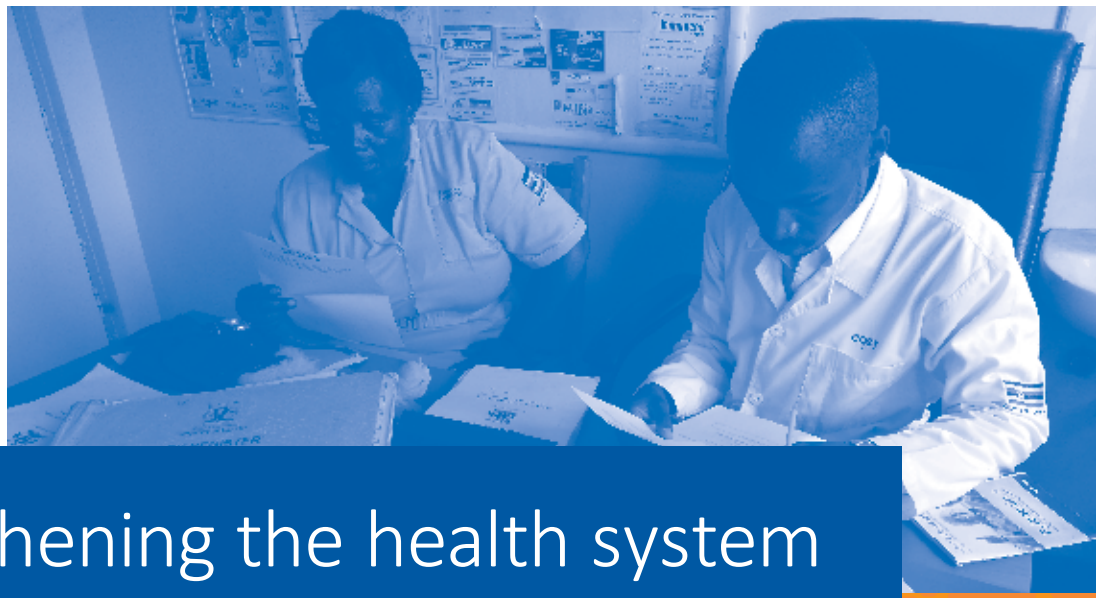


Strengthening the health system response to violence against women in Uganda

Lessons learned from adapting and implementing WHO guidelines and tools

World Health Organization

Strengthening the health system response to violence against women in Uganda

Lessons learned from adapting and implementing WHO guidelines and tools

World Health Organization

Strengthening the health system response to violence against women in Uganda: lessons learned from adapting and implementing WHO guidelines and tools

ISBN 978–92–4-001054–3 (electronic version)
ISBN 978–92–4-001055–0 (print version)

Suggested citation. Strengthening the health system response to violence against women in Uganda: lessons learned from adapting and implementing WHO guidelines and tools. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Edit and design by Inis Communication

Printed in Switzerland

Contents

Acknowledgements

This case study reflects many years of work by the Uganda Ministry of Health with the support of the WHO Uganda country office, alongside efforts of several other UN partners and advocacy by women's health and human rights nongovernmental organizations in Uganda. A special thanks goes to Miriam Namugere from the Ministry of Health in Uganda for championing the issue of gender-based violence persistently for many years and to the women's rights NGOs in Uganda who also have tirelessly championed the need for strengthening the health response to gender-based violence, including the need for survivor-centred health care.

This case study was developed by the WHO Department of Sexual and Reproductive Health and Research: Nadine Ferris France and Anna Hoover prepared drafts of the case study and oversight was provided by Avni Amin and Claudia García-Moreno. Olive Sentumbwe-Mugisa (WHO Uganda, Gender-Based Violence focal point) has played a pivotal role in providing technical support to the Ministry of Health in Uganda on the health response to gender-based violence, and has also facilitated interviews and information gathering from key informants in Uganda.

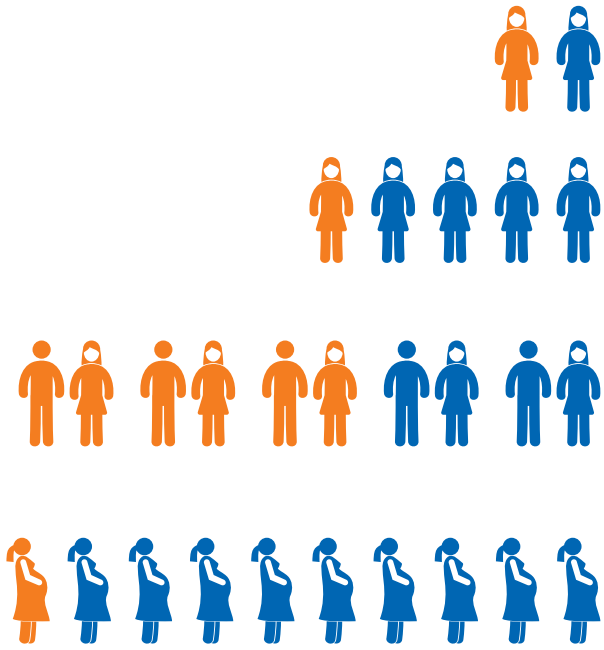
The draft has benefitted from review by Joan Kraft and Michal Avni from USAID. WHO gratefully acknowledges the support of USAID in strengthening the health response to violence against women in Uganda.

Championing a health response to gender-based violence is a long-term endeavour – one that requires persistence, patience, and painstaking small steps. It is not a linear process, rather it moves forward at times, while progressing slowly or grinding to a halt at others. We acknowledge and appreciate the efforts and persistence of all those who are involved in addressing violence against women in Uganda.

Background

Violence against women, also referred to as gender-based violence[1] is a widespread public health problem in Uganda, as it is globally. It is a pervasive human rights violation rooted in gender inequality and widely recognized as an impediment to the achievement of the Sustainable Development Goals (SDGs). While globally, one in three women have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner in the course of their lives, this ratio is much higher in Uganda (see Figure 1).

Figure 1: Violence against women in Uganda



1 in 2 women experienced physical from any perpetrator in their lifetime

1 in 5 women experienced sexual violence from any perpetrator in their lifetime

Nearly 3 in 5 ever-married women have experienced physical, sexual or emotional abuse by their current or most recent spouse/ partner

1 in 10 women who have ever been pregnant have experienced physical violence during one or more of the pregnancies

Source: (1)

The health impacts of such violence include physical, sexual, reproductive and mental health problems. Evidence suggests that women who have been subjected to violence seek health care more often even if they do not explicitly disclose the violence, than women who have not been subjected to violence *(2)*. Therefore, health care providers are well placed to identify and respond to women subjected to violence.

Uganda has made significant strides in addressing violence against women. It has a set of laws that prohibit, and policies that address gender-based violence. In order to perceive how these laws and policies were being implemented, the Ugandan Ministry of Health with support from the World Health Organization (WHO) conducted a readiness assessment exercise in 2014 to assess the strengths and weaknesses of the policy and legal response

[1] While in this document violence against women and gender-based violence are used interchangeably, we recognize that others interpret gender-based violence differently.

to gender-based violence. This is summarized in the *Readiness assessment report for addressing gender based violence in Uganda (3)*. The findings highlighted that although preventing and responding to violence against women was a priority in Uganda, and there were ongoing efforts to address it, there was a limited understanding on how to address it as a public health problem. The findings also suggested that health systems needed to be strengthened for a multisectoral response. This assessment was followed by activities undertaken by the Ugandan Ministry of Health with WHO support, to strengthen the responsiveness of health systems to violence against women in Uganda. The process, challenges and outcomes of these activities are documented in this brief.

Purpose and intended audiences

The purpose of this case study is to document the lessons learned from Uganda's efforts to strengthen the health system response to violence against women, particularly focusing on activities involving support from the WHO. It highlights the changes that have occurred as well as the opportunities and challenges encountered while making progress, and offers lessons learned on how countries can strengthen their health system response to violence against women. This case study will contribute to efforts by the WHO to monitor the implementation of the *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (4)*. The global plan of action was endorsed by the health ministries of 193 countries at the World Health Assembly in May 2016 and includes a monitoring framework that requires WHO to monitor the progress made and document lessons learned from countries.

The intended audiences of this case study comprise: policy makers in Uganda including district health managers who wish to scale up health system response to violence against women; health policy makers from other countries in sub-Saharan Africa and elsewhere who want to intensify national and sub-national efforts to strengthen the health system response to violence against women; donors; as well as United Nations agencies, professional health bodies and nongovernmental organizations (NGOs) implementing or providing technical support on health systems response to violence against women.

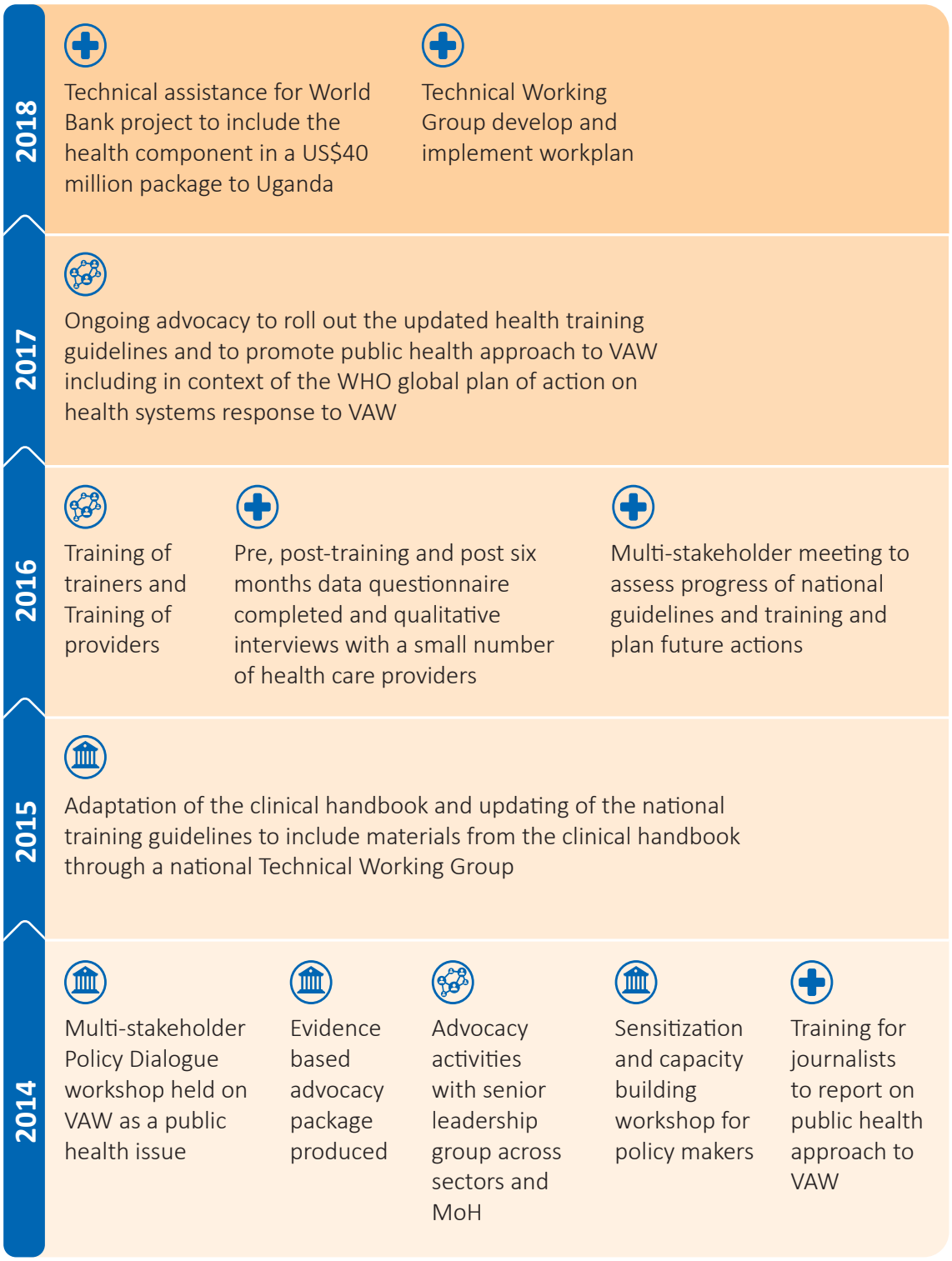
Process and methods

Case study methodology

This case study describes the activities carried out in Uganda over a period of five years (2014–2018; see Figure 2), and how these activities contributed to changes at: the policy level (i.e. changes in national guidelines); the institutional level (i.e. in health facilities); and the community level (i.e. changes in social norms and activism in the community). While activities conducted in Uganda operated primarily at the institutional and policy levels, this analysis finds that outcomes of these activities have filtered down to influence some changes at the community level. This process is shown in the theory of change diagram (see Figure 3).

This case study uses mixed methods to demonstrate the progress made over time, the challenges and the lessons learned. Perceptions of policymakers and institutional stakeholders are included throughout this document through "Voices from the Field", as are stories of community level changes. Specific data sources used for this case study include: findings from the readiness assessment of the policy response to gender-based violence in Uganda (2014); statistical analyses of results from questionnaires administered at pre-training (baseline), post-training and post-six months of training of 45 health providers (2016); and key informant interviews with the Ugandan Ministry of Health and the Ministry of Gender, health care workers, non-governmental organizations, donors and United Nations agency representatives in Uganda (2018).

Figure 2: Timeline of WHO-supported activities



Note: Detailed timeline describing activities supported by the WHO are available in Annex 2

VAW: violence against women

Figure 3: Theory of change

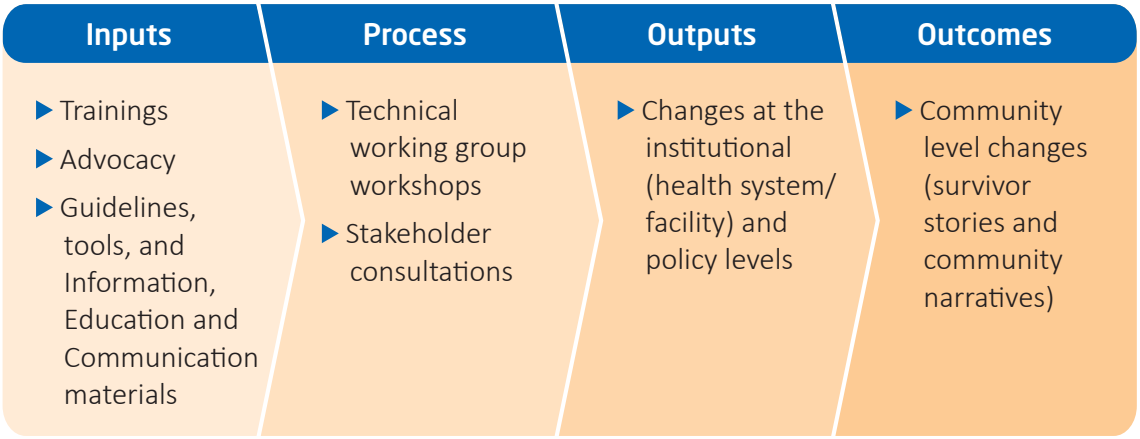
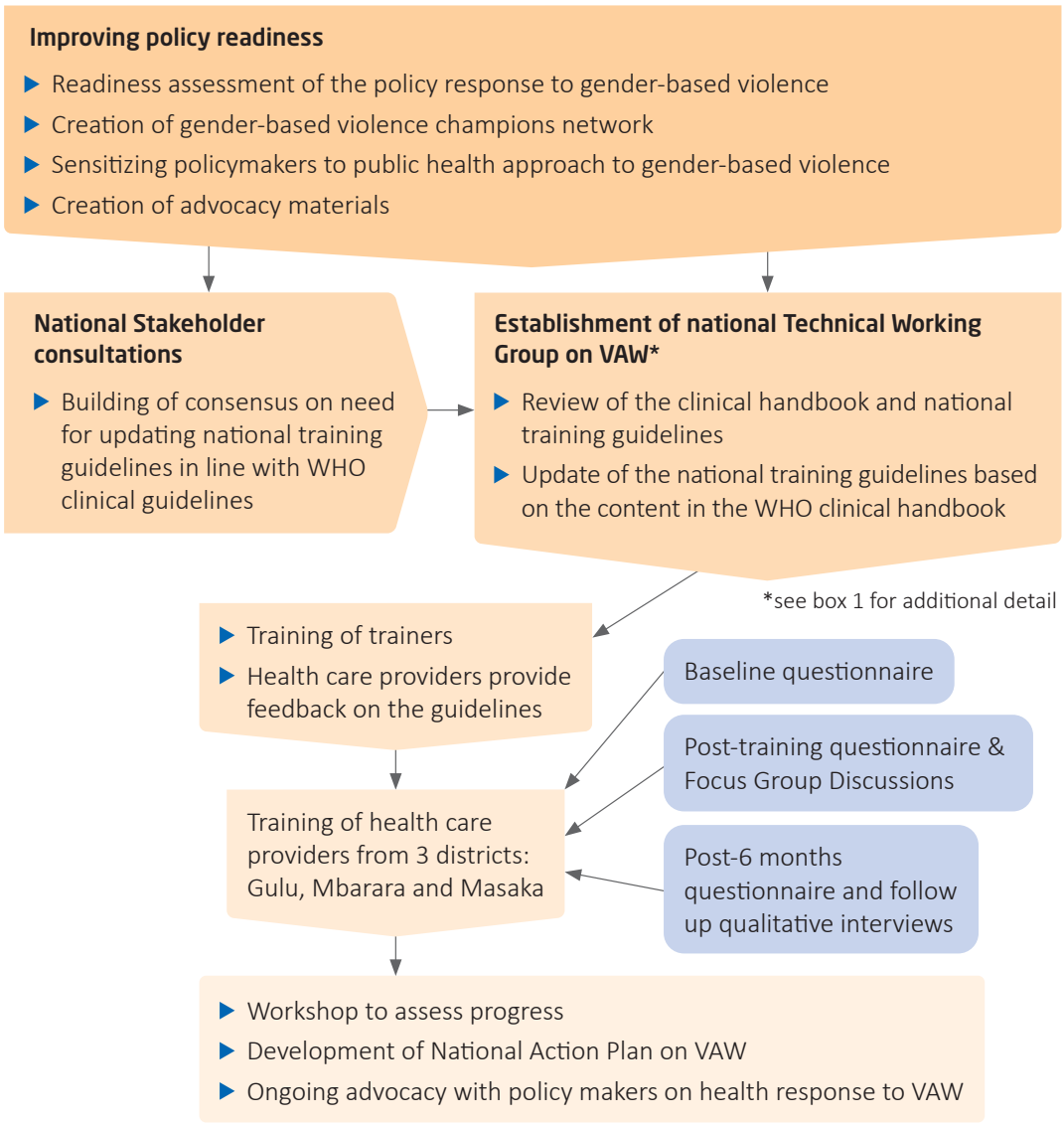


Figure 4: Overview of the process followed for adaptation and uptake of the guidelines



This case study also details the piloting process of the updated national training guidelines for responding to violence against women, conducted in selected districts of Uganda. This process operated both at the public policy level through the adaptation of the national training guidelines (see Box 1), and at the institutional level through training of trainers and health providers. Qualitative interviews conducted with health providers including family planning providers post training illustrated changes at the health provider and facility levels. The step-by-step process used for piloting is summarized in Figure 4 above and further elaborated in Annex 2. The process of updating the national training guidelines as the first step in the piloting of the clinical handbook is described in Box 1.

Voices from the Field

We are proud of the clinical guidelines and the training and now have a team of master trainers and a number of trained health care providers. We will continue to train health care providers and ensure mentorship for them.

Miriam Namugere,
Ministry of Health

Box 1: Updating training guidelines for health care providers on the management of gender-based violence

In 2013, the WHO produced clinical and policy guidelines for responding to two main forms of violence against women – intimate partner violence and sexual violence. This was followed in 2014 by a clinical handbook that provides operational guidance to health care providers on:

- how to provide a safe, survivor-centred and effective response to survivors of intimate partner violence and sexual violence (it includes the 'how to' of providing first-line support which involves active listening, LIVES approach (Listen, Inquire, Validate, Enhance safety and Support), among others);
- comprehensive post-rape care; and
- additional support for mental health.

The update of the Ugandan national training guidelines involved stakeholders from all sectors (e.g. non-governmental organizations, United Nations agencies, Ministry of Health and Ministry of Gender, Labour and Social Development, medical professional bodies, practitioners across all fields of health, police and justice). The training is for nurses, midwives, doctors, clinical medical officers and other health professionals and is conducted by a master trainer with the help of participant manuals that includes job aids adapted from the WHO clinical handbook. The updated national training guidelines are divided into six modules:

1. Overview of gender-based violence
2. The law and gender-based violence
3. Communication, psychosocial and mental health counselling
4. Clinical management of gender-based violence survivors
5. Networking including referral pathway and social mobilization
6. Monitoring and evaluation.

Findings: Pathways to change at the policy level

Output level changes in awareness, leadership, political commitment and policies

A readiness assessment of the policy response to gender-based violence conducted in Uganda in 2014 showed a deficit in commitment and resources to address violence against women (see Figure 5) *(3)*. While the assessment found that legislation, mandates and policies to address gender-based violence were strong, overall readiness was quite low, and attitudes towards addressing the topic as a priority were variable. Fewer than 15% of participants found gender-based violence to be a high priority compared to other health and social issues, highlighting problems such as a lack of coordination mechanisms, and low community involvement in addressing gender-based violence. The results of the readiness assessment were fed into a multi-stakeholder policy dialogue on a public health approach to violence against women, as the assessment also suggested that violence against women was primarily seen as a justice sector issue. To strengthen policy commitment to a public health approach to violence against women, a gender-based violence champions group comprising senior policy makers across sectors, UN agencies and development partners was created. They were equipped with an evidence-based advocacy package that comprised messages on the public health impacts of violence against women.

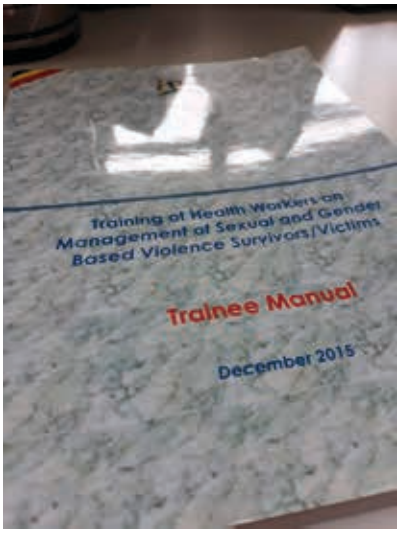
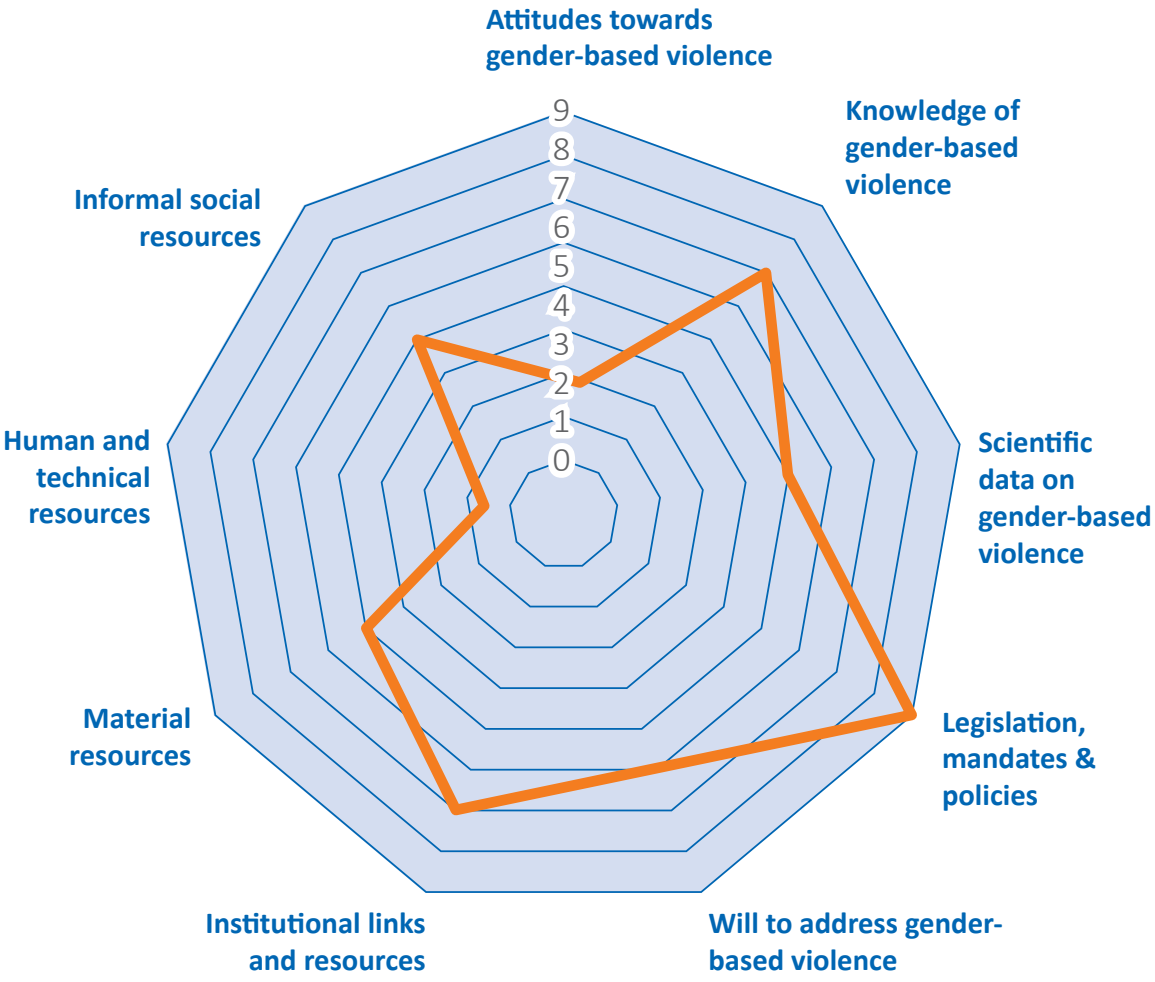


Figure 5: Gender-based violence readiness assessment: Scores on a radar diagram (3)



Five years on, there is a strengthened commitment across multiple sectors on prevention and response to violence against women as a public health approach. As indicated by the key informants interviewed for this case study and reflected in the Voices from the Field, there is an improved commitment by all – from the health care providers themselves to district and national governments, non-governmental organizations, United Nations bodies, donors and professional medical bodies – to work together to improve the situation for the survivors.

In the health sector, sustained advocacy with senior and mid-level officials of the Ugandan Ministry of Health, training of health care providers, and provision of technical support has contributed to greater engagement in the multisectoral response to gender-based violence including through improved collaboration and coordination across the health, police and justice sectors. For example, in addition to a multisectoral *National Policy on Elimination of Gender-based Violence in Uganda (2016–2021)*, there is also a *National Action Plan on Elimination of Gender based Violence in Uganda (2016–2021)*. Both these documents define the role of the health sector in providing services to survivors of gender-based violence.

Donor and development partner response

From 2019, substantial financial support from the European Union (through the Spotlight Initiative) and other development partners to the Ministry of Gender, Labour and Social Development and the Ministry of Health contributed to an intensified focus on violence against women as a social, legal and public health issue. In 11 districts of Uganda where the United States Agency for International Development (USAID) supports the Ministry of Health to improve services for women survivors of violence, health worker training is conducted using the *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015)*. These guidelines reflect WHO guidelines (2013) and tools (2014). An implementation assessment of Uganda's policy frameworks on gender-based violence and family planning conducted in 2018 found that the training guidelines were well-received, and concluded that the training guidelines were one of the four key drivers of effective policy implementation of gender-based violence in the context of family planning *(5).*

Findings: Pathways to change at the institutional level

Output level changes: Improvements in service delivery

Three years after the training of master trainers and health care providers from three districts, the key informants interviewed for this case study indicated that more cases were being reported through the hospital gender-based violence registers, and that health professionals were better able to provide care for the survivors.

Gender-based violence registers are now being used systematically in many facilities and this data is fed into the Health Management Information System.

To support the reporting of violence to health care providers in Mbarara Regional Referral Hospital, trained nurses deliver health promotion sessions, including on violence against women, to the large group of women waiting for services. This helps some women to disclose any violence to trained staff during their routine health visits. In Masaka Regional Referral Hospital, trained nurses from the maternal and child health unit identify women who attend antenatal and child health services. Women who disclose violence are referred to MIFUMI, a non-governmental organization working in communities

Voices from the Field

More cases are being identified, particularly ones that would have been missed before such as from physical and psychological violence.

Juliet Cheptoris, Chair, Technical Working Group on the health sector response to violence against women

to provide direct domestic violence services to survivors. MIFUMI is located just 100 metres from the maternal and child health unit on the hospital grounds itself, making referrals easy. Also, 1000 metres outside the hospital grounds is a safe house/women's shelter run by the MIFUMI. This model allows women to receive medical, legal and social support all within close reach of each other. Every week the health care providers and the MIFUMI team meet together to discuss cases and share learnings.

Improvements have also been reported in medico-legal evidence collection including through documentation in police forms despite continuing challenges (see Box 2).

Box 2: Collecting evidence of sexual violence against women: Health care providers play a key role

For a case of sexual violence to go to court in Uganda, the survivor must submit Police Form 3 completed by a health worker to document forensic evidence. In 2013, there were only eight high level health professionals in the whole country who could fill in Police Form 3. As a result of advocacy and lobbying by non-governmental organizations, United Nations agencies and others, the cadre of health care providers who could fill in this form was expanded to allow medical officers, midwives and others to fill them in. The Ministry of Health issued a circular in 2016 to let health facilities know and asked that this service be provided free of charge to survivors who need it.

However, a number of challenges were raised:

- Several health care providers are still not trained on how to fill in a Police Form 3. If it is not filled in correctly and signed off appropriately, it is not acceptable in court.
- Health care providers fear going to court and are intimidated to speak in such fora.
- Patients are being charged to support the costs of health care providers who have to pay for their own transport to attend court hearings.
- Reimbursement of health worker transport costs is included in the Justice, Law and Order Sector budget rather than the Ministry of Health budget, which makes reimbursement very difficult for health care providers. A health worker in Iganga had to go back 11 times for one court case at his own expense.
- Court hearings can take 11 months to eight years requiring a health worker to be available to attend all times.
- Postponed and prolonged court case appearances mean that health care providers are away from their routine work.
- Health care providers live in the same communities within which the violence has happened; thus giving evidence in court can put them in danger from perpetrators, making them afraid for their personal safety.

Changes in health worker capacities

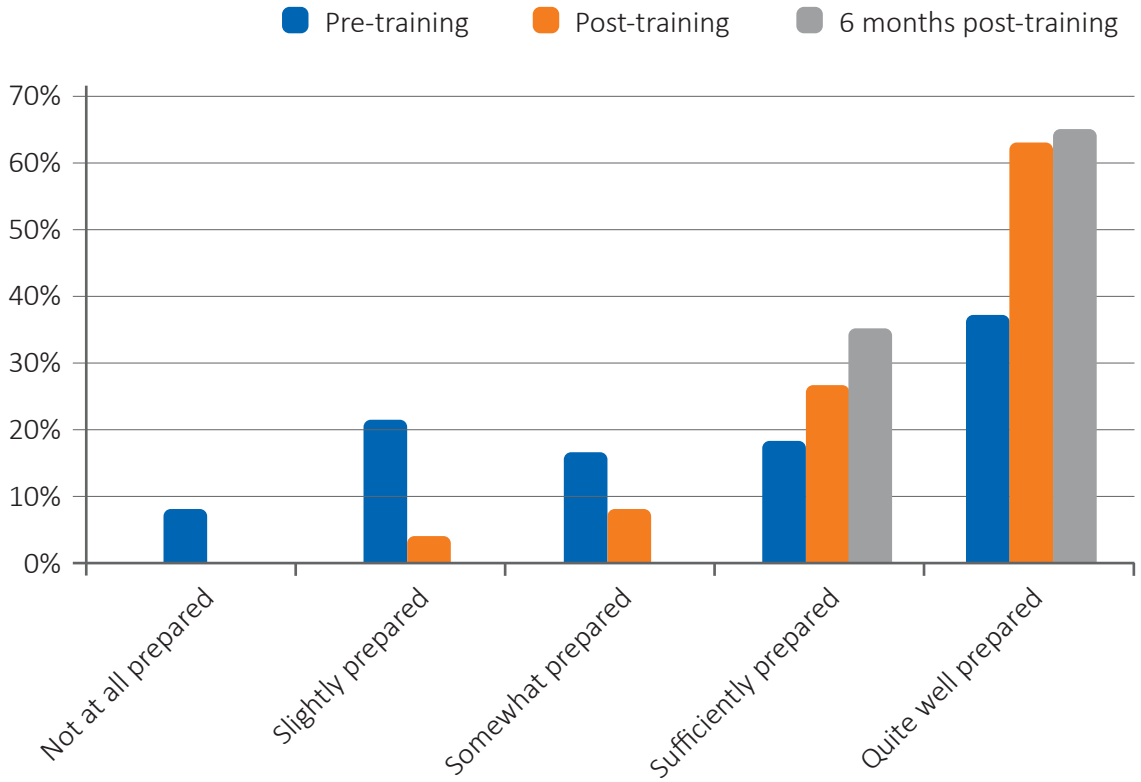
Findings from the knowledge, attitude and practice questionnaires administered to 45 trained health care providers in the three districts at before, immediately after and post-six months of training, suggest improved capacities in responding to survivors. For example, while immediately after training there was significant improvement in knowledge on and attitudes towards violence against women, and preparedness to provide care to survivors of violence against women, these results were also sustained at six months after the training. Figure 6 below shows the improvement in health care providers' perceptions of their preparedness to respond to cases of violence against women with approximately 60% of providers reporting that they were quite well prepared to respond to violence against women post-six months of training as compared to 35% of health care providers reporting this prior to training.

Voices from the Field

We have seen good progress in the health sector in recent years – many health care workers have been trained on gender-based violence about how to provide services for the survivors who show up for support. Some health units are able to provide emergency services including emergency contraceptives, HIV post-exposure prophylaxis and treatment of injuries.

Tina Musuya- Executive Director,
Center for Domestic Violence Prevention

Figure 6: Health care providers' perceptions about their preparedness to deal with violence against women



To facilitate health care providers to apply the training, they were given job-aids which were made available on clinic walls (see Figure 7).

Figure 7: Job aids in Mbarara Regional Referral Hospital

HELPING WOMEN COPE WITH NEGATIVE FEELINGS FOR SEXUAL AND GENDER BASED VIOLENCE(SGBV) SURVIVORS	
The feeling	Some ways to respond
Hopelessness	"Many women do manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on her strengths and how she has been able to handle a past dangerous or difficult situations.
Powerlessness, loss of control	"You have some choices and options today in how to proceed."
Flashbacks	Explain that these are common and often become less common or disappear over time.
Denial	"I'm taking what you have told me seriously. I will be here if you need help in the future."
Guilt and self-blame	"You are not to blame for what happened to you. You are not responsible for his behaviour."
Shame	"There is no loss of honour in what happened. You are of value."
Unrealistic fear	Emphasize, "You are in a safe place now. We can talk about how to keep you safe."
Numbness	"This is a common reaction to difficult events. You will feel again – all in good time."
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with perpetrator	Acknowledge that this a valid feeling.
Anxiety	"This is common, but we can discuss ways to help you feel less anxious."
Helplessness	"We are here to help you."

FIRST LINE SUPPORT FOR SEXUAL AND GENDER BASED VIOLENCE (SGBV) SURVIORS

L ISTEN	Listen to the client closely, with empathy, and without judging.
I NQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to his/her various needs and concerns-emotional, physical, social and practical (e.g. childcare)
V ALIDATE	Show that you understand and believe her/him. Assure her/him that s/he is not to blame.
E NHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
S UPPORT	Support by helping her/him connect to information services and social support.

However, training alone was not sufficient for health care providers to respond to survivor needs. For example, challenges identified by health care providers included lack of skills in providing mental health care, lack of knowledge about relevant laws and legislation, having significant time limitations, lack of private space in the clinics, and having few referral services available in the community. The need for more frequent and shorter trainings was indicated.

Another concern was that due to rotating shifts of health care providers between hospital departments, facilities lost trained health care providers. Health care providers also mentioned not having the basic materials needed for collecting evidence in cases of rape, such as vaginal swabs, as well as not having printed job aids, posters and outreach materials. For women who reported violence in a busy clinic, privacy remains a challenge as there were few rooms to guarantee privacy.

Voices from the Field

After health care workers have been well trained and given job aids, but they don't have kits to collect evidence they get frustrated seeing that justice cannot be done

Joy Angulo, Regional Health Integration to Enhance Services

Findings: Pathways to change at the community level

Outcome level changes in community norms

While the primary changes documented in this case study have occurred at the policy and institutional levels (i.e. health system level), trained health care providers can contribute to making a difference at the community level: through consistent and quality support for survivors and their families; by becoming champions and advocates; and challenging norms of stigma faced by survivors which prevent them from seeking services.

One example of how health care providers challenged norms related to violence against women is described in Box 3. It is important to note, however, that changes at the community level (i.e. outcome level according to the theory of change) are slow to occur and much beyond the time required at the health system level.

Voices from the Field

Although more cases are being identified because health care providers are now trained, stigma and self-stigma remains a big issue for women in the community and it prevents them from coming forward, no matter how bad the situation.

Sr Pheobe Nangobi, Assistant District Health Officer, Iganga District

Box 3: Trained health care providers contribute to challenging community norms on violence against women

In one particular village, health care providers who had been trained using the *Training of health care providers on management of sexual and gender-based violence survivors/ victims (2015)* had been continuously raising awareness about violence against women in the community. A man in his forties who already had two wives, raped a teenage girl in his village and subsequently brought five cows to her parents as a bride price. The girl had already decided on the man she wanted to marry, but he was poorer and could not match the bride price of five cows. As it was the custom in the community, her parents felt they had to hand her over to the man who had succeeded in raping her.

The girl was devastated and ran to the health care facility where she had received care from a trained health worker who had been kind to her following her rape. She knew that it was against the norms of the community to refuse to marry the man who had raped her. When she arrived at the health facility, the health care providers instead of sending her back to the unsafe community, provided shelter and even after the community members came looking for her the health care providers did not disclose her whereabouts. They hid her in the ward and called the police to take her to a safe shelter. The health care providers took it upon themselves to talk to the community and the girl's family and helped them understand what the community was doing was harmful, that the young girl had the right to choose a partner, that she had been raped which was a crime, and that her right to safety and her autonomy should be respected. The community accepted her back and her family allowed her to marry the man she loved. **When we have well trained health care providers, their impact can be felt far and wide throughout the community.**

Yvette Alal, Senior Programme Officer, Center for Domestic Violence Prevention, 2018

Lessons learned

According to the theory of change, inputs (in the form of tools, guidelines, job-aids evidence, processes of advocacy, stakeholder sensitization, policy dialogues and trainings), contributed to changes primarily at the policy and institutional levels (i.e. in outputs). For the health system to change, policies need to guide stakeholders especially in leadership to become advocates and champions. At the institutional level, trainings, support to health care providers, job aids and improvements in facilities are required to translate policies into sustained practice. While changes in community norms underpinning violence against women (i.e. in outcomes) require multisectoral interventions that usually are outside of health systems, health care providers can contribute by becoming advocates and challenging harmful norms.

Voices from the Field

I will attend whoever comes in to save their lives and improve the quality of their lives, no matter what it takes

Dr Cost, Iganga Hospital

Policy advocacy process

- Evidence is needed to convince policy makers, hospital managers and others that violence against women is an important public health issue and that the health sector has an important role to play in abating it.
- Advocacy on violence against women as a public health issue is important on an ongoing basis.
- Convening a multisectoral stakeholder group to adapt the WHO Guidelines to nationally adapted guidelines ensures ownership.
- A Technical Working Group on health sector response to violence against women has been important in motivating the development of the national guidelines and health system plan, as well as in identifying and responding to challenges in strengthening health system response to violence against women.

Policy advocacy process

- Investing in an ongoing process of engaging stakeholders from all relevant sectors (health, justice, police, law and media) and agencies (United Nations, non-governmental organizations, Ministries, development partners and donors) is time consuming, but essential for ownership.
- Champions at the leadership level are critical to facilitating change in health system response to violence against women.
- Dedicated budget held by the health ministry of a country is needed to sustain health system response to violence against women.
- Changing health system response to address violence against women is complex; the process is not a linear one, and requires multiple engagements with many varied actors over time on a continuous basis.
- It is important to celebrate successes along the way as every little success contributes to the next achievement.

Health worker training

- Piloting the violence against women training allows for improvements in content and process before doing country-wide scale up and helps sustainability.
- Health care providers should be supported by changes/inputs at the health system level. This includes having the necessary supplies (such as job aids, necessary medications, laboratory facilities), ensuring high quality services and good infrastructure (such as rooms that allow privacy, lockable cabinets for records), providing ongoing training, and ensuring effective mentorship and support, particularly for newly trained health care providers.
- Training needs to be continuous as health care providers continuously rotate to other departments within the hospital. It also needs to be reinforced on an ongoing basis to retain knowledge and skills over time.
- Joint trainings and dialogue with the justice and police are required to address the challenges in medico-legal or forensic evidence collection, so that the barriers to presenting evidence in court, providing testimonies and making referrals for survivors are addressed.

Next steps

While progress has been made in Uganda towards the institutionalization and strengthening of a health system response to violence against women between 2014 and 2018, there are challenges ahead. Several actions can contribute to the continued strengthening of the health system response to violence against women in Uganda including:

Training and mentoring of health care providers

- Continue support to the Ministry of Health in building capacity of health care providers using the *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015)*.
- Provide ongoing training, including refreshers, supportive supervision and mentoring of trained health care providers.
- Incorporate health system response to violence against women (including post-rape care), into pre- and in-service curricula for health care providers by working with educational and professional bodies, as well as medical, nursing and midwifery schools.
- Develop a training module specifically on 'how to fill in a Police Form 3' and incorporate into the *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015).*

Advocacy

- Continue to advocate for a dedicated budget for violence against women within the Ministry of Health.
- Host a high-level meeting bringing together the health, police and justice sectors to resolve ongoing challenges in gathering and presenting medico-legal evidence from health care providers including in relation to filling out Police Form 3.

Supplies and resources

- Ensure availability of job aids and information, education and communication materials to support health care providers to do their jobs when trained.
- Investigate the possibility of developing a phone- or tablet-based application for health facilities that could contain job aids, access to training videos and other important information from the national guidelines.

Evidence

- Monitor quality of care being provided by hospital and health facilities and implement a quality assurance process for improvements.
- Conduct a follow up readiness assessment to measure changes or progress in policy level commitment to the public health approach to violence against women 2014 assessment, using the same methodology.

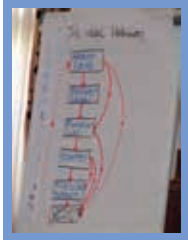
Annexes

Annex 1: References

1. Uganda: Demographic and Health Survey 2016. Kampala and Rockville: Uganda Bureau of Statistics and The Demographic and Health Survey Program; 2018 (https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf, accessed 26 August 2020).
2. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf, accessed 26 August 2020).
3. Readiness assessment report for addressing gender based violence in Uganda. Geneva: World Health Organization and The Republic of Uganda Ministry of Health; 2014.
4. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. Geneva: World Health Organization; 2016 (https://www.who.int/reproductivehealth/publications/violence/global-plan-of-action/en/, accessed 26 August 2020).
5. Rottach, E. Among, I. Gerber, W. Kaufman, R. Gender-Based Violence and Family Planning: An Implementation Assessment of Uganda's Policy Framework. Washington, DC: Palladium, Health Policy Plus; 2018 (http://www.healthpolicyplus.com/ns/pubs/10252–10455_GBVFPResearchReport.pdf, accessed 7 September 2020).

Annex 2: Timeline with activities and milestones achieved over five years (2014 – 2018)

	Activities/inputs	Outputs
2014	Readiness assessment and policy dialogue workshop: violence against women as a public health issue, Kampala	Policy readiness assessment conducted and disseminated and agreement on implementing a public health approach to violence against women including on strengthening the health system response
	Evidence based advocacy package produced	• Availability of data based evidence brief • Video on senior management commitment • Series of posters and fact sheets with information about violence against women and health consequences and risk factors
	Launch of a champions group of senior policy makers/leadership across sectors and Ministry of Health and advocacy using the advocacy package	• Consensus on next steps for strengthening health system response to violence against women • Launch of the violence against women champions network
	Sensitization and capacity building workshop for policy makers for 14 East African countries, Entebbe	• Consensus that the clinical handbook and WHO guidelines should be the basis for updating the national training guidelines for health care providers on gender-based violence • Country-level priority action areas for action on violence against women identified in eight countries, including Uganda
	Training for journalists to report on public health approach to violence against women, Entebbe	News coverage in print and TV media for East Africa on the public health approach to violence against women to generate further consensus
2015	Adaptation of the clinical handbook and update of the *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015)* guidelines to include materials from the clinical handbook through a national Technical Working Group	• *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015)* guidelines updated and disseminated • Production of Master Trainer Handbook and Trainee Manual • Job aids for health care professionals provided to clinics

	Activities/inputs	Outputs
2016 	Training of trainers & training of providers	• 45 health care providers from three districts trained to provide care for violence against women
	Questionnaires completed and qualitative interviews held with a small number of health care providers (including family planning) at pre- (baseline), post-, and post-six-months training	• Improved knowledge, attitudes and preparedness demonstrated by health care providers in the data
	Multi-stakeholder meeting to assess progress of national guidelines and training and plan future actions	Development of a national plan of action on the health system response to gender-based violence – based on the WHO global
2017 	Ongoing advocacy to roll out the updated health training guidelines and to promote public health approach to violence against women including in context of the *Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (4)*	• Component on violence against women included in: – Gender and Human Rights Manual for Health care providers – Comprehensive Family Planning Clinical Skills curriculum – Provision of Goal-Oriented Antenatal Care Protocol
2018 	Technical assistance for World Bank project to include the health component in a US$ 40 million package to Uganda	Inclusion of a US$ nine million component for the Ministry of Health to train health care providers based on the updated *Training of health care providers on management of sexual and gender-based violence survivors/ victims (2015)*, and to roll out the WHO health manager manual for improving facility readiness and to conduct quality assurance.[2]
	Technical Working Group to develop and implement workplan	Production of the Gender-Based Violence Quality Improvement Tool, Training Manual and Journal
	Key informant interviews with policy makers, health care providers, UN agencies and non-governmental agencies	Data for this case study

[2] While a grant was awarded by the World Bank including an allocation of US$ nine million for the Ministry of Health, the approval by the government of Uganda is pending.

Annex 3: Piloting process of "Training of Health care providers on Management of Sexual and Gender Based Violence Survivors/Victims"

STEP 1

Stakeholder consultations held to build consensus on the need for updating *Training of health care providers on management of sexual and gender-based violence survivors/victims (2015)* in line with the WHO clinical guidelines

STEP 2

Adaptation of WHO clinical handbook for responding to intimate partner violence and sexual violence against women *(2)* to update the national training guidelines for health care providers (see Box 1).

STEP 3

Training of trainers (n=20 master trainers over five days), followed by training of providers (n=45 over four days) in select health facilities (health centres, level III and IV and regional referral hospitals) from three districts (Gulu, Mbarara, Masaka). A questionnaire was administered to health care providers (doctors and nurses; 60% male and 40% female) at pre- (baseline) and post-training to assess progress in knowledge, attitudes and practices as well as perceived preparedness to provide care.

STEP 4

All trained providers supplied with copies of the WHO clinical handbook *(2)* as a resource and for monitoring and supervision visits conducted two months after the training to assist providers with any difficult issues that emerged.

STEP 5

Administration of follow-up questionnaires post-training and post-six months of training to assess progress in clinical practice as well as barriers and challenges to implementing knowledge gained. An analysis of the changes in provider knowledge, attitudes and practices from pre-training phase (baseline) to post-training follow up is documented in a report (available upon request).

For more information, contact
Department of Sexual and Reproductive Health and Research
World Health Organization
20 Avenue Appia
CH 1211, Geneva 27
Switzerland
Email: srhavp@who.int
www.who.int/health-topics/violence-against-women
ISBN 978–92–4-001054–3 (electronic version)
ISBN 978–92–4-001055–0 (print version)