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GENDER-BASED VIOLENCE AND FAMILY PLANNING

An Implementation Assessment of Uganda's Policy Framework



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Note: All direct quotes in this report are taken verbatim from informant interviews.

Abbreviations

CDO	community development officer
CSO	civil society organization
DHO	district health officer
DHS	Demographic Health Survey
EC	emergency contraceptives
GBV	gender-based violence
HMIS	health management information system
HP+	Health Policy Plus
IUD	intrauterine device
mCPR	modern contraceptive prevalence rate
MGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
NGO	nongovernmental organization
SGBV	sexual and gender-based violence
USAID	U.S. Agency for International Development
UNFPA	United Nations Population Fund
UWOPA	Uganda Women’s Parliamentary Association
WHO	World Health Organization

Introduction

Gender-based violence (GBV) is an umbrella term for any harm that is perpetrated against an individual based on his or her biological sex, gender identity, and/or sexual orientation. Rooted in structural gender inequalities and power imbalances between women and men, GBV takes on many forms and can occur throughout the life cycle. Worldwide, more than one-third of women report having experienced physical and/or sexual violence (WHO, 2013). In Uganda, GBV prevalence rates are among the highest in the world. The 2016 Uganda Demographic Health Survey found that among women 15 to 49 years of age, 51 percent had experienced physical violence and 22 percent had experienced sexual violence in their lifetimes (UBOS & ICF, 2018). Sexual coercion is common in Uganda—21 percent of women reported that their spouse or partner had physically forced them to have sex when they did not want to. Similarly, a study of rural Ugandan secondary students in Mbarara found that, among girls who had ever had sex, 43 percent reported having had sex because they “were too afraid to say no” (Ybarra et al., 2012). Another study of pregnant women ages 15-24 in Kampala found that 24 percent of participants had experienced sexual coercion within the past twelve months, and that unwanted pregnancy was higher among those who were sexually coerced (Tusiime et al., 2015).

The negative consequences of GBV on women’s reproductive health are many, and include unintended pregnancy, unsafe abortion, increased vulnerability to sexually transmitted infections, pregnancy complications, and increased adolescent pregnancy (Maxwell et al., 2018; Pallitto et al., 2013; WHO, 2013; WHO and LSHTM, 2010). These health effects are the direct result of physical and sexual trauma. In addition, indirect effects of violence can limit women’s and girls’ sexual and reproductive control, including reduced autonomy and decision-making power around sex and contraceptive use (Miller et al., 2010a; Miller et al., 2010b; Pallitto et al., 2013; Tusiime et al., 2015).

In response to the pervasive problem of GBV, many countries have introduced multisectoral policy and legal frameworks to prevent and mitigate the negative consequences of violence. The health sector has a critical role to play in a multisectoral response; however, integrating GBV prevention and response into health systems has been gradual and social, cultural, and health system barriers inhibit effective implementation (García-Moreno et al., 2015). In Uganda, the GBV referral system is not functioning adequately, linkages between the health and the criminal justice system are weak, and health facilities lack qualified staff, infrastructure, and supplies to manage care and treatment for GBV survivors (Henttonen et al., 2008; Kaye et al., 2005; Manyire, 2013; WHO, 2016). Studies cite a lack of advocacy, accountability, and adequate resources for implementation as some of the factors that contribute to weak implementation of GBV policies and laws in Uganda (Ahikire and Mwiine, 2015; CEDOVIP, 2015a; CEDOVIP, 2015b).

It is within this context that the U.S. Agency for International Development (USAID)-funded Health Policy Plus (HP+) project conducted an assessment to identify GBV policies and guidelines in Uganda and examine how such policies are being implemented and monitored. The study team analyzed whether current policies address the family planning needs of GBV survivors and examined whether their implementation promotes access to family planning among women of reproductive age. This analysis is needed to develop practical recommendations to strengthen implementation of GBV policies and improve service delivery to better meet the family planning needs of GBV survivors.

Scope of the Assessment

The purposes of this study were to (1) ascertain the extent to which GBV policies and operational guidelines are implemented by the Ugandan health system, and (2) whether policies are implemented to the scope and depth needed to generate positive GBV and family planning outcomes. In addition, we aimed to identify the key drivers of and barriers to effective GBV and family planning policy implementation and formulate practical solutions and approaches that the health sector can implement to accelerate effective GBV policy implementation and improve family planning outcomes.

Study Overview

Research Study Framework

The study team applied policy implementation and political economy analysis frameworks to determine the extent to which GBV policies are being implemented in Uganda. The combined framework draws heavily on the Policy Implementation Framework developed by the USAID Health Policy Initiative, HP+'s predecessor project (Bhuyan et al., 2010) (Figure 1).

The framework defines seven dimensions for GBV policy implementation, including technical and political factors that hinder and/or support policy implementation. A description of the seven dimensions and the questions they examine is provided below:



1. **Policy, formulation, and dissemination:** the policy content, nature of the formulation process, and degree of dissemination.
2. **Social, political, and economic context:** the social, political, and economic factors outside of the policy process that can either drive or hinder effective implementation. This dimension considers social norms, attitudes and beliefs; skills; legal and regulatory environment; governance and accountability processes; and informal norms that affect policy implementation.
3. **Leadership for policy implementation:** recognizes that strong leadership and commitment are needed to put policies into practice. Without strong leadership, follow-through, accountability, and sufficient resource mobilization will not occur.
4. **Stakeholder involvement in policy implementation:** recognizes that, while policy formulation is increasingly a multisectoral endeavor, this engagement doesn't necessarily continue through the policy implementation stage. Thus, it is crucial to consider the extent of stakeholder involvement in policy implementation and the nature of relationships and collaboration among stakeholders.
5. **Planning for implementation and resource mobilization:** considers the planning, resources, and capacity needed to facilitate policy implementation.

6. **Operations and services:** refers to the coordination among mechanisms, operational systems, and capacity of individuals and organizations charged with delivering services outlined in the policy.
7. **Data, monitoring, and reporting results:** recognizes the importance of regularly gathering, disseminating, and using feedback to assess progress toward achieving results.

Methods

Background desk research

The HP+ study team conducted a desk review to develop a profile of the GBV sector in Uganda that focused on the role of the health system and how it implements GBV prevention and response policies and programs. The study explored the status of the GBV sector, including structure and organization, legal and policy frameworks, key institutions and processes, resource flows, and key actors. It examined the processes for measuring performance of GBV prevention and response policies, as well as constraints and barriers to GBV policy implementation, including sociocultural and gender barriers, and political will.

We also conducted a text analysis of the relevant policies to assess the essential elements of effective policies, such as clear goals and objectives, and institutional arrangements. The analysis examined whether policies included strategies to reduce GBV by including both GBV prevention *and* response actions. In addition to providing necessary background information on the GBV sector, the desk review and text analysis informed the design of the key informant interviews that followed.

Key informant interviews

The HP+ study team used semi-structured interview guides to conduct key informant interviews from June to December 2017 at the central level and in eight districts: Kampala; Gulu and Lira (northern region), Kween, Mayuge, and Moroto (eastern region); and Mbarara and Kisoro (southwestern region). The rationale for selecting these regions was based on geographic and sociocultural diversity, GBV prevalence, modern contraceptive prevalence rates (mCPR), and the presence of GBV programs (Annex A). The interview questions aimed to examine the seven dimensions of policy implementation outlined above, including stakeholders' experiences.

HP+ conducted nine key informant interviews with representatives from the central government and Kampala-based non-governmental organizations (NGOs) and donors. HP+ selected the representatives based on their involvement in the implementation of GBV policies and action plans.

We also conducted 70 district-level key informant interviews. The following types of professionals were selected based on their involvement in implementing GBV policies and plans at the district level:

- District health officers
- District community development officers
- District gender focal points
- District chief administrative officers
- District chairpersons or councilors for women

- Sub-county community development officers
- NGO/civil society representatives
- GBV shelter staff/administrators
- Health officers in charge of public and private facilities
- Health providers (public, private NGO, private for-profit)

HP+ did not interview GBV survivors or clients of GBV services, and none of the interview questions explored an individual's experience of violence. All primary data collection methods were reviewed and approved by Palladium's Internal Research Review Committee.

Validation meeting

HP+ facilitated a meeting with representatives from the Ugandan Ministry of Health (MOH), Ministry of Gender, Labour and Social Development (MGLSD), civil society, and USAID in July 2018 to share and validate findings from the assessment, and incorporated feedback from participants into this report.

Findings

Policy Formulation and Dissemination

HP+ identified 22 national policies and/or guidelines that address GBV and/or family planning in Uganda (see Annex B for the complete list of policies included in the study). Of these, 10 policies explicitly addressed GBV and family planning; the other 12 policies addressed either GBV or family planning. Table 1 provides a summary of the integrated GBV and family planning strategies found in Uganda's national laws, policies, and guidelines. It describes the role of each component in tackling GBV in Uganda at facility, community, and national levels across the World Health Organization's (WHO's) six health system components, or "building blocks," defined as service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance (WHO, 2010).

The primary role of the health system, as defined by the policy framework in Uganda, is to provide post-GBV care services.

The study team's text analysis of select policies found that the GBV policies included clear objectives and purpose statements that corresponded with the need to reduce GBV and outlined strategies and actions to prevent and respond to GBV. The *Costed Implementation Plan for Family Planning* and the *Comprehensive Family Planning Skills Curriculum* were the only policy documents that included an objective of improving family planning outcomes; however, in most cases, policy documents included the provision of family planning services as part of the package of post-GBV care services. In line with international recommendations, Uganda's GBV policy framework clearly defines the health system's primary role as providing post-GBV care services, which includes provision of emergency contraceptives (ECs) (Garcia-Moreno 2015; WHO 2017). The health system also has a role to play in GBV prevention through awareness-raising, advocacy, and data collection.

The *National Action Plan on Elimination of Gender-based Violence in Uganda* included a detailed implementation plan, clearly defined indicators, and a monitoring and reporting plan. It was also one of only two policy documents to provide budgetary or resource allocations for each initiative. None of the policies identified sources of funding.

The study team noted a discrepancy in the policies related to provision of ECs, a critical component of post-GBV care services. The *National Referral Pathway for Prevention and Response to Gender-based Violence Cases in Uganda* and the *National Guidelines for the Provision of Psychosocial Support for Gender-based Violence Victims/Survivors* state that health providers can provide EC within 72 hours of unprotected sex or rape, while the *Training of Health Workers on Management of Sexual Gender-Based Violence Survivors/Victims* and the *Comprehensive Family Planning Clinical Skills Curriculum* allow for EC to be provided within 120 hours. Respondents did not mention this discrepancy during the interviews, though most health providers reported that EC should be provided within 72 hours.

The study team also inquired whether respondents discussed GBV during regular family planning counseling sessions; most health providers reported that they do not. This is likely related to the fact that the recently published *Comprehensive Family Planning Clinical Skills Curriculum (2017)*, which provides guidance on exploring a patient's experience of GBV during family planning counseling sessions, has not yet been disseminated. Dissemination of these guidelines is a critical need. Participants from the validation meeting also discussed at length the importance of getting appropriate information into providers' hands.

Key informants consistently stated that the policies are not adequately disseminated to district or subcounty levels. Many respondents reported being aware of the policies' existence but were unfamiliar with the details, and lamented that their districts did not have access to the technical and financial resources necessary for disseminating the policies as widely as needed. Hard copies of the policies were not available in most districts, and only a few respondents reported being able to access the policies online. Policies are not translated into local languages, making the English policies that do exist inaccessible to portions of the population.

Table 1. Integrated GBV and Family Planning Policy Provisions in Uganda¹

Building Block	Provisions
Service Delivery	<ul style="list-style-type: none"> • Identify survivors of violence when conducting family planning counseling • Provide post-GBV medical care and family planning services, e.g. pregnancy tests, emergency contraceptive pills, copper-bearing intrauterine devices (IUDs), etc. • Provide GBV medical services free-of-charge • Provide post-clinical care family planning services • Make timely referrals to medical services • Raise community members' awareness of GBV services (e.g., emergency contraceptive pills, GBV prevention activities, etc.) • Form male action groups to spearhead GBV prevention campaigns • Mobilize and sensitize boys and men to their roles in preventing and responding to GBV

¹ The list of policies used to prepare this list include: *National Domestic Violence Act*, *Comprehensive Family Planning Clinical Skills Curriculum: Volume III Trainer-Trainee Materials*, *National Policy on Elimination of Gender-based Violence in Uganda*, *National Action Plan on Elimination of Gender-based Violence in Uganda*, *National Guidelines for the Provision of Psychosocial Support for Gender-based Violence Victims/Survivors*, *Uganda Clinical Guidelines 2016: National Guidelines for Management of Common Conditions*, *Training of Health Workers on Management of Sexual and Gender-based Violence Victims/Survivors: Trainer's Guide and Trainee Manual*, *Uganda Family Planning Costed Implementation Plan 2015-2020*, *National Referral Pathway for Prevention and Response to Gender-based Violence Cases in Uganda*, *Guidelines for Establishment and Management of Gender-based Violence Shelters in Uganda*, and *National Advocacy Strategy: Towards a Quality Population*.

Building Block	Provisions
Workforce	<ul style="list-style-type: none"> • Build capacity of health sector staff on clinical management of GBV survivors • Raise health workers' awareness of the link between GBV and family planning • Disseminate the Referral Pathway Guide and Standard Operating Procedures to all duty bearers • Sensitize actors in the referral pathway to their roles and responsibilities in responding to GBV cases
Supplies and Infrastructure	<ul style="list-style-type: none"> • Supply pregnancy tests • Supply emergency contraceptive pills • Supply copper-bearing IUDs • Establish emergency shelters
Policy, Governance, and Leadership	<ul style="list-style-type: none"> • Integrate GBV prevention activities into national and local planning and budgeting • Review police curriculum to ensure that GBV is included in basic and advanced training courses • Issue guidelines for timely GBV clinical management • Integrate GBV into existing nursing and paramedic curricula • Advocate for provision of essential GBV-specific services in all public and private medical facilities • Advocate for establishment of drop-in centers for GBV services within existing service points • Influence policymakers to strengthen and implement existing policies that empower women to access and use reproductive health commodities • Declassify emergency contraceptives
Information	<ul style="list-style-type: none"> • Monitor GBV and family planning service provision and availability of supplies • Use the integrated family planning register • Use the national GBV database
Financing	<ul style="list-style-type: none"> • Advocate for budget allocations for GBV in sectors (i.e., education, health) and local governments

Despite these dissemination challenges, recent efforts by the MOH and partners, such as the WHO, to train providers on the clinical management of sexual and gender-based violence (SGBV) survivors have been well-received by health providers and district health officers (DHOs). With the exception of Kween, informants from all districts reported that they received training on the SGBV guidelines and health providers stated that the trainings, which use the MOH's 2015 handbook *Training of Health Workers on Management of Sexual Gender-Based Violence Survivors/Victims*, improved their knowledge and skills in handling GBV cases. It taught them how to examine SGBV survivors, ensure confidentiality, ask important probing questions, provide post-exposure prophylaxis, and offer family planning to prevent unplanned pregnancies. Respondents reported that the training gave them more confidence to screen for GBV and comprehensively address survivors' needs. Other respondents reported that the training reduced their fears about completing the Police Form 3—a medical examination form that police give to survivors of a crime involving sexual violence—and going to court. One respondent said that the training enabled her to feel confident mentoring colleagues on SGBV services, particularly in administering EC pills and post-exposure prophylaxis. However, respondents reported that they did not receive a copy of the guidelines during the training,

which would have been a helpful resource. In addition, respondents requested that more health providers receive the training, and asked that they receive regular refresher trainings and mentorship.

In addition to national policies, some local governments have begun developing local ordinances, by-laws, and policies on GBV. Gulu and Lira, for example, recently developed GBV ordinances, and some sub-counties and districts have developed ordinances restricting alcohol use, which many respondents regarded as a cause of GBV. Developing by-laws takes time and money; because of this, respondents reported that ordinances are not drafted unless an NGO provides support. For example, the United Nations Population Fund (UNFPA) and Women in Governance supported Moroto and Lira, respectively, to develop standard operating procedures for the GBV referral pathway. Similarly, as local governments do not have funding for policy dissemination, civil society organizations (CSOs) sometimes step in to help disseminate local by-laws and ordinances.

Social, Political, and Economic Context

Cultural and patriarchal beliefs that condone or normalize violence make implementing GBV and family planning policy provisions challenging. For example, one respondent in Moroto noted that it is culturally acceptable for courtship to involve “a little bit of force.” A respondent in Gulu reported that the community does not consider violence a problem until severe injuries or death occur. This perspective was expressed during the validation meeting when participants underscored the inherent conflict between policy and cultural norms. “Policy is clear but culture is very complex,” one participant explained. “Both can be progressive or not.” Participants expressed interest in having cultural norms that normalize or condone GBV clearly highlighted and discussed as part of GBV policy dissemination efforts.

A respondent reported that participating in the MOH’s *Training of Health Workers on Management of Sexual Gender-Based Violence Survivors/Victims* enabled her to manage the “...patient as a real patient not...just a survivor with police issues.”

“Like the cultural aspect of child marriage, the cultural belief of [female genital mutilation]... all these are cultural aspects which are embraced by the community. But then the policy says we should fight against them but culture says it’s okay... How do we merge cultural aspects with implementing the policies?”

- Key informant from Lira

Culturally, violence is considered a private issue and stigma is attached to reporting GBV to authorities. The Uganda Demographic Health Survey found that 71 percent of women who had experienced sexual violence never sought help nor told anyone about the violence (UBOS & IFC, 2018). Interview respondents reported that survivors, their families, and communities often prefer to settle violence cases out of court. In some cases, girls are pressured to keep quiet about violence to protect the perpetrator; in other cases, parents will exploit the situation for financial gain—instead of reporting an incident to authorities, parents will tell the perpetrator to “come and negotiate.” Women who report violence may

be blamed for exposing the perpetrator and “getting him in trouble.” In other cases, women are reluctant to report their spouse/partner because they cannot afford to lose the financial support he provides. Organizations filing GBV cases on behalf of survivors have also been blamed for “spoiling marriages.” Some health providers reported being afraid of retribution by perpetrators if they were to complete the requisite police form reporting incidents of violence.

This conflict between culture and policy is also present with regard to family planning. Respondents reported that, although demand for family planning has increased over the past three years, some religious leaders continue to oppose family planning and speak out against the use of contraceptives. During the September 2017 National Family Planning Conference, the launch of the *National Policy Guidelines and Services Standards for Sexual and Reproductive Health* stalled when political, cultural, and religious opponents of the policy argued that family planning services should not be provided to adolescents younger than 18 years old. They contended that the policy violates the Constitution, which only allows for consensual sex and marriage among people 18 years of age and older.

“Those making policy also come to work with their own cultural baggage—in many cases, normalizing GBV in their own work.”

- Meeting participant

In many communities, men are not supportive of family planning; respondents reported that disagreement between husbands and wives about contraceptive use can lead to violence. Health providers in Lira and Mayuge reported that they have difficulty reaching men effectively with family planning messages and services. Participants in the validation meeting also brought up male engagement as a significant area that needs attention in GBV and family planning outreach, noting, “If men get informed, men change!” They reported that the SGBV manual for health providers is written in a gender-neutral way (recognizing that both men and women can be survivors), but doesn’t offer a specific strategy on how to support male survivors.

In some districts, the government and CSOs are implementing innovative approaches to address cultural barriers to GBV policy implementation. For example, Lira’s district government collaborated with cultural leaders to develop an action plan to promote positive aspects of culture, including the promotion of gender equality and reduction of GBV. The district leadership involves cultural leaders in their social development activities so that they can work with, rather than against, these influential figures in addressing sensitive gender and social issues. Also in Lira, the district government, in collaboration with local CSOs, organized a successful program called “Kick Violence Out of Lira.” The two-part program consisted of a series of conversation circles with primary school children on issues of sexual and reproductive health, rights, and GBV, culminating in a sub-county-wide football competition. The event brought together over 1500 schoolchildren, parents, and community members and leaders; 85 percent of the participants were men. Attendees watched the football match and engaged in pre- and post-game discussions on sexual and reproductive health, rights, and GBV.

Donors and NGOs in Uganda have piloted successful community-based GBV prevention programs such as [SASA!](#), the REAL Fathers Initiative, and Safe Homes and Respect for Everyone (SHARE) Project (Table 2) (Abramsky et al., 2016a; Abramsky et al., 2016b; Chadwick, 2016; Ashburn et al., 2017; Wagman et al., 2015). Each of these programs addresses the inherent and systemic imbalance of power between women and men and creates an open, safe space to discuss the unequal power dynamic, the cultural norms that support it, and a way forward to support women and men alike. While these programs have been effective at changing attitudes and behaviors toward GBV, they have yet to be implemented on a large scale in Uganda.

Table 2. Community-Based GBV Prevention Programs in Uganda

Program Name	Date	Location	Description
SASA!	2007–present	Piloted in Rubaga and Miakindye divisions in Kampala; subsequently implemented in 32 sub-counties in eastern Uganda	A community mobilization program that targets the core drivers of GBV by addressing power imbalances between women and men, and boys and girls
REAL Fathers Initiative	2013	Implemented in Attiak sub-county, Amuru District, northern Uganda	A 12-session mentoring program for fathers to reduce child exposure to violence at home
Safe Homes and Respect for Everyone (SHARE) Project	2005–2009	Implemented in four regions in Rakai, central Uganda	An integrated service delivery and community mobilization program that provides HIV services, promotes safe HIV disclosure, and changes norms and behaviors related to violence

Leadership and Stakeholder Involvement in Policy Implementation

The MOH, MGLSD, and UWOPA champion GBV and reproductive health issues; the MOH and UWOPA work together to lobby for incremental increases in the health budget, particularly for maternal health services. These bodies maintain regular contact with each other, though their interactions usually intensify during budget negotiations. Respondents reported that UNFPA, WHO, UN Women, and NGOs raise awareness of policymakers about the importance of reducing GBV to improve health and achieve national development goals. Donors, such as WHO, USAID, and UNFPA, are also actively involved in supporting development and implementation of GBV policies.

In districts, respondents perceived that the Community Development Department and the community development officers (CDOs) are GBV “program owners,” while the District Health Department and DHOs are responsible for family planning programming. According to respondents, other district stakeholders actively involved in the GBV response include the police, local councilors (locally elected officials), courts, NGOs and CSOs, religious and cultural leaders, and donors.

In most districts, respondents named several champions actively working to implement GBV policies in their communities. In Kisoro, government representatives encouraged cultural and religious leaders to talk about GBV in their communities. They also advocated to the local council to incorporate GBV into laws. In Mbarara, Moroto, and Kween, local council chairpersons and resident district commissioners advocated to integrate GBV programs into budgets, trainings, and other planning documents. Respondents in most districts perceived the CDO as a GBV champion. Nevertheless, one respondent noted that CDOs may not be able to yield much influence on budgets because central ministries and district political leaders are the key decisionmakers. Overall, the role of religious and political leaders is mixed; some respondents stated that they are strong advocates for GBV services, while others reported that these leaders do not see GBV as a problem in their communities and do not advocate for family planning or GBV services.

Although the level of coordination among the various actors varies by district, two mechanisms for stakeholder coordination at district and subcounty levels emerged from the informant

interviews: referral networks and district coordination meetings. Referral networks consist of stakeholders from health, legal, and law enforcement sectors, as well as members of local councils, community leaders, and psychosocial providers. More information about how referral networks operate is contained in the Operations and Services section below.

Most of the districts reported that regular GBV coordination meetings were taking place; respondents expressed that they appreciate the meetings and consider them useful. During the meetings, participants share data, discuss challenges, and make plans to improve service delivery. The effectiveness of coordination meetings was documented in an evaluation of the Government of Uganda-Irish Aid Joint Programme, which was implemented from 2010-2015 in eight districts, including Mayuge. The evaluation found that holding quarterly coordination meetings improved collaboration among GBV actors, which in turn helped to improve GBV service delivery. The program, which equipped actors responsible for implementing services with knowledge and skills in GBV, was successful in improving referral mechanisms and holistic service delivery to GBV survivors. This could be an effective model for strengthening GBV services and coordination in additional districts (UWONET, 2016). However, the meetings are supported financially by donors; it is not clear how districts would find the resources to hold the meetings should donor funding end.

Implementation Planning and Resource Mobilization

Respondents reported that GBV and family planning programs at central and district levels are under-resourced. A study by CEDOVIP found that although the MOH included GBV-related activities in its annual workplan, the health budget did not allocate funding for most of the planned activities (2015b). The same study also found that health facility budgets do not reflect acquisition of EC or pregnancy test kits—necessary components of post-GBV care. Local revenue accounts for only around one to two percent of total revenue at the district level; therefore, districts are almost entirely dependent on external sources for funding (i.e., central government, donors, or CSOs). As a result, their ability to set and fund priorities is severely limited (UWONET, 2011).

In the absence of strong government investment in GBV prevention and response, donors and NGOs, such as UNFPA and WHO, are filling the funding gap by implementing GBV projects and/or providing direct funding to district governments. Donor-funded projects are greatly appreciated and valued by district authorities, and many respondents reported that close coordination with donors and CSOs enables them to implement GBV programs that they otherwise would not have the resources to conduct. On the other hand, heavy reliance on donor funding is not programmatically or financially sustainable.

According to interview respondents, the MOH prepares an annual GBV training plan, which guides priorities for training, such as districts with high prevalence of GBV, cadre of staff, and focal persons to be trained. Donors, such as WHO, UNFPA, and USAID through the SUSTAIN Project, have funded some trainings for health workers on management of SGBV cases, but the lack of sufficient government financing is hampering the ministry's ability to expand the training to reach all health providers. The HP+ study team requested data from key informants on the number of people trained and locations and dates of the trainings, but this information was not available in a central location and therefore could not be easily accessed.

To work around these funding gaps, some respondents stated that they have integrated GBV into other activities, such as a youth program, a nutrition training for village health teams, a vaccination program, and health facility-based health education talks. Overall, respondents expressed commitment to making optimal use of limited resources to advance GBV programs;

however, their ability to fully implement the programs is severely constrained by lack of resources.

Respondents noted that data plays a vital role in planning and budgeting, particularly in districts where resources are constrained and only the most pressing issues receive funding. Districts lack reliable data on GBV, which makes it difficult for managers to make the case for increased investment in GBV programs. Similarly, data systems do not capture how GBV influences unplanned pregnancies or family planning outcomes. Meanwhile, reliable data monitoring and reporting systems are in place for other priority areas, like maternal and child health, which equips decision-makers with the necessary evidence to prioritize funding over other areas.

Operations and Services

In informant interviews, health providers generally spoke knowledgeably of post-GBV health services and were able to explain the package of services according to SGBV clinical management guidelines, including the provision of pregnancy tests and EC pills. Most providers stated that EC pills should be provided within 72 hours of unprotected sex—however, updated health sector guidance states that EC pills can be provided within 120 hours of unprotected sex; this indicates that providers may be following outdated guidelines.

While health providers reported knowing how to manage GBV cases, they stated that they are unable to provide services according to the guidelines due to a lack of supplies, including EC, rape kits, and disposable clothing to give to survivors when their clothing must be collected as evidence. Respondents from all districts except Moroto reported frequent stockouts of EC and the MOH's August 2017 Stock Status Report confirmed that stockouts of EC were expected at national medical stores and the Uganda Health Marketing Group in the next quarter. Respondents reported that they work around the stockouts by redistributing EC from facilities with stocks to those without, prescribing combined oral contraceptive pills as EC, or referring survivors to private clinics. The SGBV management guidelines recommend using copper-bearing IUDs as a method of EC if pills are not available; however, none of the respondents reported that they offered IUDs to survivors when EC pills were out of stock.

Health providers reported that survivors rarely return for follow-up visits, which restricts their ability to track survivors and provide post-GBV care services, including family planning counseling on short- or long-term contraceptives.

Because of contraceptive stockouts, as well as the ways in which 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 for contraceptive needs. In the case of stockouts, 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 essential care.

Respondents reported challenges in implementing the GBV referral guidelines effectively. Health providers and police are aware that survivors should be referred to health clinics within 72 hours—however, survivors don't always have the time or financial resources to travel from police station to health clinic, especially when they are geographically distant from one another. Most health providers reported that survivors rarely return for follow-up visits, which restricts the providers' ability to track survivors and provide post-GBV care services, including family planning counseling on short or long-term contraceptives. In other instances, the referral network is interrupted because police or local councilors try to negotiate with the perpetrator

and the survivor to resolve the conflict outside of court, and therefore do not make timely referrals to health facilities. In fact, some health providers reported that they wished survivors would go directly to the health facility, instead of first reporting an incident to the police, because, as one respondent explained, they “waste a lot of time at the police.”

Another frequently mentioned challenge in implementing the referral guidelines was the practice of police officers and health providers occasionally asking survivors to pay for a post-GBV service. This leads to a breakdown in trust and the effectiveness of the referral network. For example, respondents reported that police occasionally ask survivors for transportation funds to apprehend a perpetrator. Respondents also reported that some health providers try to charge survivors to complete the Police Form 3 or receive a pregnancy test or EC, even though those services are supposed to be provided free-of-charge.

In most districts, respondents reported that the private health sector does not play an active role in the GBV referral network; however, the private sector regularly steps in to supply contraceptives when needed. Public health providers refer survivors to private clinics when their own facilities are stocked out of EC pills and private health facilities also provide public facilities with contraceptive supplies when they face stockout issues.

In terms of demand for GBV services, respondents reported that while demand for family planning has improved in recent years, community awareness of EC remains low. The exception to this is in Kampala, where some respondents expressed concern that young women were using EC as a routine contraceptive method in place of short- or long-term methods like oral contraceptive pills or IUDs.

Data, Monitoring, and Reporting

Over the past five years, the MGLSD has taken steps to improve GBV data and reporting through development and implementation of the national GBV database. The database is managed by the MGLSD and aims to collect, store, and analyze GBV incident data across all districts. The database uses the GBV incident report form (found in its *Standard Operating Procedures for the National Gender-based Violence Database*) to ensure that consistent GBV data is collected by all actors (e.g., police, health facilities, community development departments, etc.). The GBV incident report form does not track family planning indicators, such as the provision of EC, contraceptive use, or pregnancy outcomes.

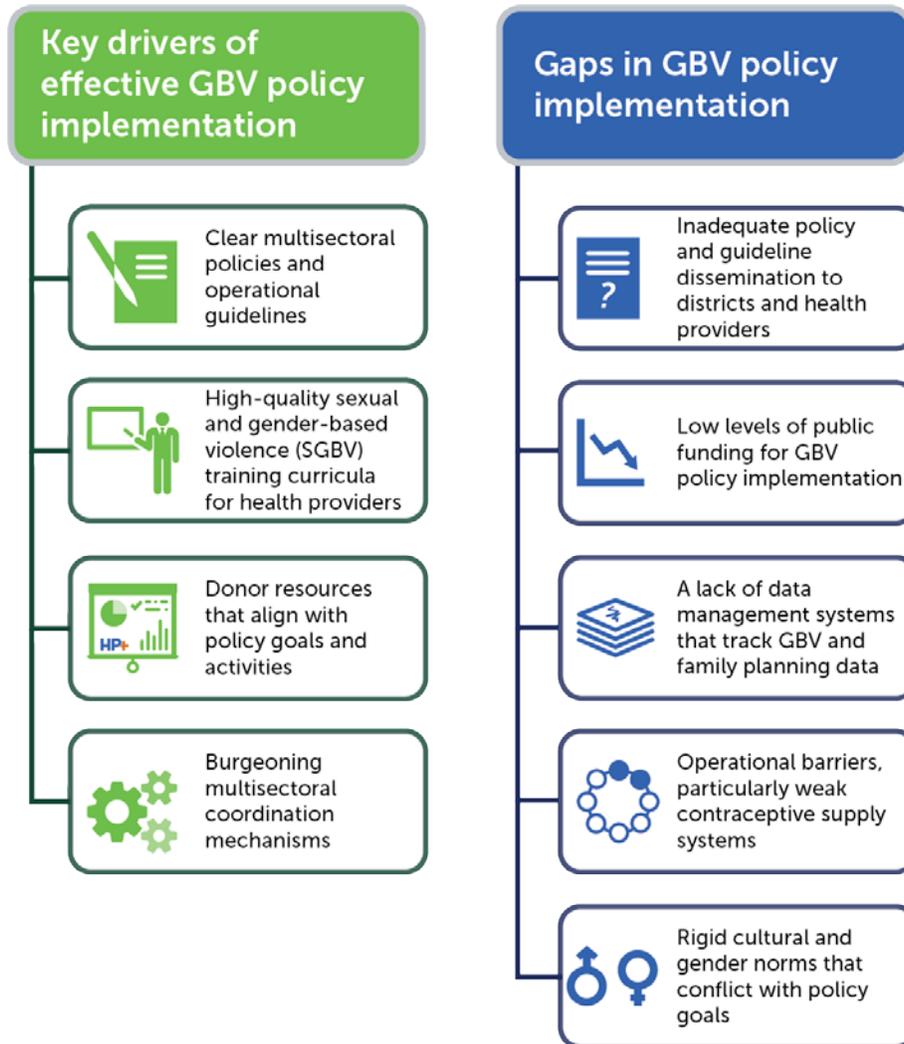
In the health sector, GBV is reported using the Health Management Information System (HMIS) 105 form, which records GBV under the category of trauma/injury. The form also collects data on sexually transmitted infections and miscarriages due to GBV. However, the form does not link provision of EC or contraceptive use with experience of GBV. Nor does it collect data on the number of unintended pregnancies that result from GBV. The result of this disconnect is a lack of reliable data on the number of GBV cases; provision of health and family planning services; referrals; and family planning outcomes, which limits the ability of decisionmakers to plan and allocate resources to GBV and family planning programs. To address this gap, the WHO and MOH have recently begun piloting a GBV register in select health facilities with the goal of eventually integrating it into the HMIS.

The DHO and some health facility directors reported conducting routine monitoring and supervision of health facilities and providers; however, a systematic means for monitoring, documenting, or following-up on the provision of post-GBV services does not exist.

Conclusion and Recommendations

This study adapted the Policy Implementation Framework to analyze how GBV and family planning policies in Uganda are being implemented. The study identified several drivers and constraints of effective GBV and family planning policy implementation, summarized in Figure 2.

Figure 2. Key Drivers of and Gaps in GBV Policy Implementation



To address these gaps, we suggest the following policy and program recommendations to strengthen implementation of GBV and family planning policies in Uganda:

Raise community awareness of and update policy recommendations for provision of emergency contraceptives

With the exception of Kampala, respondents in all districts reported that their communities are not aware that EC pills are a safe and effective method for preventing pregnancy after unprotected sex or rape. To raise awareness of EC in communities, the DHO should require

health providers to include information about EC in their health education talks, village health teams should discuss EC during community sessions, and the MOH and DHOs should collect data to monitor whether awareness of EC is increasing in communities and adjust awareness-raising strategies as needed.

Some policy documents, including the national referral pathways and psychosocial support guidelines, state that health providers can provide EC within 72 hours of unprotected sex or rape. Other policies, such as the management of SGBV guidelines and the family planning skills curriculum, allow for EC to be provided within 120 hours. In practice, most health providers participating in this study reported that they provide EC within 72 hours of unprotected sex. The MOH and MGLSD should clarify that the appropriate timeframe for provision of EC is within 120 hours and update and disseminate policy documents accordingly.

Develop GBV policy dissemination tools (e.g., infographics and job aids)

Uganda has put in place a policy framework for GBV prevention and response that provides for the family planning needs of GBV survivors. However, interview respondents reported that national policies are not adequately disseminated to district or subcounty levels, and copies of the clinical guidelines for management of SGBV survivors are not available in clinics. To help disseminate policies, the government and/or NGOs should develop simple infographic posters that summarize GBV policies, outline the roles and responsibilities of duty bearers, and provide information on GBV survivors' rights and available services (e.g., post-GBV services provided free-of-charge).² The posters should be developed in multiple languages and required to be posted in every police station, health clinic (public and private), medical school, and GBV shelter. Wherever possible, the posters should be distributed to religious leaders who could decide how best to share them with their congregations. In addition to the infographic posters, the MOH should develop simple job aids for health providers that summarize the *Training of Health Workers on Management of Sexual Gender-Based Violence Survivors/Victims (2015)* and the *Comprehensive Family Planning Clinical Skills Curriculum (2017)*. The job aid should also highlight that EC can be provided up to 120 hours after unprotected sex and that copper-bearing IUDs can be used in case of EC pill stockouts.

Recent literature on translating national policies to the local level indicates that media efforts—for example, radio programs and journalist trainings on how to cover GBV—provide demand-side interest and accountability measures that can significantly advance policy implementation at the local level (Mhagama, 2015; Tettey, 2011). Finding opportunities to make the media aware of these relevant policies in Uganda—community-based GBV prevention efforts and health service support in particular—would likely affect local knowledge, attitudes, and practices around this sensitive topic and help move policy to action.

Form coalitions to advocate for increased budget allocations

Financial resources to implement GBV policies and programs remain exceptionally low in Uganda. The MOH, MGLSD, UWOPA, and civil society already advocate to parliament for increased resources for GBV and health programs, yet resources remain limited. In this resource-constrained context, stakeholders should intensify their efforts to advocate for and mobilize resources to support implementation of GBV policies at the district level.

² For examples, see the World Health Organization's *Violence Against Women* infographics, available at http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf.

Strengthen GBV and family planning data management systems

Data is a vital component of government planning and budgeting, particularly in resource-constrained settings. The current HMIS and GBV databases do not provide sufficient information on the number of GBV cases, provision of post-GBV family planning services and referrals, or unintended pregnancies that result from GBV. This lack of data limits the ability of decision-makers to plan and allocate resources to GBV and family planning programs. To improve understanding of the family planning needs of GBV survivors, and how well the system is meeting those needs, the MOH should implement the GBV register (currently being piloted by the WHO) on a large scale and integrate the data into aggregate reporting forms (i.e., HMIS 074 and HMIS 105) (WHO, 2017).

The MOH could also conduct periodic health facility surveys to review client records and assess GBV service needs and gaps, and/or conduct evaluations by establishing quality assurance standards and measuring progress against those standards. The MOH and MGLSD should also advocate to include GBV and family planning indicators into relevant population-based studies currently being conducted in Uganda.

Cost district-level GBV activities

A lack of sufficient financial resources for GBV and family planning programs and services is a common challenge experienced across all districts surveyed. Respondents reported working around the funding gap by integrating GBV into other programs and services. By treating GBV as a cross-cutting issue, however, there is a lack of information about the true costs of providing GBV services and little is known about how much is actually spent on GBV prevention and response. This lack of data inhibits effective planning and budgeting at the national and district levels. The MOH should cost district-level GBV activities, such as service provision, coordination meetings, and transportation for the referral pathway, and use that data to inform budget advocacy and planning.

Develop a multi-year SGBV training plan with dedicated resources for health providers

Over the past three years, the MGLSD and the MOH have developed new operational guidelines and training manuals related to GBV and family planning service provision. The MOH, with support from donors, has trained some health providers on the SGBV clinical guidelines. However, not all districts have been included in the trainings and no system is in place to track which providers have been trained. In addition, health providers who have participated in the trainings are now requesting refresher sessions. The MOH should develop a comprehensive dissemination and training plan with dedicated resources to reach health providers in all districts with the SGBV trainings, including refresher sessions, and provide participants with printed copies of the policies, guidelines, and training manuals. The plan should include measures to track which providers have been trained so that there is a clear understanding of the human resources available to provide post-GBV care services in each district.

Strengthen health providers' family planning counseling skills to address GBV

In the MOH's *Comprehensive Family Planning Clinical Skills Curriculum*, discussing a woman's history of violence is a component of the "Rapport Building, Exploration, Decision Making, Implementing the Decision" (REDI) counseling framework—a tool that health providers use to counsel women and men on family planning. However, most respondents in this study reported that they do not ask patients about GBV during regular family planning

counseling sessions. Discussing GBV is important because women experiencing violence may have unique concerns and needs that influence method choice and ability to continue using contraceptives (MacQuarrie et al., 2016). The MOH should scale-up pre- and in-service training on family planning clinical skills, including how to discuss and counsel women and men on topics related to GBV and sexual coercion, to enable health providers to provide high-quality family planning services to all individuals according to their unique circumstances.

Engage the private health sector in the GBV referral network

Private health providers coordinate with public providers to ensure contraceptive stocks are available in health facilities in Uganda. However, the involvement of private health providers in GBV referral networks and coordination mechanisms is limited. The DHO and CDO should invite private health providers to participate in quarterly GBV coordination meetings and integrate them more fully into GBV prevention activities and the referral network.

Expand community-based GBV prevention programs

Norms around gender and GBV often conflict with the goals of GBV prevention and response policies. In collaboration with the government of Uganda, donors and NGOs have piloted successful GBV prevention programs, yet these programs have not been adopted or expanded on a large-scale. These evidence-based GBV prevention programs are a critical area for ongoing investment and scale-up to address harmful norms and practices that contribute to GBV and hinder access to post-GBV services in Uganda. National and district stakeholders should form coalitions to advocate for increased government investment in GBV prevention programs, particularly those that include components of male engagement, as these have been found to be successful and more easily integrated into communities. In addition, the DHO and CDO should explore opportunities to integrate GBV prevention programs into existing community-based programs, such as through village health teams. Finally, the MOH should explore opportunities to address cultural norms that condone GBV into their policy dissemination efforts with the aim of making a positive impact on the attitudes and practices of those responsible for implementing GBV policies in Uganda.

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Annex A. District Selection Criteria

Statistics are sourced from the DHS 2016 (UBOS & ICF 2018) and represent SGBV experienced by women over the 12 months preceding the DHS. The national average is 12.7 percent.

Region	District	Rationale for Selection
Capital Corridor	Kampala	<ul style="list-style-type: none"> • Policy capital • Has relatively comprehensive GBV prevention and response services • 7.1% SGBV prevalence • mCPR is 39.4%
Northern Urban Corridor	Gulu	<ul style="list-style-type: none"> • Representing Acholi sub-region, where SGBV prevalence is estimated to be 4.8% • mCPR in Acholi sub-region is 30.2% • Has GBV response services, including safe shelters • Urban hub of Acholi sub-region
	Lira	<ul style="list-style-type: none"> • Representing Lango sub-region, where SGBV prevalence is estimated to be 11.9% • mCPR in Lango sub-region is 41.4% • Has GBV response services, including safe shelters • Urban hub of Lango sub-region
Eastern Corridor	Kween	<ul style="list-style-type: none"> • One of the few communities that practices female genital mutilation • Rural district • Has GBV response services, including safe shelters
	Mayuge	<ul style="list-style-type: none"> • Representing Busoga sub-region, where SGBV prevalence is estimated to be 13.2% • mCPR in Busoga sub-region is 28.6% • Rural district • Has GBV response services
	Moroto	<ul style="list-style-type: none"> • Representing Karamoja region, where SGBV prevalence is estimated to be 10.8% • mCPR in Karamoja region is exceptionally low, at 6.5% • Has GBV response services • Urban hub of Karamoja
Southwestern Corridor	Mbarara	<ul style="list-style-type: none"> • Representing Ankole sub-region, where SGBV prevalence is estimated to be 19.1% • mCPR in Ankole sub-region is 36.2% • Has GBV response services • Urban hub of Ankole
	Kisoro	<ul style="list-style-type: none"> • Representing Kigezi sub-region, where SGBV prevalence is estimated to be 16.7% • mCPR in Kigezi sub-region is 43.2% • Rural district

Annex B: Complete List of National Policies Reviewed

Policy Name	Lead Ministry/Dept	Date Published	Type	GBV Interventions	Family Planning Interventions
Comprehensive Family Planning Clinical Skills Curriculum: Volume III Trainer-Trainee Materials	Ministry of Health	2017	Curriculum	Yes	Yes
National Action Plan on Elimination of Gender-based Violence in Uganda (2016-2021)	Ministry of Gender, Labour, and Social Development	2016	Action plan	Yes	Yes
National Guidelines for the Provision of Psychosocial Support for Gender-based Violence Victims/Survivors	Ministry of Gender, Labour, and Social Development	2016	Guidelines	Yes	Yes
National Policy on Elimination of Gender-based Violence in Uganda (2016-2021)	Ministry of Gender, Labour, and Social Development	2016	Policy	Yes	Yes
Strategy for Improving Health Service Delivery (2016-2021)	Ministry of Health	2016	Strategy	No	No
Uganda Clinical Guidelines 2016: National Guidelines for Management of Common Conditions	Ministry of Health	2016	Guidelines	Yes	Yes
Health Sector Development Plan 2015/16-2019/20	Ministry of Health	2015	Plan	Yes	Yes
Standard Operating Procedures for the National Gender-based Violence Database	Ministry of Gender, Labour and Social Development	2015	Operational guideline	Yes	No
Training of Health Workers on Management of Sexual and Gender-based Violence Victims/Survivors: Trainer's Guide and Trainee Manual	Ministry of Health, Reproductive Health Unit	2015	Training curriculum	Yes	Yes
Uganda Family Planning Costed Implementation Plan, 2015-2020	Ministry of Health	2014	Plan	Yes	Yes

Policy Name	Lead Ministry/Dept	Date Published	Type	GBV Interventions	Family Planning Interventions
National Advocacy Strategy: Towards a Quality Population 2013-2020	Population Secretariat, Ministry of Finance, Planning and Economic Development	2013	Strategy	Yes	Yes
National Referral Pathway for Prevention and Response to Gender-based Violence Cases in Uganda	Ministry of Gender, Labour, and Social Development	2013	Operational guideline	Yes	Yes
Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda	Ministry of Health	2013	Plan	No	Yes
Guidelines for Establishment and Management of Gender-based Violence Shelters in Uganda	Ministry of Gender, Labour, and Social Development	2012	Guidelines	Yes	Yes
The Domestic Violence Regulations, Statutory Instruments Supplement No. 34	Ministry of Gender, Labour, and Social Development	2011	Guidelines	Yes	No
National Domestic Violence Act	Parliament	2010	Law	Yes	No
The Prohibition of Female Genital Mutilation Act	Parliament	2010	Law	Yes	No
The Prevention of Trafficking in Persons Act	Parliament	2009	Law	Yes	No
National Population Policy for Social Transformation and Sustainable Development	Ministry of Finance, Planning, and Economic Development	2008	Policy	No	Yes
Uganda Action Plan on UN Security Council Resolutions 1325 & 1820 and the GOMA Declaration: Commitments to Address Sexual Violence Against Women in Armed Conflict	Ministry of Gender, Labour, and Social Development	2008	Action plan	Yes	No
The National Gender Policy	Ministry of Gender, Labour, and Social Development	2007	Policy	Yes	No
The Constitution of the Republic of Uganda	--	1995	Law	Yes	No

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