The Domestic Violence Law; Keeping every man, woman and child in Uganda safe at home!"

A call for the **health sector to meet the needs** of Gender Based Violence Survivors/ Victims in Uganda. (August 2015)

Background/**Introduction**

Gender Based Violence (GBV) remains a significant public health problem in Uganda since it has serious physical, mental behavioral, sexual and reproductive health consequences. The 2010 DV Act defines domestic violence as any act which "**harms, injures or endangers the health, safety, limb or well-being, whether mental or physical, of the victim or tends to do so and includes causing physical abuse, sexual abuse, emotional, verbal and psychological abuse and economic abuse; harasses, harms, injures or endangers the victim with a view to coercing him or her or any other person related to him or her to meet any unlawful demand for any property or valuable security; has the effect of threatening the victims or any person related to the victim by; or otherwise injures or causes harm, whether physical or mental, to the victim**". The 2011 Uganda Demographic and Health Survey (UDHS) showed that at least 56% of women aged 15-14 years had ever experienced GBV.[1] Furthermore, a significant number of women has ever experienced sexual gender based violence (SGBV). The 2011 UDHS showed that 19% of women report that their first sexual encounter was against their will. Based on Uganda's population of 6.95 million women aged 15-49 years in 2014, the above incidence of sexual GBV translates to about 1.3 million women who have been forced to have s ex against their will.

In addition, at least 16% of the women have experienced violence at their most vulnerable biological state—during pregnancy (the perpetrators are either partners or other relations). Also, vulnerable groups such as adolescent girls are severely affected by acts of SGBV. According to the annual police crime report, the number of reported defilement cases—one of the worst forms of sexual violence—increased from 7,360 in 2009 to 9,598 by 2013.[2]Violence damages women's and girls' health in many ways, both immediate and long-term, both obvious and hidden. Women/girls who have been abused or assaulted need care and support.

GBV is very costly—both to the survivors of GBV as well as institutions that respond to GBV incidents. Based on a study undertaken by CEDOVIP in 2012, it was estimated that GBV costs the Uganda economy about UGX 77 billion annually.[3] Within this, survivors of GBV lose UGX 22 billion due to lost productivity and out of pocket expenses dealing with GBV incidents Furthermore, GBV costs the police and Ministry of Health (MoH)—the two leading public institutions in GBV response—an estimated UGX 37.7 billion annually to deal with GBV.

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The National GBV (NGBV) policy allocates responsibilities with regards to preventing GBV as well as providing care and support services to GBV survivors to a number of public institutions. The responsibilities for the MoH under the NGBV include: (i)providing medical services such as post rape treatment;(ii)building staff capacity to provide counselling for GBV victims/survivors; (iii) mainstreaming GBV issues into the day-to-day functions of the ministry;[4] (iv) build capacity of health personnel on readiness to provide court evidence on GBV issues when needed; (v) mobilize adequate resources for GBV programmes; (vi) establish emergency measures in dealing with GBV victims/survivors; and (vii) establish forensic services to support medico-legal services for GBV cases.

This brief highlights the gaps in GBV implementation of the National Action Plan on GBV by MoH to ensure access to essential services for GBV survivor/victims in Uganda. It is based on the analysis of the 2014/15 Health Ministerial Policy Statement which captures the proposed different GBV interventions to be implemented by health facilities and corresponding budget allocations.

Gaps in **health sector implementation** of the National Action Plan on GBV

1) The health sector is affected by the limited capacity to fully implement the DV Act. For example, health workers lack expertise in examining and documenting evidence using the revised Police Form 3 and also do not understand how to facilitate survivor's access to justice. Partly as a consequence, about one in every four files for rape or defilement cases registered at the DPP office are closed due to lack of evidence.

2) Health facilities do not make adequate provisions for medical-legal service. Institutions do not go a step further beyond providing clinical services, to enable staff testify in courts during GBV cases.

3) Furthermore, although the MoH is mandated to spear-head medico-legal services relating to GBV cases, there is limited mention of forensic examination in ministerial policy statements; although the inputs for such examinations are not expensive. District health officials rarely appreciate the usefulness of these examinations in prosecuting SGBV crimes.

4) The MoH work plan lists a number of activities as part of the GBV response without the necessary appropriations. For instance, for 2014/15 activities, the MoH intends to undertake the following activities in the current financial year: provide counselling services to survivors of GBV admitted at shelters; create an information centre for GBV survivors and link survivors to support groups. However, the MoH budget does not reflect any allocation for most of the above planned activities. Furthermore, comprehensive counselling to the victims/survivors may not be feasible due to a relatively very high patient to health worker ratio at most public health facilities.

5) Health facilities do not make adequate provisions to address SGBV. According to the guidelines by MoH on management of GBV cases, health facilities are supposed to stock pregnancy test kits and emergency contraception; and also provide ARVs and Post-Exposure Prophylaxis (PEP) for treatment of rape victims. The health facilities budgets do not reflect the acquisition of the above key inputs. The MoH has focused on the distribution of sexual assault forensic evidence collection kits in the established public shelters and these are few in comparison to general health facilities.

6) Finally, the MoH also faces challenges in capturing and reporting on GBV incidents. For instance, whereas the MoH is mandated to provide comprehensive medical services to GBV survivors, most reporting on GBV cases handled focuses on rape and defilement. As such, the MoH does not report on handling of non-sexual cases.

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Analysis of GBV activities in the 2014/2015 budget proposals for Ministry of Health

List of intervention: Source 2014/2015 budget estimates	Issues addressed in GBV policy	Budget Allocation 2014/15 (UGX millions)	Analysis	Proposed activities	Estimated Cost (UGX millions)
1. Procure and distribute sexual assault forensic evidence collection kits	Enhancing access to essential services for survivors + Integrate human rights based approach into health services by establishing appropriate measures for dealing with GBV survivors/victims.		No specific budget earmarked.	4. Procure post-exposure prophylaxis used in the treatment of rape victims	390
2. Conduct readiness assessment for SGBV prevention and response.	Mainstream GBV issues in legislations, programmes and plans.		This was accomplished.		
3. Conduct training workshops on Sexual and Gender Based Violence	Mainstream GBV issues in legislations, programmes and plans.		Build staff capacity in examination of SGBV cases.	Train at least 600 health workers based at the regional referral hospitals	180
4. Establish emergency measures for dealing with GBV victims/ survivors.				Run 13 shelters at health facilities (5 shelters established in 2013 and 9 additional shelters established in 2014). Target is 3,000 survivors.	
5. Establish forensic services to support medico-legal services for GBV cases					
6. Run established GBV shelters					510
7. Build capacity of health staff on readiness to provide court evidence on GBV issues				Conduct 15 in service training sessions during 2014/15	68
8. Establish 3 new GBV shelters.				Construct/ rehabilitate existing facilities.	2,250
Total					**3,398**

Mission: To advocate for the Implementation of the Domestic Violence Act 2010.

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Recommendations:

1. There is need to train health workers on the appropriate handling of GBV cases. For instance, there is need to improve pre-hospitalization services and causality/ emergency room services, including by training emergency room staff to provide timely and quality emergency trauma care to mitigate negative consequences of violence. Apart from treatment and counselling, health practitioners should be able to provide information on the available options to victims/survivors to enable them seek redress including reporting to police or legal options, shelter etc.

2. SGBV is a rampant occurrence and as such health facilities should budget adequately to provide comprehensive services to SGBV victims. Furthermore, there are negative attitudes towards completion of the required PF3 form with some health workers providing inadequate information which may not be usable by courts. Magistrate's courts have funds provided by JLOS to support health workers who have to provide medical-legal evidence in courts. The MoH need to know who is directly in charge of these funds and also openly communicate to the health workers about who to get in touch with to claim this transport money. Furthermore, health facilities should provide time off duty to appear in court as well as training them of the importance of testifying and how to testify in GBV cases in court.

3. There is need to make specific appropriation in the health budget and scale up of GBV interventions. Only recognizing the challenge without matching it with the necessary budget allocations will not lead to reduction in occurrence of GBV.

4. There is need to amend the Health Management Information System (HMIS) codes to ensure that GBV incidents addressed at health facilities are suitably captured. Appropriate coding would ensure that health facilities are able to track GBV incidents and also go a step further to ensure that they allocate resources for GBV interventions. The HMIS could also help identify and address barriers to access to services for survivors of violence, improve the quality of services and monitor and evaluate progress in providing quality health services to survivors.

Endnotes

1 Uganda Bureau of Statistics and ICF Macro International (2012). Uganda Demographic and Health Survey 2011: Preliminary Report. Calverton, Maryland: UBoS and Macro International Inc.

2 Uganda Police Force (2014) Annual Crime and Traffic/Road Safety Report 2013 (Kampala: Uganda Police Force)

3 CEDOVIP (2012) Economic Costs of Domestic Violence in Uganda (Mimeo Kampala: CEDOVIP).

4 Mainstreaming entails making attempts to address GBV from a variety of angles. According to the World Bank (2014), mainstreaming GBV may include: providing direct assistance to survivors (capacity-building of GBV CSOs); engaging in prevention programs (legal assistance, advocacy for new laws and guidelines to prevent GBV); and gathering evidence. Most important, GBV concerns should be addressed during the design and implementation of large scale projects.

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