

Impacts of COVID-19 on Gender-Based Violence (GBV) and Sexual and Reproductive Health and Rights (SRHR) Programs and Services

“De-prioritization of GBV/SRHR services and trivialization of GBV by political leadership is having devastating consequences for women and girls.”
–Local NGO

BACKGROUND

The Government of Uganda’s lockdown to curb the spread of COVID-19 banned all public and private transport, closed schools and markets, and mandated a country-wide curfew. From the onset of the pandemic, the government trivialized growing rates of GBV and did not recognize the entirety of SRHR services as essential, disrupting service delivery systems and threatening the wellbeing of women and girls.

Researchers at Columbia University and Makerere University¹ interviewed 27 GBV and SRHR service providers and other stakeholders between July and September 2020 to understand how restrictive policies to contain COVID-19 and de-prioritization of GBV and SRHR services affected critical GBV/SRHR services.

KEY FINDINGS FROM STAKEHOLDERS & FRONTLINE SERVICE PROVIDERS

GBV WORSENERD AS SERVICES WERE DISRUPTED

According to service providers, reports of GBV increased in the initial months of lockdown. Service providers attributed this increase in GBV cases to women and girls’ prolonged confinement with abusers and pandemic financial stressors. The government did not allocate the Ministry of Gender funding in the initial COVID-19 response plan, failing to support an already fragile system of GBV prevention and response. The government closed the court system to all cases except capital offenses and disruptions of medical services and referral services made prosecution of perpetrators of GBV difficult. The government lockdown also delayed GBV-related legislation.

TRANSPORTATION RESTRICTIONS DISRUPTED MATERNAL HEALTH SERVICES

The government’s initial ban on *boda bodas*, a critical mode of travel, and women’s fears of breaking curfew kept expectant mothers from reaching health facilities, increasing the need to deliver at home despite potential complications. When the government relaxed restrictions, public transport costs increased to 5 times the normal price. Skilled hospital staff were also scarce as many had been moved to COVID-19 response teams. Accessing healthcare was quite difficult, especially for those in rural areas and pregnant women. Health providers had difficulty reaching patients for in person follow up due to delays in government-issued travel stickers.

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KEY FINDINGS FROM STAKEHOLDERS & FRONTLINE SERVICE PROVIDERS (continued)

VULNERABILITIES EXACERBATED AMONG AT-RISK POPULATIONS

Government imposed curfews and school closures cut adolescents from their social networks, halting access to sexuality education and youth-friendly family planning services and exposing them to increased risk for teenage pregnancy. Rising food insecurity contributed to an increase in child marriage and unintended pregnancy as some teens resorted to transactional sex to meet basic needs. Most HIV/AIDS services remained open, but access proved difficult. In the first two months of lockdown, there was a 30% decrease in HIV-positive people picking up ARVs. With the closure of informal businesses, sex workers lost jobs, homes, transportation, and urban refugees faced the loss of an informal source of income. Those with disabilities faced further marginalization, stigma, and obstacles in receiving health information and services without public transportation.

"We used to have [HIV/AIDS] outreaches for clients at the hotspots. However, most of the hotspots were closed. The transport system was closed... because of this lockdown, some mothers delivered HIV positive babies, because they could not come to the facility to pick their drug refills."

NGO/SERVICE PROVIDER INNOVATIONS SUSTAINED SERVICES

There is no "one stop shop" for GBV and SRHR services in Uganda, making referral systems and collaboration between organizations crucial. NGOs transitioned to Zoom, WhatsApp, or Skype to communicate and coordinate services. Use of toll-free lines increased and, when possible, NGOs created their own mobile apps to continue service provision. The app *SafePal* was developed for confidentially reporting instances of GBV; the *Puliida Wo* app was created to connect GBV survivors with health, legal, and psychosocial support. However, technology-based solutions benefited only those with internet availability and smartphones. Implementing partners used mobile clinics to provide SRHR services directly to hard-to-reach groups.

WAYS FORWARD

Uganda's government and donors should earmark funds for comprehensive GBV and SRHR services in all emergency response plans and support greater leadership roles for GBV and SRHR service providers in policy design and implementation. At a minimum, these plans should

- ❖ specify what these services include and who is responsible at all stages of the referral and care chain
- ❖ anticipate and mitigate the impact of stay-at-home orders on SRHR services and GBV prevention and response
- ❖ address the needs of hard-to-reach and stigmatized people such as those in rural areas or without internet access, adolescents, sex workers, refugees, migrants, LGBTQI people, and people with disabilities
- ❖ engage GBV and SRHR service providers, civil society networks, and community-based organizations in plan design, build on their innovations, and strengthen their ability to safely deliver services at the community level, coordinate with other parts of the referral and care chain, and monitor and adjust to emerging opportunities and constraints

Donors and financial institutions supporting Uganda should improve transparency and accountability by earmarking longer term, flexible funding for GBV and SRHR and publishing timely reporting on disaggregated funding amounts, recipients, and impact indicators.