



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

GUIDELINES TO IMPLEMENT

THE POLICY ON PREVENTION AND RESPONSE TO SEXUAL HARASSMENT



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TO SEXUAL HARASSMENT**

2018

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ACRONYMS

AU	African Union
CAO	Chief Administration Officer
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
COMESA	Common Market for Eastern and Southern Africa
CPD	Continuous Professional Development
CSOs	Civil Society Organisations
DEC	District Executive Committee
DEVAW	United Nations Declaration on Violence Against Women
DHO	District Health Officer
DSC	District Service Commission
EAC	East African Community
EOC	Equal Opportunity Commission
GDIA	Gender Discrimination and Inequality Analysis
GDP	Gross Domestic Product
HIV	Immune Deficiency Syndrome
HRH	Human Resources for Health
HSC	Health Service Commission
IEC	Information, Education and Communication
IG	Inspectorate of Government
IGAD	Inter Government Authority on Development
IPs	Implementing Partners
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPS	Ministry of Public Service
NEPAD	New Partnerships for African Development
PHRO	Principal Human Resource Officer
PISD	Post Traumatic Disorder
PNFPs	Private Not for Profit
PS	Permanent Secretary
R&S	Rewards and Sanctions
R&SC	Rewards and Sanctions Committee
RO	Responsible Officer
SH	Sexual Harassment
SHFA	Sexual Harassment Formative Assessment
SHFPP	Sexual Harassment Focal Point Person
STDs	Sexually Transmitted Diseases
UHRC	Uganda Human Rights Commission

FOREWORD

Equal treatment at work as well as a safe, healthy and satisfactory work environment is a right under the 1995 Constitution (as amended) of the Republic of Uganda. The Constitution, Employment Act and other laws and policies prohibit discrimination against anyone on grounds of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

Sexual Harassment is a type of sex or gender-based form of discrimination involving unwelcome sexual conduct or pressure in the workplace and /or any other place. The law provides protection against such a conduct and it applies to both men and women.

Sexual harassment is a multi-faceted problem and normally manifests as a professional misconduct, gender based form of discrimination, a civil wrong and a criminal offence. Everyone (men and women, employers and employees) has a responsibility to prevent and stop the vice because of its far-reaching negative consequences of lost career opportunities, low productivity of health workers, poor service delivery and negative institutional reputation.

In 2016, the Ministry of Health with assistance from IntraHealth International carried out the Sexual Harassment Formative Assessment (SHFA). This study revealed that sexual harassment starts during recruitment of health workers, mainly perpetrated by men in positions of power in recruiting positions. This behavior continues in the workplace, where some in-charges /supervisors offer unjustified incentives in exchange for sex.

To address the challenge of sexual harassment, the Ministry of Health developed guidelines on the Prevention and Response to Sexual Harassment (herein after referred to as "Guidelines") to assist and guide users in implementing effective and standardized mechanisms for prevention and response to sexual harassment complaints in the health sector at all levels. These guidelines will help improve work conditions, workforce productivity, retention and morale of workers in the sector.

The guidelines were developed through a meticulous and consultative process involving senior technical and management teams at the Ministry of Health in collaboration with other Government Ministries, Departments and Agencies, Development Partners and the Academia.

The guidelines shall apply to all medical practitioners in public, private not for profit, private for profit health facilities, health training institutions (public and private), and any other persons and organizations providing health care in both formal and informal environments. They will also apply to all health workers including Heads of Departments, Unit Managers, Supervisors, Facility in-charges, technical staff, administrative and support staff, and interns in addition to all stakeholders who participate in health sector programs, activities at central, local government and other institutions. The Human Resource Department is mandated to oversee their efficient implementation at all levels.

I implore all staff and those charged with human resource management to be vigilant and make use of this useful tool for better workforce management and improved health service delivery.



Hon. Dr. Jane Ruth Aceng
MINISTER OF HEALTH

ACKNOWLEDGEMENTS

These Sexual Harassment guidelines define sexual harassment in work place, applicable legal and policy frameworks and outlines strategies for prevention and response services and implementation mechanism for addressing this concern in the health sector. Further, the guidelines provide detailed reporting and complaint handling mechanisms, monitoring and evaluation system as well as institutional stakeholders involved in fighting sexual harassment.

The development of these guidelines was financially and technically supported by the USAID-funded Strengthening Human Resources for Health (SHRH) Activity implemented by IntraHealth International. I am immensely grateful to Dr. Vincent Oketcho, the Chief of Party, Dr. Susan Wandera, Dr. Lule Haruna, Mr. Mugalu Kamyia, Ms. Alice Nayebare and the entire staff of IntraHealth International for the technical support and leadership.

I thank Leah Goldmann, Dr. James Mugisha, Samson Olum and officials from the Ministry of Health, Ministry of Public Service, Ministry of Local Government, Ministry of Gender, Labour and Social Development, Health Service Commission, Uganda Human Rights Commission, the Judiciary, Health Professional Councils, and the Academia for their relentless work, immense participation and contribution towards the development of these guidelines.



Dr. Diana Atwine

PERMANENT SECRETARY

A health sector that ensures zero tolerance to sexual harassment, upholds gender equality and human rights, and improves productivity of the workforce and its clients.

1.1 Introduction

A safe working environment is conducive to achieving strong and productive results in health service delivery. In order to create such an environment, it is vital to ensure that the workplace is free from sexual harassment among other forms of discrimination. According to Uganda's legal and policy frameworks, sexual harassment is illegal. Various studies have indicated that sexual harassment is widely spread and is manifested in different forms.

The Government of Uganda has made several efforts to protect workers from any form of harassment including sexual harassment. The Constitution of the Republic of Uganda (1995) as (amended) guarantees all Ugandans equality, dignity and non-discrimination. Ministry of Health reaffirms its zero-tolerance for sexual harassment and is committed to creating an environment that respects and protects the rights of all its members, male and female. The Employment Act (2016) prohibits sexual harassment while the Sexual Harassment Regulations 2012 include information on reporting and disciplining perpetrators of this offense.

These guidelines provide guidance on definition of sexual harassment; applicable legal and policy frameworks; and outline strategies for prevention and response services and implementation mechanism for addressing sexual harassment in the health sector. The guidelines also provide detailed response mechanisms to complaints of harassment, monitoring and evaluation of sexual harassment reported complaints as well as institutional stakeholders in fighting sexual harassment.

Cases that occurred prior to 1st February 2018 shall not fall under these guidelines and should be handled in accordance with the pre-existing procedures.

For ease of implementation, these guidelines have no budget implications and are designed to be integrated into existing institutional management systems at all levels.

1.2 Background

Sexual harassment has implications on the organizational performance, workers and service delivery. For example, it can result in stress, anxiety, sleep disturbances, Post-Traumatic Stress Disorder (PTSD), reduced output and performance and loss of self-esteem and confidence.

Despite efforts by Government to deal with this problem, sexual harassment continues to be reported as indicated in the survey results in the following subsection. This therefore calls for concrete measures to address sexual harassment at the work place. It's against this background that the Ministry of Health developed guidelines on prevention and response of sexual harassment in the health sector to provide critical guidance and reference by employers and workers to prevent and effectively respond to sexual harassment.

1.2.1 Situational Analysis

Sexual harassment takes different forms which include: unnecessary touching, inappropriate medical examinations, suggestive compliments, winking, visual messages of sexual nature, use of vulgar language, display of objects of sexual nature, and outright demand for sex. All these mainly affect workers in subordinate positions and result into hostile working environment. Often times, sexual harassment in the work place is often “normalized,” under-reported/not reported, attracts secondary victimization, the victims rarely receive justice because they become compromised and end up giving in.

Various studies conducted in Uganda by different sectors and institutions including; Health, Education, Agriculture, Cabinet and Makerere University pointed out the existence of sexual harassment in workplaces. In the health sector, the studies revealed that majority of the victims of sexual harassment are female health workers victimized by their male supervisors and managers.

In 2003, the Ministry of Health conducted a study on health worker retention which revealed that one in four workers (24%), (majority of whom were female nurses) stated that they had been subjected to abuse (sexual harassment) by a supervisor. Approximately one in five reported abuse by patients or patients’ relatives (21%) while 16% reported abuse by peers. The study cites research that demonstrates that workers quit their job in response to such abuse or harassment.

A 2012 Uganda Ministry of Health *Gender Discrimination and Inequality Analysis (GDIA)* 2016 found that 32.1% of employee survey respondents reported that sexual harassment involving manager/supervisor expectations of sexual favors in order (for staff) to get a good evaluation, a promotion, or a salary raise (i.e., quid pro quo sexual harassment) were either “somewhat common” or “very common.”¹ Employee survey respondents reported other forms of sexual harassment: 1) Sexually suggestive gestures (30%); 2) Being exposed to sexually explicit discussions or conversations (24.7%); 3) Unwanted attempts to establish sexual relationships (22.4%); and 4) Being the object of sexual jokes, comments or leering (19.4%)². These assessments demonstrated that sexual harassment was a silent and unregulated problem in Ugandan health workplaces mainly affecting female health workers.

Although there are laws in place to deal with sexual harassment such as Public Service Standing Orders 2010, Employment Act (2007) and the Employment (Sexual Harassment) Regulations (2012) made there under, their implementation is still weak. It is also necessary for the health sector to have its own specific measures to deal with its unique circumstances.

1.3 Rationale for the Sexual Harassment Prevention and Response Guidelines

Sexual harassment prevention and response is crucial to good health systems governance and human resources management leading to achieving equal opportunity, non-discrimination and gender equality in the health workforce.

¹ Uganda Ministry of Health. 2012

² Also see the 2016 Uganda Ministry of Health Sexual Harassment Formative Assessment (SHFA)

It is essential for addressing health worker attrition, job dissatisfaction and low productivity, victimization, poor performance, accidents, unwanted pregnancies, interpersonal conflict and absenteeism among others.

Uganda has adopted various international, regional and national legal and policy frameworks that address issues of discrimination including sexual harassment which the government is enjoined to implement.

Despite the existing laws, policies and institutions in place to address sexual harassment, the vice has persisted because of misuse of power, unclear expectations of professional behavior, unclear evidentiary and reporting requirements, health facility conditions with no privacy or space, lack of awareness, limited implementation of laws, inability to apply the existing sanctions and regulating mechanisms that let harassers operate with impunity, ethnic stereotypes and cultural expectations of male-female relationships among others.

In order to ensure that sexual harassment is explicitly addressed in all its operations, the Ministry of Health developed guidelines to implement the policy on prevention and response to sexual harassment for the Sector.

2.1 Purpose

The guidelines are intended to assist and guide users in implementing effective and standardized mechanisms for prevention and response to sexual harassment complaints in the health sector at all levels. They will also guide users on implementation of processes on recruitment, deployment, confirmation, promotion, remuneration, performance management, training and staff development, retirement of health workers and resource allocation.

2.2 The Goal

The goal of the guidelines is to establish a safe, respectful and healthy working environment and uphold individual dignity of health workers for better service delivery.

2.3 The Overall Objective.

The overall objective is to provide guidance for implementation, enforcement, monitoring and evaluation of sexual harassment prevention and response measures in the health sector.

2.3.1 Specific objectives:

1. To raise awareness on sexual harassment and discrimination in both public and private health institutions;
2. To institutionalize a reporting and redress mechanism for sexual harassment prevention in the health sector;
3. To empower employees in the health sector to ensure accountability of perpetrators;
4. To advocate for resource mobilization for capacity building of stakeholders and effective implementation.

2.4 Guiding Principles

The implementation of the guidelines will be guided by the following principles.

Human Rights

The right to a safe and healthy working environment is a universally and fundamentally recognized human right to which men and women are entitled. Therefore elimination of discrimination and sexual harassment is very key in realization of this right.

Equal opportunity and non-discrimination

A health sector where women and men have equal opportunity for employment, pay and promotion; equal access to and control over resources and benefits at the workplace without discrimination on the basis of gender, age, ethnicity or disability.

Right of Association

The right of association under the Labour Act No.7 of 2006 particularly the right not to interfere with, restrain or coerce an employee in the exercise of his or her rights guaranteed under the Act and other related laws.

Confidentiality

The guidelines recognize that sexual harassment leads to stigmatization and victimization of victims and whistle blowers. All interventions to implement these guidelines shall ensure

confidentiality, privacy and respect of the parties especially the victims and whistle blowers. All service providers and duty bearers shall ensure that information about parties to sexual harassment complaint especially the victims shall only be divulged with their consent in order to ensure their safety and security.

Gender Equality

A health sector where women and men have equal chances to realize their full rights and potential to participate in the workforce, contribute to health development, and benefit from its results. This includes sensitivity to the effects of unequal power relations.

Survivor-Centered Approach

A survivor-centered approach necessitates that response and intervention to address sexual harassment centres on the voice and consent of the survivor / victim. The substantive participation of the survivor / victim should be considered at every stage of the prevention and response process.

Integrated Community Approach

Significant change is possible when all community members take collective responsibility to eliminate the root causes of sexual harassment: gender inequality, abuse of power, and lack of respect for human rights. This approach creates individual responsibility on men, women, boys and girls, policy makers, community leaders, religious leaders, and other stakeholders, to prevent and respond to sexual harassment.

In addition, men as potential perpetrators of sexual harassment must be involved and engaged in combatting sexual harassment through community sensitization and promotion of healthy attitudes as champions of sexual harassment prevention.

Multi-sectoral Approach

The guidelines shall promote integrated approach and collaboration in the sector departments, institutions, units and facilities as well as other relevant Ministries, Departments, Agencies (MDAs) and Local Governments.

Integrity in investigations

All members involved in investigation will have high credibility, sensitivity and technical competency to handle such grievances.

Timely response to all reported complaints

The investigation procedure should be completed as soon as possible and should not take more than 30 days.

Respect for Natural Justice

Each complaint should be addressed responsibly and impartially, taking into account rules of natural justice in inquiry process for complainant/harassees, witnesses and the alleged harasser or perpetrator.

Evidence-based

These guidelines and their implementation will be grounded in robust, empirical research and evidence, using good practices that have been proven successful in similar contexts.

2.5 Scope

The guidelines apply to all medical practitioners in public, private not for profit, private for profit health facilities, health training institutions (public and private) and any other persons and organizations providing healthcare in both formal and informal environments. They will also apply to all health workers (heads of departments, unit managers, supervisors, facility in-charges, other technical staff, technical advisors, administrative and support staff, interns, etc) as well as to all stakeholders who participate in health sector programs, activities at central, local government and other institutions.

Private Sector Institutions are hereby called upon to adapt these guidelines with necessary modifications to fit and or suit their specific context.

Harassment frequently involves an abuse of power where the targets experience difficulties in defending themselves. Harassment at the workplace is any unwelcome or offensive action, repeated or unreasonable act, addressed to a worker or a group of workers that causes difficulty in the performance of an assigned job or causes a worker to feel that he/ she is working in a hostile working environment which poses risk to the health and safety of the worker.

3.1 Definition of Sexual Harassment

For purposes of these guidelines, Sexual Harassment (SH) shall refer to unwelcome, offensive & unwanted behavior by its nature, singular or through persistent conduct by the supervisor, peer to peer, manager, in-charge, service provider that may be verbal or nonverbal to a supervisee, peer, junior staff, or clients of a sexual nature that has a negative and harmful effect on that person's (harassee) dignity as well as their employment, career, job performance or job satisfaction and access to services that may be direct or implicit.

For avoidance of doubt, consensual behavior that is mutually desired and agreed upon, with both parties willingly participating, shall not constitute sexual harassment. Wanted, welcome advances, flirtation or attempts at gallantry are not sexual harassment. Whether behavior is or is not harassment does not depend on the harasser's intention but on the target's perception of what is unwelcome, unwanted and offensive.

Note: Whereas there is no Ugandan law that forbids civil servants and other categories of workers working in the same institutions from being involved in a consensual romantic relationship and/or marriage, good practices from other organizations suggest that the two work in separate departments; and require that they should not be in a supervisee/supervisor relationship to avoid conflict of interest or its appearance. In the exceptional circumstances that there is a consensual romantic relationship between supervisor and supervisee, the management should exercise some discretion in their judgment to ensure there is no favoritism or appearance of favoritism, and decrease the likelihood of sexual harassment in the workplace.

3.2 Who can be sexually harassed?

Sexual harassment mainly affects the following, but is not limited to:

- » Health sector workers (including health workers and other support staff/volunteers, including VHTs) in both subordinate and management positions, and/or at the peer-to-peer level.
- » Patients/clients can be both perpetrators and victims of sexual harassment.

While sexual harassment is often committed against the juniors/clients, it is also possible for a manager/provider to be sexually harassed by juniors/clients.

3.3 Categories of Sexual Harassment

There are two categories of sexual harassment:

- A. Hostile Work Environment** is conduct that creates an intimidating, hostile, degrading or humiliating work environment for the recipient/victim. This can also involve threats to one's safety and their career.

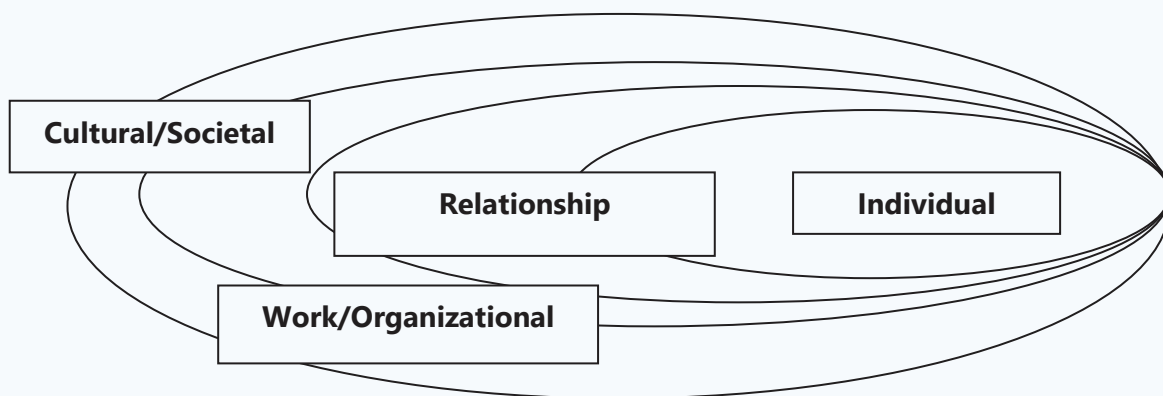
B. Quid Pro Quo (“this for that” exchange) is a demand by a person in authority for sexual favours in exchange for work related benefits e.g. a wage increase, promotion, training opportunity, transfer or the job itself.

Hostile Work Environment and Quid Pro Quo can manifest in a variety of ways, including:

- » **Physical harassment** - includes unwelcome and/or unnecessary touching in a sexual manner such as kissing, patting, pinching, glancing and staring with lust and inappropriate medical examinations among others.
- » **Verbal harassment** - includes unwelcome comments about a person’s private life, body parts or appearance, sexually suggestive jokes, innuendos and comments; suggestive or insulting sounds; outright demand for sex and use of vulgar language among others.
- » **Gestural harassment** - includes sexually suggestive body language and/or gestures, repeated winks, licking lips.
- » **Written or graphic** - harassment includes displays of objects of sexual nature (such as pornographic materials, sexually explicit pictures, screen savers or posters) and harassment via emails and other modes of electronic communication.
- » **Psychological/emotional harassment** - consists of persistent proposals and unwelcome requests, unwanted invitations to go out on dates, insults, taunts, and innuendoes of a sexual nature.

3.4 Causes and Contributors to Sexual Harassment in the Social Ecological Model

The socio-ecological model² below explains factors at the individual, relationship, organizational and societal level that increase the likelihood of sexual harassment.



Individual level: Includes biological and personal history factors (e.g. education, beliefs, etc.) among victims, bystanders, perpetrators.

Relationship level: Includes proximal social relationships, most importantly those between victims and harassers. This category also recognizes power differentials or closeness between colleagues (i.e. supervisor/supervisee) at work or the stress of working away from home and spouse.

² <http://www.cdc.gov/violenceprevention/pdf/SVPrevention-a.pdf>

Work/Organizational level: Organizational culture includes values and beliefs, norms, practices, written and unwritten rules for interaction in which social relationships are embedded. This category also encompasses misuse/abuse of organizational power, lack of space for privacy and separation of sexes, lack of and/or inadequate enforcement of sanctions against perpetrators, poor induction of health workers on appropriate professional behavior and unsupervised/unregulated and/or unnecessary medical examinations (e.g., lack of strict guidelines for health worker conduct during medical examinations).

Societal/cultural level: Includes peer groups, schools, religious and community institutions outside the work organization as well as larger societal factors that create unacceptable climate for violence, and reduce inhibitions against violence (e.g., norms of inequality, discriminatory policies, etc.). This category also involves facilitators of sexual harassment such as ethnic and regional gender stereotypes, and unemployment and poverty which were perceived to make women vulnerable to quid pro quo sexual exchanges.

3.5 Consequences of Sexual Harassment

There are several possible consequences of sexual harassment for the victim, the perpetrator, the organization, and society.

a. Victims

- HIV/STDs/abortions/unwanted pregnancies
- Depression
- Demotion
- Loss of respect for manager/supervisor/harasser
- Favors granted if one complies/not granted if one doesn't comply
- Unwanted or forced transfers
- Poor performance
- Forced marriages
- Poor performance appraisal, failed promotion
- Fear to work with harasser/avoidance
- Late salary
- Loss of career capital
- If the organization doesn't have a policy against SH, it is difficult to get a legal remedy
- Loss of job
- Loss of self-confidence
- Legal costs
- Secondary trauma

b. Perpetrators

- HIV/STDs
- Being avoided/feared to work with
- Conflict with victims
- Loss of respect
- Poor performance
- Poor performance appraisal, failed promotion
- Violator of human rights
- Loss of job
- Civil claims
- Criminal charges
- Incurrence of legal costs

c. Health services/Organizational Level

- Absenteeism
- Attrition (dismissal, resignation, transfer)
- Lower productivity level
- Professional dissatisfaction
- Hostile, tense environment
- Disrupted team work
- Avoidance of harasser
- Supervisor authority undermined
- Violation of patient/community trust
- Poor quality of care (barrier to use)
- Tainted reputation
- Clients coming late for services
- Poorer client health
- Poorer health seeking behavior
- Incurrence of legal costs through industrial actions
- Criminal charges
- Civil claims

d. Societal

- Decreased productivity
- Decreased GDP
- Violation of human rights which negatively impacts both the state and individuals
- Reinforcement of patriarchal norms
- Poor health outcomes

Sexual harassment is a human rights issue with far reaching legal and socio-economic consequences for governments, organizations, and individuals. To promote productivity in the health sector, health workers must be protected against and held accountable for the occurrence of sexual harassment. Therefore, there is a legal obligation upon all stakeholders to promote, protect, and fulfill those rights as enshrined in legal and policy frameworks at the international, regional, and national levels.

4.1 International and Regional Legal and Policy Frameworks

Uganda is party to various international and regional instruments on gender equality and women's empowerment and human rights, most of which have been domesticated in national laws and policies.

The international instruments include: The Convention on Elimination of All Forms of Discrimination Against Women (CEDAW, 1979); The Beijing Declaration and Platform for Action (1995) and its follow up recommendations (2000, 2005, 2010); The Commonwealth Plan of Action on Gender Equality; The United Nations Declaration on Violence Against Women (DEVAW, 1993); and The United Nations Sustainable Development Goals (2015); The Discrimination (Employment and Occupation) Convention, 1958 (No. 111); the Equal Remuneration Convention, 1951 (No. 100).

At the regional level, the instruments to which Uganda is a party include: The African Charter on Human and People's Rights; The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol) (July 2003); The East African Community (EAC) Treaty (2000); AU Gender Policy (2009); The Common Market for Eastern and Southern Africa (COMESA) Treaty; Gender Policy (May 2002); The Inter Government Authority on Development (IGAD) Gender Policy and Strategy (July 2004); The New Partnerships for African Development (NEPAD); International Conference on the Great Lakes Region (ICLGLR) Protocol on the Prevention and Suppression of Sexual Violence against Women and Children (2006); and The AU Heads of State Solemn Declaration on Gender Equality (July 2004) among others.

4.2 National Legal and Policy Frameworks

At the domestic level, sexual harassment has been recognized as a type of gender-based discrimination.³ The legal and policy frameworks mandate the government of the Republic of Uganda to take all necessary actions to ensure that health facilities and institutions adopt a zero-tolerance approach to sexual harassment.

These guidelines operationalize existing national legal and policy frameworks which include: The Constitution of the Republic of Uganda (1995) as amended; The Employment Act (2006); the Employment (Sexual Harassment) Regulations, (2012); The Penal Code Act (Cap 120) (As Amended); The National Gender-Based Violence Policy (2017); The Domestic Violence Act (2010); The National Development Plan (NDPII); The Uganda Public Service Standing Orders (2010); The Code of Conduct and Ethics for Uganda Public Service (2005); The Uganda Gender Policy (2007);

³ Refer to The 1995 Constitution of the Republic of Uganda, as amended and the Domestic Violence Act, (2011).

The Guidelines for mainstreaming Gender equality into Human Resource Management in the Public Service (MoPS, 2011); The Guidelines for Mainstreaming Gender Equality into Human Resources Management in the Health Sector (MoH, 2017); the MoH Clients Charter; and the Codes of Conduct for different Health Professional Councils, among others.

These laws provide necessary basis for these guidelines although the health sector institutions and management procedures must be operationalized to effectively prevent and respond to such emerging misconduct.

Whereas the Penal Code Act (Cap 120) makes provision against certain sexual offenses, - for instance defilement, rape, etc - it is not exhaustive in as far as addressing sexual misconduct, especially in the workplace and this calls for special administrative procedures. Furthermore, although the Employment (Sexual Harassment) Regulations (2012) provide for control of sexual harassment in workplaces, they are of general application and require that different institutions/sectors develop specific guidelines to address such occurrences. These guidelines will therefore supplement and implement the existing laws and policies.

Sexual harassment must be eliminated to create a conducive work environment for both health workers and clients. These guidelines adopt a public health approach to reduce sexual harassment in the health sector through the following steps:

1. *Define the problem of sexual harassment*, as outlined in Section 1 of these guidelines;
2. *Identify risk and protective factors* which have been enumerated in Sections 3 and 5 of these guidelines;
3. *Develop and test prevention strategies* as indicated in these guidelines;
4. *Ensure widespread adoption* through policymaker/decision maker engagement, and wide dissemination.

Furthermore, this approach is community-oriented and demands collective responsibility from the entire community, including men and women, to prevent sexual harassment.⁴

Public health interventions are grouped into three prevention categories based on when the intervention occurs:

- a. Primary Prevention:** Approaches that take place before sexual harassment has occurred to prevent initial perpetration or victimization;
- b. Secondary Prevention:** Immediate responses after sexual harassment has occurred to deal with the short-term consequences of violence;
- c. Tertiary Prevention:** Long-term responses after sexual harassment has occurred to deal with the long term consequences of sexual harassment and harasser treatment interventions if need arises.

5.1 Primary Prevention

These guidelines propose the following strategies to prevent the occurrence of sexual harassment at all levels of the work place.

- a. Dissemination of Anti-Sexual Harassment Laws, Regulations, Relevant Policies and Guidelines;**
All staff shall be made aware of the existence of sexual harassment as a problem in the health sector. The MoH, in conjunction with other line ministries, shall take all necessary steps to extensively disseminate anti-sexual harassment laws, regulations and related policies to staff at all levels. This will improve staff awareness on sexual harassment legislative framework and procedures of reporting and management of sexual harassment complaints.
- b. Induction and Orientation of Staff;**
The MoH, other line ministries, and institutions at the national, regional, district, and facility level shall induct and orient all staff on the nature, magnitude and effects of sexual harassment in the health sector. The staff shall also be oriented on the reporting and management procedures of sexual harassment complaints.

⁴ CDC- Sexual Violence Prevention: Beginning the dialogue

- c. **Integration of anti-sexual harassment training into curriculum for Pre-service and in-service training/continuous professional development for all health workers;**
Anti-sexual harassment training shall be integrated into curriculum of pre-service and in-service training and Continuous Professional Development (CPD) for all health workers to create awareness, accountability, and behavior change.
- d. **Issuance of Administrative Circulars on Sexual Harassment;**
The MoH, in collaboration with the Ministry of Public Service, shall regularly issue Administrative Circulars to all Local Governments, Health Departments and Health Institutions including Private not for Profits, to guide prevention and response to sexual harassment.
- e. **Social Behavior Change Communication (SBCC);**
The MoH, in collaboration with other stakeholders, shall routinely carry out social behavior change, sensitization and advocacy programs on zero tolerance to sexual harassment for staff at all levels. These activities demand the dissemination of Information, Education, and Communication (IEC) materials and other strategies aimed at educating health sector employees and clients on sexual harassment prevention and response. Interventions may include radio messaging campaigns and bystander interventions that interrupt negative social behavior, model positive behavior and change social norms. The National Integrated Strategy for Health Promotion and Social Behavior Change Communication can be adapted to sensitize communities on sexual harassment prevention.
- f. **Evidence and Action-Based Research on sexual harassment;**
The MoH, in collaboration with partners and stakeholders (especially Ministry of Gender Labour and Social Development (MGLSD), shall build capacity of national, regional hospitals and district local governments to conduct gender-responsive and action-based research at respective levels. This will enable MoH and partners to regularly conduct evidence and action-based research that highlights the root causes, consequences and complexities of sexual harassment so as to develop appropriate, gender-responsive interventions that reduce its occurrence.

5.2 Secondary Prevention

This section details procedures for secondary prevention, which include the reporting and response mechanisms after the occurrence of sexual harassment.

5.2.1. Reporting Mechanisms

In addition to the primary prevention strategies mentioned above, the guidelines adopted secondary prevention (response) strategies to deal with the complaints of sexual harassment that may arise. The following reporting mechanism has been provided for and adopted in these guidelines.

- a. **Sexual Harassment Focal Point Person;**
There will be a Sexual Harassment Focal Point Person (SHFPP) designated to receive and handle complaints of sexual harassment at all levels of health service delivery. Any person who is sexually harassed may report directly to the SHFPP thus all institutions in the health sector shall designate SHFPP in accordance with the provisions of these guidelines

b. **Ministry of Health Call Center (0800-100-066);**

The MoH has a central call center that receives all complaints and inquires on health issues. Whereas in every institution there is a provision for an institutionalized sexual harassment complaint mechanism, this does not stop any complainant/harassée who has no confidence in the local mechanism to make a direct call through the call center. All calls with complaints of sexual harassment shall be directed to the SHFPP at MoH who will redirect the complaint to the appropriate person/body for further handling.

c. **Suggestion Box;**

All Institutions in the health sector shall ensure that there are suggestion boxes in place to enable staff who cannot report directly to SHFPP to drop their complaints. This will largely encourage anonymous reporting. When sexual harassment complaints are dropped in suggestion boxes, the identified complainant shall be directed to the SHFPP for further management.

d. **Other;**

In addition to the above, in circumstances where the complainant/harassée is uncomfortable reporting their complaint to the SHFPP, s/he can report directly to:

- i. Responsible Officer (RO), Supervisors, Human Resource Officers, District Health Officers, and other relevant authorities within the institution in which the complaint arises. Upon receipt of the complaint, these officials shall follow the procedure outlined in these guidelines;
- ii. Health Professional Councils, Equal Opportunities Commission, Inspectorate of Government, Uganda Human Rights Commission, and Police if the matter so necessitates.

5.2.2 Response Mechanisms

This section outlines a step-by-step process of reporting, investigating, determining and providing appropriate responses to the sexual harassment complaints reported.

Any person may report complaint(s) of sexual harassment to the SHFPP within the institution. A complaint may originate from any of the following persons:

- a direct victim of sexual harassment,
- an indirect victim,
- a bystander (such as a member of staff or client/patient), among others.

Every complaint received should be handled in accordance with the laid down procedures.

Note: The complainant/harassée shall have 6 months from the last instance of sexual harassment within which to report to the SHFPP. However, the complainant/harassée may report any prior incidents of sexual harassment that happened before the 6-month period.

The SHFPP will provide counseling and guidance, and inform the complainant/harassée of the formal and informal procedures, including investigation and handling of the complaint. In accordance with the survivor-centered approach, it is ultimately the decision of the survivor to choose whether to use the informal or formal procedure.

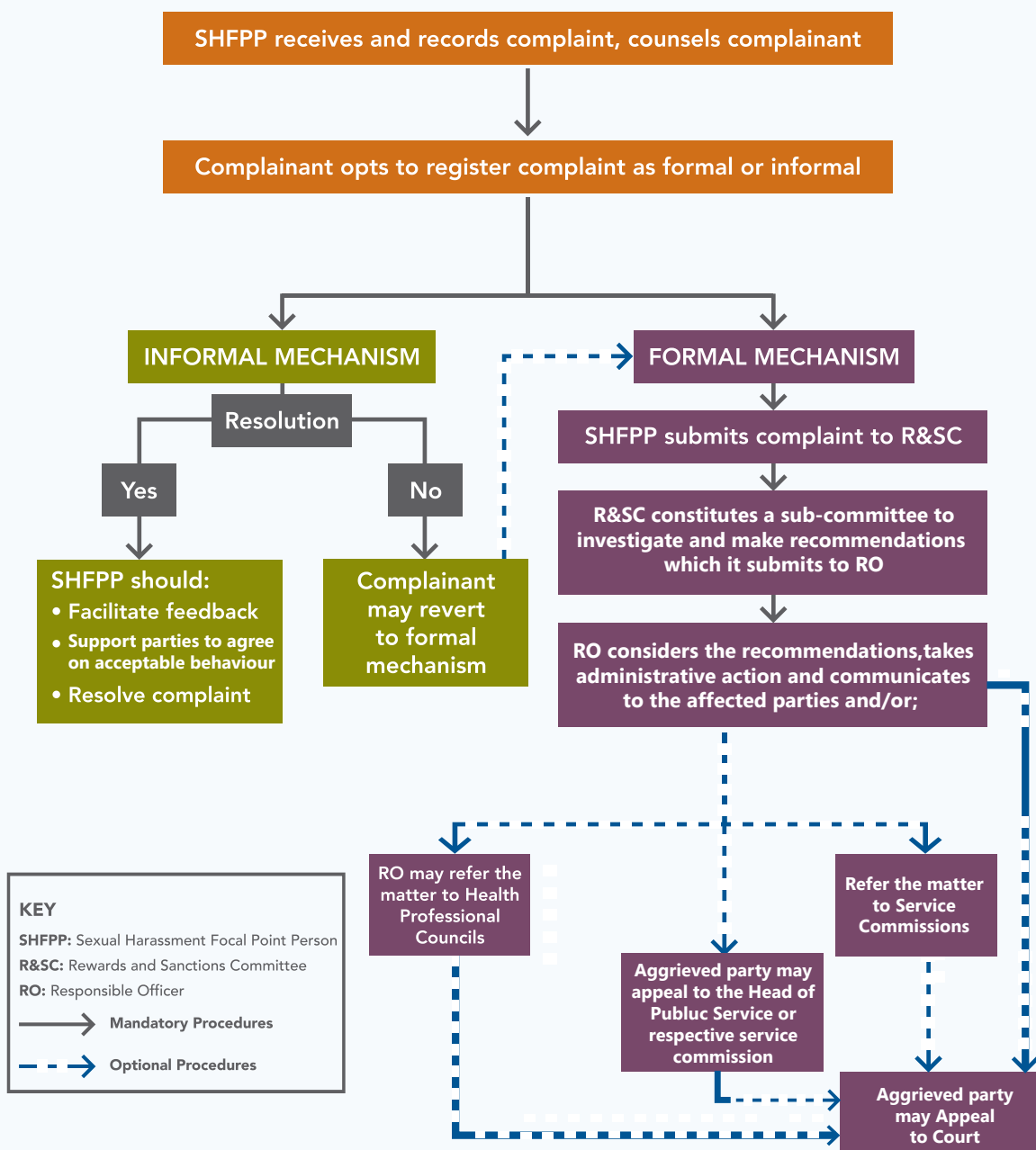
Formal complaints procedure involves taking pre-defined steps such as reporting, investigation, calling witnesses and making a report about the findings.

On the other hand, informal complaints procedure does not require following pre-defined steps indicated in the formal procedure but rather encourages amicable settlement of the issue involving the concerned parties.

It is upon the complainant/harassée to choose which of the two procedures to use. By lodging an informal complaint, the complainant/harassée shall not be barred from seeking formal redress to the complaint.

Record all complaints - While it is imperative to protect the identity of complainant/harassée of sexual harassment, responsible duty-bearers shall keep a record of the number of both informal and formal incidents and outcomes. This record will provide the basis for reporting, monitoring, and evaluation provided for in these guidelines, which is further detailed in Section 7 on Monitoring and Evaluation.

Procedure for Handling Sexual Harassment Complaints



i. Informal Complaints Procedure:

Informal procedures emphasize early intervention to address violations before problems escalate. The hallmarks of the informal procedures are clear communication of expectations, a focus on future acceptable behavior, and maintaining confidentiality to protect the privacy of everyone involved.

A complainant / harassee of sexual harassment who does not want to go through the formal system may opt for informal complaints procedure which must be settled within **7 working days**.

The complainant/harassee shall have primary autonomy in the choice of how s/he wants the informal complaint procedure to be handled, regardless of the proposals enumerated below. Further, the complainant / harassee shall be at liberty to choose between the supervisor / manager or the SHFPP to mediate / facilitate the resolution of informal complaint. Some of the informal processes to be employed may include but not limited to:

1. Truth-telling-The complainant / harassee explaining to the perpetrator/harasser that their conduct is not welcome;
2. The complainant/harassee requesting a supervisor or relevant officer to privately and informally speak with the offender/harasser on their behalf;
3. The complainant / harassee seeking confidential advice on possible solutions from a supervisor, trusted colleague or an officer trained to deal with harassment issues;
4. Should the concerned parties be willing, form peer-to-peer groups to handle and resolve complaints of sexual harassment. The peer group can guide the parties in reaching an amicable settlement which may include: apology, a commitment for non-reoccurrence, compensation as they may deem fit, among others. The peer-to-peer groups must be knowledgeable about sexual harassment and must give feedback to the SHFPP to determine the course of action.

By lodging an informal complaint, the complainant / harassee shall not be barred from seeking formal redress to the complaint if she chooses.

ii. Formal Complaints Procedure:

The formal complaint process shall be no longer than **30 working days** from receipt of complaint to resolution if S/he chooses.

A complainant / harassee shall not be required to exhaust all informal attempts of resolution before choosing to lodge a formal complaint.

Formal Investigation starts at two fronts: 1) when there is a disagreement at the informal level and the complainant/harassee decides to lodge a formal complaint or 2) when, from the start, the complainant/harassee indicated s/he wanted to lodge a formal complaint.

1. Upon receipt of the formal complaint, the SHFPP will within **10 working days**:
 - i. Document the complaint in detail;
 - a. In case of complaint of physical injury, the SHFPP shall immediately refer the complainant to the hospital or health facility for medical examination and treatment

- ii. Notify the RO of the complaint and commence investigation;
 - iii. Conduct full investigation using Forms B1 and B2 including documenting the date(s), type (s) of harassment, interviewing witnesses, and collecting evidence available (e-mail, voice mail, etc), among others;
 - iv. Forward full investigation report to the R&S Sub-Committee for consideration.
2. R&S Sub-Committee will convene and review the investigation report within **7 working days** and forward the Report of Findings (in Form C) to the RO with its recommendations for consideration;
 3. Upon receipt and consideration of the Report of Findings, the RO will make final decision or refer the matter to the Service Commission and communicate to the parties involved about the decisions and sanctions to be taken in **3 working days**.
 - » Where the parties are satisfied with the decision of the RO, the complaint will be considered settled.
 - » Where any of the parties is still not satisfied, s/he may appeal in accordance with the appeal procedures laid down in these guidelines.

iii. Handling of Sexual Harassment Complaints between Patient/Client and Health Workers

- a. Should a patient/client sexually harass health worker, the concerned health worker or a bystander shall report to the RO in case the matter requires administrative response. However, should the matter be of a criminal nature, s/he is at liberty to refer the matter to police for further handling;
- b. Should a health worker sexually harass a patient/client, the concerned patient/client or a bystander is at liberty to report through any of the mechanisms outlined in section 5.2.

iv. Substantiating a Claim of Harassment:

The balance of probability should be sufficient to substantiate a claim, requiring that the dispute be decided in favor of the party whose claims are more likely to be true. In substantiating the claim, reference should be made to the concerned parties' documentation which may include emails, pictures, letters, videos, voicemails, messages, and any other evidence that may be available, in addition to witnesses.

To substantiate a claim of sexual harassment, the R&S Sub-Committee must determine if the claim is a criminal offence warranting reference to the criminal justice system or if the conduct is calling for administrative redress. If the complaint is of a criminal nature such as rape, defilement, sexual or indecent assault (as provided for under the Penal Code Act (Cap 120), the case should be immediately referred to the administrators of criminal justice system for further management. However, if the claim is not criminal in nature, the R&S Sub-Committee must determine if it is hostile work environment or quid pro quo, following the criterion below:

a. Hostile Work Environment:

The harassment is severe and regular enough to interfere with a complainant/harassée's ability to do their job and creates an offensive work environment. Some considerations include, among others:

- i. Whether the conduct was verbal or physical or both

- ii. Frequency of conduct
- iii. Whether the conduct was hostile, intimidating, and/or offensive
- iv. Whether the alleged harasser was a co-worker or a supervisor
- v. Whether the complainant/harassée feels the conduct interferes with their job performance.

Note: that isolated incidents of harassment may be sufficient to constitute a claim of sexual harassment.

b. Quid Pro Quo Sexual Harassment:

At least one instance of an individual extorting sexual favors in exchange for professional benefits has occurred. Given the power differential and coercive nature of quid pro quo sexual harassment, a complainant/harassée's compliance in providing sexual favors does not negate a claim of sexual harassment.

In determining if a claim of sexual harassment can be substantiated, the sub-committee should consider the different ways that individuals (men and women) may perceive sexual harassment. Evidence shows that women are more likely to view a situation as sexual harassment than men, particularly in instances of hostile work environment category of sexual harassment. While an alleged harasser may not consider their conduct offensive, the complainant/harassée's perception of the behavior should be paramount in making a final decision.

v. Unsubstantiated Claims

If the complaint of sexual harassment is found to be unsubstantiated, will be dismissed.

vi. Retaliation

All parties involved in an investigation who acted in good faith will be protected from retaliation. Reminders of this prohibition against retaliation will be made during the investigation. If anyone involved as a complainant/harassée or a witness among others - at any stage of the complaint handling process feels they have been retaliated against, they are encouraged to report it to the SHFPP or a supervisor so it can be addressed immediately.

vii. Possible Sanctions

- a. If the R & S sub-Committee substantiates the claim of sexual harassment and recommends disciplinary sanctions to be imposed by the RO against the perpetrator, such sanctions should be proportional to the severity of the harassment;
- b. Where the sanction proposed exceeds the mandate of the RO, such a matter shall be referred to the Service Commission or Health Professional Council (HPC) for appropriate action;
- c. These sanctions will be determined in accordance with the existing laws and policies including but not limited to: Employment Act (Sexual Harassment) Regulations, Public Service Standing Orders and Public Service Code of Conduct and HPCs' Codes of Conduct among others.

Some of the administrative sanctions may include: written warning or disciplinary measures in employee's file; verbal warning and feedback on prohibited behavior; a "stay away" letter or restraining order; suspension of employment or of certification to practice; demotion; transfer of harasser with a report indicating reasons for transfer; termination from employment in the public health sector; and/or voluntary transfer of complainant/harassée that avoids unintended,

negative professional consequences. For cases which cannot be handled administratively, they will be referred to the criminal justice system especially when a criminal offence such as rape, defilement, indecent assault, molestation etc. has been committed.

Note: Instituting a criminal case against the perpetrator is not a bar to commencement of the administrative procedures. The two procedures can go on concurrently should the complainant/harassée so choose.

The RO shall ensure that the sanctions imposed on the perpetrator be implemented. The Rewards & Sanctions Sub-committee shall conduct regular checks to ensure that disciplinary sanctions imposed are being implemented. Additionally, the R&S Committee shall make annual reports to the RO detailing the status of compliance with these guidelines.

viii. Appeal Procedure

Appeals shall be available to both parties, whether the complaint is confirmed or dismissed, up to **14 days** after initial ruling on or determination of the complaint. The aggrieved party shall notify the RO of the intention to appeal in writing. While the accused has the right to appeal, the appeal mechanism should conduct a document review and avoid re-interviewing the complainant/harassée, unless there is evidence of significant failure in the original investigation process. There are two appeal procedures:

1. Internal Appeal Procedure

A party who is dissatisfied with the decision of the RO, may appeal to: The Head of Public Service / Secretary to Cabinet;

- a. If either party is dissatisfied with the decision of the Head of Public service/Secretary to Cabinet, s/he may appeal to the respective Service Commission for redress.
- b. If either party is dissatisfied with the decision of the Service Commission, s/he may appeal to Courts of Law.

2. External Appeal Procedure

A party who is not satisfied with the internal mechanism may appeal as follows;

- a. The dissatisfied party may appeal to the Commissioner Labor, District Labor Officer;
- b. A dissatisfied party with the decision of the Commissioner Labor, District Labor Officer, s/he may appeal to the Industrial Court;
- c. A dissatisfied party with the decision of the Industrial Court, s/he may appeal to the Court of Appeal.

5.3 Roles of Duty-Bearers within the Response Mechanism

Duty-bearers should always refer to the existing national policy, and legal framework such as Employment Act and the employment (Sexual Harassment) Regulations 2012. Duty-bearers should be also guided by the principles outlined in Section 2.4 of these guidelines.

i. Sexual Harassment Focal Point Person (SHFPP)

The SHFPP shall:

- a. Receive and register informal and Formal complaints in **Form A1 or A2**, respectively;
- b. Counsel complainant/harassée and inform him/her of available options for redress;
- c. Conduct full investigation using Forms **B1 and B2** and compile report on behalf of the R&SC Sub-Committee;
- d. Submit report to the R&SC sub committee for consideration;
- e. Act as an ex official member and secretary to the R&S Sub-committee;
- f. Follow up with complainant/harassée in one month after the conclusion of the case to establish whether the offending behavior has ceased.

ii. Rewards and Sanctions Committee (R&SC)

The R&SC has the mandate to investigate, handle, determine and make appropriate recommendations on all disciplinary complaints, including sexual harassment.

This committee shall:

- a. Establish, from among its members, a permanent standing sub-committee to receive, hear, investigate and make recommendations on complaints of sexual harassment on its behalf. This Sub-Committee shall be comprised of the chairperson and two other willing and knowledgeable members.
 - i) The SHFPP shall be an ex official member of the R&S Sub-Committee (i.e. s/he will not vote) and act as a secretary for the meetings.

iii. Rewards and Sanctions (R&S) Sub-Committee on Sexual Harassment

This Sub-Committee will act on behalf of the R&S Committee and all its decisions will be deemed to be the decisions of the R&S Committee.

The Sub-Committee shall perform the following roles:

- a. Receive, review and consider sexual harassment investigation reports from the SHFPP;
- b. Prepare Report of Findings (Form C) and provide recommendations under the complaints procedure to the RO;
- c. Keep a record of the nature of sexual harassment offences, proceedings, documents, information and action taken;
- d. Make periodical reports on the status of implementation of these guidelines to the Ministry of Health;
- e. Carry out any other duties as may arise for sexual harassment prevention and response.

iv. Responsible Officer

The RO may include the PS, CAO, Town Clerk, Hospital Director, District Health Officer (DHO) and Facility In-Charge, among others.

The RO shall:

- a. Designate a SHFPP who is at least in a senior management position, of high moral standing and unquestionable integrity, knowledgeable, with interest in the subject and is willing to work in that capacity. This designation shall be done in a participatory process involving all staff.

- b. Receive notification of complaints from the SHFPP on any complaint;
- c. Supervise the operations of the SHFPP, R&S Committee, and R&S Sub-Committee;
- d. Receive and consider final report and recommendations from the R & S Sub-Committee;
- e. Issue sanctions against perpetrator that fall within his/her (RO's) mandate;
- i. Where the proposed sanctions exceed the RO's Mandate, refer the matter to the Service Commission for action;
- f. Make and communicate final decision to the involved parties;
- g. Inform the involved parties of their right to appeal.

5.4 Conflict of interest

Note: In case of conflict of interests regarding any of the previously mentioned duty-bearers, or where one of the duty-bearers is alleged to be the perpetrator, such a person will stand aside to allow proper flow of investigations and implementation of sanctions, if necessary.

A duty-bearer who stands aside shall be replaced by a suitable person to be determined by the appropriate authority. Regarding the implementation of sanctions, where the duty-bearer is alleged to be the perpetrator, his/her role shall vest in the following bodies:

- » In case of a PS, the Head of Public Service/Secretary to Cabinet takes responsibility.
- » In case of a Hospital Director, the Hospital Board takes responsibility.
- » In case of a Health Facility in-charge, the Health Unit Management Committee takes responsibility.
- » In case of a Local Government official, the PS at the MoH takes responsibility.
- » In case of a SH Focal Point Person, a Human Resource Officer takes responsibility.

The Sexual Harassment Guidelines will be implemented through a multi-sectoral approach by MoH, line ministries, relevant service commissions, public and private health institutions and facilities at central and regional levels, Health Training Institutions, Health professional councils, local governments, and implementing partners, among others.

The primary responsibility of overseeing the implementation of these guidelines shall rest with the Human Resource Department at MoH, and other institutions at Central and Local Government levels as well as private institutions.

6.1 The Ministry of Health

The Ministry of Health will:

- a. Communicate zero tolerance for sexual harassment through written and verbal means;
- b. Provide overall oversight in implementation of these guidelines at all levels;
- c. Issue out administrative circulars to central and regional institutions and local governments on the implementation of the guidelines in collaboration with Ministry of Public Service;
- d. Ensure the wide dissemination (including posting on MoH website) and enforcement of these guidelines and other sexual harassment related policies and laws;
- e. Train the Sexual Harassment Focal Point Persons at all levels, in implementation of these guidelines;
- f. Strengthen the capacity of the Rewards and Sanctions Committees at all levels in handling sexual harassment complaints in collaboration with Ministry of Public Service;
- g. Build the capacity of all staff in sexual harassment prevention and response mechanisms.
- h. Within its available means, provide copies of these guidelines to health sector employees;
- i. Ensure that the composition of the Rewards and Sanctions Sub-Committee on Sexual Harassment is gender-balanced, has at least one member of the senior management, and has a staff member who is trained in handling sexual harassment;
- j. Lead monitoring and evaluation activities for sexual harassment prevention and response mechanisms;
- k. Through its Human Resources Department:
 - i. Create a directory of Sexual Harassment Focal Point Persons and other relevant duty-bearers and stakeholders in the health sector's prevention and response mechanism, update this information as necessary, and make it readily available to the public and health workers;
 - ii. Standardize case numbers for reporting procedures across all districts.

6.2 The Ministry of Public Service

The Ministry of Public Service will:

- a. Issue out administrative circulars to central and regional institutions and local governments on the implementation of the guidelines in collaboration with Ministry of Health;
- b. Incorporate Sexual Harassment Prevention and Response Mechanism in induction and orientation of staff training programmes.

- c. Strengthen the capacity of the Rewards and Sanctions Committees at all levels in handling sexual harassment complaints in collaboration with Ministry of Health;
- d. Implement the Public Service Standing Orders and the Code of Conduct and Ethics for Uganda Public Service (2005).

6.3 Ministry of Gender, Labour & Social Development (MGLSD)

The Ministry of Gender, Labour & Social Development will:

- a. Provide policy direction on the implementation of these guidelines;
- b. Set standards and offer technical support in handling complaints of sexual harassment;
- c. Investigate and arbitrate sexual harassment related complaints and appeals through its Department of Labour and Industrial Relations;
- d. In Collaboration with the Ministry of Health build the capacity of Health Workers on Sexual Harassment Prevention and Response.

6.4 Ministry of Local Government

The Ministry of Local Government will:

- a. Oversee the implementation of guidelines at the local government level;
- b. Monitor and evaluate activities for sexual harassment prevention and response mechanisms in collaboration with MoH at Local Government Level;
- c. In collaboration with MOH, build the capacity of the district local government institutions to make and implement by-laws and policies on sexual harassment prevention, reporting and response.

6.5 Ministry of Education and Sports, (including Health Training Institutions)

The Ministry of Education and Sports will:

- a. Oversee the implementation of guidelines at the level of health training institutions;
- b. Review curricula and incorporate content on sexual harassment prevention and response, especially in health service management;
- c. Provide summary of these guidelines to all students and faculties in Health Training Institutions;
- d. Monitor and evaluate activities for sexual harassment prevention and response mechanisms in collaboration with MoH.

6.6 Service Commissions

The Service Commissions include: Health Service Commission, Public Service Commission and District Service Commissions.

The Service Commissions will:

- a. Investigate and determine complaints submitted either as complaints of first instance or appeals;
- b. Take administrative action in respect of complaints referred to them by RO in accordance with Section 5.3
- c. Review arbitrary decisions that may be made by RO;
- d. Train Commission staff in sexual harassment prevention and response mechanisms.

6.7 Health Professional Councils

There are four health professional councils: Uganda Medical and Dental Practitioners' Council, Uganda Nurses and Midwives Council, Allied Health Professional Council and Uganda Pharmacy Board.

The Health Professional councils will:

- a. Sensitize Health Professionals, clients/ attendants/patients, on sexual harassment;
- b. Develop and disseminate anti-sexual harassment IEC materials;
- c. Disseminate these guidelines to all health workers;
- d. Strengthen a comprehensive reporting and investigation mechanism for sexual harassment cases, including designating focal person to receive a complaint;
- e. Handle disciplinary complaints arising from professional misconduct including sexual harassment;
- f. Compile and disseminate lessons learnt and good practices in sexual harassment complaints;
- g. Revise and disseminate respective codes of conduct to reflect stronger provisions on sexual harassment prevention and response mechanisms;
- h. Entertain, investigate and make a finding on complaints from clients/patients and other members of the public on allegations of sexual harassment against health workers in line with the Ministry of Health's 2009 Joint code of Conduct and Ethics for Health Workers in Uganda;
- i. Put in place mechanisms of protecting their membership from sexual harassment emanating from their clients/patients for example, put in place examination protocols and standard operating procedures (SOPS) that would insulate them against such. These may include:
 - i. In line with the client's charter, any medical examination shall be done in the presence of a third party. In case of a child patient below 12 years old, the examination should happen in the presence of their guardian. In case of an adolescent (13 years to 17 years) or an adult patient (18 years and above), the examination should happen in the presence of another health worker. However, patients older than 18 years old may consent to abstaining from the presence of a third party during an examination.
 - ii. Private parts' examination to be done with full written consent of the patient/client or the parent/guardian and co-signed by the health worker in the presence of a third party.
 - iii. Put in place IEC materials in conspicuous places detailing the dos, don'ts and obligations of a patient/client in relation to sexual harassment prevention.
 - iv. Community outreach programs to educate the potential clients/patients and members of the public on preventing, responding to and reporting cases of sexual harassment from either side.

6.8 Equal Opportunity Commission (EOC)

The EOC will:

- a. Investigate and determine complaints submitted either as first instance or appeal;
- b. Train EOC staff in sexual harassment prevention and response mechanisms.

6.9 Uganda Human Rights Commission (UHRC)

The UHRC will:

- a. Investigate and determine complaints submitted either as first instance or appeal;
- b. Review arbitrary decisions made by RO;
- c. Train staff in sexual harassment prevention and response mechanisms;
- d. Initiate investigation on its own into matters of sexual harassment at all levels.

6.10 Inspectorate of Government

The IG will:

- a. Investigate and determine complaints submitted either as first instance or appeal;
- b. Review arbitrary decisions made by RO;
- c. Train staff on sexual harassment prevention and response mechanisms;
- d. Sensitize the public about different forms of abuse of authority including sexual harassment.

6.11 Uganda Police Force (UPF)

UPF will:

- a. Investigate any complaint of sexual harassment that contains criminal elements (rape, defilement, indecent/sexual assaults etc) reported to it;
- b. Collect evidence (direct, indirect, physical or forensic) necessary to sustain the charges if any in the courts of law;
- c. Arrest and detain the alleged perpetrators in connection with the complaint in accordance with the law;
- d. Refer the victim for psycho-social, medical and other support services to the relevant institutions; and;
- e. Give evidence in court in support of the charges that may be preferred against the perpetrators whenever called upon.

6.12 National and Regional Level Health Institutions and Facilities

These Institutions and Facilities will:

- a. Build the capacity of all staff in sexual harassment prevention and response mechanisms;
- b. Designate a SHFPP;
- c. Ensure that the composition of the Rewards and Sanctions Sub-Committee on Sexual Harassment is; gender-balanced, has at least one member of the senior management, and has a staff member who is trained in handling sexual harassment;
- d. Strengthen the capacity of the Rewards and Sanctions Committees and Sub-Committees to handle sexual harassment complaints;
- e. Establish Rewards and Sanctions Committees in institutions where they do not exist;
- f. Ensure that these guidelines are widely disseminated and accessed by all the staff.
- g. Develop and disseminate anti-sexual harassment IEC materials.

6.13 Local Government and Other Health facilities

Local Governments and other Health Facilities will:

- a. Ensure that the Sexual Harassment Guidelines are widely disseminated and accessed by all the staff;
- b. Designate and train a SHFPP in collaboration with Ministry of Health;
- c. Strengthen the capacity of the Rewards and Sanctions Committees and Sub-Committees to handle sexual harassment complaints;
- d. Ensure that the composition of the Rewards and Sanctions Sub-Committee on Sexual Harassment, is gender-balanced, has at least one member of the senior management, and has a staff member who is trained in handling sexual harassment;
- e. Establish Rewards and Sanctions Committees in institutions where they do not exist.
- f. Develop and disseminate anti-sexual harassment IEC materials.

6.14 Health Training Institutions

Health Training Institutions will:

- a. Ensure that the guidelines are widely disseminated and accessed by all the staff;
- b. Strengthen the capacity of the Rewards and Sanctions Committees and Sub-Committees to handle sexual harassment complaints;
- c. Ensure that the composition of the Rewards and Sanctions Sub-Committee on Sexual Harassment, is gender-balanced, has at least one member of the senior management, and has a staff member who is trained in handling sexual harassment;
- d. Provide a summary of the guidelines to all students and faculty;
- e. Establish Rewards and Sanctions Committees in institutions where they do not exist;
- f. Provide sexual harassment training to all students and faculty.
- g. Develop and disseminate anti-sexual harassment IEC materials.

6.15 Implementing Partners

In collaboration with MoH, Implementing Partners will:

- a. Ensure that the guidelines are widely disseminated and accessed by all the staff in the health sector;
- b. Integrate a component on sexual harassment into existing capacity building programmes for health workers;
- c. Conduct advocacy and sensitization activities to spread awareness on sexual harassment in the health sector;
- d. Mobilize resources for implementation of the guidelines.

This section describes the monitoring and evaluation (M&E) mechanism to be followed while implementing sexual harassment prevention and response interventions. M&E activities focus on measuring progress towards achievement of workplan indicator targets, outcomes and documentation of lessons learned in the institutions to enable management and identify areas of success, challenges and adapt strategy to effectively achieve set targets.

MOH shall establish a multi-sectoral anti-sexual harassment taskforce to oversee the implementation of interventions against sexual harassment. Similar structures shall be formed at facility and local government levels. Facility levels should aim to include public and PNFPs, sub county and parish chiefs, in-charges, gender/Labour officer and office of the chief administration officer (CAO).

Local government includes the District Health Office (DHO) that will chair and house the taskforce. Other members will include; the labour office, head of community development, district planner and the CAO's office.

The taskforce shall, among others, compile workplans and budgets, monitor activities, discuss monitoring report as well as submit reports to the district planner, district executive committee (DEC) and council for necessary action.

Additionally, the MOH and districts should;

- i. Instruct supervisors and managers to take all complaints of sexual harassment seriously, regardless of whether they conform to the institution's guidelines.
- ii. Monitor supervisors and managers to ensure that they comply with the institution's sexual harassment guidelines.
- iii. Develop annual workplans that integrate anti-sexual harassment activities and periodically generate reports for employers/management.
- iv. Regularly evaluate the effectiveness of the existing mechanisms for preventing and responding to sexual harassment at the workplace.

The Quality Assurance Department at MOH will co-opt M&E specialists from Implementing Partners (IPs) for monitoring and evaluating the sexual harassment interventions.

7.1 Reporting Mechanisms

The M&E task team will collect base line data and thereafter, periodically collect routine data on the progress of implementation within the pre-determined timelines and resource limits. The M&E team will review completed activity reports by implementing teams as well as conduct site visits to verify reported data. Progress of activity implementation will be discussed with institution teams periodically as a feedback mechanism through technical meetings. Activities whose implementations is not on course or whose targets have not been met will be identified and discussed with implementing teams to devise strategies to achieve them.

7.2 Monitoring and Evaluation Indicators

The following are some of the proposed indicators that can be monitored, however, institutions can decide on other indicators out of this list as desired to measure progress and attainment of targets;

1. Availability of work plans and budgets integrating sexual harassment prevention and response strategies;
2. Availability/accessibility of sexual harassment implementation guidelines;
3. Percentage of health workers trained on sexual harassment prevention and response;
4. Clear sexual harassment reporting system in place;
5. Number of sexual harassment complaints reported and resolved;
6. Availability of Information, Education Communication (IEC) materials e.g. posters, booklet;
7. Proportion of managers of professional councils trained to resolve complaints of sexual harassment;
8. Functional rewards and sanctions committee;
9. Functional rewards and sanctions sub-committee on sexual harassment;
10. Availability and use of suggestion boxes;
11. Existence of a Sexual Harassment Focal Point Person.

Outcome indicators will measure attainment of the following key Human Resources for Health results:

- » Change in sexual harassment complaints at all levels.
- » Reduction in staff attrition rates at institutions i.e. MOH, districts and health facilities.
- » Increased retention of health workers in health facilities.
- » Reduction in absenteeism rates in health facilities.

7.3 Data Quality Management

To ensure that the quality of data from the set system is reliable for decision-making, standard data quality assurance procedures will be implemented. Institutional M&E will ensure that data reasonably meets the national and international standards of data quality i.e. validity, reliability, precision, timeliness and integrity. Strict data quality control procedures will be implemented in data collection, aggregation, analysis, storage as well as confidentiality in reporting and dissemination of data.

Routine data quality assessments will be conducted at primary data sources and aggregation sites to verify the accuracy of reported data. This will include reviewing institution databases and personnel records at the appropriate site/station e.g. DHO, PHRO, health facilities, MOH and IPs.

The findings of the data quality assessments will form a basis for follow-up, adjustments in reported data and plan for supporting program teams and partners to improve data quality.

7.4 Evaluation

There will be systematic evaluations to establish the results and impact of implementing the sexual harassment guidelines in the health sector.

This will ultimately strengthen the quality of intervention and consequently improve outcomes for the health sector resulting into a work climate free from sexual harassment at all levels.

8.1 Definition of Terms and Concepts

DISCRIMINATION: This is any act, omission, policy, law, rule, practice, distinction, condition, situation, exclusion or preference which, directly or indirectly, has the effect of nullifying or impairing equal opportunities or marginalizing a section of society or resulting in unequal treatment of persons in employment or in the enjoyment of rights and freedoms on the basis of sex, race, colour, ethnic origin, tribe, birth, creed, religion, health status, social or economic standing, political opinion or disability (Equal Opportunities Act, 2007).

DISCRIMINATION IN EMPLOYMENT AND OCCUPATION: This refers to practices that place individuals in subordinate or disadvantaged position in the workplace or labour market because of sex, religion, social economic class, political opinion, ethnicity or other attribute that bears no relation to the person's competencies or the inherent requirements of the job.

GENDER DISCRIMINATION: This refers to any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women or men, irrespective of their marital status in the political, economic, social, cultural, civil or any other field. Gender discrimination includes discrimination on the grounds of maternity and family responsibilities and extends to sexual harassment (of both women and men).

HARASSEE: This is a person who is a victim/survivor or complainant of acts of sexual harassments. This can be anyone including: a man, woman, supervisor, supervisee, patient/client, health worker, employer, employee or peers.

HARASSER: This is a person who perpetrates and/or commits acts sexual harassment. This can be anyone including: a man, woman, supervisor, supervisee, patient/client, health worker, employer, employee or peers.

HOSTILE WORK ENVIRONMENTSEXUAL HARASSMENT: This occurs when unwelcome conduct of a sexual nature creates an intimidating, threatening or abusive working or learning environment or is so severe, persistent or pervasive that it affects a person's ability to participate in or benefit from any program or activity. While a person engaging in harassing behavior most often has some form of power or authority over the person being harassed, that is not always the complaint. The harasser can be a peer of the person being harassed. Sometimes the harasser is harassing a person who has power over them. For example, a supervisee can sexually harass a supervisor or a student can sexually harass a faculty member. This can also be manifested through pervasive unwelcome sexual comments or jokes that continue even though the recipient has indicated that those behaviors are unwelcome.

POWER RELATIONS: These are ways in which different groups are able to interact and control other groups based on their relative position in society. Due to unequal gender power relations (e.g. men's relative control over resources and power in society compared to women's), women are disproportionately victims of sexual harassment.

QUID PRO QUO SEXUAL HARASSMENT: This means "this for that." This type of harassment occurs when it is stated or implied that employment decision about an employee depends upon whether employee submits to conduct of a sexual nature. Quid pro quo sexual harassment also occurs when it is stated or implied that an individual must submit to conduct of a sexual nature in order to benefit. So, for example, if an employee is made to believe that a promotion is likely if the employee goes on a date with the employee's supervisor, the employee is possibly being subjected to "quid pro quo" sexual harassment.

RESPONSIBLE OFFICER may include the PS, CAO, Facility In-Charge, Hospital Director, among others.

SEXISM: This refers to the ideology of male supremacy (or superiority) and the beliefs that sustain it. Patriarchy is sustained by sexism. This ideology is expressed in norms of privilege (such as touching) which sustain the practice of sexual harassment.

SEX DISCRIMINATION: This is a behavior. It occurs when employment decisions are based on an employee's sex or when an employee is treated differently because of his or her sex. For example, a female supervisor always asks the male employees, in a co-ed workplace, to move the boxes of computer paper. Or, a male supervisor always asks the female employees, in a co-ed workplace to plan office parties.

SEXUAL HARASSMENT: This is a behavior. It is defined as unwelcome behavior of a sexual nature. For example, a man whistles at a woman when she walks by. Or a woman looks a man up and down when he walks towards her. Sexual harassment can also be a gender issue and can be directed to the individual because of their sex.

Sexual Harassment consists of comments (innuendos, suggestive or insulting sounds, jokes, labeling, requests for sexual intercourse) or behaviors (touching, patting and pinching) of a sexual nature that are unwanted, unwelcome, unacceptable, and offensive based on unequal power relations, which harms the dignity of a person. Sexual harassment contains: (i) an implied or express promise of preferential treatment in the employment; (ii) an implied or express threat of detrimental treatment in employment; and, (iii) an implied or express threat about the present or future employment status of the employee and either by its nature or through repetition has a detrimental effect on that employee's employment, job performance or job satisfaction (Employment Act of Uganda, 2006).

SEXUAL VIOLENCE: This is a sexual act committed against someone without that person's freely given consent including sexual assault, rape, and sexual abuse.

STEREOTYPING: This is the assigning of roles, tasks and responsibilities to a particular group on the basis of pre-conceived prejudices. Gender stereotyping occurs when the personal characteristics deemed necessary for a job are inconsistent with characteristics generally associated with women.

An example is saying “That woman is a man” to describe female managers who are perceived to perform on an equal basis with male managers.

SUBTLE SEXUAL HARASSMENT: This is a behavior but not a legal term. It is unwelcome behavior of a sexual nature that if allowed to continue could create a Quid Pro Quo and/or a Hostile Work Environment for the recipient. For example, unwelcome sexual comments, jokes, innuendoes.

UNWANTED PERSONAL ATTENTION: Letters, telephone calls, visits, pressure for sexual favors, pressure for unnecessary personal interaction and pressure for dates where a sexual/romantic intent appears evident but remains unwanted.

UNWANTED PHYSICAL OR SEXUAL ADVANCES: Touching, hugging, kissing, fondling, touching oneself sexually for others to view, sexual assault, intercourse or other sexual activity.

UNWANTED SEXUAL STATEMENTS: Sexual or “dirty” jokes, comments on physical attributes, spreading rumors about or rating others as to sexual activity or performance, talking about one’s sexual activity in front of others and displaying or distributing sexually explicit drawings, pictures and/or written material. Unwanted sexual statements can be made in person, in writing, electronically (email, instant messaging, blogs, web pages, etc.) and otherwise.

VICTIM BLAMING: This occurs when a victim of a crime is held entirely or partially responsible for the harm enacted upon them, such as when a victim of sexual harassment is blamed because of their clothing.

Appendices Forms for Reporting, Registering and investigating a Complaint

Form A1- Informal Complaints Register

Instructions

- Steps 1-3 must be filled immediately upon receipt of complaint by the SHFPP.
- Steps 4 and 5 must be completed within 15 days upon receipt of complaint. Should a supervisor/manager facilitate the mediation, the SHFPP is responsible for collecting information for steps 5, 6 from said supervisor/manager.

Date: _____

Case Number: _____

1. Description of Sexual harassment:

Date of Incident _____ Frequency _____

Form of SH _____

2. Names of Concerned Parties:

Complainant/harasee: Age _____ Sex _____ Position _____

Alleged Perpetrator: Age _____ Sex _____ Position _____

3. Option Taken by Complainant/harasee : _____

4. Action Taken by Mediator/Facilitator: _____

5. Other Relevant Comments:

Follow- Up

To be filled in 1 Month After conclusion of complaint, by R & S Committee

Name of Investigator: _____

Title: _____

Date: _____

Signature: _____

Form A2- Formal Complaints Register

Instructions:

-Steps 1-3 must be filled immediately upon receipt of complaint by the SHFPP;

-Steps 4 and 5 must be completed within 30 days upon receipt of complaint.

Date: _____

Case Number: _____

1. Description of Sexual harassment:

Date of Incident _____ Frequency _____

Form of SH _____

2. Concerned Parties:

Complainant/harasee Name _____ Age _____ Sex _____

Position _____ Contact _____

Alleged Perpetrator Name _____ Age _____ Sex _____

Position _____ Contact _____

3. Action Taken by Committee: _____

4. Appeal or other form of action, if any: _____

5. Other Relevant Comments

Follow- Up

To be filled in 1 Month After conclusion of complaint, by R & S Committee

Name of Investigator:

Name of Aggrieved Party:

Title: _____ Title: _____

Date: _____ Date: _____

Signature: _____ Signature: _____

Form B1- Investigating a Complaint (to be filled by SHFPP)

1. Case Number _____
2. Names of Parties Involved: Party Complainant/harasee _____
Alleged Perpetrator _____
3. Date(s) of Incident(s) _____
4. Location(s) of Incident(s) _____
5. Details of incident(s): _____

Effect of incident(s) on aggrieved party (emotional, physical, psychological, job performance):

6. Witnesses, if any (Please attach testimonies):

7. Evidence, if any (Please attach evidence):

Exhibit(s), if any (Please attached exhibits):

Steps taken by the Complainant/harasee to stop the harassment, if any:

Additional Comments (if any):

Name of Investigator: _____ Name of Complainant/harasee: _____

Title: _____ Title: _____

Date: _____ Date: _____

Signature: _____ Signature: _____

Form B2- Investigating Alleged Perpetrator’s Account (to be filled by SHFPP)

Case number: _____

- 1. Names of Parties Involved:
Alleged Perpetrator _____
Complainant/harasee (if known) _____

- 2. Date(s) of Incident(s) _____
- 3. Location(s) of Incident(s) _____
- 4. Details of explanation: _____

- 5. Witnesses, if any (Please attach testimonies):

- 6. Evidence, if any (Please attach evidence):

- 7. Exhibit(s), if any (Please attached exhibits):

- 8. Steps taken by the Alleged Perpetrator to address the situation (if any):

- 9. Additional Comments (if any):

Name of Investigator: _____ Name of Alleged Perpetrator: _____
Title: _____ Title: _____
Date: _____ Date: _____
Signature: _____ Signature: _____

Form C: Report of the Findings (to be filled by R&S Sub-Committee on SH):

- 1. Case Number: _____
- 2. Date: _____
- 3. Complainant/harasee Name _____ Position: _____
Alleged Perpetrator Name _____ Position: _____
- 4. Location of the incident(s): _____

- 5. Brief details of case:
 - a. Summary of complaint:

 - b. Summary of alleged perpetrator’s account:

6. Summary of findings:

7. Explanation for the findings:

8. Recommendation for Action:

Names, Title, and Signatures of R&S Sub-Committee Members:

Name	Title	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____



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