The Ministry of Health:
Addressing The Unmet Health Needs of Survivors of Gender-Based Violence and Providing Vital Prosecution Support

Intimate partner violence, sexual violence, and other forms of gender-based violence (GBV) remain rampant throughout Uganda, resulting in significant adverse impacts on the physical, mental, and sexual health of women and children. GBV is a major public health problem.

While the Government of Uganda has put in place impressive laws and policies to protect the rights and interests of women and girls, including the Domestic Violence Act 2010, the Prohibition of Female Genital Mutilation Act 2010, the Prevention of Trafficking in Persons Act 2009 and the National Policy on the Elimination of Gender Based Violence , implementation remains limited and abuse rampant. Reporting of GBV remains low and legal cases experience dismissal more often than conviction – often due to lack of medical evidence and health worker's failure to testify in court – resulting in impunity for many GBV-related crimes. Survivor support services, including critical medical and psychosocial support for survivors, remain extremely limited and uncoordinated. Health care providers frequently fail to recognize GBV in a timely manner, initiate discussion on GBV with suspected or known victims, provide needed medical interventions, refer survivors, or provide evidence for prosecution.

There are myriad complex reasons as to why GBV remains so pervasive – ranging from negative cultural and gender norms, to limited understanding of the law, and institutional weaknesses. **A critical reason why Uganda has been unable to curb these abuses is the failure of sectors to adequately fund interventions necessary to provide critical support to survivors, ensure accountably for perpetrators, and prevent and respond to GBV.**

56% of ever-married Ugandan women (aged 15-49) experience spousal violence[1]

One million Ugandan women (13%) experienced sexual violence last year[2]

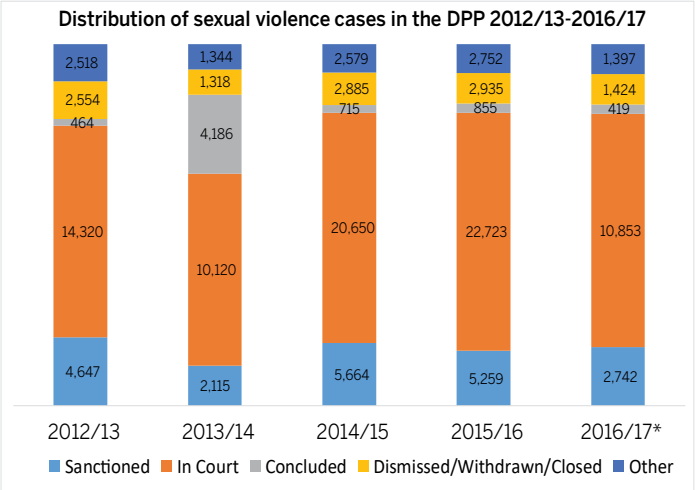
6% of women (aged 15-49) who have experienced physical and sexual violence sought help from a medical personal[1]

49% of women and 41% of men believe a man is justified to beat his wife for specific reasons[1]

GBV costs **77.5 billion UGX** annually in expenses and lost profits[3]

Health care providers spend an estimated UGX 18.3 billion annually to address the health impact of GBV.[3]

Sector Priorities in the National GBV Action Plan

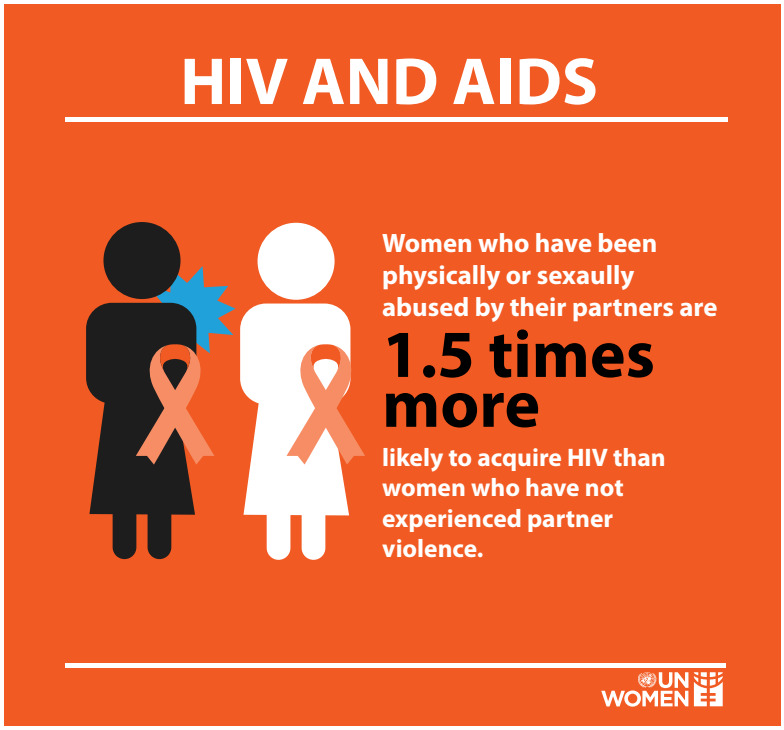


Source: ODPP Case Statistics 2012/13-2016/173

25% of the cases are closed due to lack of evidence.[4]

At least 16% of women experience violence during pregnancy.[5]

The first sexual encounter for 19% of women was an act of sexual violence.[5]



The 2016 National Action Plan on the Elimination of Gender-Based Violence (NGBV Plan) requires Ministry of Health to prioritize and fund the provision of essential medical services to survivors of GBV and medical evidence to support the investigation and prosecution of perpetrators of GBV.

Through national and global policies and agreements, Uganda has committed to eliminating all forms of violence against women and girls in the public and private spheres, recognizing that this is a prerequisite for sustainable national and social development and a critical public health concern. The Ministry of Health (MoH) plays a vital role in both GBV prevention and response, particularly in the NGBV Plan priority area of **provision of care to survivors, but also in ending impunity for GBV**. Under the NGBV Policy, as well as NDPII, the MoH is required to commit adequate resources to implement enumerated GBV-specific interventions. However, the MoH budget fails to allocate specific funds for GBV-interventions or designate any GBV-related strategies or programs.

The NGBV Policy requires the MoH to lead and adequately fund the following critical strategic actions:

- Provide timely and confidential medical and psychological support services to GBV survivors, including essential GBV-specific medical services and examinations (e.g. PEP kit);
- Develop, implement, and monitor guidelines for handling cases of GBV;
- Build the capacity of health sector staff on clinical management of GBV cases, identification of GBV, and the provision of psychosocial support to survivors and medical evidence for GBV legal cases (including the collection of forensic evidence, completion of Police Form 3, and testifying in court);
- Provide forensic services at health facilities to support the prosecution of perpetrators;
- Appropriately document all cases of GBV identified by or reported to a health unit;
- Guide and refer survivors to other support and protection services; and
- Sensitize communities about the mental, physical, and health implications of GBV.

Recommended Sector Priorities 2018/2019

Adequately Fund Essential Medical Services for Survivors of GBV

The MoH fails to allocate sufficient funds to provide essential medical services for survivors of GBV, increasing the risks of secondary harm, including HIV/AIDS, STIs, and unwanted pregnancies. Survivors of sexual violence need immediate access to emergency contraception, pregnancy test kits, ARVs, Post-Exposure Prophylaxis (PEP), and medications for treatment for other STIs. Health facilities must be equipped with the necessary medical supplies and capacity to effectively identify when these services are required and how to effectively and respectfully communicate the need to survivors.

MoH must ensure that facilities adequately budget, plan and maintain sufficient stocks of critical drugs and medical supplies.

Improve Forensic Services to Support Prosecution of Perpetrators

The NGBV Policy identifies ending impunity for GBV as a critical priority area. Ending impunity and providing accountability for perpetrators is indispensable to eliminating GBV in Uganda. While JLOS institutions carry the primary mandate, the health sector plays a vital role in the investigation, restraint, and prosecution of perpetrators of GBV by providing the police and ODPP with the medical evidence they need to prove their case.

Legal cases, particularly of sexual violence, are withdrawn or dismissed at a significantly higher rate than are fully adjudicated, largely due to lack of evidence, including medical evidence.[5] This is often the result of the failure of many health workers to complete or adequately complete the required police form 3 (PF3), which documents the injuries sustained by the victim/survivor; unwillingness or inability of those who do complete the form to testify during court; and insufficient collection and analysis of forensic evidence. Despite their mandate, the majority of health workers are reluctant to examine victims and often improperly demand payment to complete the PF3.

The MoH must allocate specific resources within the health sector budget to train and equip health staff and facilities to collect and provide high quality evidence to support the investigation and prosecution of GBV-related cases, including capacity to complete the PF3 and testify in court.

Systems should be put in place (including paid time off and facilitation to testify in court or provide a police statement) to normalize and prioritize this core function within the health sector, and to hold staff accountable for corruption and refusal to complete the PF3 and testify in court.

Improve Multi-Sectoral Coordination and Referral Services

Recognizing the complex and holistic needs of survivors of GBV, health workers are required to listen, counsel, guide and refer survivors of GBV to other service providers for support, protection, and reporting in a safe and confidencial manner. This includes to GBV shelters, legal aid service providers, justice sector institutions, police, and other available social services.

Health facilities must have established multi-sectoral coordination mechanisms and referral pathways that are effectively communicated to patients, with appropriate follow-up support.

Strengthen Health Workers capacity to handle GBV Cases

Survivors of GBV require specialized support and medical treatment. Health workers must be trained and equipped for the clinical and non-clinical management of cases of GBV and to provide survivor-centred services, including: (i) screening for early identification of and intervention for cases of GBV; (ii) sensitivity to and respect for the unique needs of survivors of violence; (iii) how to create a safe environment to enable the survivor to express often difficult and personal details pertaining to the nature of the abuse, ensuring privacy and confidentiality at all stages; (iv) the documentation of the abuse and harm (both in the medical records and police records); (v) provision of counselling and psychosocial support to survivors; (vi) referring and supporting survivors to report the abuse and/or seek other support and protection services; and (vii) their role and mandate towards survivors of sexual and non-sexual GBV (including intimate partner violence).

The MoH must allocate specific funding for capacity building health workers to appropriately handle cases of GBV.

The MoH should work closely with the Ministry of Education to include GBV in the curriculum for pre-service health workers.

Streamline Systems for Collection and Reporting of GBV Data

Across sectors there are significant gaps in GBV-related data collection and timely reporting, including within the health sector. The Health Management Information System (HMIS) codes need to be amended and health staff trained to ensure the accurate capturing of GBV incidents addressed at health facilities. Appropriate coding will not only ensure that health facilities are able to track GBV incidents, but also support appropriate budget allocation for GBV-related interventions, help identify and address barriers to accessing services for survivors, improve the quality of services, and monitor and evaluate progress in the provision of quality health services to survivors of violence.

Financial resources are needed to modify HMIS codes, train and mentor health facility staff to effectively capture GBV data, and to streamline data collection systems with other GBV-databases (including JLOS institutions and the Ministry of Gender, Labour, and Social Development).

References

1 Uganda Bureau of Statistics 2016, Uganda Demographic and Health Survey, Kampala, Uganda.

2 Uganda Bureau of Statistics, 2016 Uganda Demographic and Health Survey, Kampala, Uganda, and Calverton, Maryland, USA.

3 Center for Domestic Violence Prevention (CEDOVIP) 2012 The Economic cost of Domestic Violnce in Uganda.

4 Center for Domestic Violence Prevention (CEDOVIP). 2012. Economic Costs of Domestic Violence in Uganda. Kampala, Uganda.

5 ODPP Case Statistics 2012/13-2016/17.

6 Uganda Bureau of Statistics 2006, Uganda Demographic and Health Survey, Kampala Uganda.

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