Prevalence and Forms of Sexual Violence Among Women Seeking HIV Services At Selected Health Facilities in Buhweju District, Southwestern Uganda

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Abstract

Background: Sexual violence is a global health concern affecting more than a third of women especially those in low and middle income countries. HIV is one of the consequences of sexual violence but it can also be a risk factor. Different forms and contexts of sexual violence exist and have a negative impact on the psychological wellbeing and health care seeking behaviour and of the victims and their families. This study determined the prevalence and forms of sexual violence among women seeking HIV services at selected health facilities in Buhweju district, southwestern Uganda.

Methods: This was a cross-sectional study among 324 HIV positive women in four health facilities in Buhweju district, southwestern Uganda. We used a researcher administered questionnaire to collect data on sociodemographic characteristics, burden and forms of sexual violence, services sought by the victims and sexual violence screening by health workers. Data were analyzed with Chi square and logistic regression using SPSS version 20 at 95% level of significance

Results: A total of 324 women participated in the study with a mean age of 35.05 ± 12.212 years and majority had primary level of education. The prevalence of sexual violence among the study participants was 32.7% (106/324). The most common forms of sexual violence were sexual humiliation, forced genital touching and insertion of an object into genitalia. Husbands of the victims were the most common perpetrators, less than a quarter of the victims of sexual violence disclosed the incidents and only 15% of the victims sought medical help. The common medical help sought included post-exposure prophylaxis (4.9%), HIV test (9.3%) and emergency contraception (5.6%). Being married (p = 0.035, 95%CI 0.069-0.905) was protective against sexual violence.

Conclusion and recommendation: A third of HIV women seeking care from health facilities in Buhweju district experience sexual violence, more than three quarters of the victims do not disclose the incidents to other people and very few seek medical help. The most common forms of sexual violence include sexual humiliation, forced genital touching and insertion of an object into genitalia.

Introduction

Sexual violence is a public health concern with a global prevalence of 35.6% [1]. In Sub-Saharan Africa, about 44% women experience intimate partner violence and 18.8% is attributed to sexual violence alone [2]. In Uganda, more than 22% women aged 15–49 report to have experienced sexual violence at some point in their lives compared to less than 8% men [3]. The World Health organization (WHO) defines sexual violence as ‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any other person regardless of their relationship to the victim, in any setting, including but not limited to home and work [4]. Different forms and contexts of sexual violence include rape; unwanted sexual advances or sexual harassment including demanding sex in return for favors; sexual abuse of children, forced marriage; denial of the right to use contraception; forced abortion and forced prostitution [4]. Although

they may not disclose the event itself, victims of sexual violence may seek medical help [5, 6] and the health workers are critical in recognizing and responding to the victim's needs [7]. Sexual violence can directly lead to HIV infection due to the trauma involved that may increase the risk of transmission [8, 9]. Therefore, research about association of sexual violence and HIV/AIDs is important as it can shift the practice priorities and ensure victims of sexual violence can receive comprehensive services.

Sexual violence has been highly associated with HIV infection and if this problem is not well mitigated, it may negatively affect the mental health of the affected women. Although HIV services in Uganda have improved over the years there is limited evidence that routine screening for sexual violence is included in the service package. This study aimed to determine the prevalence and forms of sexual violence among women seeking HIV services at selected health facilities in Buhweju district, southwestern Uganda.

Methods

Study design

This was a cross sectional study using a researcher administered questionnaire to collect data on sociodemographic characteristics, experiences and forms of sexual violence, services sought by the victims and sexual violence screening by health workers. The data were corrected in March and April, 2021.

Study setting

The study was carried out at the antiretroviral therapy clinics in the selected health facilities (Nsiika HC IV, Karungu HC III, Bihanga HC III and Burere HC III) in Buhweju district, southwestern Uganda. The district is found in Southwestern Uganda about 70.7Km northwest of Mbarara city and the main economic activity in the area is agriculture with tea and coffee as the major cash crops (UBOS, 2017). The district has a population of 144,100 people with 51.1% of them being women. Total estimated HIV population is 2994 with 1796 being women. Buhweju district is a "hard-to-reach" district associated with bad terrain, "sharp rolling hills" and has poor road infrastructure that makes it inaccessible during rainy seasons. This may hinder access to the services available for victims of sexual violence.

Study population

The study was conducted among 324 women aged 15 years or older seeking HIV services at selected health centers in Buhweju district.

Data Collection Procedure

We used a researcher administered questionnaire. Questions about sexual abuse were adapted from the Norvold Abuse Questionnaire (NorAQ), a tool with good reliability and validity [10]. The questionnaire was structured into two sections; socio-demographics and questions about sexual violence and services to

victims of sexual violence. The participants were selected using consecutive sampling on the specific days when they attended the HIV services. They were approached and given information about what the study was about and were allowed to ask questions. Those who accepted to participate in the study signed the consent forms before the research assistants administered the questionnaire. After the interaction, the participants were given UGX 5000 as transport refund.

Data Management And Analysis

After data collection, questionnaires were kept in box files and cross-checked for completeness. Data were then entered into a google sheet using a google form programmed not allow progression if specific information was not entered. Out of range and missing values were omitted at data analysis. Using SPSS, categorical variables were analyzed using Chi-square and logistic regression at 95% level of confidence. Model goodness of fitness was tested using the Hosmer-Lemeshow test at $p > 0.05$.

Results

Participant characteristics

A total of 324 participants completed the study tools, response rate, 85.5% (324/379). Mean age was 35.05 ± 12.212 years; the age range was 18–76 years and the median age was 32 years. Majority (76.2%) of the participants had primary level of education (Table 1).

Table 1
Sociodemographic characteristics of 324 HIV positive women at health facilities in Buhweju district, southwestern Uganda

Variable	Description	Frequency N (324)	Percentage
Age (years)			
	18–30 yrs	146	45.1
	31–59 yrs	162	50.0
	60 + yrs	16	4.9
Marital status			
	Single	28	8.6
	Married	223	68.8
	Widowed	43	13.3
	Divorced	30	9.3
Education			
	No formal education	11	3.4
	Primary	247	67.2
	Secondary	60	18.5
	Tertiary	6	1.9
Employment			
	Business/Self-employed	48	14.8
	Employed	13	4.0
	Unemployed	36	11.1
	Farmer/Peasant	227	70.1
Distance to Health Facility			
	1Km	38	11.7
	3Km	159	49.1
	5Km	99	30.6
	More than 5Km	28	8.6

Prevalence of sexual violence among HIV positive women in Buhweju district

The prevalence of sexual violence among the study participants was 32.7% (106/324). Sexual violence was most common in divorced women (40%) and least common among the unmarried women (14.3%). It was also higher in women with no formal education (36.4%) and those aged 60 years old (43.8%). Details are shown below in Table 2.

Table 2
Prevalence of sexual violence and associated factors among 324 HIV positive women at health facilities in Buhweju district, southwestern Uganda

Variable	Description	No sexual violence n (%)	Experienced sexual violence n (%)
		218 (67.3)	106 (32.7)
Age (years)			
	18–30	94 (29.0)	47 (14.5)
	31–59	115 (35.5)	52 (16.0)
	60+	9 (2.8)	7 (2.2)
Marital status			
	Single	24 (7.4)	4 (1.2)
	Married	147 (45.4)	76 (23.5)
	Widowed	29 (9.0)	14 (4.3)
	Divorced	18 (5.6)	12 (3.7)
Education			
	No formal education	7 (2.2)	4 (1.2)
	Primary	163 (50.3)	84 (25.9)
	Secondary	42 (13.0)	18 (5.6)
	Tertiary	6 (1.9)	0 (0.0)
Employment			
	Business/Self-employed	29 (9.0)	19 (5.9)
	Employed	10 (3.1)	3 (0.9)
	Unemployed	22 (6.8)	14 (4.3)
	Farmer/Peasant	157 (48.5)	70 (21.6)
Distance to Health Facility			
	1Km	25 (7.7)	13 (4.0)
	3Km	114 (35.2)	45 (13.9)
	5Km	62 (19.1)	37 (11.4)

Variable	Description	No sexual violence n (%)	Experienced sexual violence n (%)
		218 (67.3)	106 (32.7)
	More than 5Km	17 (5.2)	11 (3.4)

Forms Of Sexual Violence, Perpetrators And Supports Sought

The most common forms of sexual violence were sexual humiliation, forced genital touching and insertion of an object into genitalia. The husbands were the most common perpetrators and the victims still had fear of the perpetrators. Less than a quarter of the victims of sexual violence disclosed the incident to another person. Only 15% of the victims sought medical help. The common medical help sought included post-exposure prophylaxis (4.9%), HIV test (9.3%) and emergency contraception (5.6%). Details are in Table 3 below.

Table 3

Forms of sexual violence, perpetrators and supports sought among 324 HIV positive women at health facilities in Buhweju district, southwestern Uganda

Form of sexual violence	Frequency	Percentage
Sexual humiliation	85	26.2
Forced genital touching	149	46.0
Insertion of an object into genitalia	111	34.3
Perpetrator of violence		
Husband	165	50.9
Ex-husband	28	8.6
Boy friend	19	5.9
Others	28	8.6
Fear of perpetrator		
Fear of the perpetrator	132	40.7
Disclosure of sexual violence		
Disclosure to someone	132	22.1
Person disclosed to		
Current partner	24	7.4
Father	3	0.9
Friend	13	4.0
HIV services		
Sought medical help	49	15.1
Post-exposure prophylaxis	16	4.9
Received HIV test after sexual violence	30	9.3
Emergency contraceptives	18	5.6
Provider of care/support		
Own family	12	3.7
Friend	15	4.6
Health workers screen for sexual violence	155	47.8
Frequency of sexual violence screening		

Form of sexual violence	Frequency	Percentage
Very often	108	33.3
Not often	134	41.4

Factors Associated With Sexual Violence

At bivariate analysis, being married was protective against sexual violence (p = 0.035, 95% CI 0.069–0.905). Other factors were not significantly associated with sexual violence (Table 4).

Table 4
Factors associated with sexual violence among 324 HIV positive women at health facilities in Buhweju district, southwestern Uganda

Variable	Description	Unadjusted OR	95% CI	P-Value
Age (years)				
	18–30	1		
	31–59	0.643	0.225–1.833	0.409
	60+	0.581	0.205–1.646	0.307
Marital status				
	Single	1		
	Married	**0.250**	**0.069–0.905**	**0.035****
	Widowed	0.776	0.355–1.694	0.524
	Divorced	0.724	0.275–1.910	0.514
Education				
	No formal education	1		
	Primary	1.52	0.34–5.84	0.539
	Secondary and tertiary	1.37	0.75–2.51	0.301
Employment				
	Business/Self-employed	1		
	Employed	1.469	0.772–2.796	0.241
	Unemployed	0.673	0.180–2.520	0.556
	Farmer/Peasant	1.427	0.690–2.952	0.337
Distance to Health Facility				
	1Km	1		
	3Km	0.804	0.292–2.21	0.672
	5Km	0.610	0.265-1.40	0.245
	More than 5Km	0.922	0.390–2.18	0.854

Discussion

This study aimed to determine the prevalence and forms of sexual violence among women seeking HIV services at selected health facilities in Buhweju district, Southwestern Uganda. The prevalence of sexual

violence was 32.7%, and the most common forms of sexual violence were sexual humiliation, forced genital touching and insertion of an object into genitalia. Husbands were the most common perpetrators and less than a quarter of the victims disclosed the incidents to other people. Only 15% of the victims sought medical help and the most common medical help sought included post-exposure prophylaxis, HIV test and emergency contraception. Being married was protective against sexual violence. This study contributes to the existing literature about sexual violence in HIV positive women especially in the rural Uganda.

The sexual violence prevalence of 32.7% in our study was quite high. Living with HIV and experiencing sexual violence is a double burden on the affected women and could have long lasting physical and psychological consequences. This double burden could easily affect their adherence to treatment and their general wellbeing.. However, our finding is similar to the global prevalence of sexual violence of 35.6% as reported by the World Health Organization [1]. On the other hand, the prevalence in our study is much higher than the national prevalence of 22.8% reported by the Uganda Bureau of Statistics in the 2016 Uganda Demographic health survey[11]. It is also higher than the rate reported in South Africa and Rwanda among individuals living with HIV [12, 13]. Our prevalence is lower than what has been reported by Breiding and colleagues (2014) in the united states [14]. The difference in the prevalence could be due to variations in the study population and setting.

Although there were associations between sexual violence and a number of factors, only marital status was statistically significant. Being married lowered the risk of sexual violence. It is possible that married women consider some aspects as part of normal marital challenges and may not consider them as sexual violence. Our finding is similar to what has been reported by previous studies..

Among the forms of sexual violence experienced, insertion of penis or any other object into the vagina, rectum or mouth was the most common (34.3%). This seems to be the same in precious studies [15].This is the most common direct way of heterosexual HIV transmission. As indicated by previous research, sexual violence increases the victim's vulnerability to HIV. Our study was conducted in a rural and hard-to-reach setting and majority of the participants were low of low socio-economic status with low bargaining power. As such, they may not be able to protect themselves against sexual violence and the associated risk of HIV infection.

Despite the high burden of sexual violence in our study, few participants had reported the incidents to other people. This could be related to the stigma associated with reporting. A study in south Africa supports this view that being a victim of sexual violence is seen as a stigmatizing and shaming experience that makes it difficult for women to talk about it with other people [16]. Relatedly, a small proportion of the victims of sexual violence, only 9.3% sought medical help after the sexual violence incident. This is in agreement with findings from previous studies (33, 34) in which experiencing violence was found to be associated with reduced HIV testing, care and treatment [17].

Despite the progress made in HIV care, sexual violence among women living with HIV does not seem to receive appropriate attention from the health workers. According to our study, very few participants

reported ever having been asked by health workers about sexual violence. Yet, incorporating services for victims of sexual violence in the HIV general services could yield positive results. Screening for violence can provide an entry point for identifying the victims and responding to their individual needs. HIV care providers can encourage women to always seek for treatment of injuries, sexually transmitted infections, unwanted pregnancies and refer them to other services that may be needed [18].

Strengths And Limitations

We recruited participants from a very remote district where limited research about the experiences of sexual violence has been conducted and thus assume that the findings of this study were novel and will act as a reference for future studies. There was low turn up of participants at the different health facilities since data collection was done during the rainy season where most people in the area are planting. This was partly addressed by increasing mobilization using the village health teams (VHT's) and peer educators. The risk of COVID-19 was also a limiting factor whereby we provided free face masks and hand sanitizers to curb the spread.

Conclusions

A third of HIV women seeking care from health facilities in Buhweju district experience sexual violence and the most common forms of sexual violence are sexual humiliation, forced genital touching and insertion of an object into genitalia. Most of the sexual violence is perpetrated by the husbands and more than three quarters of the victims do not disclose the incidents to other people..

Declarations

Competing interests

The authors declare no competing interests.

Consent for publication:

Not applicable

Availability of data and materials

All the data needed for this manuscript has been included. In case there is a need for clarifications, the corresponding author can be contacted.

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Ethical considerations

This study was reviewed and approved by the research ethical committee of Mbarara University of Science and Technology (08/12-20). Administrative clearance was sought from the District Health Officer of Buhweju district and the Health workers in-Charge of the selected health facilities. All participants provided informed consent before taking part in the study. Participant identifiers such as names and initials were not included at data entry and were kept confidential to the research team. All procedures were performed in accordance with relevant guidelines.

Authors' contribution

GM conceived the idea. All the authors participated in proposal development. GZR supervised the RAs during data collection. GM and GZR did data analysis and wrote the first draft of the manuscript. All authors reviewed and approved the final manuscript for submission to the journal publication.

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