Access to Care for Survivors of Gender Based Violence in Uganda: A Literature Review

Katerina Holeckova
Czech Republic

Master of International Health
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KIT (Royal Tropical Institute)
Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

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A thesis submitted in partial fulfilment of the requirement for the degree of Master in International Health

by

Katerina Holeckova
Czech Republic

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Where other people's work has been used (either from a printed source, the internet, or any other source), it has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis" Access to care for survivors of GBV in Uganda: A literature review" is my own work.

Signature:

Katerina Holeckova

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Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

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Definition of key concepts

Access to health care - is defined as a way of approaching, reaching, or accessing services that individuals or communities can use according to identified needs. Access is influenced by relation of potential users and resources (patient and health services).

Domestic violence - refers to violence caused by any member of the family or household against other members of that same family or household - e.g., elders, women, children - and thus not necessarily against a partner. It is occasionally used correspondingly with intimate partner violence.[1]

Gender Based Violence – refers to a deliberate act of violence that an individual inflicts upon another person based on that person's gender.

Healthcare – is seen as a product of supply factors such as accessibility – location, availability, costs - and demand factors such as healthcare practices.

Intimate partner violence - is another term under the umbrella of gender-based violence and refers to physical, psychological, and sexual harm caused by an intimate partner. This intentional behavior includes threats, power of control, physical and emotional violence, sexual violence and beatings.[2]

Rape – is a physically forced penetration of the vulva or anus using the penis or other parts of the body.

Sexual violence – is any unwanted sexual act, attempt or comment against another person's sexuality using coercion regardless of the relation to the victim and place.

Survivor – is defined as a person who survives after a deadly event; surviving includes healing, recovery, and coping with daily life activities.

The terms *survivors* and *victims* are widely used in the literature and gender-based violence (GBV) programs. The term victim is used more in the medical and legal sphere, whereas the term survivor is more used in the social and psychological sphere.

The term survivor emphasizes empowerment, capacity building by an individual to cope and recover, while the term victim is more stigmatizing and can be professed as helpless and destructive.[3]

This paper will use the term survivor to reduce further stigmatization of the ones who experienced or were exposed to GBV.

Acronyms

DRC	Democratic Republic of Congo
DV	Domestic Violence
GBV	Gender-Based Violence
GE	Gender Equity
HC	Health Centre
IACS	Inter-Agency Standing Committee
IPV	Intimate Partner Violence
LMICS	Low- and Mid-Income Countries
MoH	Ministry of Health
NGO	Non-Governmental Organization
PTSD	Post-Traumatic Stress Disorder
RRGH	Regional Referral Governmental Hospital
SADC	Southern Africa Development Community
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
SV	Sexual Violence
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VAW	Violence Against Women
VHT	Village Health Team
WHO	World Health Organization

Abstract

Background:
Globally, gender-based violence (GBV) is one of the most ancient and widespread human rights violations, currently affecting one in three women in their lifetime. That translates to about worldwide 35% of women who experience intimate partner violence (IPV) and 7% of women who experienced sexual violence (SV) by a non-intimate partner during their life. In Uganda, the incidence of GBV is well above the global average with 56% of women experiencing IPV caused by their spouse, and 22% of them experiencing SV. The government of Uganda had made effort to address GBV in the country through national policies and guidelines. Despite their efforts the implementation part of the national guidelines and policies remained weak.

Limited access to health care and a lack of awareness of GBV are two general factors contributing to ongoing violence in the community. Therefore, it is important to understand what the barriers are to access care following an experience of violence in Uganda. Also, it is necessary to identify what the level of awareness of GBV is among the Ugandan population.

Objective:
To describe the problems with access to medical care and barriers related to GBV in Uganda. And what evidence has been shown to be effective, using country with similar context as illustrative examples.

Methodology:
Based on the conceptual framework of access to healthcare for GBV survivors developed by Levesque et al., a literature review has been conducted using different database sources, including PubMed, Cochrane, Google Scholar, science databases, and relevant organizations' websites.

Findings:
There are supply and demand-side factors that influence access to GBV care in Uganda. On the supply-side there is a lack of information to people about available GBV services. Further maldistribution of available GBV services, shortage of medical health workers in the health facilities, limited funding that are available for the GBV medical services, cultural norms and accepted practices, and a lack of community support to the survivors to seek GBV medical care. The demand-side factors comprise individuals' insufficient knowledge about the importance of the services. Furthermore, the long waiting hours and establishment of privacy at the SV clinics limits individuals to seek medical care after rape. Also, the ability to pay for GBV medical services for survivors. The various dimensions of access that have been identified are interdependent, and they often have an impact on each other at different times and stages when needed by the survivors.

In order to improve access to care and services for GBV survivors, there is a need to conduct more in-depth research that explores community and health-care barriers to accessing GBV medical care in Uganda. Additionally, the Ministry of Health and stakeholders involved in the GBV medical care in Uganda may benefit from lessons learned from countries such as Zambia, Kenya, and The Republic of South Africa where GBV was eliminated. These include establishing SV clinics, ensuring privacy, and serving all medical needs of a patient through a good referral network if needed, improving support from the community, and raising general awareness of GBV.

Key words:
Gender Based Violence, Sexual Violence, Access to Care, Uganda, Survivor, Healthcare

Word Count: 13 509

Introduction

Gender-based violence (GBV) is a severe and extensive universal health problem that globally affects women, girls, boys, men, and violates human rights.[3] GBV is a broad umbrella term for many different forms of violence, including sexual violence (SV), rape, sexual harassment, and exploitation, forced child marriages, interpersonal violence, female genital mutilations, physical violence, emotional and psychological violence social or economic violence, rape as a weapon of war, forced pregnancy or termination of pregnancy, forced prostitution, and threads with a sexual character.[2]

The World Health Organization uses its own definitions of GBV and SV. It defines GBV as: "*any harmful act that is perpetrated against a person's will and that is based on socially ascribed differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private*."[2] And it defines SV as: "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work*."[2]

Gender-based violence (GBV) is a severe and extensive universal health problem that globally affects women, girls, boys, men, and violates human rights.[3] It is estimated that 736 million women – almost one in three – experienced some form of violence.[3] GBV has serious short- and long-term consequences that are physical, mental, and social, affecting the survivor, its family, and community. The health consequences for survivors include injuries, unwanted pregnancy, sexually transmitted infections/diseases (STIs/STDs), HIV, infertility, pregnancy complications, pelvic pain, and urinary tract infection. Mental health complications that survivors encounter include post-traumatic stress disorder (PTSD), depression, anxiety, substance and alcohol abuse, self-harm, sleep disorder, and suicidal thoughts. Additionally, survivors of GBV may also face stigma and rejection from their families and communities.[1] Worse still, GBV affects the survivors' sense of self-worth and self-esteem and it extends to the society as a whole.[4]

GBV disproportionally affects low- and middle-income countries (LMIC) and regions. Access to GBV care for survivors is lacking due to barriers such as stigmatization, lack of resources, information, programming, medical professional services, and community support. I have experienced this problem in Uganda, where I have had the opportunity to work as a midwife in different medical and cultural environments. In 2017, I started working for an international non-governmental organization (NGO), operational in different refugee settlements in the fields of sexual and reproductive health (SRH), including sexual and gender-based violence (SGBV). I have seen many similarities in all the projects that I have worked in regarding issues related to access to care for survivors of gender-based violence (GBV). One of the projects I was involved with in Uganda had a specific focus on GBV encountering many cases of sexual violence when survivors seek medical care services within our clinic. While I mainly worked

in refugee settlements spread over the country, I also had the opportunity to support the Uganda Regional Referral Governmental Hospital (RRGH) to establish a sexual violence (SV) clinic where there was little to no focus on survivors, their access to care and prevention of violence in the community.

This observation about the poor functioning of the national healthcare system in Uganda brought me to my thesis topic, which is the identification and description of difficulties GBV survivors face in accessing GBV care and the examination of how this access can be improved. I hope that the results of my efforts will provide evidence of the problem at stake and guidance for the government, policymakers, health care providers and facilities, programme managers and NGOs for further interventions to improve access to care for GBV survivors including community awareness raising programmes to mitigate GBV in Uganda.

1. Background

Gender-based violence (GBV) is a widespread worldwide problem that affects one in three women in their lifetime. The World Bank estimated that 35% of women globally have encountered physical and/or sexual or non/partner violence, 7% of women sexual assault by a non-partner, while 200 million women worldwide experienced female genital mutilation.[5] GBV is clearly a public health issue and should be managed and controlled with a public health approach in which the problem of GBV is stated, risks are identified and addressed and preventive strategies are adopted.[6]

The burden of GBV in Uganda mirrors the worldwide patterns, where in Uganda women are three times more likely than men to be the victims.[6] For example, in Uganda the female prevalence of SV varies from region to region as illustrated in Figure 1. Uganda, in general the physical violence is reported by 29% and rape by 26% by the girls and women aged 15 - 49.[7] SGBV is defined in Uganda as "*any harmful act of sexual, physical, psychological, mental, and emotional abuse that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females*"[6]. Addressing and reducing the incidence GBV is considered as a key component to achieve the Sustainable Development Goal number five by 2030 in Uganda.[8] As a response the government of Uganda developed the National Plan of Action for SGBV in 2019 to strengthen the role of the health system to respond to GBV on the national level in order to create a more healthier and productive environment.[6]

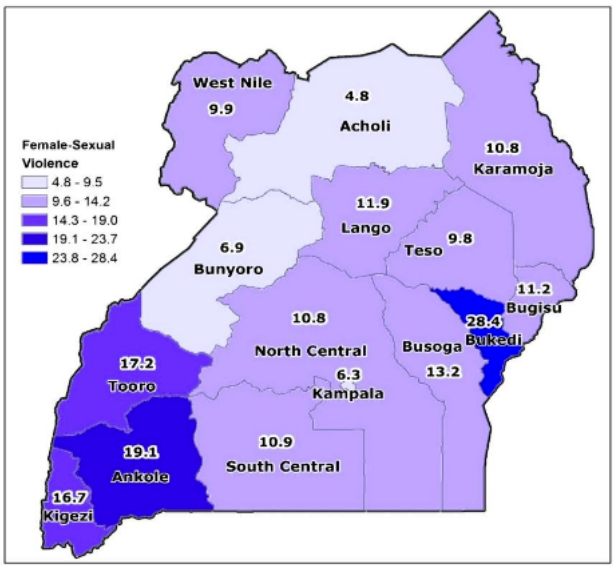

Figure 1. Female prevalence of SV in Uganda.[6] *Source: http://library.health.go.ug/publications/gender-based-violence/national-plan-action-sexual-and-gender-based-violence-and*

In Uganda many lives are affected by GBV as it can cause long-lasting consequences. According to the Ministry of Gender, Labor and Social Development, a prevalence study conducted in 2008 showed that 39% of women and 11% of men had experienced sexual violence.[9] Particularly among displaced and refugee population coming from neighboring countries e.g. South Sudan, Somalia, etc. 44% of refugees knew somebody who experienced SGBV in the past.[10] According to the 5-year interagency SGBV strategy done by UNHCR in 2016 – 2020 in Uganda only 33.5% women and 35.5% of men had self-reported SGBV.[10] The challenges regarding GBV raise up cultural silence that is one of the main barriers to seek help for survivors. Seeking help and reporting when experiencing GBV is in the community associated with stigma, shame, fear for the perpetrator. In addition there are structural barriers of distance from their home to the services, lack of available services in their areas, cost of the medical services and protection of the survivors that are an obstacles to access care.[11] In Uganda, the current health system is decentralized, where the survivors are having first contact often through village health team or health post and if needed further refer to higher level of care. [22] Also the health facilities lack sufficient qualified staff, medical supplies, confidential counseling, and treatment to respond to GBV survivors' needs.[22]

As of 2019, there were 6,937 healthcare facilities in Uganda, 45% of which were governmental, 14% private/not-for-profit and 40% private/for-profit. The national level includes national referral hospitals, regional referral hospitals and semi- autonomous institutions such as blood transfusion services, national medical stores, public health laboratories, and a national health research organization with the aim to deliver a minimum health care package to the population[18]. In the districts there is a tiered approach that begins at level I which features village health teams (VHTs), made up of volunteers who deliver predominantly preventive services, health education, and simple curative services in the communities. Level II is comprised of health centers (HC) with outpatient services run by nurses and a catchment area of up to 5000 people. At level III, HCs contain both outpatient and inpatient services in addition

to simple diagnostic services and maternity care. They are managed by clinical officers and serve up to 10 000 people. Level IV HCs are managed by medical doctors and can provide surgical services, blood transfusion, and comprehensive obstetric emergency care in addition to the services listed above.

The Ministry of Health (MoH) coordinates different stakeholders responsible for implementation of care, planning of activities, budgeting, policy formulation and regulations. However, the MoH is failing to improve compensations for the medical staff, as well as failing the consistent supply of the medicine and other medical equipment needed in the hospitals and HCs across the whole country. This leads to gaps in care and aids in paralyzing of the whole health system[21].

In order to increase the access of GBV care for survivors in Uganda, understanding the GBV context in Uganda including what are the factors influencing barriers in implementation of effective GBV access to care in Uganda is essential. [13] The aim of this paper is to explore the factors influencing the barriers survivors are facing while seeking medical and legal help after experiencing GBV in Uganda. The literature review provides evidence that is crucial for a design and implementation of adequate access to medical and legal care for survivors experienced GBV. The lessons learned from countries with a similar GBV context as Uganda can be useful when designing and implementing access to medical care for GBV survivors.

2. Problem statement, Justification, Objectives and Methodology

2.1. Problem Statement

Addressing GBV in Uganda is challenging and despite of the national guidelines and policies there remains little evidence and actions as to what effective approaches to be taken in the country.

The Sub-Saharan Africa has important role to eliminate all aspects of GBV to achieve Sustainable Development Goals (SDS's). GBV in Sub-Saharan Africa shows the highest prevalence rate on sexual violence (18.75%) and non-intimate partner violence (44%) among women and girls.[14] In Sub-Saharan Africa, GBV is well known especially in the countries where there is conflict and/or displacement of population as the population is more vulnerable.[2] Specifically in Uganda 22% of women and girls had experienced some form of GBV in their life time. This translates to 1 million of women and girls are exposed to GBV in Uganda.[15] Further according to the UNHCR, sexual violence by intimate partner experienced 36% women and girls, sexual violence by non-partner experienced 28% women and girls in their life time across all regions in Uganda.[17] Also the countries neighboring Uganda with similar context reported an estimated incidence of women that have experienced some sort of GBV as follows: Rwanda 41%, Kenya 44%, Tanzania 40%, the Democratic Republic of the Congo 57%, and South Sudan 50%, respectively.[16]

GBV is a public health issue. In Uganda, are many factors that contributes to the increase of the GBV such as abuse of gender power, sexual violence, poverty, etc. Those contributing factors needs to be addressed through intervention not only in the health sector but also across other sectors like social and leagal.[6] Furthermore, survivors that experienced GBV are facing various barriers to access the health care services due to gaps in the current health care system and further weak coordination among the existing referral medical services.[18,19]

Generally, all survivors, as per minimum standards, should have access to comprehensive professional care and support to reduce the impact of the experienced sexual violence.[20] In Uganda, comprehensive quality services on the supply side such as medical, legal, security and protection services are often not available.[11] So, survivors on the demand side are facing multiple barriers to get medical service including fear from perpetrators, lack of economic resources, social stigma, restricted laws, and policies.[15]

Also, GBV is underreported for various reasons such as stigma, limited access to services, cultural and personal factors, as well as perceptions and influence of perpetrators.[14,16] Numbers found in literature are mostly based on estimation. The estimation demonstrates the size of the problem, and it should be acknowledged that the number given represents only the survivors who reported experiencing GBV and not the actual numbers of survivors who experienced GBV.[3]

Furthermore, in Uganda, a health service is often the only service GBV survivors are seeking. Receiving quality medical care within 72 hours can prevent and reduce the risk of STI, HIV, and unwanted pregnancy and prevent further sexual violence from occurring by addressing safety issues.[21] A timely and appropriate healthcare response is a life-saving intervention.

It is essential to develop guidance to improve survivors' access to GBV services and ensure the quality of these services with a specific focus on health, justice, social services. However, there are still challenges to address and meet all the survivor's needs.[22] Even though humanitarian organizations and the national government have scaled up a strategic priority to respond and prevent GBV.

Uganda developed the National Plan of Action for Sexual and Gender-Based Violence and Violence Against children in 2019 together with The National Policy on Elimination of Gender-Based Violence of 2016. The plan of action and policy were designed to provide a comprehensive response to the survivors and eliminate GBV.[6,23] However, despite of their plan due to the social attitudes that put less values in women, and poor implementation across the society. Tackling GBV in Uganda is important so that women and girls can enjoy their sexual and reproductive rights and fulfill their potential.

2.2. Justification

While 22% of women and girls in Uganda experience GBV during their lifetime, many of them do not access medical care and legal services. This thesis explores the factors underlying the limited access to comprehensive GBV services. Questions that guide the research done in this thesis are: Why aren't survivors seeking medical care? What are the barriers in accessing medical care and what are the possible solutions to addressing and overcoming those barriers?

The poor access to comprehensive care for GBV survivors has motivated me to further explore issues of access to medical care in the country. In this paper, the barriers to accessing medical care were intended to explore the demographics, health care seeking behaviors and care provided by health professionals to GBV survivors in Uganda. The conceptual framework developed by Levesque et al., 2013 was selected and used to identify and discuss factors related to access health care for GBV survivors.

The findings from the literature review will provide guidance and further strategies to adapt the conceptual framework model of health care for GBV survivors. The long-term aim is to increase access to timely quality of medical GBV care.

In Uganda without adequate access to GBV medical professional services, survivors will continue to suffer in silence. The continued suffering makes this study a timely review of the problem of access in all its complexity. There is a big need to address the identified issues to access the comprehensive medical care and present them to the government and key stakeholders to their GBV implementations programs to decrease GBV in the country and reach the SDG 2030.

Lastly, I will conclude with recommendations that were in the need of my paper and can be adapted and fill the gaps for the sake of improving the access to medical care implemented in Uganda for stakeholders involved with planning, regional, local government, NGOs, healthcare structures, workers, and community representatives.

2.3. General Objective

The paper aims to review and describe barriers that GBV survivors are facing while seeking medical care and what strategies could be used from similar country contexts to improve the GBV medical services in the country.

2.3.1. Specific Objectives

1. To describe and analyze factors influencing the seeking of care by GBV survivors in the health system (supply side)
2. To describe and analyze individual and/or community factors influencing the seeking care by GBV survivors in Uganda (demand side)
3. To evaluate lessons learned in other LMIC countries with settings similar to the ones in Uganda and these countries' experiences in addressing medical care for GBV survivors, in order to learn from them in case of relevance to the situation in Uganda.
4. To present recommendations for policy makers, included those in charge of health for integrating medical services for survivors of GBV into the Ugandan national healthcare system.

2.4. Methodology

2.4.1. Literature Review Strategy

In order to fulfil the above objectives, a review of available literature, documents, journals and reports was conducted. This review includes peer-reviewed articles, books, dissertations, diploma theses, conference papers, primary and secondary

sources of information, national policy and legislative texts, grey literature such as governmental reports, policy statements and issues papers.

Different databases and sites such as PubMed, Scholars, Health Database, Medline, the Cochrane Library have been searched and examined for relevant literature. Keywords like GBV, sexual violence, access to care, Uganda, survivor, and health care have been used to search online. The keywords were used with the connector AND; OR when searching relevant databases and engines. Ugandan national guidelines and policies, surveys, reports, and studies were searched as well as the UNFPA, WHO, World Bank, UNHCR websites and their documentation was also searched for relevant information. The list of references of relevant literature was reviewed using the snowballing approach to identify relevant literature. Further, literature with best practices in LMICs on the demand and supply side has been searched and selected to determine lessons learned of relevance to consider by the Ugandan healthcare system.

Literature search key words and terms	access, health care, gender, gender-based violence, sexual violence, intimate partner violence, rape, GBV, SGBV, IPV, intervention, program, prevention, health system, challenges, response, health system, community, Uganda, low- and middle-income countries, barriers, access, gender, healthcare system, approachability, affordability, availability, accessibility, knowledge
Inclusion criteria	- Literature published or accessible in English - Literature addressing GBV and/or access and/or health care and/or barriers and/or challenges and/or programming and/or response and/or prevention - Primary and secondary information addressing or reducing GBV - Available studies addressing government or healthcare system services for GBV - Multi country programs with a context similar to the Ugandan one,

	including case studies were included as part of Objective 3 - Different types of evidence were contemplated including qualitative and quantitative data, - Grey literature including government publications, reports, presentations, dissertations, policies and procedures, guidelines, and peer review literature
Exclusion criteria	- Literature published prior to 2000 to limit outdated literature and publications - Literature published other than in English - Literature with no public health component (for example focusing only on refugee population or repatriations to survivors)

Table 1. Literature search key words and terms, inclusion, and exclusion criteria

Strategy for analysis
- Each article and report have been analyzed and individually coded according to the type and presented quality evidence, inclusion of outcomes. - Each item got its unique code according to the objective and was then coded according to parts of the adapted conceptual framework they met. - To address the level of health care response in the country governmental programs and interventions were analyzed, whether they were run independently or in partnership with other stakeholders, whether referral mechanisms to health facilities were sufficient and clearly outlined, or whether the health care response was run independently by other key stakeholders - The results were collected and combined for each objective and according to the conceptual framework

Table 2 . Strategy for analysis

2.4.2. Conceptual Framework for Access to Care

Access to health care can by examined through the conceptual framework "Access to Healthcare" as developed by Levesque et al. as presented in Figure 3.[24] Access conceptualized an approach to healthcare that enables providers to give appropriate medical care and for communities and consumers to use appropriate care according to their needs. Access to health care is context specific and based on the interplay between healthcare providers, health systems, health facilities, individual patients, households, social norms, and the physical proximity between the above actors.[25]

The framework of Levesque et al. was selected to guide the paper on the supply side by examining the relation between the health systems and populations and on demand side to explain barriers to medical services in different phases of accessing medical care by GBV survivors in Uganda.

The model is structured around the different stages of accessing the healthcare system on the part of providers and patients—healthcare needs, the perception of needs for care, health care seeking, reaching, utilization, and consequences. Feeding into these stages of engagement are provider and healthcare system-level, supply-side factors and patient-level, demand-side factors.

On the supply-side there are the health care services themselves (prevention, promotion, and curative) and on the demand-side are mostly a combination of individual characteristics and social determinants of health. Each of these factors are linked to a given stage of the central part of the model. This framework presents five dimensions of service accessibility (approachability, acceptability, availability and accommodation, affordability, and appropriateness) on the supply side to interact with corresponding abilities on the demand side (ability to perceive, ability to seek, ability to reach, ability to pay and ability to engage), as presented in figure 2. The specific objectives of my study are grounded within this conceptual framework, while the framework will guide the presentation and discussion of the results of the literature review regarding the available access to health care for GBV survivors.

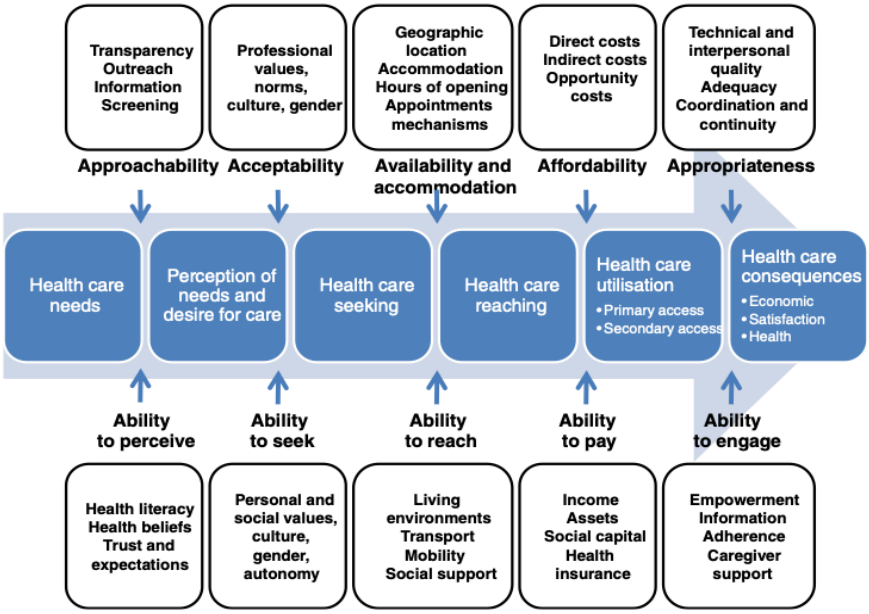

Figure 2: A conceptual framework of access to health care, Levesque et al., 2013. [24]

Levesque's dimensions for access to care	**Definitions**
Supply side	
Approachability	People facing health needs can identify that some form of services exists, can be reached, and have an impact on the health of the individual.
Acceptability	Cultural and social factors determining the possibility for people to accept the aspects of the service and the judged appropriateness for the persons to seek care.
Availability and accommodation	Health services (either the physical space or those working in healthcare roles) can be reached both physically and in a timely manner.
Affordability	The economic capacity for people to spend resources and time to use appropriate services.
Appropriateness	The fit between services and clients' needs, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided.
Demand side	

Ability to perceive	Translates to ability of individuals to recognize their needs for medical care.
Ability to seek	Relates to that individual decide and express the intention to receive medical care.
Ability to reach	Enables individuals physically reach the medical services.
Ability to pay	Determines the ability to pay for medical services from individual saving without compromising of resources required for their basic needs.
Ability to engage	Individuals actively participate in their treatment and decision-making about their medical care, and it commit to its completion.

Table 3: Levesque conceptual framework definitions; Source: Levesque JF, Harris MF, Russell G. Patient-centered access to health care: conceptualizing access at the interface of healthcare systems and populations. Int J Equity Health. 2013;12:18.[24]

3. Findings

In this section, the access to health care for GBV survivors in Uganda will be examined using the conceptual framework as presented above. The review's focus starts in the center of the framework. Each stage along the health seeking process will be discussed accordingly to the demand and supply side factors. The highlight words in bold reference the "conceptual framework".

3.1. Perception of Needs and Desire for Care

3.1.1. Approachability (Supply Side Factors)

The Ugandan health sector only recently started to address GBV care, and there are still significant gaps. Health services are provided by public and private (for-profit) facilities. Most of the survivors' **approach** GBV care through health centers, hospitals, and for-profit health clinics. However, the health services are expected to provide non-discriminatory services at no charge.[26] The services provided in specialized health structures are most likely well known and accepted by the population. However, not all the services are available in all the regions and areas of Uganda.[26]

In health facilities, the majority of the medical care for GBV survivors is provided by midwives, clinical officers and occasionally a medical doctor. The provided services in the health facilities are lacking confidentiality, medication, a referral pathway to socio-legal services, and the provision of **information** about existing services to the clients.[26] The main

reason for that is that the government health budget is inadequate for the hospital and health centers demand and that leaves the GBV services understaffed, underutilized and with lack of motivation and information to the clients.[27]

Thus, survivors are suffering from inadequately **approachable** care. Therefore, in collaboration with other NGO partners and stakeholders, the MoH aims to build the capacity of national and regional hospitals, and health centers to be able to respond to GBV survivors' needs to seek professional care.[28] However, the general standards of GBV medical services particularly in the government set up is poor as the services are understaffed with health care providers that are not having adequate knowledge about GBV care and that makes the GBV services un-approachable. In the NGO and private facilities better quality of care is offered for survivors of GBV. Where more attention is focused on trainings on such service.[27]

Moreover, better utilized and well-staffed health facility with functional GBV service will improve the service and transparency about available medical care. In Uganda, lack of understanding when to access GBV care affects the usage of the available GBV services.[29] A qualitative study conducted in Uganda found that GBV was a big concern especially that communities were not sensitized about GBV available services in their area[30]. UN agencies had reported that working together with local leaders and attending education sessions about when to access GBV medical care and what services are available in the health facility might improve the understanding in the community.[31] However, the results of Uganda's demographic and health survey, 2011, shows that up 42% survivors of GBV do not seek medical assistance due to the lack of knowledge about the available services.[30]

To be able to pass **information** in the community about impacts of GBV, multimedia plays one of the essential roles according to the Ministry of Labor and Social Development's 2016 country report. The media were used for educational messages and peer to peer education about GBV.[32] Similarly, a national survey in Nigeria identified a positive influence on access to care for survivors when **information** about GBV is introduced by the media. Additionally, in South Africa, media exposure of GBV information improves access to services for GBV survivors.[33] In the media it is useful to focus on providing services such as hotlines, shelters, and crisis centers which survivors can access. Additionally, positive statements from survivors about their experience help to draw attention of the listeners or when in the newspapers positive stories to be place on the front page to help build awareness.[34]

However, in Uganda, where usage of multimedia has been inconsistent, no relation between access to medical assistance for survivors and media exposure has been found. This fact could be due to the level of media coverage in the country.[35] In Uganda, not all of society has access to smartphones, television, radio, or other relevant media sources such as newspapers, magazines, information, and educational material. The exposure depends on socio-economic factors such as living location, education level, and wealth status. The National Multimedia Strategy Against GBV found that over 70% of society (women and men) listen to the radio at least once a week, as shown in figure 3.[32]

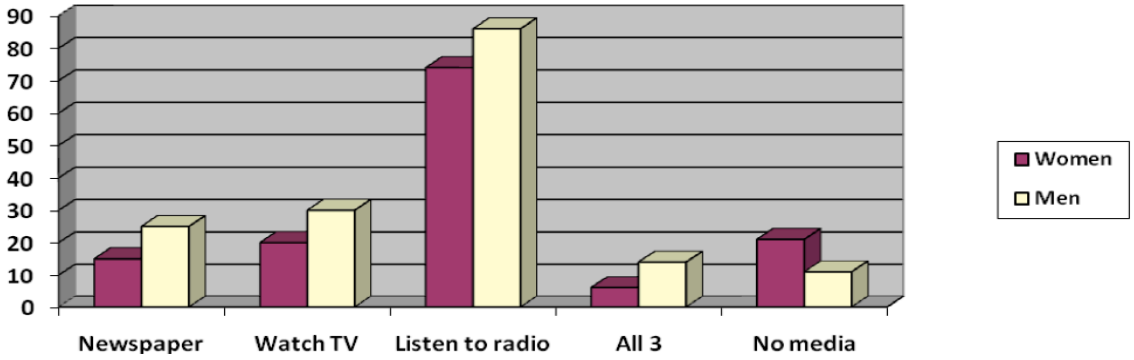

Figure 3: Exposure to mass media by men and women in Uganda; Source: https://uganda.unfpa.org/sites/.[32]

Generally, **outreach** activities that are supported by communities contribute to the improvements of health seeking behaviors among GBV survivors.[36] In South Africa the effort was made in the local communities to consecrate perception about GBV. Further in the communities was to increase the education level about GBV and such approach proved as effective especially when the communities had chance to participated in the education program and improved the behavior seeking medical care when experienced GBV.[37] Similarly, in Uganda the GBV community support activities are implemented by the health team workers in the villages. The health talks about impacts of GBV are done by the village health workers[38]. The objective is to improve the quality of care through standardizing communication strategies for the benefit of all community members, especially the vulnerable ones in the rural areas where access to medical care is more difficult due to the distance to the facility and availability of trained health care professionals.[38,39] Further, the Government and World Bank report of 2019 identified that GBV survivors face many barriers in the community while seeking medical care.[19] It is important to link **outreach** activities to the village health team that usually plays a crucial role in providing support to the survivors. The support includes psychological first aid, advising, and linking survivors to seek further professional medical care.[38] However, in Uganda the proper training, education, and knowledge handling (focusing on such clients) from the health team is still insufficient. Also, lack of funds from the government to support the outreach health team negatively affects the community that plays a critical role in linking survivors to the proper medical services.[18]

A study conducted by Musoke et al. in 2018 shows that the outreach health team plays an important role, especially female workers, which positively impacted GBV survivors who were able to seek timely care in some rural areas of Uganda.[12] Further, a national cross-sectional study found that 63% in the **outreach** village health teams are females which play a crucial role in the GBV service. As the outreach health team members are the first contact for someone living in rural areas, they play an important role to the survivors in access to GBV care.[38]

3.1.2. Ability to Perceive (Demand Side Factors)

Utilization of the available GBV medical care is limited to the individuals to have the capacity to analyze and understand the basic GBV medical information that are needed to make appropriate health decision. Lacking **health literacy and beliefs** in the importance to seek health care after rape, is one obstruction to on-time medical treatment for survoviors.[18]

A study conducted in Congo in 2012 found that an absence of **health literacy** when nonappearance of direct medical complications (resulting from GBV) such as visible injuries, was one of the most common reasons not accessing immediate medical care.[40] In addition, a multimedia strategy report shows a lack of knowledge about the importance to seek medical care after rape in the rural communities in Congo.[32] Similarly, in Uganda lack of trained health care professionals, long distance to travel to the health facility contributes to the decision that survivors when experiencing GBV not to seek help especially in the absence of injuries and direct complications.[31] The lack of insufficient health literacy creates mis**trust** in the services and survivors' **expectations** are not met. This leads to delay in medical care that results in survivors suffering in silence. [31,41]

It is essential to understand the local and traditional **health literacy** within the context of Uganda. Women participation in health programs to increase their knowledge about GBV is essential. Further participation of women and men is significant when adopting health information in the community to introduce new modes of communication and continuously trained personnel for continuity.[37]

3.2. Health Care Seeking

3.2.1. Acceptability (Supply Side Factors)

Professional values and norms are fundamental convictions of individuals or groups regarding the work they are supposed to do and the quality of the work they are supposed to deliver. As part of the professional values, each health care provider's values influence their medical decisions. Therefore, personal, and professional values can impact patient care and improve the decision-making process towards the most comprehensive and appropriate care. The professional values and norms are guided by the ethical code to avoid self-interest and also to avoid harm, and to improve the health of the patients.[42] An example of conflicting **professional values and norms** is the provision of safe abortion care and termination of unwanted pregnancy as a part of GBV medical care. As many female survivors are facing unwanted pregnancies as result of rape, in Uganda safe abortion care is restricted by law. Abortion can be only performed to save woman life. Because of the existing restrictive law many health care professionals are reluctant to perform safe abortion care out of fear from legal consequences.[43] Sadly, this results in resorting to unsafe methods that can lead to many lifetime complications or even death. This places a burden on the Ugandan health system as the complications of unsafe abortions need medical care and contribute to maternal mortality and morbidity in the country.[44]

Furthermore, a study in Uganda done by Moyo et. al found, when mapping the availability of GBV clinics with health care provision, staff adequately trained on **professional values** as part of GBV care were inadequate in these clinics.[45] One of the reasons is lack of education and training for health care staff about the necessity of GBV medical care. The National Plan of Action for SGBV in Uganda acknowledged the limitation and gap in trained health-care providers to respond appropriately to GBV survivors.[6] Another reason is that midwives and nurses in the government settings are restricted by the national legal system to fill in and sign police forms which is mandatory when survivor report rape to the police. Only medical doctor are entitled to sign such form.[46] As there is a shortage of health care staff in the health facilities not always doctors are available to fill and sing the form. So survivors are force to long waiting time which discourage them to seek medical care.[46] UNFPA has developed a support program to address GBV with an objective to initiate a better response to help the needs of GBV survivors in Uganda. However, UNFPA primarily focused on coverage of the areas with refugee settlements, as shown in figure 4, while these programs should also be expanded to the host communities.[15]

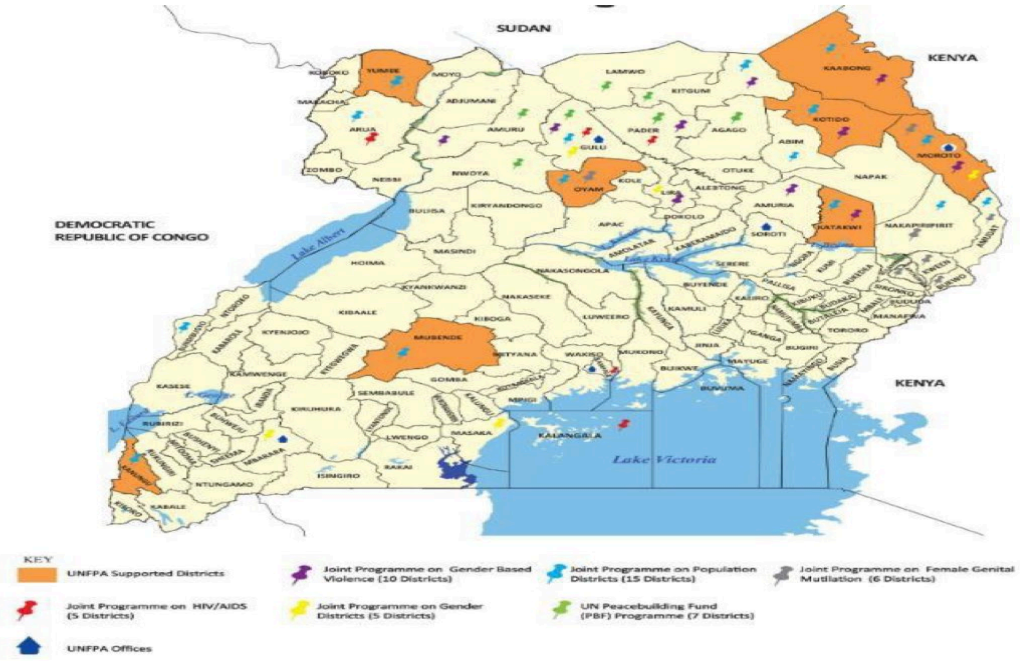

Figure 4;: Map of Uganda with UNFPA – GBV-country program on GBV-training. Source: https://uganda.unfpa.org/sites/default/files/pub-pdf/GBV_0.pdf. [15]

Furthermore**, gender** is another factor that affects the access to the provision of GBV care negatively. It is part of the **professional, social and cultural norms** that the supply side contributes to the acceptability of GBV care. Gender as a social norm affects survivors seeking professional health care.[11] For example, in Uganda, as a part of some cultures, women are not

allowed to seek male health care practitioners, or women are not allowed to visit health services alone without a family member. This creates inequity in seeking medical care provision and has negatively affect women's health when experienced GBV.[47] The National Plan of Action for SGBV had put objective to address and advocate for gender equity to empower women and girls to make health decision.[6] However, despite the government effort the plan of action is underutilized or missing in the most areas of the country.[47]

3.2.2. Ability to Seek (Demand Side Factors)

Personal and social values are part of the **cultural** and traditional beliefs. In Congo, as reported in a Congolese community-based study in 2012, traditional and religious beliefs are playing a curtailing role for GBV survivors to seek professional medical care or can also cause delay in seeking this care. The study further presented that survivors see medical care as unimportant and mostly stigmatizing and rather prioritize traditional medicine over professional care.[40] Like in Congo, in Uganda people use traditional medicine as a part of its **culture** and beliefs. This practice negatively affects survivors who do not receive timely medical care or not at all. **Cultural and social** preference to seek traditional healers instead of medical care professionals is due to stigma and low cultural acceptance of GBV survivors in the community.[48]

In general, **socially, and culturally**, sexual violence mostly stays hidden as survivors fear for their safety or fear stigma from the community. As well the services in the health facilities are lacking confidentiality and it contributes to the health seeking behaviors. [48] In Ethiopia, for instance, survivors participating in a national study highlighted the critical part of privacy and confidentiality which might improve early seeking medical care.[49] Uganda is facing the same challenges where survivors are lacking privacy and confidentiality in the health facilities, which are such an essential part of survivors care.[44] Similarly, as in Ethiopia, in Uganda, **culturally,** survivors are facing stigma by family and community, as well fear of further violence from the perpetrator, insecurity, and helplessness.[24]

Another contributing factor to the ability not to seek GBV care is the waiting time to receive care; long waiting hours alongside busy waiting areas in the health facilities.[17] In addition to the previous findings, improvements in confidentiality-separated waiting rooms, reassurance regarding security and regaining of **autonomy** would improve the response to GBV survivors needs in Uganda.[44] Moreover, the majority of the provided care for GBV survivors is lacking visual and auditory confidentiality.[17] Levesque et al., 2013, pointed out that some clients that seek medical care expecting to have medical care provider by the same sex as the client, as such respecting the culture of the client.[24] In Uganda, some survivors, as part of the **social values** and the nature of the GBV, fear receiving care from providers of another sex.[50] However, female survivors as well as male survivors express a strong preference for female health care providers. A report from Congo in 2018 presented a women experience, where they had uttered that the gender of the health care provider is not so important such as taking the time and put the survivor care as priority and listen to their needs to ensure respectful care and

confidentiality. The survivors expressed that such a positive attitude eliminate feelings of frustration and mistrust regarding the provided care to them.[51]

There are more **social and cultural** barriers that influence the decision to not seek help after experiencing GBV. For instance, individual beliefs and perceptions of the non-confidential nature of health services influence an individual does not disclose or report GBV. However, various National Guidelines including National Referral Pathway Guidelines have been developed to support the establishment of confidential services and a referral mechanism but due to the barriers that national health system and actors are facing it is difficult to implement such guidelines where confidential services are established and available for survivors to seek assistance. Further, lack of skilled health workers in health workforce are missing to respond appropriately to the survivors.[12] However, no specific care model or strategy is effective in every context, which means that the government and different stakeholders should adapt current available guidelines to fit Uganda contexts.

Furthermore, **autonomy** in obtaining education especially for women, empowers them to make timely decisions to access timely GBV care. Therefore, a community that obtained a higher level of education had better and more on time utilization of healthcare services, as well as resources to pay costs for provided care.[52] Education is a crucial element to transform the root cause of violence, especially GBV. It is a important social, psychological, and emotional process. Hence, as part of **autonomy**, young people need to have an early education about what is GBV, how to recognize it and prevent it. In addition, promoting gender equity as **social value** while addressing SGBV contribute to prevention and early seeking behavior.[53]

A UNHCR Prevention and Response training package of 2016 shows a strong link between education and knowledge about GBV in the community in developing countries.[11] Better community health education helps in a survivor's **autonomy** to decide to seek professional medical care on time.[54] A 2014 UNHCR report about GBV in developing countries found that women with higher education are more **autonomous** and have a better ability to report domestic violence when it occurs. Further the report shows that secondary and higher educated women are more likely to report GBV to the authorities compared to women with no education and who are more dependent on their partners.[16]

In Uganda, survivors who obtain a higher education are more **autonomous** seeking GBV services.[55] According to UNESCO in 2018, Uganda has an adult literacy rate of 77%, with an adult male rate of 83% and an adult female rate of 71%, showing a significant gender gap.[56] This can have an impact on access to medical GBV care. As previous mention evidence showed that women who obtained higher education have better ability to seek medical care. Additionally, minors and adolescent survivors are a vulnerable group regarding GBV. However, as part of the culture, minors and adolescents are excluded from SRH education, and they are often not specifically targeted to receive and access reproductive health care. Their age and decision-making power also put up barriers to seeking timely medical care on time of occurrence when experienced GBV.[18] Therefore, particular attention should be given to incorporate SRH education to the curriculum in the schools to enable children and youth to

receive information what to do when experiencing and how to prevent GBV. For example, teachers and parents should receive health education about the prevention and possible implications of GBV, pointing out the importance of receiving early treatment and counseling when GBV occurs. In addition, the health system should ensure youth and children friendly care in the health services and incorporate them in the national health education.[20] In Tanzania a study was done to assess knowledge about GBV services on adolescent girls. It was found that only few participants (30.7%, n = 124) had demonstrated knowledge about GBV services in their area. Additionally, only 93% of total participants (374) had received education session about available GBV medical services, only 66% accessed GBV medical services and only half of those participants were satisfied with provided services. The study concluded that GBV services remain underutilized, and interventions needs to be done to improve GBV youth friendly services.[57]

In Northwest Ethiopia, a qualitative study conducted on the perception of GBV among married women showed that GBV is widely accepted as part of their **cultural and social values.** Violent acts are tolerated rather than judged in the community. Further, it was found that marital rape is not clearly understood in the community. Marital rape is common among married couples with no trend to disapprove it. The study showed that community awareness could improve reduction in violence against women in the married relationship.[58]

In Uganda, **gender** plays a crucial role in the society. Women are often considered subordinate to men. Despite social and economic changes in society and the country, GBV and sexual assault continue to be a predominant concern among the community. A high level of illiteracy and poor socio-economic situation among women directly influences the level of GBV, specifically domestic violence. Such cases occur because female household members cannot make decisions or their decisions are not valued by the males.[59] Further, women are facing repeated abuse and stigma from society which directly affects their physical and mental health.[60] According to the WHO, women are more likely to fall victim to sexually transmitted infections (including HIV), injuries, depression, and suicide attempts as a result of rape.[61]

A study conducted in Senegal showed that decision-making **autonomy** increases significantly with education and age of the women.[60] Furthermore, according to the Ethiopian Demographic and Health Survey in 2018, 69% of women, aged 15 – 49, could receive immediate medical care after experiencing GBV and make a health-seeking decision without any problem. The health seeking behavior is influence by the education for girls in the country.[62] Further in Ethiopia, individuals with family and community-supportive attitudes are more likely to seek medical care when GBV occurs.[12] Research shows in Northern Ethiopia, that women that are positively supported by their families and communities are more likely to seek help while in the community where sexual violence is tolerated or considered normal, help-seeking is noticeably low.[63]

3.3. Health Care Reaching

3.3.1. Availability (Supply Side Factors)

Generally, in LMICs physical accessibility and availability of health care is the main key of access to health care.[64] **Availability** refers to services that can be reached physically and timely by people who need them. In addition, the health services have adequate services and resources to provide care such as client friendly **opening hours**, available **appointments** to accommodate client needs and short waiting times for the services.[24]

Health facilities and their **geographic** location controls the level of access.[64] In Nigeria concentration and distribution of healthcare facilities closely associates with utilization of care. Further, data from Indonesia shows that implementation of clinics that clients can assess, providing SRH services, and are actively screening for GBV, increase the response from the survivors. [24] However, in Uganda not all the health facilities have the capacity and trained staff to perform such active screening and the identification of survivors is still low compared to other countries e.g., Papua New Guinea where 59% of women aged 15 – 49 experienced some form of GBV in their lifetime.[65]

In Uganda, the healthcare system has been inequitable. Quantitative study shows that distance to the health facilities is restricted by **geographical location** where the health facilities are far influence the poor seeking health behaviors among the survivors. This fact that health facilities are far increases to seek care from traditional and community healers instead of health professionals.[66] Another factor that influences the level of availability is the **opening hours** of the healthcare facilities. Though 24-hour care services should be provided. It was reported that most of the healthcare facilities are operating only during the daytime and a maximum of 8 hours per day. Some even only 4 hours per day.[67] This limits the access and timely response to medical care that survivors needs. Therefore, human resources and their operational working hours in the health facilities is a key indicator of access to GBV medical care and a timely response to the survivors in Uganda.[68]

Furthermore, many factors influence availability of health workers. There are significant problems with working and living conditions in most of the health facilities in the rural areas. High workloads and lack of supplies, drugs, water, and electricity compromise perform of their job. All those factors contribute to the attitude of the health staff's regarding their performance. As a result the medical staff has limited time and resources to attend survivors.[68]

3.3.2. Ability to Reach (Demand Side Factors)

Transport from rural areas to health facilities is still a challenge in Uganda due to the poor infrastructure in the country. Overall, big cities are having better access to the health facilities compared to the rural areas. Thus, the access to medical care is often lacking equity. In the

rural areas where the population is poorer and the demand for medical care is higher the health centers are disproportionally distributed compared to the urban areas. It has been a concern of government of Uganda with future goals to create and increase access to the vulnerable population of rural areas to primary care and continuity of medical care.[66] In Uganda, evidence shows that the density of GBV clinics in the rural areas is lower compared to urban areas[69]. According to the Health Sector Development Plan, 75% of the population should live within five kilometers from the health facility.[66] Generally, almost 80% of the Ugandan population lives in the rural areas. As evidence shows, this reduces the use of health care by the population, as distribution and **transport** to the health center are unequal as the population lives further from the health structure.[26] Only 30% of population in rural areas in Uganda are living within a five km radius of functional health center with appropriate trained health staff to care for survivors of GBV.[41]

A study conducted in Bangladesh shows that rural settings of health facilities corelate with utilization of care.[70] Another study done in Kenya and Zambia revealed inadequate access to health facilities. Survivors needed to travel long distances to obtain medical. Additionally, survivors were concerned by the cost of **transport** and distance to the health center when follow up medical appointment was requested.[71] Like in Kenya and Zambia, Uganda reported the same main reasons that not being able to reach health facilities on time was due to the long distance and unavailable **transport** in the rural areas.[41] In addition, difficult and in some areas dangerous roads and journeys to reach a health center were also one of the contributing factors. Similarly, a survey done by the Ministry of Health, reported cost of **transport**, long distance travel and unavailable comprehensive care as the main factors influencing not using health services, especially in rural settings[72].

"Because of how clinics are structured, GBV survivors are often unable to receive all post-GBV services in one location. They may receive an exam in one department, for example, and then be referred to another department to receive medication. In the case, the survivors may have to visit a different clinic entirely. Visiting multiple locations can be difficult logistically and emotionally, especially in the absence of a good case management system and can lead to delays in receiving medical care." (Female survivor, Kiryandongo, Uganda).[18] This points out the distance to the health facility as one of the barriers to GBV medical care in Uganda. Although, according to the WHO, one hour of walking distance is a minimum standard to reach a primary health facility. Uganda uses a range of five kilometers, approximately 1.5 hours of walking distance to access health facilities.[67] In Uganda, availability of transportation is very limited. A lack of public and private transport makes access and referrals difficult, especially in the rainy season[72]. The poor road conditions and lack of transportation limit survivors to seek medical care as well as community health teams to provide adequate health education on prevention of GBV. On the other hand, using bicycles to reach a health facility instead of public transport or walking, saves time. Most of the population is cycling to the health center and the visits increase from 72% to 91%. This bicycle strategy appears to increase the overall access to health facilities[66].

Social support is an important component in the response to GBV and in the provision of proper care, protection, and integration in the society. Social aspects from an individual who has experienced GBV, are guided through thoughts, emotions, behavior, memory, perception and understanding effecting relationships with families and community. **Social support** that is addressing trauma, isolation and stigmatization has been a major gap in GBV care in Uganda[72].

Also, a poor **living environment** and a family's poverty increase the risk to GBV. Access to comprehensive care where medical treatment is available including rape kits for survivors is essential and should be included in each health structure in the country.[28] Further **social support** where psychosocial assistance is included in the treatment as well safe space and protection if the survivors required, should be essential part of GBV medical care.[3]

3.4. Health Care Utilization

3.4.1. Affordability (Supply Side Factors)

Direct costs that are associated with the provided health services determines the level of access and their use. In Uganda, governmental health facilities and their care started to be free in 2001 when users fees were eradicated, but informal payments in forms of bribes, **indirect costs**, still exists until today.[66] In 2000, The Uganda Minimum Health Care Package was implemented as improvement of access to health care for the poor. However, even though utilization of the implemented package in the country increases drug availability and opening of new health structures in the rural areas, it also leads to resource limitation and results in re-prioritization of clients. This implementation package leaded to availability only for the higher level of facilities such as hospitals that have increased inequity to access and disadvantage the poor.[73] For instance, many clients attending GBV care claimed having to pay for medicine and for some of the diagnostic services or being directly referred to the private sector for such services.[28] Not only direct costs but also **indirect costs** bring discouragement to the most vulnerable population which pushes them to not seek GBV care when experienced at all or seek care provided by traditional healers. For example, GBV services are provided for the clients who can directly the medical costs which is mostly individuals in the urban areas. In rural areas, **indirect costs** and informal payments are barriers to access timely GBV care and use of services that survivors can benefit from.[67]

Further, transportation is one of the **indirect costs** to care and can be a barrier to care as discussed previously. In addition to the travel, also waiting time in the health facility causes loss of income and productivity. Survivors prioritize to stay in their small business to earn income rather than to seek medical care[24,74]. SGBV counselors in the rural villages reported that survivors are coming to them and begging for transportation as part of **indirect costs**; "We've done a lot of information sessions to sensitize the community about what they should do on the referral pathway [if they experience SGBV], but the community can't follow it because of these challenges – they don't have transport to go there. So, if they're not able to come right away, they may only receive emergency care after three days." Another counselor stated that unfortunately many of the survivors don't come at all after the SGBV incident

because they cannot afford the transport costs. All those delays increase the risk of medical complications. Many of the staff pay out of their pocket for the transport for the survivors to reach services. However, some of the service providers are not aware of these transport costs and simply ask the clients to come back tomorrow or another day for follow up care without considering the inability of survivors to pay the cost of transportation.[75]

3.4.2. Ability to Pay (Demand Side Factors)

Generally, the **ability to pay** for medical care depends on the socio-economic status and **income** of the population. The wealth index measures the ability of the people to pay for their health care. In Cameroon, a study proved the direct relation of the ability to pay and the increase of the use health care[76].

To have effective response, survivors that have been raped should seek medical care within 72 hours after the incident. However, many survivors are unable to afford such medical care that usually costs from 10,000 to 20,000 Ugandan Shillings while a minimum **incom**e in Uganda is 6,000 Ugandan Shillings. In addition, the survivors are unable to reach the clinic due to the distance and transportation costs. This results in the therapeutic loss (prevention of unwanted pregnancy, HIV and STI), as well as loss of forensic evidence and justice.[77,78]

"What discourages me from going to the police and health center is that they all want money. The higher you go up the chain of justice, the more money they want, and I don't have the money. I already don't have money for medicines, where will I get the money for justice?" Asha, SGBV survivor.[79] Overall, 74% of women in Uganda stated that obtaining money for their treatment is the biggest challenge to accessing health care after the GBV incident, followed by the distance, and finding transport to the healthcare facility. Survivors living in the rural areas are more likely compared to the women from the urban areas reporting problems in accessing medical care on time.[76]

Health insurance could be one of the options to obtain better access to medical care in Uganda. In the country health insurance coverage remains low, with private insurance covering 1% of the population, mainly among people living in urban areas. The National Health Insurance Fund has drafted insurance plans to enable access to care for all people. However, for its effectiveness and implementation, the government should address the identified Bill gaps and address them through lessons learned from other countries like Kenya, Ghana or Rwanda where medical insurance was effectively introduced, to be able to provide the right to care as the universal right.[80]

3.5. Health Care Consequences

3.5.1. Appropriateness (Supply Side Factors)

The main victims of GBV in Uganda remain women that translate to 22% according to the National Health Survey in 2016.[6] As in Uganda, in Nepal the incidence of GBV for women

(48%) is very high. Many of the cases in Nepal remain unreported due to the silence of the victims and fear for the perpetrators.[81] Generally, for health care providers dealing with GBV survivors, provision of medical care can be a very challenging and sensitive task which needs **technical and interpersonal quality**. It starts from identification of the violence by asking the proper questions without judgment and intrusiveness. Recognition of GBV signs is important knowledge for health professionals because they are usually the first contact for GBV survivors.[82]

In Brazil health care workers are having difficulties coping with and handling GBV-related subjects due to the inadequate training.[12] However, a positive attitude was found when appropriate training for GBV care was delivered. Case management of those trained improve and barriers towards GBV was eliminated[21]. Levesque et al. stressed the importance of patient-centered care as a human right. Patient-centered care includes **adequate** knowledgeable staffing, quality medication and appropriate equipment as the key components of quality of care.[36] In Uganda, the knowledge and response by health workers to GBV survivors significantly increased after a six-month training as shows Fig 5. For instance, an immediate post-training assessment showed significantly improved attitudes towards GBV survivors.[83]

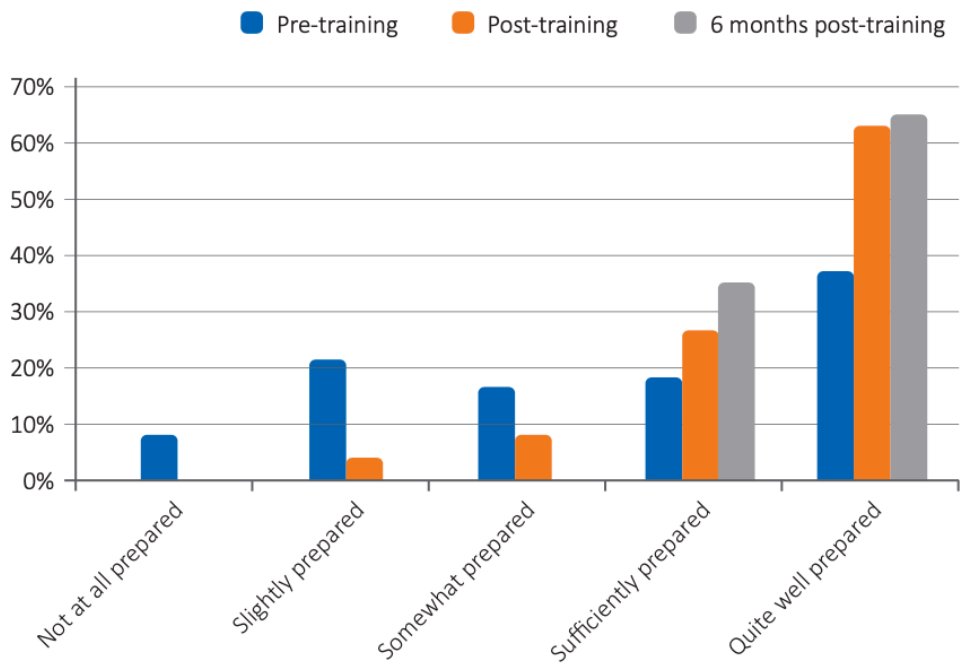

Figure 5: Perception of health care providers on preparedness to respond to GBV survivors[83].

Contradictory, another study done in Uganda, found that training for health care workers itself is not sufficient to respond to the survivors' needs.[83] For instance, health care providers are lacking the **technical quality** to respond to the needs of survivors. They lack clinical management of the survivors, time, space and confidentiality in the health facilities, with few options for referral services that are available to the local community.[83] **Coordination and continuity,** accessing care for GBV survivors still has many gaps as previously listed. Lack of

available care in the health facilities together with trained health care staff remains a challenge. Lack of available programs addressing GBV in the health facilities together with lack of protocols to be used for treating survivors was reported by the health survey done in Uganda.[45]

However, despite all the gaps the government is progressively working on drafting protocol management of GBV according to World Health Organization (WHO) guidelines. It would be necessary to stress the importance of implementation to facilitate timely response. The timely implementation of protocols would increase the **continuity** of medical GBV care for survivors.[45]

3.5.2. Ability to Engage (Demand Side Factors)

How one perceives the service quality is a significant aspect for making decisions to access health care in general.[84] The role and responsibilities of the health care providers is to actively build a relationship with the community (leaders, community focal points and women representatives) to spread **information** about the importance of GBV care through provision of trainings to the community.[85] Further, the engagement of men in the community is an important aspect of the GBV access to care for women to reduce stigma and fear and to build their **empowerment.**[86] Engaging men in GBV prevention directly, brings positive change in their attitudes towards female survivors.[87] In Uganda, UNFPA shows a positive engagement on the community level through communication, discussion, participation, teamwork, and **empowerment**. It is important to engage communities to break the silence that is often an obstacle to accessing care for GBV survivors. For example, through religious leaders and female representatives that play crucial role in the community.[11] However, the capacity to engage health care providers by training them and to support GBV survivors with essential **information and empowerment** are key factors[88].

4. Lessons Learned from Other Countries

Experiences from other countries with contexts similar to the Ugandan will be presented and discussed in this section, using the conceptual framework as guidance. However, the focus will be some of the stages distinguished as central building blocks of access to health care in the framework, including needs and desire for care, health care utilization, health care consequences. These factors are presented in multiple levels: system-level, supply-side and patient-level, demand-side (as experienced in other countries). The remaining stages of care from the conceptual framework were left out as no evidence for them was found in the literature review.

4.1. Perception of Needs & Desire for Care

A New World Bank project was established to help SGBV survivors in Congo, Burundi, and Rwanda to deliver integrated medical, legal, and socio-economic services as **approachability** (supply side). The project further strengthens medical care and its access for vulnerable and

poor women experienced SGBV as **ability to perceive** (demand side). The project strengthens access to care mainly at the entry point for SGBV survivors and focused on training health care workers to respond and meet the survivors needs. The workers were taught screening, counseling, medical treatment, and referrals to other support services.[89]

In Eastern DRC community-based organizations provide support to help survivors. The survivors reached to the trained personnel in the community and after is linked to the organization that provides medical care. Such medical support is a great advantage for the survivors where they feel heard and supported.[19] Also, the project in Eastern DRC supports a regional policy to address SGBV, including research and capacity building. This will help to promote gender equity, violence prevention and changes in individual behavior and to empower survivors to cope with their trauma and isolation after rape[19] as **approachability** (supply side).

South Africa has one of the biggest rates of GBV in the world. The objective of community assistance in this country was to improve access to medical care and create awareness about SGBV. The program was led by a variety of national associations in collaboration with the government. The program focused on community awareness and **information** (supply side**).** Through campaigns and media GBV referral pathways was introduce to the community. Such awareness increased the access to medical care for survivors from 42% to 55% .[90]

Moreover, in Zambia, an increased effort was made to encourage **outreach activities** (supply side) to reduce GBV. The main objective was to promote social changes at the community level by the health team. The team actively worked with the community through health talks, role play education to introduce the importance of the GBV and its prevention.[91] Further, in Zambia CARE International implemented a project on mobilization of broad public awareness and **information** (supply side), strengthening the community referral system for GBV survivors. CARE helped link the community with respective health facilities to receive survivors if needed. Also, CARE closely worked with village leaders in the country and organized community meetings to share information about GBV impacts and established referral pathways. The essential part was that the community leaders attended trainings on GBV for understanding its impacts. During the trainings were discussed GBV challenges, the way forward and how to create community awareness. The results showed effectiveness in raising awareness and attitude shifting towards the community and an increase in access to care for GBV survivors with community support.[90]

In South Sudan and Somalia, UNICEF led a Community Care program to address prevention and providing of **information** (supply side)**,** leading to positive changes in social norms and gender equity. The Community Care program was developed to decrease GBV with the goal to support communities and create healthy, safe, and peaceful environments to eliminate GBV through **transparent** (supply side) services. The UNICEF program created a partnership with local communities to be able to respond to the urgent need to increase access to medical care for survivors. Further, strategies were developed to prevent GBV. The program creates community dialogues with the aim to generate collective reflection and explore existing norms

of GBV and how to prevent harmful norms/practices. Single and mixed groups from the community members attended the program. It was found that the program influenced a positive change in the social norms, **health beliefs** (demand side), in the communities of South Sudan and Somalia.[92]

4.2. Health Care Utilization

Financing can affect access to comprehensive care for survivors as **affordability** (supply side). Generally low- and middle-income countries usually rely on combinations of governmental and private (out of pocket) resource contributions. Studies from several African countries showed that full implementation of national health insurance as a sustainable health financing system is the most equitable option to improve general access to health care compared to the voluntary health insurance which leads to inequity. This type of financing health care expenses help to increase the affordability to GBV services and help increase the usage of service.[66] However, each year 97 million Africans (8.2%) population are pushed to out of pocket payments for medical treatment including GBV medical treatment which push them into the poverty according to the World Bank.[19] In Sub-Saharan Africa, such as Kenya, improved access to health care including GBV services through community-based health insurance, which is equitable across the population and more sustainable. The health services had improved to higher quality and affordability to the community. The community-based health insurance protects the poor where each family pays monthly contribution to the fund and claims it when need it including GBV services[93], **ability to pay** (demand side). Further, some of the healthcare financing approaches included tax-based insurance to increase access to medical care in Ethiopia and South Africa. In Rwanda, the government increased financial investments in healthcare and enabled access to care. Further it was found that access to general medical care increased the access for survivors to seek medical care and legal.[94]

4.3. Health Care Consequences

Generally, focused GBV programs are helping to strengthen the access to comprehensive services for survivors. The programs include health, justice and psychological services required by GBV survivors across all the sectors of GBV care. The knowledge from the programs were used in some developing countries as policy frameworks and guidelines. The programs mainly focused on improving access by strengthening the community knowledge about GBV, referral system from the community to the health facility, trained healthcare workers for treatment and referral to legal services.[95] As evidence in the literature shows, utilized GBV programs improved access to health, justice, and socio-economic factors in response to GBV in South Africa, Zambia, and Kenya. In Zambia, after utilization of such a program, an increase by 48% in reporting sexual violence to police and early referral to medical care[91], as **appropriateness** (supply side). Further, the information from the program influences policy development in the countries of Ethiopia, Zambia and Kenya and demonstrates an effective approach for improving GBV response as **appropriateness** (supply side). A comprehensive overview helped to frame the gaps in the current GBV response and actively influence access to medical

care and its implementation. The approach also strengthened police and health services response and created a strong referral pathway. Training emphasized on medical and justice response. However, further work is needed to recognize GBV care for children as there were identified gaps in the medical and legal service.[96]

The Southern Africa Development Community (SADC) adopted a Protocol on Gender and Development, 2008 according to the findings from the GBV programs.[37] Many members of SADC such as Botswana, Lesotho, Mauritius, South Africa, Zambia, Zimbabwe used GBV programs as effective responses to GBV by including them in national laws, policies, and action plans as **appropriateness** (supply side). The protocol involved implementation of clear action to prevent, fight and reduce GBV. Evidence shows that the GBV target was met through the government efforts to their community through set goals in the Protocol. The GBV improved from 47% in 2009 to 68% in 2015. Awareness of GBV and legislation significantly improved with the increase of GBV care by the survivors.[37]

In recent years the model of "One Stop Center" facilitates is established to respond comprehensively to the survivors, **appropriateness (**supply side). The one stop center has many positive benefits for the survivors, One Stop Center refers to health, psychosocial, police and legally coordinated care available in one location or through a referral pathway across all care. This model helps improve access to care in South Africa, Kenya, and Malawi. The survivor-centered approach created a supportive environment for GBV survivors in which their rights were respected, and safety ensured. Clients are treated with dignity and respect. This helps survivors' recovery and ability to reinforce their capacity to make decisions, as **ability to engage** (demand side)[97]. In Zambia, implementation of One Stop Centers helped to respond to IPV and SV. A study was conducted to evaluate the One Stop Center model and it was found that health facilities and hospitals where a One Stop Center was established, the health needs of survivors were met. The care provided included medical, legal and psychosocial support.[91] In Nepal, One Stop Centers were integrated to the health mobile camps of conflict affected areas. It was identified that survivors are receiving comprehensive care, minimizing stigma, and ensuring confidentiality. 86% of survivors reported good level of care including free drugs and treatment, no waiting time and professional behavior of health care providers. However, the challenge remains with survivors report to the police because of fear from stigmatization.[98]

5. Discussion, Conclusion and Recommendations

5.1. Discussion

In this section I will discuss the conceptual framework and its outcomes, with examples from countries other than Uganda, which can be of use in the Ugandan context. The conceptual framework I adopted was found very useful to structure the findings of the literature review that I used. The framework is very broad, and it addresses steps and conclusions regarding access to health care for GBV survivors.

The discussion will cover the health care (supply side) and survivors (demand side). Gender was a topic discussed throughout different sections of the paper. Further, some limitations were experienced due to the research methodology or size of the study. Generalization of the findings might not be possible. For example, some studies found health structure evidence in the urban areas where the respondents were survivors and it led to the better access to GBV care.

5.1.1. Perception of Need & Desire for Care

Approachability (Supply Side) & Ability to Perceive (Demand Side)

In Uganda, unequal access to **outreach** (supply side), interventions through media and key **information** (supply side), to the community is determined by the socio-economic level and perceived needs to GBV care access amongst individuals and communities. Previous experience with the GBV care influences current decisions to seek care. Hostile experiences like low confidentiality and privacy, unavailability of healthcare providers, together with low knowledge of how to handle GBV survivors and low quality of care affect the decision of survivors to seek or not seek care. As an outcome, community awareness and **information** (supply side) should be created to stress the needs and importance to getting GBV care on time; and ensure cultural norms are respected while assuring confidentiality of GBV care.

Limited understanding and awareness about access to care is mainly prevalent in the rural areas compared to the urban areas. These issues can be tackled by extending coverage of GBV key messages, **information** (supply side), and training through different available means such as radio, **outreach** health team (supply side), community, and health workers. Further, to consider lessons learned from different countries with similar context, such Zambia, as One Stop Center or community **approach** (supply side), seem to be beneficial in the Ugandan setting. It increases awareness when survivors need access to care, as well as increasing the knowledge and importance of GBV care. The target for the awareness and sessions are the most vulnerable, poor population and community who experience GBV and living in the rural areas of the country. Further, it helps to create ownership and decrease stigma in the community. However, some of the communities may feel resistance as a denial of GBV in the community. Thus, it is important to involve the community to create positive attitudes and respect the community's opinions to be able to reach acceptance and create awareness. Through community leaders and representatives, it is easier to deliver key messages promoting early access to GBV care and its importance, along with understanding a survivor's stigma and fear, **ability to perceive** (demand side).

However, the low media coverage in rural areas remains a challenge to spread health **information** (supply side), and it should be well planned while implementing such programs. Surprisingly, the research shows the positive impact of the presence of the **outreach** health team (supply side), on better access to care of GBV survivors. Thus, it is important to continue to conduct training and new implementation strategies to target rural communities.

5.1.2. Health Care Seeking

Acceptability (Supply Side) & Ability to Seek (Demand Side)

Cultural (supply side), traditional, personal and community beliefs influence views on GBV and its access to care. Bearing in mind the individual aspects, women's education and social status is directly linked to their ability to freely access, as is the ability **to seek** (demand side) medical GBV care. Higher education is directly linked with an increase of autonomous decisions and less impact by established views when to seek GBV services. In addition, education brings broader knowledge about available GBV services and influences its usage when experience GBV. The reviewed study shows that when survivors are supported by the community and family members, timely access to GBV care is done.

Further, GBV survivors are facing challenges with restrictive abortion laws when fall pregnant after rape. Many GBV survivors are unable to access free termination of pregnancy. This results in unsafe abortions where women may experience lifetime complications and even death. Health care professionals fear conducting such services, but they are ready to offer care when the restrictive law provides clear explanation and refers to **professional values** (supply side). The outcomes from the paper show lack of privacy and confidentiality while providing care for survivors, discouraging them to attend the GBV services. Also, stigma and abuse from the community has further impact on the access, referring to **ability to seek** (demand side). In addition, female health workers, especially nurses and midwives, are facing many challenges while providing service as the nurses and midwives feel undermined when treating GBV survivors. In the GBV process the legal documents can be filled only by medical doctor or clinical officer, which causes delays in timely response. Further education about GBV for health care providers enables them to provide comprehensive care including medico - legal documentation.

Generally, education is the key element to reducing GBV in the community and confidential response by the health staff. Promotion of gender equity and addressing GBV promotes prevention and early approach to care when GBV occurs, referring to **acceptability** (supply side).

5.1.3. Health Care Reaching

Availability (Supply Side) & Ability to Reach (Demand Side)

Access to health care is the main factor that is influence by the location of health facilities. The distribution of health facilities is unequal, and survivors are forced to seek traditional healers instead of professional care. The health facilities are lacking 24-hour care and the clinics are only open for a limited number of hours per day. This inability to access together with significant shortage of available drugs, water, and electricity especially in the rural areas of the country, are barriers for the GBV survivors.

Furthermore, low involvement of health providers in managing issues, which contributes to low job satisfaction and high turnover of health workers, refers to **availability** (supply side). Not all the health facilities have the capacity and trained health care providers to respond to GBV survivors. The facilities are facing challenges with lack of available programs, guidelines and protocols when managing and treating GBV survivors. The government of Uganda is actively working to draft guidelines to support and address the importance to respond to GBV care.

In addition, lack of **transportation** (demand side) to reach health facilities, especially in the rural areas, influences the level of access. In urban areas where transport is available more easily, the access level to health care is higher. Distance and access to care directly influences access to care. Challenges in the referral system is another contributing factor where survivors need to travel to different areas to obtain psychological and legal help. However, positive social support from the community is an important component to reach health care on time as the literature review in the paper shows, refers to **ability to reach** (demand side).

5.1.4. Health Care Utilization

Affordability (Supply Side) & Ability to Pay (Demand Side)

Despite free health care in Uganda, individuals still need to pay for medication and some of the healthcare provided services. **Indirect costs** (supply side) are factors that discourage poor and vulnerable individuals to seek professional care, together with informal payments (in the form of gifts and bribes) and transportation charges. Some care that survivors are seeking is unaffordable such as follow up or referral to further care (psychological and legal).

Travel and waiting times are an additional burden when survivors in productive activities are losing their income (women selling their products in the market). The economic status of the individual or family affects the decision to seek care. Poverty can negatively influence the ability to get care, where individuals cannot bear the costs even though the health care should be for free, but the indirect cost has negative impact over the decision-making process.

In addition, Ugandan residency is a key factor to attend and afford care. In urban areas survivors have better ability to afford care compared to the survivors in rural areas. **Health insurance** (demand side) coverage remains low (1% of population) and mainly among urban populations. Ugandan government, like in Kenya, Ghana, or Rwanda, should identify bill gaps and provide the right to care for the entire population of the country.

5.1.5. Health Care Consequences

Appropriateness (Supply Side) & Ability to Engage (Demand Side)

Technical and interpersonal quality (supply side), together with adequate coordination and continuity of provided health care to the clients that includes educated staff, medication, and

equipment are key requirements for proper GBV care. This resource availability can influence the approach to care. Further, quality of care influences health seeking behaviors or decisions. In addition, proper knowledge from the health workers on how to deal with GBV survivors positively influences the first contact with survivors. Patient-centered care is an important component of quality of care as a human right. In Uganda, technical and quality care can be addressed through specific GBV programs for health care professionals.

Furthermore, community engagement and relationships show importance in the acceptance of GBV care, refers to **ability to engage** (demand side) and its attendance as disclosed earlier.

5.2. Conclusion

The results of the literature review show an apparent inequity in access to comprehensive care and ongoing challenges in accessing and seeking GBV care in Uganda. The major role factors on the demand side are a low socio-economic status, poor education, residency in rural areas, and cultural and community norms and beliefs. On the supply side is location and distance to the healthcare facility, quality of provided care, availability is further determining the access to comprehensive GBV care for survivors seeking help. Therefore, the focus of the national government when creating and updating guidelines and strategies should be to consider the challenges of the most disadvantaged which include the poor, less educated and rural populations. Also, everyone, community, and household need to be addressed to increase the effectiveness of future interventions to improve seeking behavior to comprehensive GBV care.

Lessons learned from other countries such as Zambia, Kenya, or South Africa should be part of the strategies to ensure 24-hour comprehensive care availability, a community education approach, and knowledge improvement for healthcare providers. Meanwhile, proper financial resources should be allocated to ensure response to the GBV burden in the country. Awareness about GBV in the community is part of the community-based strategy awareness. Hence, the focus should be shifted to the capacity building of the community to be able to take part in the planning and decision-making in GBV awareness. These primary concerns of poverty and vulnerability were discussed. As a result, the Ugandan government should create GBV care in rural areas and ensure access for all survivors. Lastly, research is needed to explore further limited country-specific evidence considering some aspects of access to care and its utilization.

5.3. Summary of Recommendations

I. To develop GBV awareness and strengthen knowledge on the community in the rural areas using the village health team.
II. To use media especially radio to spread GBV awareness and its prevention.
III. To develop confidentiality and privacy in GBV services. Each health facility creates a GBV clinic that is confidently accessible by the survivors.

IV. To improve knowledge of health care staff attending to GBV survivors in both rural and urban areas. GBV training program attendance should be mandatory for all health care providers.

V. The Ugandan government should reinforce access to GBV care for free through updating and implementing its policies.

VI. Health facilities should establish culturally accepted GBV services close to the communities and widely spread messages regarding the availability of GBV care.

VII. To improve legal system where midwives would be recognized as primary caregivers and would be able to sign medico-legal documents for better response to legal requirements.

VIII. To establish a community approach including raising awareness of prevention of GBV and transferring ownership.

IX. To improve prevention, education, adequate response, and advocacy regarding GBV on national level. The Ministry of Health should push for mandatory implementation of the national GBV policies. Regular trainings and check up on successful implementation the policies need to do as follow up strategy.

X. Ministry of Health should focus on development of preventive programs that are focus on prevention of vulnerable population especially girls and women from GBV.

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