Using reproductive health services to address sexual and gender-based violence in post-conflict northern Uganda.

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Abstract

Abstract

Background Sexual and gender-based violence (SGBV), including rape and child sexual abuse, remains a significant challenge in post-conflict northern Uganda, including within refugee settlements. Many victims have never sought help from health-related services. Consequently, the scale of the problem is unknown, and SGBV victims' injuries, both psychological and physical, remain undetected and unaddressed. We hypothesized that health workers in rural Reproductive Health Services could provide a valuable resource for SGBV screening and subsequent referral for support.

Methods Our project had three elements. First, Reproductive Health Service workers were trained in the knowledge and skills needed to screen for and identify women who had experienced SGBV, using a questionnaire-based approach. Second, the screening questionnaire was used by reproductive health workers over a 3-month period, and the data analysed to explore the scale and nature of the problem. Third, victims detected were offered referral as appropriate to hospital services and/or the ActionAid SURGE (Strengthening Uganda's Response to Gender Equality) shelter in Gulu.

Results 1656 women were screened. 778 (47%) had a history of SGBV, including 123 victims of rape and 505 victims of non-sexual violence. 1,254 (76%) had been directly or indirectly affected by conflict experiences; 1066 had lived in IDP camps. 145 (9%) were referred at their request to Gulu SGBV Shelter under SURGE. Of these, 25 attended the shelter and received assistance, and a further 20 received telephone counselling.

Conclusion Undetected SGBV remains a problem in post-conflict northern Uganda. Reproductive Health Service workers, following specific training, can effectively screen for and identify otherwise unreported and unassisted cases of SGBV. Future work will explore scaling up to include screening in hospital A&E departments, incorporate approaches to screening for male victims, and the impact of taking both screening and support services to rural communities through local clinics with mobile teams.

Background

The civil war in Northern Uganda in the early 1980s lasted twenty years. The rebels in the North continued to pursue a campaign of terror after peace had been established in the rest of Uganda, only resolving from 2007–8 onwards. Sexual and gender-based violence (SGBV), including rape and child sexual abuse, was prominent and persisted in many 'internally displaced persons' (IDP) camps in the region, and has continued into the post-conflict period.[1–5] It remains a significant challenge in the whole of the region including within refugee settlements. Regional cultural practices and a lack of awareness of womens' rights under Ugandan law, relating to SGBV, can lead to abuses being seen as "normal" in a cultural context.[2,4,6–14]

The nature of the experiences cause personal shame and stigma often to the extent that many of the victims do not seek help from health-related services, including psychological or mental health services, and their injuries, both psychological and physical, remain undetected and unaddressed, as do issues of pregnancy and children resulting from SGBV experiences[5,11,15]. Methods of screening populations to identify victims would therefore be valuable.[15–17]

Most women do attend Reproductive Health Services at some time during their adolescent or adult years, giving health workers an opportunity to screen for and manage SGBV-related problems. Unfortunately, most health workers are not trained in the management of SGBV currently, which reduces their ability to care for this group.

We hypothesized that health workers in Reproductive Health Services, often the first point of contact for a victim, could provide a valuable resource for screening their patient cohort for SGBV, such that a significant number of these women and girls could be actively detected and offered treatments, in addition to those who had already self-presented. This would first require training, for example in the form of workshops for health workers so that they were then able to use the existing health systems to further advocate for these rights, create awareness, screen for SGBV and manage/refer cases for further support.

The current project had three elements. First, health workers in Reproductive Health Services in Gulu Regional Referral Hospital and in Awach Health Centre IV (Health Sub District) in Northern Uganda, were trained in the knowledge and skills needed to screen for and identify women who had experienced SGBV and had not sought the help of existing services, using a questionnaire-based approach.

Second, the screening questionnaire was used by health workers over a 3-month period, and the emerging data were used to explore the scale and nature of the problem.

Third, those detected were offered referrals to hospital services where appropriate, and/or to existing SGBV support services, namely those provided by the ActionAid SURGE (Strengthening Uganda's Response to Gender Equality) programme at the SGBV shelter in Gulu.

Methods

Training

Two teams of 15 and 14 health workers in Reproductive Health Services, from Gulu Regional Referral Hospital and from the nearby Awach Health Centre IV respectively, were trained in workshops held on consecutive days in October 2018.

The training was delivered by two Gulu University lecturers in Obstetrics and Gynaecology, two visiting professors at Gulu University, a forensic pathologist, and two members of staff from the SURGE SGBV shelter—namely, a social worker (with specific psychology and counselling training in SGBV) and a lawyer

(also specialising in the field of SGBV). Basic education on SGBV rights under the law, and basic counselling of victims were included in the training.

Questionnaires

A questionnaire was designed based on one devised and used in Rwamwanja Refugee Settlement, Kamwenge Districtby the Population Council (PC) in 2016[17]. We added questions relating to a variety of different SGBV experiences, and questions about experiences of conflict [fig.1]. In addition, we included a consent form [fig.2] adapted from one designed by the ICRC (International Committee of the Red Cross). An algorithm [fig.3] was used to check that there was sufficient privacy for confidentiality to be provided during the patient encounter, a fundamental need for interviews of this nature.

Questionnaire data collected during the project implementation provided an estimate of the current prevalence of SGBV within a cross section of those women attending reproductive and gynaecological health services in the study regions, during a 3-month period.

Victims were referred for appropriate care by hospital services (these were not specified in our questionnaire but included treatment for sexually transmitted diseases and ante- and post-natal care, as well as other gynaecological care related to their experiences) and also referred, if they wished, for more specialised counselling, support for police and court processes, community follow-up, couple mediation or in a few cases, protection, as dictated by their needs.

Each of the health workers was given a supply of questionnaires for completion. Between November 2018 and January 2019, questionnaires were completed and consequent referrals made.

Outcomes

The main outcome measure was number of women attending reproductive health services, who screened positive for experience of SGBV.

Secondary outcomes were number of victims who wished to be referred to hospital or other services, and numbers who attended non-hospital based referrals and received assistance from those services.

The non-hospital based SGBV services to which referrals had been made were consulted, in order to determine the numbers of referred women who attended their referrals (always made on the basis of the patient's wishes).

Ethics.

The project proposal was submitted to Gulu University Research Ethics Committee (GUREC) and was approved after some adjustments had been made.

Patient and Public Involvement

Patients and the public were not involved in the design of this study.

Results

In the three months and in the two health units, individual questionnaires were used to screen 1656 women. Reproductive healthcare workers reported that the questionnaires were straightforward to use, and they made no major suggestions for changes.

Primary outcomes

Analysis of the 1656 questionnaires revealed that 778 screened women (47%) had a history of SGBV.

Secondary outcomes

Of these, 145 (9%) were referred at their request to Gulu SGBV Shelter under SURGE. Twenty-five (17%) of those referred attended the shelter and received assistance, and a further twenty (14%) received counselling by phone. Young mothers who had been victims of defilement received help (mainly financial and logistical) with the medical needs of their children, as well as with transport to hospital and/or other services.

Other outcomes

[i] Demographics

The largest age group screened were women between 20 and 30 years of age—45% (748). 68% (1,129) of those screened resided in rural areas.

[ii] Types of SGBV experience

The questionnaire results revealed that victims had been subject to various types of SGBV [Table].

Nº. victims	Percentage	SGBV experience
123	15.8%	Rape
126	16.2%	Forced intimacy other than rape
266	34.2%	Forced sex within an intimate relationship
82	10.5%	Forced marriage
322	41.3%	Sexual harassment
505	64.9%	Gender-based (non-sexual) violence

***Table**: Numbers of victims (and percentages of the 778 SGBV sufferers) of various categories of SGBV. Each of these categories was non-exclusive and women may have answered in the affirmative in several categories.*

The total included several cases of defilement (defined in Ugandan law as forced sex with a child under the age of 18).

[iii] Conflict experience.

A large majority—76% (1,254)—had been directly or indirectly affected by the insurgency (or other conflict experiences).

1066 (64%) of the cohort screened had lived in IDP camps, and 170 (10%) had been abducted and experienced forced sex.

Discussion

We have shown that it is possible with a relatively simple project (our questionnaire, and utilising existing services) effectively to discover cases of SGBV which would otherwise have remained unreported and unassisted. The specifically-trained health workers who administered the questionnaires to women attending reproductive health clinics were enthusiastic and in general well-motivated to deliver the SGBV screening. It was clear that it would be entirely feasible for screening and referral for SGBV cases to continue in terms of commitment of health workers.

Up to 47% of those women screened had suffered SGBV of some sort, a higher than expected percentage exceeding global prevalence estimates from previous studies.[18,19] Our study strongly suggested that there is a need for *active* continued screening, especially in consideration of those women who chose to be referred for help, who were previously not known to be victims, and who may well not otherwise have sought further help.

Whilst screening appeared effective for giving women a new opportunity to gain assistance, one problem that emerged was that some referred victims did not contact the services to which they were referred. 148

women were referred (at their request), but only 45 of these made contact with the SURGE centre, either in person or by telephone.

No data were collected regarding more detailed demographics or contact information to enable follow-up enquiries, and so the reasons for failure to contact or attend the SGBV centre are conjectural. We think it likely, however, that issues (i) of transport (most of the women, 68%, lived in rural areas at some distance from the town where the SGBV Shelter and services were located, and were of low economic status) and (ii) of privacy, may have contributed significantly (the shame and stigma associated with these experiences cannot be overestimated and there have also been fears of reprisal or of not being believed or supported, described in other studies[13–15]).

Contacting referred victims for their reasons would help clarify this question, but would involve a further level of follow up which might be difficult to achieve in practice. Nevertheless, if we are correct in our assumptions, then introducing not just creening but also support services more locally in rural communities might offer solutions to these difficulties and result in more victims of SGBV receiving services. This will be included in our planning of the second phase of this project.

There is also the issue of the wider social value of regular SGBV screening in these and other health-care settings: over time, it would raise awareness among women of their rights under the law, it would contribute to education of the wider communities and to reducing stigma among victims and their families, removing some of the obstacles to help-seeking behaviours.

Limitations Of The Study

The study assessed the feasibility of such a screening project and its value in discovering undetected cases of SGBV. We do not in any way claim to uncover all cases. By its nature (using reproductive health services) our study did not include screening for male victims of SGBV—although the majority of SGBV is against women, in some estimates male victims comprise up to 14%.[6,12,20–22] Nor would our study have revealed cases where victims did not attend specifically reproductive health services.

Women who had experienced SGBV were not asked if they had already received any help for their experiences, and an assumption was made that they had not, which if mistaken, may have been an additional reason for the relatively small number who chose referral to the SURGE services.

The passage of time since the incident may also have contributed to the low numbers seeking help.

A projected second phase, a larger study, will incorporate approaches to include screening for male victims, including raising awareness amongst other staff of existing trained SGBV health workers who can be called to assist in Emergency Departments when victims of SGBV of either gender, present as patients.

Conclusion

We have shown that an investigative project using services already available locally but with some additional training, and taking advantage of existing expertise and experience, can be useful for planning future strategy concerning the detection and management of SGBV. Our study could lay the groundwork for the expansion and development of services to disadvantaged rural communities, by a further phase of the project.

We hope that this will eventually lead to its incorporation into health service policy. Over time, the provision of such services as an accepted part of community health may assist women to come forward more willingly and reduce the stigma of so doing within their communities.

Declarations

Ethical approval and consent to participate

This study was approved by Gulu Ethic Research Committee (GUREC)—Ref No. GUREC—002–19 since it involved human subjects. Each participant consented and singed a written consent form before participating in the study.

Consent for publication

Though this manuscript doesn't contain any identifying images or personal or clinical details of participants, there is a component in the written consent form for the participants which included a statement that the findings for this study shall be shared to help in the fight of sexual and gender-based violence across the globe.

Availability of data and material

The datasets used and/or analyzed during the current study available from the corresponding author on reasonable request

Competing interest

There is no financial or non-financial conflict of interest to declare from the funder and authors.

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in post conflict. Funder had no role in the conception of the idea, development of the proposal, data collection and analysis and preparation of this manuscript.

Authors' contributions

All the authors - OK, PFP, NS and CH participated in the concept development, proposal development, data analysis and writing of this manuscript and all authors have approved this manuscript for submission.

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