Term

Performance Targets							
Intermediate Outcome Indicators	**Base year**	**Baseline**	**2021/22**	**2022/23**	**23/24**	**24/25**	**25/26**
Dpt 3 coverage	2019/ 20	95%	98%	99%	100%	100%	100%
Total users for modern contraceptive methods (excluding condoms and Fertility Awareness methods)	2019/ 20	2,933,109	3,120,862	3,320,633	3,533,192	3,759,358	4,000,000
% of the functional HC IVs (offering caesarian and blood transfusion section)	2019/ 20	50%	60%	70%	80%	85%	90%
% of sub-counties with HC IIIs	2019/ 20	50%	55%	60%	65%	70%	75%
Proportion of established positions filled	2019/ 20	63%	68%	73%	78%	83%	88%

Source: NDPIII 2020/21-2025/26

Section 3: Programme Past Performance and Interventions for the Ensuing Year

This Section illustrates the achievements of the sub-programme for the period under review, the planned sector interventions for the ensuing year, and budget allocation.

It highlights gender and equity outputs attained breaking them by sex, age, disability, and region/location depending on the intervention/context.

- Twenty-five wheelchairs were distributed to PWDs in Moroto District.
- Conducted social mobilisation for house-to-house polio campaign in 10 districts.
- Mobile phone registration of pregnant women by VHTs - Family Connect – in 2 sub-counties of Oyam District.
- Construction of 34 staff housing units at HC IIIs in Karamoja.

Programme Interventions for the Ensuing Financial Year

At BFP level, broad interventions are listed where gender and equity issues will be implemented.

- Expand community-level health promotion, education, and prevention services in all programs to reduce risks of exposure to communicable and non-communicable conditions with targeted interventions in districts with low coverage.

- Improve the Reproductive, Maternal, Neonatal, Child and Adolescent Health services.
- Improve the functionality of health facilities at all levels (scale up the 5s-CQI approach to improve quality of care).

Budget Allocation

The Budget for public health services interventions 1 and III is Ug shs **11.4 billion**. No specific breakdown to GE interventions.

The Budget for curative and rehabilitation services is Ug shs **1,026.86 billion**. This covers interventions for improvement of functionality of health centres through improved availability of medicines and commodity supplies, and improved diagnostic services. No specific breakdown to GE interventions.

Section 4: Programme Challenges in Addressing G&E Issues

This Section highlights internal and external challenges as well as emerging issues that will affect the sub-programme performance in addressing gender and equity issues.

- Challenges of integration of gender and equity issues in planning, budgeting and implementation including ring fencing resources at the implementing agencies.
- Limited availability of the critical cadre in the health sector, such as midwives, to implement reproductive health activities especially ANC and deliveries at health facilities.

Mainstreaming Gender and Equity in the Ministerial Policy Statement

The Ministerial Policy Statement details how the outputs indicated in the Budget Framework Paper will be implemented by the respective Departments at Vote level. The outputs and targets are translated into detailed activities with specific budget allocations. It is important that the gender and equity issues that were identified for implementation are clearly translated into detailed activities with specific budget allocation. It is also vital to indicate the gender and equity activities in the work plan - drawn in four quarters, clearly indicating which activities will be implemented in quarter 1, 2, 3, and 4; as well as specifying responsibility.

Conclusion

- It is a legal requirement to mainstream gender and equity in the BFP and MPS.
- This is necessary for accelerated inclusive growth and development.
- This entails prioritising G&E issues and identifying and costing strategic interventions.

Preparations of Budget Estimate

Preparation of Budget Estimates

- Votes receiving ceilings from the Programme Working Group.
- Votes set priorities based on the Strategic Investment Plans.
- Accounting officers set programme ceilings.
- Heads of programmes cost activities based on the Chart of Accounts.
- Programme budgets are consolidated into the vote budget.

The gender and equity issues highlighted in the NDP must be included in the Vote priorities and Programme budget.

8.1.3 Presentation and Approval of the National Budget Framework Paper

Cabinet approval of National Budget Framework Paper (before 31st December).

National Budget Framework Paper (NBFP)

- Spells out the major National Priorities.
- How the resources have been allocated to achieve the National Objectives.
- It incorporates the inputs of the consultative process
- Proposes the necessary trade-off to Cabinet endorse.

Parliamentary Approval of the NBFP

In line with the PFMA, the National Budget Framework Paper is presented to Parliament by 31st December. The NBFP is discussed by Sectoral Committees of Parliament which submit their reports to the Parliamentary Budget Committee.

It must be presented with a Certificate of Gender and Equity Compliance from the Minister responsible for Finance, in consultation with the Equal Opportunities Commission.

Further consultations

- **Inter-Ministerial Consultative Meetings (February)** between the Ministry of Finance and programme ministries to discuss programme budget priorities and allocations as well as outstanding policy issues.
- The gender and equity issues can be on the agenda.

Parliamentary approval of the budget

- The Minister of Finance must present the annual budget of a financial year to Parliament by 1st April.
- The Speaker commits the proposed budget to the Budget Committee of Parliament and to each Sectoral Committee of Parliament.
- Parliament considers and approves the budget by 31st May, if it is presented with a Compliance Certificate of Gender and Equity.

Presentation of the Budget Speech

The Minister presents the Budget Speech at a seating of Parliament **(June)**. The Budget Speech articulates:

- Highlights of the Economic and Fiscal Performance in and the outlook for the financial year.
- Emerging trends in the domestic, regional and international economy.
- Strategy for expanding Employment and Growth Opportunities.
- Proposed taxation measures and the way forward.
- A good entry point for a Gender Budget Statement which includes health gender and equity issues and Programmes.

8.1.4 Budget Execution

- Appropriate entry point is through monitoring and evaluation.
- Appropriate performance health gender and equity indicators should have been designed at the budget formulation stage.
- Tracking performance of gender and equity responsive health programmes is important to foster effective implementation.

8.2 Mainstreaming G&E in the Local Government Budget Cycle and Process

Articles 190-197 of the Constitution of the Republic of Uganda, 1995, provide for the finances of the Local Governments. The Local Government Act mandates Local Governments to plan, budget and implement social services with health policies and plans among them, through the Primary Health Care system. Districts and Municipal Councils therefore take primary responsibility for delivery of frontline healthcare services through the 'Primary Health Care' grant system where funds are transferred directly from the Ministry of Finance, Planning and Economic Development (MFPED) to local government general accounts.

8.2.1 The Budget Process

- The budget is prepared through an open, transparent and widely participatory process.
- The objective of the consultative process is to solicit the views of all stakeholders in the preparation of the Budget and consequently ensure that the LG budget reflects the views, aspirations and priorities of all stakeholders.

8.2.2 Entry points for GE Mainstreaming

- The Local Governments Budget Committees agrees on the rules, conditions, and flexibility of the coming planning and budgetary process. The rules should be responsive to G&E, compliance.
- MFPED issues the first Budget Call Circular: Indicative Planning Figures to Local governments (LG examines the BCC health priorities and establish outputs that are targeting G&E).
- The National Budget Conference (LGs can critically raise and discuss the G&E concerns in the health sub-programme).
- Regional Budget Conference (Since NDPIII is hinged on regional development, discuss and share the G&E outputs for health sub-programme).
- Executive Committee determines sub-programme allocations; sub-programme departments prepare write ups for Local Government Budget Framework Paper. (The Health Department should ensure gender and equity issues in the NDP are addressed among the departmental priorities).
- Lower Local Governments prepare Development Budgets and Plans (look out for gender and equity issues in the health sub-programme of the NDP).
- Meeting of the Executive Committee and Sector Committees to review draft BFP from Lower Local Government (Ensure the G&E issues of the Health Department are included in the BFPs).
- LG Budget Conference (discuss outputs that are G&E responsive).
- Budget reviews by Standing Committees of the Council (look out for Health Department G&E issues).
- Budget Approval by the Council (Council should make sure the Health Department addresses the G&E concerns in the NDP before approval).
- The draft LG BFP is reviewed by the Technical Planning Committee (The Committee should ensure that the G&E issues in Health Department are addressed in the BFP).
- LG Sector Committees review budgets, after receiving feedback from MFPED (Look out for gender and equity issues in the health Department).

- Executive Committee examines final budget (look out for gender and equity areas missed).
- The Executive Committee lays the budget and work-plan before the LG Council (Ensure that the G&E concerns in the Health Department are included).
- LG Budget Conference (discuss outputs that are G&E responsive).
- Budget reviews by Standing Committees of the Council (look out for G&E issues for the Health Department).
- Budget Approval by the Council (Council should make sure the Health Department has addressed the G&E concerns in the NDP before approval).
- Parish Development Committee (PDCs): bottom-up participatory planning.
- Sub-County Budget Conferences. (See image below)

- District Budget Conference (Different stakeholders).
- Sectoral Committees
- Technical Planning Committee
- Executive Committee
- Council Approval

8.2.3 Local Government Delegated Functions

Health service delivery is decentralised to local government level. The Ministry of Health is responsible for policy review and development, supervision of health sector activities, formulation and dialogue with health development partners, strategic planning, setting standards and quality assurance, resource mobilization, advising other Ministries, Departments and Agencies on health-related matters, and ensuring quality, health equity, and fairness in

contribution towards the cost of health care. The districts and sub-districts are responsible for the financing, delivery, and management of health services at the primary level of the health system which includes the VHTs, Health Centre IIs, Health Centre IIIs, Health Centre IVs, and general hospitals.

Delegated Local Governments functions

The Local governments have several delegated functions as laid out by the Local Government ACT cap 243. These include:

- Planning functions from the parish to district level.
- Legislative powers where Higher LGs make ordinances and Lower LGs make bye-laws.
- They have Local Council Courts which handle civil offences.
- They have powers to levy taxes.
- They monitor the projects in their area.

Conclusion

It is now a legal requirement to mainstream gender and equity in the BFP which is necessary for accelerated inclusive growth and development.

8.3 Gender and Equity Budgeting Statements

It is a summary of the health sub-programme's gender and equity issues to be addressed, planned interventions, expected outcome, planned outputs, activities, performance indicators and budget allocations in the ensuing Financial Year.

Rationale

Preparation of a Gender and Equity Budget Statement for the health sub-programme is important as:

- It makes it easier to see the gender and equity issues, and planned interventions in the budget to be addressed by the health sub-programme for the ensuing FY.
- It takes less time for the Equal Opportunities Commission to assess compliance to gender and equity budgeting as everything is in one section and summarised rather than being spread out over various sections of the BFP, which is a large document.
- It is a perfect solution for assessment of compliance to gender and equity budgeting for the 132 districts n the country. It would take several days with many assessors, to complete the exercise.

- The Gender and Equity Budget Statements can be used at the budget preparation stage. The statements will explicitly state the gender concerns, interventions to address the concerns, the expected outputs and outcomes, and the corresponding budgetary allocations.

The Gender and Equity Budget Statement, therefore, should:

a) Report on the status of gender equality and equity.

b) State the government priorities for improving gender equality and equity.

c) Indicate the budget measures aimed at promoting gender equality and equity.

8.3.1 Structure and Content of the Gender and Equity Budget Statement

i. List of gender and/or equity issues to be addressed in a sub-programme and their causes.
ii. Implication of the gender and equity issues if unaddressed.
iii. Proposed interventions to address the causes.
iv. Planned outputs.
v. Expected outcomes.
vi. Performance indicators.
vii. Budget allocation.

Illustrations

Issue: High teenage pregnancy rate

Uganda has a high teenage pregnancy rate, with 25% of girls aged 15-19 having begun childbearing (UDHS, 2016). This is mainly due to limited availability of youth friendly facilities at which adolescents can access Family Planning services in privacy. In the past there have been increased FP clinics/frequency at health facilities without provisions for youth friendly corners.

Implication of high pregnancy rate

If not addressed teenage pregnancy leads to unplanned births. In addition, it causes high maternal mortality due to unsafe abortions or complications experienced by adolescent girls at the time of delivery.

Interventions to address the causes

The Ministry of Health plans to roll out youth-friendly services in all government Health Centre IVs and district hospitals.

Planned outputs with targets

- A total of 200 Youth Corners set up in HCIVs and district hospitals.
- A total of 800 Peer Educators facilitated.

Expected outcomes in terms of contributing to the sector objectives

This will lead to improved access to FP for the youth.

Performance indicator(s)

- Number of youth friendly corners established in HC IVs and district hospitals.
- Number of Peer Educators facilitated.

Budget for the planned outputs

Ug shs 500,000,000 (Five hundred million) allocated.

Summary Gender and Equity Statement for the Health Sub-Programme

Uganda has a high rate of teenage pregnancy at 25%, leading to unplanned births and high maternal deaths. Adolescents are unable to access FP due to limited availability of youth friendly services. A total of 200 youth friendly corners will be set up at HC IVs and district hospitals, and 800 Peer Educators facilitated. This is expected to improve access to FP for youth, reduce teenage pregnancies and maternal deaths. A total of Ug shs 500,000,000 is allocated for the activities.

9.0 GENDER AND EQUITY RESPONSIVE MONITORING AND EVALUATION

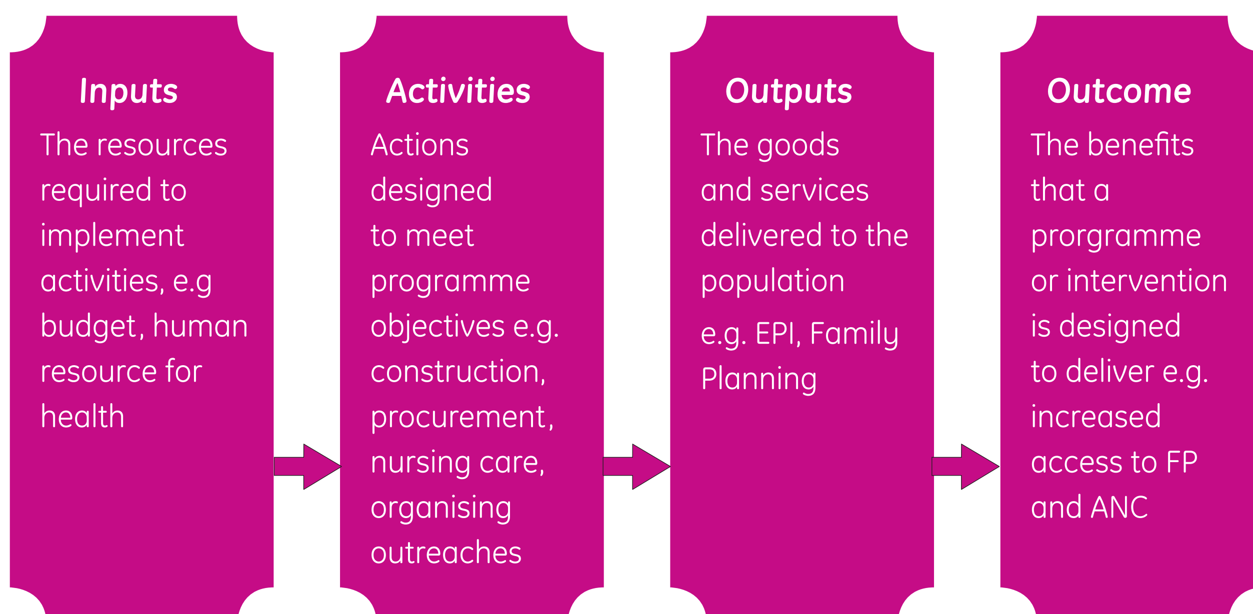
Monitoring is a continuous process of data collection and analysis, carried out during the implementation of health projects, programmes, policies or Plan to assess progress towards realisation of set goals and objectives. It tracks implementation and compares progress to the expected performance, and observes how the values of different health indicators against stated goals and targets change over time.

It is through monitoring that the health sub-programme can establish whether it has achieved its annual performance targets for service provision or not. For example, for FY 2018/19 the health sector was able to achieve only 8 of the 41 performance targets set. These were: people living within 5 kilometers of a health facility (86%), ART Coverage (86%), Malaria cases per 1,000 persons per year (14/1,000), Facility based fresh still births (9 per 1,000 deliveries), Maternal deaths among 100,000 health facility deliveries (92/100,000), Timeliness of reporting (98%), and Approved posts filled (76%) - (Ministry of Health, 2020).

Monitoring of health projects/programmes is done at intervals. There are quarterly health performance reviews, and annual health sub-programme reviews. On the other hand, evaluation is usually conducted midway (mid-term) or at the end of the implementation of a project or Programme.

9.1 Programme Logic

The Programme Logic illustrates a results chain in the implementation of a health programme. It shows the linkage between inputs or health resources to activities, outputs and outcomes or benefits of implementing a health programme. The four stages are chain linked in a logical order, that is, resources are needed to conduct activities, which leads to provision of services for the population and eventually health outcomes. The Programme Logic can be used to monitor the sensitivity of health projects/programmes to the needs and priorities of vulnerable groups including women, men, children, youth, older persons, PWD, and those in disadvantaged locations by incorporating a gender and equity dimension at all stages of the results chain, as illustrated below.



9.2 Gender and Equity Responsive Monitoring and Evaluation

Gender and equity responsive monitoring and evaluation involves tracking health programme/project execution to assess the degree of fairness of provision of services among the categories in society. G and E monitoring tries to establish whether a health programme addresses the different priorities and needs of the vulnerable groups.

Inputs –To monitor inputs, it is vital to establish how the resources are being allocated to the various health activities. It is important to monitor how adequate the inputs are. For example, monitoring the adequacy of the budget for: Maternal health services, orthopedics; and immunisation outreaches. The shortages should be monitored and corrective measures taken.

Activities/processes – It is vital to monitor the scope of coverage of the health activities. For example, whether the planned activities at the health centre address the specific needs of women, children, distant parishes and villages. For instance, if it is construction of a health facility, it is essential to establish whether ramps are constructed to enable people with physical disability to access the health facilities; if it is immunisation, to establish whether outreaches are organised for the distant villages. Each challenges ought to be identified with possible solutions.

Outputs – It is crucial to monitor whose needs the results are targeting or likely to meet. For example, are women attending ANC? Are women giving birth at the health centres? Are adolescents getting FP supplies? Any challenges ought to be identified and solved.

Outcomes - The benefits that a health project or intervention is designed to deliver. It is necessary to monitor the immediate changes among the beneficiaries. For instance, through

the Health Management Information System (HMIS), to establish health services utilisation by the various social groups: who is accessing and using the health services or who is not? It is important to monitor whether there are any changes in deliveries at the HC? Any change in ANC attendance? Any change in immunisation coverage? If certain groups are not accessing services, to establish the reasons for non-accessibility; and who is/not satisfied with the health services. For example, if a health facility does not have a youth friendly corner, adolescents are not likely to go there for FP.

9.3 Gender and Equity Responsive Health Indicators

Health indicators are quantitative (calculable) or qualitative (perception) factors or variables that provide a simple and reliable means to measure achievement, reflect the changes connected to a health intervention, or to help assess the performance of a health project, programme or Plan. Indicators show the health status and health service, the progress being made, and how far it is from the goal.

Gender sensitive indicators

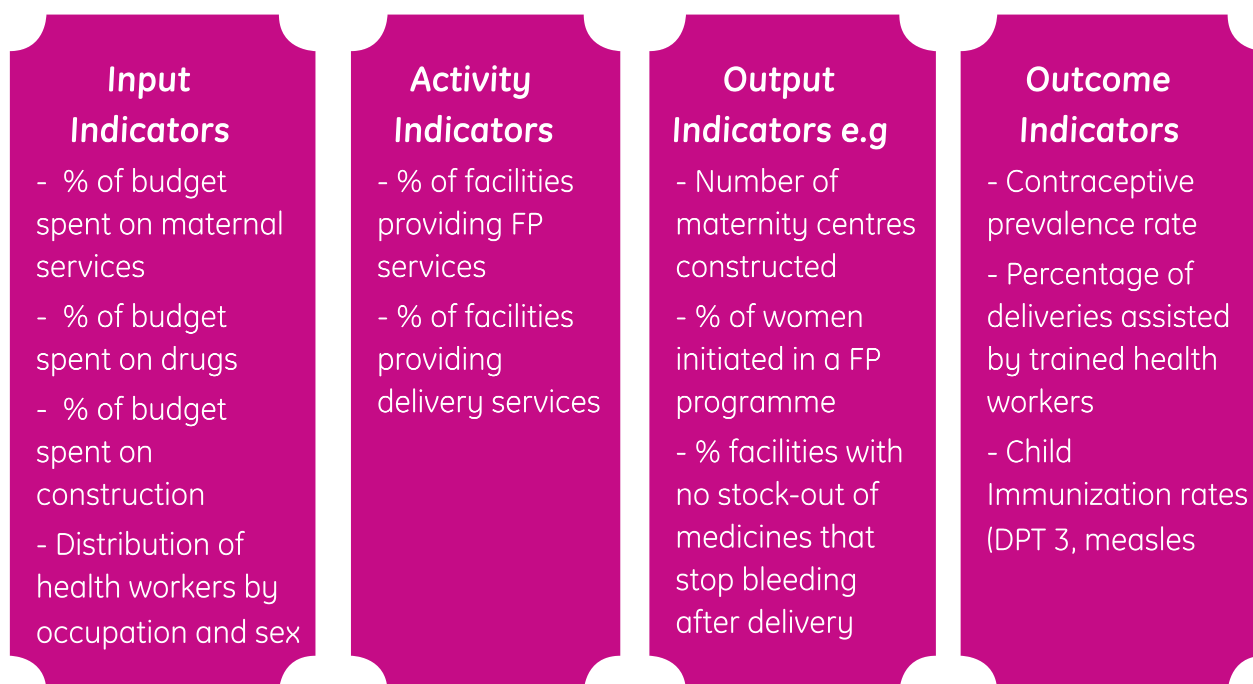
Gender sensitive indicators are needed to give information on changes in achieving gender equality. Examples of gender related indicators include: Maternal Mortality Ratio 336/100,000 in 2016 (UDHS 2016) and 438/100,000 in 2011 (UDHS 2011); Contraceptive prevalence rate 35% in 2016 (UDHS 2016) and 26% in 2011 (UDHS 2011). ANC 4+ visits 42% in FY 2018/19 and 38% in FY 2017/18 (MoH, 2019).

Equity sensitive indicators

Equity sensitive indicators are needed to give information on changes in access to, participation in and the benefits among socio-economic groups and locations. The equity indicators review changes in aspects of geographical location, disability, and age. The information could also be on minority groups. Examples of equity indicators:

- Infant mortality Rate 43/1,000 live birth (UDHS 2016)
- Under five mortality rate 64/1,000 (UDHS 2016)
- Disability prevalence 12.5% (UDHS 2016)

Indicators may be generated along the M&E Chain as illustrated in diagrams below:



Mainstreaming G&E in existing indicators

Gender sensitive indicator:

The value of the indicator is measured separately for men and women and so allows comparisons to be made between the two groups: e.g. indicator to monitor human resources for health. This is important to reveal the differential impact on men and women of a given policy or intervention.

Refer to Section on *Identification of GEB Issues Using Statistics*, Table 3 on Staffing Levels for Critical Cadres in the Public Health Sector, 2017/18.

According to the table, for every three doctors there is one female doctor (3:1). For every three Clinical Officers there is one female Clinical Officer (3:1).

The indicator can be gender specific e.g. proportion of places reserved for girls' admission to Medicine courses at public universities.

The indicator can be implicitly gendered - in this case, the indicator makes no explicit reference to gender, however, if it is interpreted within a broad context, the indicator is of reference to women or men. E.g. Number and percentage of reported rape cases who accessed post exposure prophylaxis treatment. The victims are almost exclusively female.

Equity indicators

The value of the indicator is measured separately for age (children, youths, older persons); disability (physical, hearing impairment, sight impairment, concentration); location (rural/urban, districts, hard to reach). Example of deliveries and live births by location (districts) in table 9.1:

Table 9. 1: Number of Deliveries and Live Births by Region

Sub-Region	No. of Deliveries	Live Births
Acholi	60,501	59,851
Ankole	91,145	89,893
Bukedi	63,476	60,558
Bunyoro	60,234	57,904
Busoga	97,863	96,045
Elgon	62,208	61,010
Kampala	91,900	89,867
Karamoja	32,029	31,716
Lango	65,074	64,015
North Buganda	115,853	114,094
Rukiga	47,778	47,277
South Buganda	115,856	114,710
Teso	65,924	65,224
Tooro	107,580	106,085
West-Nile	102,900	101,399
Grand Total	**1,180,321**	**1,159,648**

Source: Ministry of Health, Annual Health Sector Performance Report, FY2018/19

The indicators on deliveries and live birth can be broken down further to show other dimensions of equity, e.g. by age group of mothers.

9.4 National Priority Gender Equality Indicators

The National Priority Gender Equality Indicators (NPGEIs) is a framework to guide the development and production of gender responsive indicators in Uganda. The NPGEIs were developed under the framework of the Plan for National Statistical Development and the UN Joint Programme on Gender Equality and Women's Empowerment to guide the mainstreaming of gender in statistical production processes in the National Statistical System. The framework presents gender responsive indicators for six thematic areas including Health. The NPGEIs respond to national, regional and international demands for gender statistics, particularly the NDPIII and SDGs. The progress is measured through the implementation of various five-year National Development Plans.

The following are the key NPGEIs for the health sector, reprocessed by UBOS in 2017 and 2018, using information extracted from the UNHS 2012/13, UDHS 2011, existing census, and other administrative information generated by the Ministries, Departments and Agencies (MDAs) in the sector.

SDG - NPGEI Indicator 3.9: Prevalence of stunting in children under 5 years of age by sex

- Boys (37%) and girls (29%) under 5 years are stunted. Stunting in children under five years in rural is almost twice as high as the urban areas

NPGEI Indicator 3.10: Prevalence of wasting in children under 5 years of age by sex

- Boys (4.9%) than girls at (4.6%) under 5 years. Wasting was more pronounced among children whose mothers had no education than mothers with some education.

Indicator 3.11: Prevalence of under-weight children under 5 years of age by sex

- Boys (14.9%) than girls at (12.7%) under 5 years. It was more than double among children under 5 years in the rural than in the urban areas.

SDG Target: NPGE Indicator 3.12: Prevalence of anemia among women of reproductive age, 2011

- Prevalence of anemia among women of reproductive age was 23 percent. Rural 19.9% and urban 23.8%.

SDG NPGE Indicator 3.13: Infant Mortality Rate

- Boys (70 deaths per 1,000 live births) and girls (59 deaths per 1,000 live births). The IMR was nearly twice as high in the rural areas (47 deaths per 1,000 live births) as in the urban (25 deaths per 1,000 live births).

SDG Indicator NPGE Indicator 3.14: Under five mortality rate

- Boys (70 per 1,000 live births) than girls (59 per 1,000 live births). Under five mortality is nearly twice as high in rural areas (47) than in urban (25).

SDG NPGEI Indicator 3.16: Proportion of births attended by skilled health personnel

- Percentage of births assisted at delivery by a skilled provider stood at 58 percent. Younger mothers (67 percent of those below 20 years) were attended to by a skilled provider, compared to their older counterparts (51 percent of those 35-49 years).

SDG NPGE Indicator 3.20: Adolescent (15-19 years) fertility rate

Proxy: Age Specific Fertility Rate (15-19 years), 2011.

- The ASFR for women aged 15-19 years (adolescents) stood at 134 live births per 1,000 women. It was higher in the rural than urban areas.

SDG NPGE Indicator 3.23: Proportion of women (aged 15-49) who make their own sexual and reproductive health decisions

- Rural 16.8 Urban 17.6. There is no significant difference between age groups for women who make their own sexual and reproductive health decisions by age group.

SDG NPGE Indicator 3.25: Proportion of population aged 15-49 years with health Insurance by sex, 2011.

- Only one (1) percent of women aged 15-49 years and men aged 15-54 years had health insurance in Uganda. There were no marked differences between the proportions of women covered under insurance, and those of the men.

SDG NPGE Indicator 3.28: Share of the population living with HIV/AIDS, by sex

- There were more females than males living with HIV/AIDS at 8 and 6 percent respectively.

SDG NPGE Indicator 3.32: Percentage of eligible persons receiving ARVs by sex.

- At national level there was equal use of ARVs among eligible male and female at 19 percent; at the rural area was the same trend at 17 percent each whereas in the urban areas slightly more women (24 percent) than men (23 percent) had used the ARVs.

Indicator 3.34 Prevalence of lower respiratory infections by sex

- 15 percent of children showed symptoms of Acute Respiratory Infection (ARI) in the two weeks preceding the survey. There was no marked difference in prevalence of ARI between girls and boys. Prevalence of ARI was higher in the rural than urban areas. It was highest among children aged 6-11 months and it declined thereafter.

9.5 Sustainable Development Goals

Monitoring is also used to track progress towards achievements of international and regional commitments that the government is committed to achieve, for example the Sustainable Development Goals (SDGs).

The Government made a commitment to achieve the SDGs by year 2030. For example, SDG Number 3: “Ensure healthy lives and promote well-being for all at all ages,” with 13 targets. Four of the targets specifically focus on gender and equity in health provision. These are as follows:

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.

Indicators 3.1.1 Maternal mortality ratio.

Indicator 3.1.2 Proportion of birth attended by skilled personnel.

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

Indicator 3.2.1 under five mortality rate.

Indicator 3.2.2 Neonatal mortality rate.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Indicator 3.7.1: Proportion of women of reproductive age (aged 15- 49 years) who have their need for family planning satisfied with modern methods.

Indicator 3.7.2: Adolescent birth rate (aged 20-49 years; aged 15-19 years) per 1,000 women in that age group.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases, service capacity, and access among the general and the most disadvantaged population).

Indicator 3.8.2: Number of people covered by health insurance or a public health system per 1,000 population.

Sustainable Development Goal Number Goal 5: "Achieve gender equality and empower all women and girls."

Target 5.3: Eliminate forced marriage and genital mutilation.

Indicator 5.3.1 is the proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18.

Indicator 5.3.2 is the proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting.

Target 5.6: Universal access to reproductive rights and health.
Indicator 5.6.1: Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care.

9.6 NDPIII Health Gender and Equity Responsive Monitoring Indicators

The NDPIII health indicators were formulated in line with the SDGs Goal 3: "Ensure healthy lives and promote well-being for all at all ages," and Goal 5: "Achieve gender equality and empower all women and girls**"**. NDPIII objective for the health thematic area: to improve population health, safety, and management.

Table 9.2: NDPIII 20/21-24/25 Gender and Equity Responsive Monitoring Indicators

Key Result	Baseline	2020/21	2021/22	2022/23	2023/24	2024/25
Reduced Maternal Mortality Ratio (per 100,000)	336	311	286	261	236	211
Reduced Under 5 Mortality Rate (Per 1,000)	64	42	39	35	33	30
Total Fertility Rate	5.4	5.0	4.9	4.8	4.6	4.5
Reduced teenage pregnancy	25	22	20	18	16	15
Reduce prevalence of child disability	13	12	11	10	9	8
Reduce unmet need for Family Planning	28	26	22	18	14	10
Reduce GBV Prevalence	56	50	45	40	35	30
Increase proportion of population with access to universal health care	44	48.2	52.4	56.6	60.8	65

Source: National Planning Authority, 2019, National Development Plan lll, 2020/21-24/25

10.0 GENDER AND EQUITY RESPONSIVE REPORTING

Gender and Equity Responsive Reporting is the documented account of targeted health interventions taken towards addressing G&E gaps in health care indicating progress, challenges, lessons learnt, and strategies for future reference or interventions. Gender and Equity reporting gives a voice to and space for the health issues affecting women, men, PWDs, older persons, youth, hard-to-reach and hard-to-stay locations, instead of perpetuating the stereotypes in the implementation of health activities and programmes. For example, if in a monthly district health report, the District Health Officer (DHO) notices that all the HC IIIs did not treat chronic diseases, then it would mean the drugs for chronic diseases never got down to these levels. The DHO would know that older persons are not getting treatment and would raise it as an issue in his report so that drugs for chronic illnesses are sent to HCIIIs.

Gender and equity health reporting is a tool for accountability for the provision of services to vulnerable groups. For example, if a Malaria Programme distributes bed nets, G&E reporting will give a breakdown of those who received the bed nets: how many women, men, children, youth, PWDs, older persons, and hard-to-reach areas. It therefore, gives an account of the progress made towards achieving set equity and gender equality health goals and objectives.

Types of reports

There are various health sub-programme reports. It is important that GE sensitivity is in-built into all reporting requirements. The following are some of the reports:

1. Activity/field health reports
2. Progress health reports: monthly, quarterly, annual
3. Monitoring health reports
4. Mid-Term and Terminal Evaluation Health Reports
5. G&E Assessment/Audit reports

Responsibility for reporting

- At the central level, all health workers under the Ministry of Health, National and Regional Referral Hospitals.
- All lecturers in the tertiary training institutions e.g. University Medical Schools, Dental Schools, Nurse and Midwifery Training Colleges.
- All health workers in a district e.g. District Heath Team, District Hospitals, Sub-county Health teams, Health Centre Teams, and Community Health Workers.

A few considerations in reporting:

G&E reporting provides information captured from various sources, principally data and voice. In the case of data, G&E responsive reporting uses Gender Disaggregated Data (GDD) and Equity Disaggregated Data (EDD). Refer to Section on GDD and EDD for elaborations.

Reporting, through capturing the voices of the beneficiaries, aims at getting their opinions about the health programme or activity. It captures comments, from key stakeholders, on the good and bad elements of the health activity or project. The listener quotes the views, opinions, and experiences of the stakeholders verbatim. For example, the poverty assessments conducted by MFPED, asked community members what poverty meant to them. Many responded, **"Poverty is not being able to access health care".** Voices are captured through Focus Group Discussions (FGD). The FGD should have a G&E representation. For example, during a community health meeting, there should be health workers, women, men, PWDs, youth, and older persons. All the participants should be given a chance to air out their issues and suggestions.

It is crucial that health reports use simple G&E-sensitive language, and should ensure that the language does not denigrate men, women, PWDs, youth, nor older persons. For example, when reporting on a community health meeting, on attendance, the reporter should not say there were 50 men, 30 married women, 15 unmarried women, 20 disabled people, 40 youthful boys, and 10 youthful girls. This kind of negative labelling of PWDs and unmarried women is not right and makes them feel out of place. Instead, the report should note the meeting was attended by 45 women, 20 PWDs, and 50 adolescents (40 boys and 10 girls). Reporting involves all stakeholders including the G&E representatives so as to build consensus on the content of the report.

Documenting the entire process

G&E issue addressed: limited or no access to healthcare in islands of Buvuma, Namayingo, Kalangala, and Nampongwe in Namayingo District, and Tsai island in Kumi District. The GE strategies used: health services were extended to these underserved areas. Activities undertaken to address the issue: HCIIIs were constructed for the above islands. Resources used: Ug shs 20 billion was spent. Outputs: Five health centres with ramps; Five Outpatient Departments; five maternity wings; 10 Inpatient Wards (for F/M); five youth friendly corners; 10 bathrooms and 10 toilets with closed doors (F/M); 10 bathrooms and toilets for Persons with Disability (M/F); five kitchens; 50 staff houses; equipment and supplies including adjustable examination and delivery beds to cater for PWDs. Outcome realised: The health facilities provided access to 70,000 people including: men, women, children, youth, PWDs, elderly, and persons living on the islands.

It involves explaining the challenges/constraints experienced. For example, marine transport, connecting the islands to the mainland districts, was not regular. It's compounded by the frequent breakdown of the ferry service/boat, and for movement within the islands many do not have appropriate road infrastructure connecting inhabitants on the islands a situation which is worse in the rainy reason. Therefore, there were delays in delivering raw materials to the islands, and in transporting these to the construction sites especially during the rainy reason.

It involves documenting the lessons learnt and recommendations for the future. For example, among the lessons learnt, performance of the health sub-programme is affected by performance in the complimentary sub-programmes/programmes. If the health sub-programme performs well and the complimentary sub-programmes/programmes do not, it slows down the gains in the health sub-programme. For a health facility to be easily accessible, there must be a road and access roads connecting people to it. Therefore, the health sub-programme must share its future infrastructural expansion plans with the Integrated Transport Infrastructure and Services Programme and other complimentary sub-programmes/programmes, to lobby them to plan for the required complimentary services.

The importance of G&E responsive health reporting cannot be over-emphasised. When reporting on health interventions, it is important to ensure that there is a gender and equity balance of sources, voices and perspectives. Gender-equity transformative reporting will ensure that women, men, boys, girls, PWDs, older persons, youth, minority, and vulnerable groups are portrayed in a balanced and fair manner.

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Budget Monitoring and Accountability Unit (BMAU)
Ministry of Finance, Planning and Economic Development
P. O. Box 8147, Kampala
www.finance.go.ug