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# Screening for sexual and gender-based violence in emergency settings in Uganda: An assessment of feasibility

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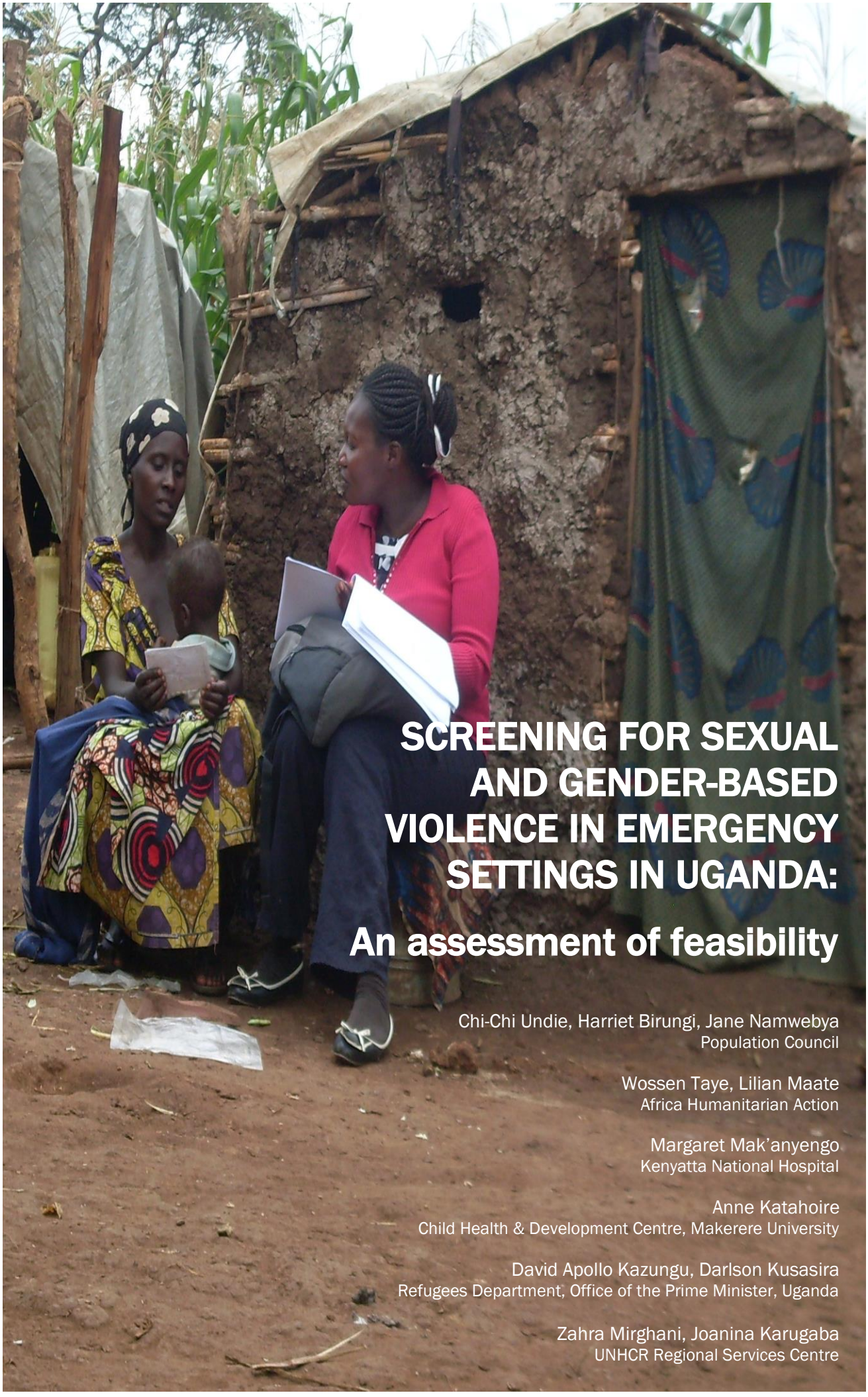
report



# SCREENING FOR SEXUAL AND GENDER-BASED VIOLENCE IN EMERGENCY SETTINGS IN UGANDA:

## An assessment of feasibility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To the people of Rwamwanja Settlement and the health providers at Rwamwanja Health Centre: Thank you for sharing your experiences with us.

# List of Acronyms

| | |
|---|---|
| AHA | Africa Humanitarian Action |
| ART | Antiretroviral Therapy |
| DRC | Democratic Republic of Congo |
| FGD | Focus Group Discussion |
| IDI | In-Depth Interview |
| IPV | Intimate Partner Violence |
| SGBV | Sexual and Gender-Based Violence |
| STI | Sexually-Transmitted Infection |
| UNHCR | United Nations High Commission for Refugees |

# Executive Summary

Sexual and gender-based violence (SGBV) is a global predicament to which over a third of women world-wide are exposed. Its negative consequences for reproductive, maternal, adolescent, and mental health are well-documented. Data from the sub-Saharan African region confirm that SGBV is a prevalent concern in emergency settings. Consequently, these settings are hard-pressed to find solutions to such violence. A growing body of evidence demonstrates that screening for SGBV can help to promote survivor detection and survivor access to comprehensive services. However, these studies have typically been conducted among the general population. As a result, there is sparse evidence for the feasibility of SGBV screening interventions in emergency contexts.

Employing a descriptive case study design, this study assessed the feasibility of implementing SGBV screening and referral protocols within health facilities in the emergency setting of Rwamwanja Refugee Settlement in Kamwenge District, Western Uganda. Providers from two health facilities were trained to screen female clients routinely for current exposure to intimate partner violence and lifetime exposure to non-partner sexual violence. SGBV survivors detected through this process were referred for further SGBV care.

The intervention occurred from September 2015 to January 2016. Data collection to facilitate the assessment of the intervention occurred over the same period of time, and included focus group discussions with 18 providers, in-depth interviews with 46 SGBV survivors, and the collation of service statistics from participating health facilities.

Key findings from the study are summarized as follows:

- Survivors demonstrated willingness to disclose SGBV.
- Providers achieved high rates of screening, survivor detection, and survivor referral.
- Survivors achieved modest rates of referral adherence.
- Survivor satisfaction with SGBV services was high.
- Provider satisfaction with implementing screening protocols was high.
- Survivor and provider recommendations demonstrated the high acceptability of SGBV screening and referral.

The study findings suggest that routine screening for SGBV can be carried out in emergency settings. The limitations of the intervention centered mainly on the issue of survivor adherence to referrals, which was relatively lower than provider referral rates. Nonetheless, the systemic issues within health facilities, which accounted for most of the referral adherence concerns, were resolvable.

Findings from the study lead to four key recommendations for strengthening SGBV screening protocols, and for addressing gaps in SGBV programming more broadly in Rwamwanja Refugee Settlement:

1. Reserve the implementation of screening and referral protocols for health facility sites where SGBV care is co-located.
2. Integrate an SGBV-informed approach into health services in general.
3. Incorporate, and enhance training for, more trauma counselors in the health facility context.
4. Adapt and test the SGBV screening intervention for the detection of, and response to, male perpetrators.

# Background and Problem Statement

Recent evidence on the scale of sexual and gender-based violence (SGBV) is unequivocal: SGBV is a global predicament to which over a third of women world-wide are exposed.[1] The first global systematic review and synthesis of the body of scientific data on the prevalence of violence by an intimate partner ('intimate partner violence') and sexual violence by someone other than a partner ('non-partner sexual violence') demonstrates that 35 percent of women world-wide have experienced either physical or sexual intimate partner violence (IPV) or non-partner sexual violence.[2] Africa is among the regions with the highest prevalence of IPV, with about 37 percent of women reporting this experience.[3]

The implications of SGBV for reproductive, maternal, adolescent, and mental health are well-documented and associated with maternal morbidity[4] and mortality,[5] and curtailed utilization of reproductive health (RH) services.[6] Beyond pregnancy and childbirth, an additional consequence of SGBV is an elevated prevalence of sexually-transmitted infections (STIs), including HIV, due to coercive (and unprotected) sex. The risk of sero-conversion following forced sex is likely to be higher than following consensual sex, especially among children.[7] Studies from diverse settings have also found that girls or young women who previously experienced sexual coercion are significantly less likely to use condoms, and more likely to experience genital tract infection symptoms.[8] Recent research also indicates that women who reported sexual or physical abuse before age 11 have greater risk of uterine fibroids in adulthood than women with no such abuse history.[9]

Data from the region confirm that SGBV is a prevalent concern in emergency settings. Crisis-affected populations are exposed to sexual violence as both survivors of conflict-related rape and increased IPV during conflict. Furthermore, evidence indicates that IPV may even intensify post-conflict.[10] Studies in conflict-ridden northern Uganda have demonstrated that 60 percent of women in this region have experienced some form of sexual violence.[11]

Ensuring that comprehensive services detect and respond to non-partner sexual violence, as well as to less overt forms of chronic violence (including IPV), is a significant challenge. A growing body of evidence in sub-Saharan Africa[12] demonstrates that screening for such forms of violence can help promote survivor detection and survivor access to comprehensive services. These studies have typically been conducted among general populations, however, and consequently there is sparse evidence for the feasibility of SGBV screening interventions in emergency contexts.

This study assessed the feasibility of implementing SGBV screening and referral protocols in health facility settings within emergency contexts. The study is an adaptation of an earlier intervention research project

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1 WHO. 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and nonpartner sexual violence. Geneva: WHO.
2 Ibid.
3 Ibid.
4 Garcia-Moreno C. 2002. Dilemmas and opportunities for an appropriate health service response to Violence Against Women. *Lancet*.
5 Espinoza H, AV Camacho. 2005. Maternal death due to domestic violence: An unrecognized critical component of maternal mortality. *Pan American Journal of Public Health* 17(2): 123-129.
6 Kaneda T, R Smith. 2015. Intimate partner violence and unmet need for family planning: Findings among women of different ages from six sub-Saharan African countries. Washington, DC: Population Reference Bureau.
7 Speight CG et al. 2006. Piloting post-exposure prophylaxis in Kenya raises specific concerns for the management of childhood rape. *Transactions of the Royal Society of Tropical Medicine and Hygiene*.
8 Campbell T, C McPhail. 2004. The Impact of rape on women's sexual health risk behaviors." *Health Psychology* 23(1): 67-74.
9 Medical News Today. 2013. African-American women who suffered abuse during childhood at increased risk for uterine fibroids. www.medicalnewstoday.com/releases/255427.php.
10 Miller L (n.d.). The irony of refuge: Gender-Based Violence against Female Refugees in Africa. Human Rights and Human Welfare: www.du.edu/korbel/hrhw/researchdigest/minority/Africa.pdf.
11 Amalo CL, Odwee JO. 2009. Sexual and gender-based violence against women in conflict areas in Uganda: A case of Kitgum District. CPMs Sessions. www.statssa.gov.za/isi2009/ScientificProgramme/IPMS/1322.pdf.
12 Laisser RM, L Nyström, G Lindmark, HI Lugina, M Emmelin. 2011. Screening of women for IPV: A pilot intervention at an outpatient department in Tanzania. *Global Health Action* 4:7288; Turan JM, AM Hatcher, M Odero, M Onono, J Kodero, P Romito, E Mangone, EA Bukusi. 2013. A community-supported clinic-based program for prevention of violence against pregnant women in rural Kenya. *AIDS Research and Treatment*; Undie C, MC Maternwoska, M Mak'anyengo, I Askew. 2016. Is routine screening for IPV feasible in public health care settings in Kenya? *J of Interpersonal Violence* 31(2): 282-301.

carried out at Kenyatta National Hospital in Nairobi, Kenya in 2012.[13] An adapted version of the intervention was introduced in the emergency context to support the operationalization of the United Nations High Commission for Refugees' (UNHCR's) current strategy for Action against Sexual and Gender-Based Violence. This strategy includes recommended actions in three key areas in order to strengthen UNHCR's capacity and expertise in addressing SGBV:

1. *Data collection and analysis*—Improve the quality of programs by adopting and maintaining appropriate SGBV data collection and analysis tools and working with institutions and partners on researching and documenting SGBV;
2. *Knowledge management and capacity-building*—Strengthen the management of SGBV programs by investing in capacity-building and expertise across the organization; and
3. *Partnerships and coordination*—Working with UN agencies, governments, non-governmental organizations, and displaced communities, strengthen SGBV prevention, response, and coordination mechanisms for effective service.

[13] Undie, C, MC Maternwoska, M Mak'anyengo, I Askew. 2013. Feasibility of routine screening for intimate partner violence feasible in public health care settings in Kenya. Population Council: Nairobi, Kenya.

# Study Aim

This study assessed the feasibility of screening for SGBV among crisis-affected populations. The dimensions of feasibility under consideration included: 1) provider capacity and willingness to screen for SGBV; 2) survivor willingness to disclose SGBV; 3) provider referral and survivor completion of referrals as a result of screening; 4) provider and survivor satisfaction with the introduction of screening and referral protocols; and 5) provider and survivor reactions to the intervention which pinpoint its acceptability.

# Context

Rwamwanja Refugee Settlement is located in Kamwenge District of Western Uganda. When this study began in 2015, the settlement was home to about 40,000 refugees, and continued settlement of new arrivals was expected until its maximum capacity of 55,000 to 60,000. The settlement is situated on about 108.5 square kilometers and comprises 15 zones, with a total of 45 villages. First established in 1963-64, Rwamwanja Settlement was selected as the study site in consultation with UNHCR and its implementing partners in Uganda. The rationale for selection had to do with the settlement's status as a 'long-term' post-conflict setting with the stability and structures required for the implementation of SGBV screening and referral protocols. Refugees in this settlement are primarily from the Democratic Republic of Congo (DRC), where violence is noted as a key reason for flight. SGBV was also observed as a concern within their new settlement home in Rwamwanja.

Consultations with UNHCR's Regional Services Centre and UNHCR's Uganda offices (Kampala and Rwamwanja) confirmed that SGBV services provided at health facilities serving refugee populations in the area required strengthening. Specifically, the capacity of providers needed to be strengthened to address the needs of SGBV survivors, and research to provide a better understanding of programming gaps was desired. Routine screening for SGBV in health facility contexts was viewed as being particularly appropriate for implementation and evaluation in Rwamwanja. Although a platform for routine screening for other issues existed for refugees upon their entry into Uganda, SGBV was not a component of this exercise. When fortuitously identified, SGBV cases were referred for further care; however, missed opportunities stemming from the lack of systems and capacity to screen routinely were acknowledged.

Rwamwanja Health Centre and Kyempango Health Centre served as the study sites. Rwamwanja Health Centre is a Level III health facility in the 'Base Camp' of Rwamwanja Settlement. Managed by UNHCR implementing partner, Africa Humanitarian Action (AHA), and serving most of the refugee and host populations in Rwamwanja, the health center is government-owned and staffed by AHA personnel. The health center has qualified health workers who provide primary health care, and trained community health workers residing in Rwamwanja are responsible for health promotion, disease prevention, and referrals to the health center. The health center is staffed by clinical officers, nurses, and a doctor with the capacity to examine sexual violence survivors, collect forensic evidence, and provide treatment to survivors, such as HIV post-exposure prophylaxis. Psychosocial support, legal aid, and the coordination of SGBV survivors' care are handled by the SGBV Response Unit, located in Rwamwanja Health Centre. Given the social support provided by the SGBV Response Unit, Rwamwanja residents are known to present at this location for a variety of non-medical reasons, as well. Consequently, this Unit was also selected as one of the screening sites.

Kyempango Health Centre is a Level II health facility located in the Kyempango zone of Rwamwanja Settlement. Established in 2013, it is a small outpost offering limited outpatient facilities.

# Study Design

Drawing on a descriptive case study design, the study assessed the feasibility of implementing routine SGBV screening protocols in health facility settings in an emergency context. Rwamwanja Health Centre and

Kyempango Health Centre were investigated jointly as a holistic single case study,[14] with service statistics collated from both health facilities. The participating departments from Rwamwanja Health Centre included the Antiretroviral Therapy ('ART') Department, the Maternity Department, the Outpatient Department, and the SGBV Response Unit. As Kyempango Health Centre is a small outpost offering only limited outpatient facilities, this site was included in the study as a single unit.

In addition to the service statistics collated from all participating sites, this case study involved focus group discussions (FGDs) with providers carrying out screening in all sites, and in-depth interviews (IDIs) with survivors identified through screening.

# Intervention Description

A three-pronged intervention was carried out over a five-month period (September 2015 to January 2016) in the participating health facility sites. The intervention involved provider training, provider screening of clients, and provider referral of SGBV-positive clients, conducted within the time period indicated below.

| | Intervention Component | Period of Implementation |
|---|---|---|
| 1. | Provider training to routinely screen for SGBV | September 2015 |
| 2. | Routine screening for SGBV by providers | September 2015 to January 2016 |
| 3. | Provider referral of SGBV-positive clients to SGBV Response Unit | September 2015 to January 2016 |

### Provider training

A total of 32 providers were trained to screen for SGBV via a two-tiered training process. In collaboration with Kenyatta National Hospital, the Population Council conducted an initial training session composed of 17 providers. Following this, AHA staff from the SGBV Response Unit cascaded the training down to an additional 15 providers. Providers were drawn from all participating sites, and mainly included nurses and counselors. The training sessions were guided by a regional training manual designed to facilitate provider screening.[15]

### SGBV screening

Trained providers began implementing SGBV screening protocols in the individual sites in September 2015. The screening questions were to be directed to female clients aged 15 and above. (Service statistics indicate, however, that 2 female clients below the age of 15 were screened.) Each female client aged at least 15 was asked 4-5 questions to pinpoint current experiences of IPV (physical, psychological, and/or sexual) and lifetime experience of non-partner sexual violence (see Appendix for screening tool).

Each site was provided with an SGBV record book to document information on clients that had been identified and referred to the SGBV Response Unit. Additionally, the SGBV Response Unit received a record book to document information on clients who presented for SGBV care following screening. Providers involved in screening were also incentivized through a stipend of approximately USD 3 per day over the life of the screening intervention.

[14] Yin, RK. 2003. Case study research: Design and methods. Thousand Oaks: Sage.
[15] Odongo, O, C Undie, M Mak'anyengo. 2016. Routine screening for intimate partner violence: A guide for trainers. ECSA Health Community, Population Council, and Kenyatta National Hospital.

### Provider referral

Clients were considered SGBV-positive if they answered 'yes' to at least one of the screening questions. Such clients were then referred to the SGBV Response Unit using a referral slip. As far as possible, referred clients were also escorted to the SGBV Response Unit by a provider or by an auxiliary staff member.

## Data Collection

Five health facility sites in Rwamwanja Settlement were selected as a joint 'case' within which findings could be described. Kyempango Health Centre (a small outpost) served as one site, in addition to four sites in Rwamwanja Health Centre (the ART Department, Maternity Department, Outpatient Department, and the SGBV Response Unit). These specific sites were selected in consultation with AHA, based on the organization's estimation of contexts in which providers could confidentially conduct screening.

The study utilized three data collection instruments, namely: two field guides for IDIs with survivors, and one field guide for FGDs with providers. The IDI guides for survivors were translated into *Kiswahili*, a language commonly spoken by the Congolese. Three experienced research assistants (2 female, 1 male) received training on SGBV, the project goals, tools contents, qualitative data collection, collation of service statistics, ethics, and verbatim hand-recording of interviews, for three days.

Borrowing from the data collection procedures of an earlier Population Council study,[16] IDIs were carried out with two categories of survivors: those designated by the study as being 'compliant'—meaning that they were screened, identified as SGBV-positive, and **successfully** referred to the SGBV Response Unit—and those designated as being 'non-compliant'—meaning that they were screened, identified as SGBV-positive, and **unsuccessfully** referred to the SGBV Response Unit. Survivors were only eligible for interview if they were female, aged 15 and above, sought services at any of the study sites, underwent screening, and were referred to the SGBV Response Unit. A total of 46 survivors were interviewed—30 'compliant' survivors and 16 'non-compliant' survivors.

Providers were only eligible to participate in the FGDs if they had participated in screening clients for SGBV in any of the study sites. A total of 5 FGDs (one per site) were conducted with 18 providers.

The study received ethical and research clearance from the National HIV/AIDS Research Committee and the Uganda National Council for Science and Technology in Uganda. In addition, ethical approval was obtained from the Institutional Review Board of the Population Council. Individual, written informed consent was obtained from all participants before conducting the interviews and discussions.

Qualitative data collection took place from October to November 2015, while the collation of service statistics from all departments spanned the entire project period (September 2015 to January 2016).

### In-depth Interviews

The IDIs illuminated survivors' perspectives on the feasibility of routine screening for SGBV. They explored the following issues: perceptions about being screened for SGBV by a provider, the acceptability and importance of routine screening, experiences with the referral process, perspectives on the quality of care and support received at the first point of contact and at the SGBV clinic, and suggestions for improvement of the intervention. 'Non-compliant' survivors in particular were also asked about barriers to referral adherence.

Survivors who had not presented at the SGBV Response Unit two weeks after referral were categorized as 'non-compliant.' Where possible, SGBV Response Unit counselors followed up with such survivors by phone to remind them of the referral, and to introduce the study to them. Those willing to participate in the study were introduced to a research assistant for an IDI.

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[16] Undie, C, MC Maternwoska, M Mak'anyengo, I Askew. 2016. Is routine screening for intimate partner violence feasible in public health care settings in Kenya? *Journal of Interpersonal Violence* 31(2): 282-301.

### Focus Group Discussions

Provider perspectives on the feasibility of SGBV screening were gained through the FGDs, which revolved around perceptions of how screening protocols were working; screening experiences with clients; and suggestions for adjustments to the screening questions or screening/referral process.

### Service Statistics

Service statistics were abstracted from September 2015 to January 2016 to determine trends in the profile of survivors identified, and the number of referrals issued and completed. The service statistics were collated by research assistants via a review of the record books in each department.

## Data Analysis

The IDIs with survivors were conducted and hand-recorded verbatim by the two female research assistants. The hand-recorded notes were subsequently transcribed in MSWord at the end of each interview day. The audiotaped FGDs were conducted by a male research assistant and later transcribed in MSWord.

A content analysis approach was employed for the analysis of the qualitative data. The areas of inquiry found in the field guides were used as thematic codes, in addition to any other issues that emerged repetitively, and that lent insight into the extent to which the intervention was feasible. The content analysis approach drew specifically on 'within-case analysis'[17]—a process in which data from all participating sites combined were reviewed to understand Rwamwanja Health Centre and Kyempango Health Centre as one joint 'case.' The process also involved confirming (or disconfirming) that there were enough meaningful data to support and justify a main theme by identifying its manifestation in each site, and in each respondent category.

Quantitative data derived from the collation of service statistics (from screening tools and record books) were analyzed manually.[18] Feasibility-related issues to be explored (e.g. number of clients screened and number of SGBV survivors identified) were tallied by hand and summarized in a data master sheet to facilitate the analysis of service statistics.

[17] Miles, MB, AM Huberman. 1994. *Qualitative Data Analysis: An Expanded Sourcebook*. Thousand Oaks, CA: Sage.
[18] Hardon, A, C Hodgkin, D Fresle. 2004. How to investigate the use of medicines by consumers. World Health Organization and University of Amsterdam.

# Key Findings

## Survivors demonstrated willingness to disclose SGBV

Survivor willingness to disclose SGBV is regarded as a key signifier of screening feasibility, given various socio-cultural obstacles that would normally hinder such disclosure. A total of 8,462 clients were screened by providers. Of these, 837 (10%) disclosed exposure to some form of SGBV (i.e. current exposure to IPV, or lifetime exposure to non-partner sexual violence) (Table 1).

**Table 1: Service Statistics for Initiating Departments* Combined**

| Total # screened and documented | Total # disclosing SGBV | Total # referred for SGBV care | Total # presenting for SGBV care |
|---|---|---|---|
| 8,462 | 837 | 806 | 512 |
| *ART, Maternity, OPD, SGBV Response Unit, Kyempango Health Centre | | | |

Of the 837 SGBV survivors detected through screening, a third (n=281) specifically disclosed having experienced non-partner sexual violence in their lifetime (Tables 2 and 3), while 84 percent (n=699) disclosed current exposure to IPV (Table 3). Psychological and physical IPV were each at least twice as likely to be disclosed as sexual IPV (Table 2).

Polyvictimization (the experience of multiple kinds of violence at the same time) manifested in two ways within the sample of survivors detected through screening. Firstly, nearly half (45%, or n=313) of all survivors disclosing IPV indicated that they were experiencing more than one form of IPV (physical, psychological, or sexual) simultaneously (Table 3). Secondly, 18 percent (n=128) of those disclosing current experience of IPV also disclosed experiencing non-partner sexual violence in their lifetime (Table 3).

**Table 2: Types of SGBV disclosed by survivors**

| Age | Intimate Partner Violence | | | Non-Partner Sexual Violence |
|---|---|---|---|---|
| | *Physical* | *Psychological* | *Sexual* | |
| Below 15 | 0 | 0 | 0 | 2 |
| 15-19 | 31 | 37 | 16 | 39 |
| 20-24 | 120 | 111 | 50 | 62 |
| 25-29 | 110 | 109 | 56 | 75 |
| 30-34 | 83 | 80 | 32 | 52 |
| 35-39 | 44 | 52 | 27 | 22 |
| 40-44 | 26 | 33 | 16 | 10 |
| 45-49 | 7 | 8 | 5 | 7 |
| 50+ | 9 | 16 | 8 | 12 |
| Totals | 430 | 446 | 210 | 281 |

**Table 3: Summary of Survivor Disclosures**

| | |
|---|---|
| Total number of survivors disclosing IPV | 699 |
| Total number of survivors disclosing more than one type of IPV | 313 |
| Total number of survivors disclosing IPV and non-partner sexual violence | 128 |

The majority of women disclosing both non-partner sexual violence in their lifetime and various forms of IPV currently, were those in the reproductive age range, 20 to 34 years. Although they were the least likely to report SGBV, it is noteworthy that SGBV survivors aged 45 and older were also detected through screening, and that they displayed similar patterns of polyvictimization in the context of IPV, and across the violence forms of IPV and non-partner sexual violence (Table 2).

## Providers achieved high rates of screening and survivor referral

A total of 8,462 clients were screened by providers over a five month period. Out of a total of 837 survivors disclosing some form of SGBV, providers from all participating departments referred 96 percent (n=806) for comprehensive SGBV care (Table 4).

**Table 4: Clients Screened, Identified, and Referred (September 2015 to January 2016)**

| Department | Total # screened | Total # of Survivors Identified | Total # of Survivors Referred | Total # of Survivors Presenting for SGBV Care |
|---|---|---|---|---|
| **ART** | **879** | **97** | **97** | **84** |
| **Kyempango Health Centre** | **780** | **120** | **120** | **73** |
| **Maternity** | **4,042** | **246** | **218** | **123** |
| **Outpatient** | **2,745** | **359** | **356** | **217** |
| **SGBV Response Unit** | **16** | **15** | **15** | **15** |
| **Totals** | **8,462** | **837** | **806** | **512** |

A recommended protocol of the screening intervention involved providers accompanying survivors from the initiating department to the SGBV Response Unit upon disclosure of violence. To promote referral adherence, survivors were to be escorted by screening providers or auxiliary staff, where desired by the survivor and where possible. Descriptions of the referral process by providers indicate that they embraced this procedure:

> I believe [referrals are] working very well. I normally escort the patients personally to the SGBV Response Unit. *FGD with Providers, Outpatient Department*

> It's not a long distance from here up to where you access the SGBV counselors. And due to the fact that we consider confidentiality, I feel comfortable and [survivors] also feel so, believing that when you escort them yourself…that it is serious and they are going to get help.
> *FGD with Providers, ART Department*

> At times, we are helped by our cleaners. When they are free, we give them the clients and they direct them…They escort them up to where the counselors are. *FGD with Providers, Maternity Department*

In addition to the high rates of screening and referral, providers further demonstrated their willingness to implement screening protocols by suggesting that the screening exercise be expanded (to weekends, for example), and even institutionalized within Rwamwanja Health Centre. Moreover, rather than regard the increased workload imposed by screening as burdensome, several providers viewed it as an indication of the value of their work as health care professionals. The following quotations provide further insight:

> [A]nother concern which I have…We are screening during the week days…But I feel we should also add on maybe the weekends. *FGD with Providers, Maternity Department*

> Some [clients] come here just to get treatment. But when they get these extra services, like screening, to release some stress from their family problems, it is so important, and I pray very hard that [screening] should continue because…[i]t is really working.
> *FGD with Providers, ART Department*

> The work[load] has increased…We have received a number of cases which we managed and they have added value to our project and we appreciate that…We used to report seven cases, but last month, we reported 14…The concern is that, after [the project end date], will we continue with the screening? *FGD with Providers, SGBV Response Unit*

## Survivors achieved modest rates of referral adherence

Of the survivors referred for SGBV care (n=806), 63 percent were documented as adhering to the referral by presenting at the SGBV Response Unit for further care. Of note is that this rate of referral adherence is 23 percentage points higher than the adherence rate achieved in a similar study among the general population.[19] Although survivor adherence to SGBV referrals was moderate compared to provider referral rates, this was not due to survivor reticence toward receiving SGBV services. (Indeed, all 'non-compliant' survivor interviewees willingly received services at the SGBV Response Unit following their interviews.) As depicted in Table 5, systemic issues at the health facilities accounted for the largest proportion of non-adherent cases.

**Table 5: Reasons for not presenting for/receiving SGBV care after violence disclosure ('non-compliant' survivors)**

| | | |
|---|---|---|
| | **Reason** | **# of survivors citing reason** |
| **Systemic Issues (Health Facility)** | **Unavailability of counselors; Poor referral; Services took too long to access at initiating department** | **9** |
| **External Barriers** | **Distance/Lack of transportation money; Was too ill** | **5** |
| **Internal Barriers** | **Was afraid abuser would be arrested; Forgot** | **2** |

For instance, a third of the 'non-compliant' survivors who did not complete their referrals due to systemic issues were actually clients who sought services at Kyempango Health Centre. As the latter does not have its own SGBV Response Unit, counselors were eventually posted to this site once a week, and survivors would receive psychosocial services by appointment, rather than on the same day. At the onset of the intervention, however, survivors identified at Kyempango Health Centre were referred to Rwamwanja Health Centre, which is distantly-located. Most survivors (4 out of the 5) citing external barriers happened to have been screened at Kyempango Health Centre, and then referred to Rwamwanja Health Centre.

## Survivor satisfaction with SGBV services was high

Overwhelmingly, survivors that sought SGBV care following screening and referral expressed deep satisfaction with the services received. In addition to the psychological relief brought about by disclosing and discussing SGBV experiences, many survivors indicated that the act of screening in itself helped enhance understanding of SGBV as a health issue of concern, and to destigmatize conversations about it. The positive attitudes of providers were also highlighted by respondents as a key facet that made seeking SGBV care worthwhile. The following quotations are representative of survivors' voices across the participating departments:

> [Through screening], you are also able to talk about personal issues that nobody bothers to ask you about because of the beliefs we have; we think it's very normal to be beaten. So, when I was asked the questions by the doctor, it was an eye-opener—especially when I sat down with the counselor and told her what I have been going through with this man. She took her time with me, and I am telling you, today, I'm going home a different person…I will also be coming for my antenatal care appointments and counseling services since you can never find a program like this anywhere else in the whole of Rwamwanja. This is a very good thing to have started in Rwamwanja, since many women here are suffering. They are being beaten and sleeping outside in the cold like me, and this will help them know there are people who care about us…When I came here, my heart was like bleeding and I was so hurt. When I was asked questions about violence, I got a chance to express myself, and now I am very relieved, since this is the first time I ever talked about it. I had no option but to go [to the SGBV Response Unit]: I felt I needed help, and after counseling, it was such a big relief. *IDI with 'Compliant' Survivor, Maternity Department*

[19] Undie, C, MC Maternwoska, M Mak'anyengo, I Askew. 2013. Feasibility of routine screening for intimate partner violence feasible in public health care settings in Kenya. Population Council: Nairobi, Kenya.

I was raped in DRC six years ago and I have never talked to anyone about it. At the time that I was raped, I only used some traditional medicine in secrecy without disclosing to my husband that I was raped because I didn't want him to know. When the counselor asked me those questions, it was like opening an old wound. It was like a weight had been lifted off my back…I only had an opportunity to talk about it today and I am relieved because I have been carrying this weight for six years.

*IDI with 'Compliant' Survivor, SGBV Response Unit*

[Y]ou can't go telling people you have a problem unless they ask you. At times, you don't even know it's an issue until you start talking about it. I have never told anybody about my rape since no one has ever asked me about it. Today, I had a chance for the first time to pour it out and cry about this terrible incident. I am fine now…I was very happy with the services and care that I got from the counselor…This was my first time of pouring out what has been in my heart for a very long time—something I have never talked to anybody about. It was such a big relief.

*IDI with 'Compliant' Survivor, Maternity Department*

I came to see the counselor because I realized after being asked questions about rape, it was time for me to talk about it. I have never thought I would ever tell anybody about it after my husband found out, and started to insult me, and I decided to keep it myself. Today, talking about it helped me a lot…[I]t was very important because I had started hating the baby I am carrying, but I have been helped, and the baby has no problem at all. I have been going through so much stress, but today, I just feel so much better than all the days I have lived with this pregnancy.

*IDI with 'Compliant' Survivor, Outpatient Department*

[I] was happy when they sent me here [SGBV Response Unit]. My head was in pain and I was bleeding badly. I thought they asked me [the screening questions] because they suspected somebody had beaten me and cut my face. They addressed this issue very well…You can never know what people are going through unless you talk to them…Honestly I was very happy…[The provider] was very warm to me and she talked to me very nicely. She listened to my story—how my husband cut my head with a machete, which left me in very bad pain. She listened to everything I said without judging me. It just felt good to talk to someone who was willing to listen.

*IDI with 'Compliant' Survivor, Outpatient Department*

## Provider satisfaction with implementing screening protocols was high

Evidence of providers' high satisfaction with implementing screening protocols emerged from the FGDs in several ways. For instance, many provider narratives of satisfaction were dedicated to the discussion of the utility of screening for not only detecting SGBV survivors, but also for the proper diagnosis of clients. Thus, provider satisfaction was often linked to the ability to enhance quality of care for clients through screening, as the following excerpts demonstrate:

I worked on a woman who complained of lower abdominal pains and peri-vaginal bleeding for a long time…I personally screened her here in Rwamwanja. I found out that six men raped her three years ago and her uterus prolapsed. I referred her for SGBV counseling and, later, for doctor review. She was taken to Fort Portal [regional referral hospital] and later referred to Kampala. She got help since she explained to me that her issue was because of rape, and after examining further, I found out that she had a prolapsed uterus…At first, I [had] just treated pelvic inflammatory disease without knowing that she had deeper things that she was not able to tell me.

*FGD with Providers, Outpatient Department*

[Screening] takes some time…but the truth is, time taken [today] while you are assisting someone will save your time tomorrow, because you will get the correct diagnosis. If you don't take time, you will [prescribe] Panadol, and tomorrow, the client will come back because the problem was not what you treated—it was psychological. So, it is better to take those two minutes [to] address…the real problem. Then, you will save more time.

*FGD with Providers, ART Department*

We realized that [there are] so many [SGBV] cases…we had not been [identifying] and noticing…because we had not been screening. But the screening has brought on board all the cases…and [clients] are really opening up…[O]ur patients, some of them come here when they are not sick, but just psychologically tortured, and [since] we were not screening, we wouldn't identify such a case. And then you find that [a client] is not sick, but has been tortured at home, being mismanaged by the husband. You find that she is coming [to Rwamwanja Health Centre]…So the screening has been important to identify such cases…and becomes a [kind of] 'medicine' for the problem.

*FGD with Providers, Maternity Department*

Providers perceived that the screening process had been instrumental in improving provider-client relationships, given the positive atmosphere that providers were obligated to create for screening. The perception that screening contributed to fostering friendlier relationships with clients also had a positive impact on provider satisfaction with implementing screening protocols:

> [The screening process] has created good friendship with our clients since we are so friendly and confidential. For instance, the lady I screened yesterday was so happy that she referred her colleague directly to me. She said she was going to send her friends over to me to get help and she did. *FGD with Providers, Outpatient Department*

> Really, screening has helped. In the little time we have done the screening, we have seen that there is a positive thing which is coming out: Me, I met a mother [who] was not breastfeeding [her] baby, and when I interacted with her, I went in and screened [her]. [T]he in-law…forced her into sex, and she ended up delivering that baby, but the in-law was not caring for the child, and neither was the husband caring for her…So this mother decided to abandon the child [and] not to breastfeed the child. By the time I saw the child, the child was already malnourished. We enrolled the child [into nutritional care] and I took [the survivor] for counseling…After counseling, the mother accepted to breastfeed the child…and she is appreciative. *FGD with Providers, Maternity Department*

> [Clients'] complaints have been minimized because they have been counseled. Most of them normally have severe headaches because they have been traumatized with family issues. Since this program started, they appreciate that they are doing well because we ask them these hidden questions that we didn't use to ask them before. *FGD with Providers, Kyempango Health Centre*

> [When] you ask someone [the screening] questions, [the person] gains confidence. Like, someone thinks, 'This health worker cares about me. He even wants to know about my home, my problems.' Sometimes, [the client] even becomes your friend because…they know you care about them. The client even opens up about other things which you don't ask about. They talk about [every] other thing, meaning that you have gone an extra mile, making someone to open up.
> *FGD with Providers, ART Department*

## Survivor and provider recommendations demonstrated the high acceptability of the intervention

The acceptability of an intervention—that is, the manner in which target beneficiaries and intervention implementers react to an intervention—represents a key dimension of its feasibility.[20]In addition to reacting to the screening intervention by disclosing SGBV and seeking care, 'compliant' and 'non-compliant' survivors alike reacted by strongly recommending a holistic approach to addressing SGBV. Screening was seen as a vital entry-point into the context of violence; however, the screening exercise led survivors and providers to conceive other related initiatives which would need to be implemented alongside screening in order to comprehensively address SGBV. Four major themes emerged from respondents' recommendations, namely, the need for: male involvement, community mobilization, integrated services, and responses to unintended pregnancy due to rape.

### Male involvement

Overwhelmingly, respondents highlighted the need to engage men to enhance the SGBV screening process in Rwamwanja Settlement. Narratives of male involvement were associated with the strongly perceived utility of such involvement for SGBV prevention and response. Survivors stressed that male partners in Rwamwanja Settlement required counseling, too, to stem the perpetration of violence.

> Why is it that you only have the program for women when men are the ones involved in [perpetrating] violence against women?…It is very important to involve men in this program as well because they are the cause of most of the violence in our community. This will give them an opportunity to learn that violence is wrong, because most of them don't know the consequences, and they think it is very normal to beat a woman. Giving them this kind of exposure may be very helpful.
> *IDI with 'Compliant' Survivor, Maternity Department*

[20] Bowen, DJ et al. 2009. How we design feasibility studies. *American Journal of Preventive Medicine* 36(5): 452-457.

> [M]en should be talked to as well, since counseling women alone may not help much until we get to the root of the problem—and that is men. When you go back [home], you will find the same man is waiting for you, [drunk] with alcohol. *IDI with 'Compliant' Survivor, Outpatient Department*

> Men should also be counseled because counseling women alone doesn't make any sense when men are the perpetrators. The women will be given counseling services but still go back to this abusive man at the end of the day. So I think it's better to start with men.
> *IDI with 'Non-Compliant' Survivor, Maternity Department*

> The counselors should come to the community and offer services to everybody, not only to women. This will enhance everyone's knowledge, including that of the abusive men we are living with.
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

In addition to perpetrator-focused counseling, many survivors who received counseling proactively expressed the desire to return to the SGBV Response Unit specifically for couples' counseling with their male partners:

> I got very good services today and I feel better than when I first arrived. I will also convince [my partner] that there is a program that has come up for couples and ask him if we can go for counseling. It is very important for this man to get the same services…He needs counseling so that he can stop beating me when I am not in the mood to have sex with him…I would like to know if we could have the same program for men. *IDI with 'Compliant' Survivor, Outpatient Department*

> I also want to see if my husband can agree for us to come for counseling together.
> *IDI with 'Compliant' Survivor, Outpatient Department*

> Can I be assisted so that my husband and I can live peacefully together at home? He is always throwing me out, and sometimes I have nowhere to go to.
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> I am coming back tomorrow with my husband for STI treatment. The doctor said it will be of no use getting treatment alone. I hope he will agree to come because he is the cause of all this. This will give us an opportunity to have counseling together and see if we can live [peacefully].
> *IDI with 'Compliant' Survivor, Outpatient Department*

Providers also observed the gap in response created by the absence of male engagement, and reiterated survivors' desire for couples counseling above other responses:

> Talking to one person [solely, instead of to both parties]—Now, I'm a woman…My husband is beating me daily…You have talked to me, the one who is being beaten. I go back [home]; they beat me [again]…[W]e should talk…to these husbands [as well.] *FGD with Providers, ART Department*

> [W]e ask the client, 'How do you want us to help you? Do you want this man arrested and to proceed to [the Legal Department]?' The client will say, 'No. I want you to counsel my husband to stop this habit so we can get back together.' *FGD with Providers, SGBV Response Unit*

Interestingly, male involvement narratives also centered on the need for the routine screening of men as an SGBV prevention and response measure. Survivors were of the opinion that adapting the screening questions for the detection of and response to male perpetrators was a needed complementary intervention:

> Now that you are asking women these questions about violence, are you asking men the same questions, or are their questions different? … I think it is important to have men's views towards violence. Like, you can be asking them: 'Have you ever beaten your wife or insulted her?' (*IDI with 'Compliant' Survivor, Maternity Department*)

> How will this message reach our men as well?…I think the same questions about violence can be asked to men in order to capture if they have ever beaten their spouse or raped someone. If they have ever done so, they can be referred for counseling to ensure that they stop this behavior. And if they don't stop beating women, then let the law deal with them. I think when they hear this, they might stop. *IDI with 'Non-Compliant' Survivor, ART Department*

> Men should also be asked the questions about violence like: 'Have you ever beaten your wife or raped anybody?' By doing that, those who have…can be given counseling and this will make the whole community be at same level. *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> I think we should start the same screening for men…to address the violence issues. We should target more men on this and see if we can have change in this community.
> *IDI with 'Compliant' Survivor, Outpatient Department*

### Community mobilization

Equally pervasive in survivor accounts were narratives on the importance of community mobilization, which was seen as critical for several reasons: First, some survivors were of the opinion that men would be unlikely to present at health facilities. Community activities were, therefore, seen as the best way to reach them:

> How can this man [my husband] be reached and get help?…I think this program should be in two phases: one for women and the other for men. For men, it should be a discussion group among themselves, because if you tell them to come for counseling, they will never reach here [the health facility]. They believe they are always right and they don't need any help.
>
> *IDI with 'Compliant' Survivor, Outpatient Department*

> I am wondering if you can send a counselor to come and talk to my husband as well because he may not come with me here [health facility]. Do you think it is possible?
>
> *IDI with 'Compliant' Survivor, Outpatient Department*

> The issue should not be addressed in the hospital alone, but also at the community level, because this is where you will find the perpetrators and the victims as well.
>
> *IDI with 'Compliant' Survivor, Outpatient Department*

Primarily, however, the vast majority of survivors advocated for community mobilization because they understood SGBV to be a complex issue much larger than any screened individual and widespread in the community. Despite this, they pointed to a culture of communal silence around violence, and a lack of awareness of its consequences and available services for addressing it in their communities:

> The only question I would ask is: How can this program be extended to the community? Because so many people there are suffering and don't know about it.
>
> *IDI with 'Compliant' Survivor, Outpatient Department*

> Is it possible to address sexual violence in our community like it is happening in the health facility?…I think it is very important to discuss the violence issues in our community since this will be an eye-opener to many who have such experiences but don't talk about it. Children are raped and they keep quiet. Men will also have a chance to learn more about violence issues, and this will help their morals. Maybe they don't know it is wrong to rape women and beat them…and they think it is normal.
>
> *IDI with 'Compliant' Survivor, Outpatient Department*

> How can women who are experiencing violence like me gain peace in their families and make sure the men get information on stopping violence?…This program should be brought to the community so that even men who are the cause of violence can benefit from it. It will also help the youth to get information and also grow up knowing that violence and rape is something that is not accepted in the community, which would be very helpful to the whole of Rwamwanja community.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> [W]e need to sensitize them more…that there is screening which is going on…and there is a solution now for them…So that, maybe with time, people can know…[W]e can move around…bring [introduce] the package of SGBV screening…[to] the whole community.
>
> *FGD with Providers, Maternity Department*

Of note is that survivors also repeatedly pointed out that more counselors would be needed to support the proposed community-level efforts.

### Integrated SGBV services

Some survivors raised the need for SGBV service integration at individual sites, and the fact that every survivor that expressed this concern was 'non-compliant' underscores the acceptability of referrals, provided they are in a more convenient manner. Importantly, most survivors who alluded to integration sought services at Kyempango Health Centre—the site at which SGBV services were least accessible.

> A counselor should always be available in any health facility, and it will be very easy for every woman to be able to access the counseling services whenever need arises.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> The best thing is to make sure the counselor comes as has been scheduled because some of us don't have transportation to go all the way to Rwamwanja Health Centre for the counseling services.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> It is important to have a counselor at Kyempango Health Centre every day so that whenever you have an issue, the counselor can attend to you immediately. This will make this program very effective and every woman will be able to get counseling services.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> I would request the health facility to come up with another strategy in which counseling services are delivered in every department to avoid a lot of walking within the facility. This will also avoid people noticing when one is going for SGBV services, as it a very secretive issue in this community.
>
> *IDI with 'Non-Compliant' Survivor, ART Department*

The need for the integration of SGBV services into various departments was also alluded to by providers:

> Maybe if all services could in the same station…Treatment and everything done from the same place instead of [making] clients to come here again… *FGD with Providers, SGBV Response Unit*

> [T]hey should give us a counselor specifically in the Maternity [department], like mostly on those big clinic days…[On] antenatal days, we always have very many clients…So, if we can get a counselor down at the Maternity to assist…it would help. *FGD with Providers, Maternity Department*

Related to the need to offer SGBV services more conveniently was the need for additional counselors to address the increased numbers of survivors seeking SGBV services as a result of the screening intervention. While the need for more counselors at the community level was observed, a similar need at the health facility level was noted by survivors and providers alike:

> They should also hire more counselors in the facility, because after having a long day standing at the health center, it is not easy to go wait again for counseling. When the counselors are many, everybody will get a chance to receive counseling services.
>
> *IDI with 'Non-Compliant' Survivor, Outpatient Department*

> [Some] clients…delay [at the SGBV Response Unit]. They have already delayed [at the ART Department], then they also go there [and] delay…sometimes it demotivates them…[C]ounseling does not need hurrying…I would suggest…if we had a way of increasing the counselors at the SGBV [Response Unit], then it would make the service better. *FGD with Providers, ART Department*

### Responses to rape-related pregnancy

Unintended pregnancy as a consequence of rape is not a new phenomenon in emergency settings,[21] and recent evidence from two Rwamwanja Settlement villages indicates that nearly half (46%) of female household heads reported experiencing non-partner sexual violence.[22] Of these, 56 percent reported ever getting pregnant as a result of such violence.

A number of survivors disclosed rape-related pregnancy during their interviews. Their concerns about how to handle unintended pregnancy due to rape, and how to cope with its psychological and financial consequences, demonstrate the need for unique RH and psychosocial responses for this population:

> I wanted to know what to do with this pregnancy. I have [STIs], this man has been forcing me to have sex…There are just many problems. *IDI with 'Compliant' Survivor, Outpatient Department*

> How does one erase memories of rape from their mind? Because whenever I see this baby, I remember [the rape incident], and I feel like killing the baby.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> What should I do if I run into the man who made me pregnant?…I would…[like to] involve the community leaders to make sure he doesn't do to anyone what he did to me.
>
> *IDI with 'Non-Compliant' Survivor, Kyempango Health Centre*

> I am currently pregnant due to rape, and now I am wondering who will take care of me and the baby once I give birth…Now that I am pregnant, how will you assist me after delivery?
>
> *IDI with 'Non-Compliant' Survivor, Maternity Department*

> Now that I am pregnant, I wanted to know how I can get support to come for services.
>
> *IDI with 'Compliant' Survivor, Maternity Department*

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[21] de Bruyn, M. 2003. Violence, pregnancy and abortion: Issues of women's rights and public health. Ipas: North Carolina, USA.

[22] Undie, C., Birungi, H. et al. 2016. Effectiveness of a community-based SGBV response model in post-conflict settings in Uganda: Tesing the Zero Tolerance Village Alliance Model. Population Council: Nairobi, Kenya.

# Conclusion

This study assessed the feasibility of implementing SGBV screening and referral protocols in health facility settings within emergency contexts in Uganda. The screening intervention concerned was adapted from an initiative previously implemented among the general population. Specific dimensions of feasibility were assessed, including provider capacity and willingness to screen for SGBV; survivor willingness to disclose SGBV; provider referral and survivor referral adherence; provider and survivor satisfaction with screening and referral protocols; and provider and survivor reactions to these protocols which underscore their acceptability.

Taken together, the study findings along these feasibility dimensions suggest that routine screening for SGBV can be carried out in emergency settings. Indeed, provider screening and referral rates (and survivor disclosure and referral adherence rates) were notably higher in the study's emergency context than among the general population under the earlier study. The relatively higher screening, disclosure, referral, and referral adherence rates under the current study reveal a real need and demand for SGBV screening in emergency settings. Moreover, narratives of acceptability and satisfaction in regard to routine SGBV screening from provider and survivor perspectives further emphasize the feasibility of the intervention.

The study concludes that routine screening for SGBV can be done in emergency settings and essentially creates its own demand once it is introduced into health facilities. Evidence from this study also demonstrates that SGBV screening, useful as it is from the perspective of survivors and providers, is merely an entry-point into the much wider context of violence, and recommendations from study participants on how to navigate that context are further indications of the intervention's acceptability and overall feasibility. The intervention's limitations mainly revolved around the issue of survivor adherence to referrals, which was relatively lower than provider referral rates. Nonetheless, the systemic issues within health facilities, which accounted for most of the referral adherence concerns, were far from insurmountable. Recommendations for resolving such issues, and general recommendations based on overall findings from the study, are presented in the next section.

# Recommendations

Findings from the study lead to a number of key recommendations for strengthening SGBV screening protocols, and for addressing gaps in SGBV programming more broadly in Rwamwanja Settlement specifically:

1. **Reserve the implementation of screening and referral protocols for health facility sites where SGBV care is co-located.**

   Despite the feasibility of routine screening for SGBV, screening in all health facility contexts in Rwamwanja is not recommended. This exercise should be reserved for health facilities that have SGBV response services on-site to ensure optimal quality of care for survivors. Alternatively, SGBV service integration could be fostered by ensuring that qualified trauma counselors are stationed at each screening site. Such measures will help to ensure optimum referral adherence rates and greater access to comprehensive SGBV care.

2. **Integrate an SGBV-informed approach into health services in general.**

   To enhance quality of care, the links between SGBV and health in general must be clarified in the context of health facilities. The majority of survivors disclosing various forms of SGBV and polyvictimization were in the reproductive age range of 20 to 34 years. In emergency contexts where the scale of SGBV is likely to be high, it would be important to integrate SGBV responses into reproductive health care particularly, and into general health service delivery, where possible. SGBV was found to be a reality for older women as well in this emergency setting. Additionally, rape-related pregnancy is a reality that must be properly addressed. Health services in general (including for children and men) in this emergency setting must integrate an SGBV-informed approach.

3. **Incorporate, and enhance training for, more trauma counselors in the health facility context.**

   Given the increased demand for psychosocial support brought about by screening, incorporating additional trauma counselors into screening sites in the Rwamwanja Settlement health system is critical. Training curricula for counselors in general must also be enhanced to attend to the SGBV realities in this emergency context. These realities include:

   - the prevalence of physical IPV in Rwamwanja Settlement (which is more prevalent than sexual IPV, but plausibly has less sophisticated responses);
   - the prevalent phenomenon of polyvictimization (which, in Rwamwanja Settlement, involves not only various kinds of IPV experienced simultaneously, but also IPV and non-partner violence experienced at the same time);
   - the need and demand for psychological counseling for perpetrating males (as a prevention and response measure);
   - the need and demand for couples (marital) counseling with an SGBV focus
   - the need and demand for appropriate psychosocial responses to rape-related pregnancy

   While counselors in Rwamwanja Settlement have proactively developed responses for addressing a few of these issues (e.g. the need and demand for couples counseling with an SGBV focus), these responses are informally devised and implemented, and need to be formalized through the development of service delivery protocols and training.

4. **Adapt and test the SGBV screening intervention for the detection of and response to male perpetrators.**

   A refugee-initiated, innovative intervention such as this could greatly enhance efforts to comprehensively address SGBV in emergency settings—particularly, if complemented by routine SGBV screening for women, and coupled with referrals for psychosocial support.

# Appendix: Screening Tool

**Screening Tool for Sexual and Gender-Based Violence (SGBV)**

**SGBV screening will be conducted by making the following statement and asking the questions below:**

Many people do not realize that violence can lead to all kinds of health problems. Because violence is so common in the lives of many women and girls, and because there is help available at Rwamwanja Health Center (RHC) for women being abused, we now ask female patients about their experiences with violence. Please be assured that your answers to these questions will be kept strictly confidential:

1. Are you currently in an intimate relationship with a person (e.g., husband, boyfriend/man friend) who physically hurts you? **Yes __ No __**

2. Are you currently in an intimate relationship with a person (e.g., husband, boyfriend/man friend) who threatens, frightens, or insults you, or treats you badly? **Yes __ No __**

3. Are you currently in an intimate relationship with a person (e.g., husband, boyfriend/man friend) who forces you to participate in sexual activities that make you feel uncomfortable? **Yes __ No __**

4. Have you ever been forced to have sex with someone that you were **NOT** in an intimate relationship with (i.e., not your husband, not your boyfriend/man friend)? **Yes __ No __**

    a. If '**YES**,' did this happen within the last six months?
    **Yes __ No __**

**[Note to provider: If one or more 'yes' options are ticked, REFER client for further SGBV care if they indicate they have never been referred before.]**

**DATE OF REFERRAL: Month _____ Day _____ Year _____**
**[Once a referral has been given, do not ask this client these questions again].**

Date: ____ Age: ____ Registration ID: _____ Household ID#: _____Personal Phone#: _____

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