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research article

Gender-based violence and its determinants during the COVID-19 lockdown in a low-income country: a cross-sectional survey

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Background: Coronavirus disease 2019 (COVID-19) is a recent global pandemic associated with multidimensional health-related effects. In the fight against the spread of this novel pandemic, the majority have been living under restrictive conditions during its related lockdown that has created a conducive environment for gender-based violence (GBV). Our study aimed to ascertain the burden and determinants of GBV during the COVID-19 pandemic-related lockdown and curfew (CPLC) in Uganda.

Methods: We conducted a quantitative descriptive cross-sectional study in Bushenyi-Ishaka municipality, southwestern Uganda in May, 2020. This study involved 339 adult participants regardless of their gender or ethnicity. Only 12 potential respondents declined to participate in this survey.

Results: The prevalence of GBV during the CPLC was 42 per cent. The majority (57%) of victims were women. More than half (54%) of the victims and survivors of GBV attributed the violence to the lockdown. The determinants of GBV included being married, using substances of abuse and having financial problems.

Conclusion: The prevalence of GBV skyrocketed during the CPLC in Uganda when compared to the period prior to the pandemic. Women were significantly more affected in all aspects of GBV. Therefore, we recommend developing targeted behavioural change communication strategies based upon our findings.

Key words COVID-19 • gender-based violence • lockdown • pandemic • Uganda

Key messages

- The main strength of this study was the fact that it was the first of its kind to be conducted in a low-income country under the unique circumstances that is, the CPLC.
- The other strength of this study was the comprehensiveness of its research subject that is, GBV, an ongoing pandemic since time immemorial, is rarely a focus of most studies in this particular field with the majority of these studies usually focusing on intimate partner violence which is just one type of GBV.
- Generally, GBV is a sensitive topic in most cultures and societies where the majority of people aren't willing to talk about it which creates an atmosphere of stigma and the associated discrimination that could have also resulted from GBV being viewed as a sensitive and taboo topic by these participants.

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Introduction

Background

The outbreak of the Coronavirus disease 2019 (COVID-19) in Wuhan, China, in December 2019 (WHO, 2020c) was declared a pandemic on 11 March 2020 (WHO, 2020b). The highly virulent nature of COVID-19 led most countries to institute lockdowns (UN, 2020b) that were meant to curb the pandemic by limiting social contact and interaction within and between communities (Mogoatlhe, 2020).

In Uganda, the COVID-19 pandemic-related lockdown (CPL) was initially instituted on 18 March 2020 (Mukama, 2020). The CPL was later followed by a night-time curfew which went into effect on 31 March 2020 (Kyeyune, 2020) in tandem with the lockdown after the identification of the first suspected case of COVID-19 ten days earlier (WHO, 2020f). The nationwide COVID-19 pandemic-related lockdown and curfew (CPLC) were additional measures to the recommended strategies of social distancing, hand washing, sanitisation and self-quarantine which had already been endorsed as key steps in reducing the spread of the pandemic (Ahimbisibwe, 2020).

Pandemics, especially those in which quarantines, lockdowns and curfews are mandated, are usually associated with an increase in gender-based violence (GBV) (Fraser, 2020; John et al, 2020). The victims and survivors of GBV are at a greater risk of experiencing GBV during circumstances of restricted social interactions (Speed et al, 2020). In terms of gender, females have a higher risk of experiencing GBV with nearly 243 million of them having already been afflicted with various types of GBV in 2019 (UN, 2020b).

GBV is any form of harmful or aggressive action or attitude perpetrated against a person's will in public or private spaces due to imbalanced power dynamics among the genders (IASC, 2005). GBV is usually rooted in societal norms and beliefs regarding gender roles and perceived adherence to culturally defined gender-based expectations. Some of the known facilitators of GBV include poverty-related stress, economic inequality and insecurity, quarantine and social isolation, calamity induced unrest and instability, as well as exposure to exploitative relationships due to altered demographics (Peterman et al, 2020). For purposes of this study, the different types of GBV reported were defined as follows: physical GBV included acts such as battering and beatings; sexual GBV included acts such as rape, sexual abuse, defilement, incest and other types of sexual violence such as sexual assault, harassment and exploitation including forced prostitution; and domestic GBV included intimate partner violence and economic violence such as denial of assets and livelihoods (UNFPA, 2012). Other types of GBV which included psychological GBV which was defined as acts of emotional and verbal abuse as well as humiliation and forced confinement; marital GBV which included practices such as marital rape, early and forced marriages as well as bride price-related violence; social GBV which included practices such as denial of education especially for females and female genital mutilation; and other additional types of GBV such as human trafficking (MoGLSD, 2016).

The severity and frequency of GBV is on the increase and this includes first time acts of violence within the family as well as other new types of GBV such as perpetrators taking advantage of the confinement associated with the CPLC to control and manipulate survivors and potential victims, restrict their movements, gain access to their residences, and coerce them into cohabitation (Pfitzner et al, 2020). It is predicted that up to 5 million additional cases of domestic GBV will occur for every month of the CPL (UNFPA, 2020a).

The prevalence of GBV in Uganda prior to the pandemic was 10 per cent, with 84 per cent of these reporting ongoing GBV, especially intimate partner violence (Undie et al, 2016), while up to 52 per cent in rural areas were experiencing physical GBV (UBOS, 2019). The region of southwestern Uganda had the highest prevalence of GBV in the country with Mbarara district, the main urban hub of the region, leading at 19.1 per cent while Kisoro, which is a rural district in the region, reporting a prevalence of 16.7 per cent (Rottach et al, 2018). Females were more vastly affected and the risk factors of GBV included poverty, substance use, overcrowding, peer pressure, limited counselling services, indignant cultural practices, unemployment and income loss (Fitz-Gibbon et al, 2020). During our literature review, we found no published articles quantitatively documenting the prevalence of GBV in Bushenyi district or any of its municipalities.

Additionally, quantitative information about the prevalence of GBV during the CPLC in Uganda is still meagre. Only a few published studies were recently conducted with most of them being qualitative in nature, using secondary data sources and

focusing more on research topics other than the CPLC such as HIV. These studies found that reported cases of GBV had increased significantly and females were at a heightened risk (Consolata and Fredrick, 2020; Nabukeera, 2020; Apondi et al, 2021; Katana et al, 2021; Ouma et al, 2021).

Several studies including a recently concluded qualitative survey in Uganda called for prioritising GBV-related challenges and recommended quantitative studies to supplement their findings so as to better understand the scourge of GBV and its associations with the CPLC (Consolata and Fredrick, 2020; Fraser, 2020; Pfitzner et al, 2020). Therefore, we aimed to determine the prevalence, characteristics and associated factors of GBV among adults in rural Uganda during the CPLC.

Methods

Study design, setting and participants

A quantitative cross-sectional study was conducted by selecting potential study participants from Bushenyi-Ishaka municipality with their enrolment taking place at Kampala International University Teaching Hospital (KIUTH). The study was conducted during the initial months of the first CPLC in May 2020 in accordance with the current guidelines and standard operating procedures for conducting GBV-related research (WHO, 2020e).

Bushenyi is a district found in the southwestern region of Uganda approximately 320km from Kampala, the capital city of Uganda. The two towns of Ishaka and Bushenyi constitute the municipality of Bushenyi-Ishaka. We selected this particular municipality because its sociodemographic characteristics were more similar to the country's than other municipalities in Bushenyi in terms of age groups and gender differences (UBOS, 2017). Bushenyi-Ishaka is also located in the region with the highest pre-pandemic prevalence of GBV in the country. Additionally, we selected Bushenyi-Ishaka due to its district being the location of the hospital within which this study was conducted, and the associated feasibility, accessibility and logistic issues given the restrictive circumstances under which this study was conducted.

Bushenyi-Ishaka consists of a hierarchy of local councils headed by a chairperson with the most grassroots being the local council one (LC1) chairperson at the village level. The LC1 chairpersons maintain a record of their village residents and vital information on events taking place in the village including cases of GBV, disputes among the residents and other transgressions of the law.

KIUTH is the largest private-not-for-profit hospital in Bushenyi established in 2007. This hospital is located 330km southwest of Kampala. It offers general and specialised medical services including GBV-related services to Bushenyi and its surrounding districts.

The inclusion criteria encompassed being an LC1 chairperson in Bushenyi-Ishaka during the CPLC and, being 18 years and above while residing in Bushenyi-Ishaka during the CPLC. We excluded potential participants afflicted with severe ailments and those who had hearing and speaking impediments due to communication challenges and confidentiality issues anticipated from utilising third parties for purposes of translation.

This study initially involved contacting LC1 chairpersons who were selected by simple random sampling. The three chosen chairpersons furnished the research team

with residential registers and records of all cases reported to their offices during the CPLC. We then chose participants from these registers and records using stratified random sampling in a ratio of 1-to-1 that is, for every third selected reported case, we chose the fifth participant from the residential registers.

We then utilised a two-stage informed consent process that involved the selected participants being initially contacted for verbal informed consent via phone calls prior to inviting them to KIUTH for in-person interviews at which point participants were asked to provide written informed consent. All this was done in accordance with recommendations for conducting GBV-related research in crisis settings (CIOMS, 2009). We also guaranteed that the national guidelines on prevention of COVID-19 were upheld (MoH, 2020). Furthermore, this study was approved by the research ethics committee of Kampala International University – Western Campus KIU-WC with the approval number Nr.UG-REC-023/202015 prior to community entry and onset of data collection.

We used the STROBE checklist (Von Elm et al, 2014) when writing our final manuscript.

Data measurement

A team of trained research assistants fluent in English and the predominant local dialects that is, Runyankole/Runyakitara and Luganda, was used to collect data using a specially designed data collection tool consisting of a semi-structured questionnaire containing an assortment of assessment items. These research assistants were recruited from the various medical cadres of the psychiatry staff of KIUTH. They received basic training in data collection procedures and were equipped with ample knowledge on GBV assessment and management.

The study tool used in this survey was developed in consultation with experts in GBV research, relevant research guidelines and surveys (MoGLSD, 2016; Undie et al, 2016). Pilot testing of the study tool was conducted among staff of KIUTH who were selected by simple random sampling to determine the accuracy, validity and reliability of the assessment items. All necessary adjustments were made to derive a final revised version that was administered to the intended participants in the main study. The final version of the study tool had three sections:

Section A: Consisting of sociodemographic factors such as age, gender, tribe, marital status, marital type, education level, employment status, residence, head of household and frequency of income.

Section B: Comprising of psychological factors such as substance use, infidelity, number of household members, frequency of daily meals, source of food, financial liabilities and social support.

Section C: Encompassing GBV assessment which entailed type of GBV, timing of GBV, reason for GBV, victim or perpetrator status and frequency of GBV.

Data were collected from participants using electronic questionnaires designed with the use of KoBo Toolbox® installed on Dell® tablets with pre-installed safeguards to minimise data loss and avoid errors during the data collection process. Upon completion of each study tool, the accrued data were automatically uploaded to a secure Google® cloud-based server which was password protected and only accessible

to the principal investigators. We anticipated recall bias due to the sensitive nature of GBV and this was mitigated for by ensuring that the data collection process was conducted in a private and confidential environment with participants being allowed ample time to process past adverse events adaptively and recollect their memories. Additionally, the research team was trained in how to deal with any anticipated abreactions that would hinder the data collection process.

Study sample size

In the pilot study, we used simple random sampling to enrol 40 participants (Hazzi and Maldaon, 2015) who were staff of KIUTH. We then randomly selected three villages from which the potential participants would be recruited. We screened 360 potential participants and recruited 351 participants for the main study in accordance with a minimum sample size calculated using the formula by WW Daniel (Daniel and Cross, 2018). The prevalence used in the calculation of this sample size was the highest prevalence of GBV in any district found in the southwestern region of Uganda which was 19.1 per cent (Rottach et al, 2018). A total of 339 participants completed fully their study tools and the data accrued from these participants were then included in the data analysis process.

Statistical analysis

Accrued data were downloaded from the cloud-based server in an excel form. This form was cleaned and coded for entry before being imported into STATA® version 12 for analysis. The results were summarised and presented in tabular format with an emphasis on the various gendered differences. The independent variables included sociodemographic and psychological factors while the dependent variables were GBV and its various types as defined by the United Nations Population Fund (UNFPA, 2012) and the Ugandan Ministry of Gender, Labour and Social Development (MoGLSD, 2015). The associated GBV characteristics such as frequency, perpetrators of and reasons for GBV were also considered as dependent variables.

Univariate analyses were employed to describe study participants in term of frequencies, proportions, means, medians, standard deviations (SD) and interquartile ranges (IQRs). The prevalences of the different types of GBV were determined as a proportion of participants among the study sample who reported GBV.

Bivariate linear and logistic regressions were used to determine the characteristics of GBV and its victims or survivors. Bivariate and multivariate linear and logistic regressions were used to assess the factors associated with GBV and its various types. The measure of association was determined by calculating the unadjusted odds ratio (UOR) and adjusted odds ratio (AOR) with a 5 per cent level of statistical significance (P-value) and a 95 per cent confidence interval (95% CI) being considered for all the aforementioned analyses.

Any missing data were catered for by recruiting more participants than the calculated minimum sample size. A total of 12 potential participants opted out of the study with most declining to offer reasons why and the few who did cited a busy schedule. We assumed that all participants who reported GBV as victims or survivors were being candid given the sensitive nature of GBV.

Study participants and public involvement

Members of the public weren't directly involved in the development of the study design, research methodology, data collection or dissemination plans of this research. However, they provided insightful information during the piloting of the study tool. A report of the research findings was made available to the department of mental health and psychiatry of KIUTH, the university library of KIU-WC as well as to the hospital and university administrations to be accessed by study participants, patients, clinicians, nursing staff and students. Furthermore, disseminative community meetings were held by the principal investigators in conjunction with the respective LC1 chairpersons of the three villages in which this study was conducted while adhering to the COVID-19 precautionary measures.

Diversity

During the designing, planning and conduction of this study, the authors prioritised issues of diversity by ensuring that all potential study participants to be recruited would be representative of all genders, ethnicities, socioeconomic statuses and religious proclivities or the lack thereof. We also ensured that no one was discriminated against based on their gender identity, sexual orientation or individual abilities. The literature reviewed as we developed the research proposal that culminated in this study focused mostly on women due to their inherently higher rates of victimisation with regards to GBV.

Results

Study participants' characteristics

The prevailing circumstances of the COVID-19 pandemic made it impossible to ascertain the exact numbers of potentially eligible study participants. The potential participants examined for eligibility were 360 with 351 being confirmed eligible and 339 being included in the study for analysis. There were 12 potential participants who opted out of the study and most of them weren't willing to disclose their reasons for their non-participation. Only 10 completed study tools were missing information on a variety of assessment items.

A total of 339 participants participated in this study with most of these participants being females (55%). Overall, their median age was 31 years (IQR = 14) with the maximum age being 90 years. The average number of household members was five with the maximum number being 18 members (SD = 3). The rest of the characteristics of the participants are illustrated in [Table 1](#).

GBV burden among study participants

The prevalence of recent GBV that is, GBV acts occurring within the last month prior to data collection, was 42 per cent (142 participants) with 43 per cent of women being affected. Participants who reported experiencing the various types of lifetime GBV were 43 per cent, with 76 per cent identifying as victims or survivors and 72 per cent being female. The most common type of GBV was psychological (27%) with domestic (21%) and physical (6%) GBV being the second and third, and women being affected the most no matter the type of GBV. Furthermore, the prevalence of past

Table 1: Characteristics of the study respondents (N=339)

Variable	n (%)
Age class (years)	
18–29	140 (41.30)
30–39	108 (31.86)
40–49	53 (15.63)
50–59	20 (5.90)
60+	18 (5.31)
Gender	
Female	188 (55.46)
Male	151 (44.54)
Marital status	
Single	185 (54.57)
Married	87 (25.66)
Cohabiting	67 (19.76)
Marital type	
Monogamy	184 (80.35)
Polygamy	45 (19.65)
Education level	
None	25 (7.37)
Primary	77 (22.71)
Secondary	92 (27.14)
Tertiary	145 (42.77)
Employment status	
Unemployed	110 (32.45)
Employed-private	68 (20.06)
Employed-government	20 (5.90)
Self-employed	98 (28.91)
Casual laborer	26 (7.67)
Others	17 (5.01)
Residence	
Rural	56 (16.52)
Urban	283 (83.48)
Head of household	
Participant	153 (45.13)
Parent	75 (22.12)
Spouse	74 (21.83)
Step-parent/Guardian	30 (8.85)
Sibling	7 (2.06)
Frequency of income	
Monthly salary	93 (27.43)
Daily wage	132 (38.94)

(Continued)

Table 1: (Continued)

Variable	n (%)
Others	114 (33.63)
Source of food	
Home garden/farm	77 (22.71)
Market	203 (59.88)
NGO/Charity	4 (1.18)
Home garden/farm and Market	48 (14.16)
Home garden/farm, Market and NGO/Charity	7 (2.06)
Financial liabilities	256 (75.52)
Substance use	108 (31.86)
Infidelity of partners	75 (22.12)
Maintained social contact	251 (74.04)

GBV that is, GBV acts occurring before the last month prior to data collection, was 72 per cent and also significantly higher among women. Experiencing past GBV was statistically significant for monthly acts of GBV whereas recent GBV was statistically significant for weekly and biweekly acts of GBV.

COVID-19 related reasons for GBV were among those found to be statistically significant. Similarly, GBV acts perpetrated by a mother or a participant 18 years and above still living with his parents or guardians were also significant. The rest of the findings related to the burden of GBV such as its various types, frequencies, reasons and perpetrators were as shown in [Tables 2, 3](#) and [4](#).

Determinants of GBV

After appropriate transformation, the number of household members was the only continuous variable that was significantly associated with lifetime GBV (coefficient = 0.185; 95% CI = 0.071–0.299; P-value = 0.002). Following the bivariate and multivariate logistic regression analyses, the gender of the study participants wasn't found to be statistically significant. However, the factors that were significantly associated with lifetime GBV included being married (AOR = 2.28; 95% CI = 1.08–4.81; P-value = 0.03), being in a monogamous marriage (AOR = 0.35; 95% CI = 0.16–0.76; P-value = 0.01), having no financial liabilities (AOR = 0.25; 95% CI = 0.11–0.61; P-value = 0.00) and having no history of substance use (AOR = 0.47; 95% CI = 0.25–0.88; P-value = 0.02). The rest of the factors that were analysed are illustrated in [Table 5](#).

Discussion

This research was the foremost community-focused and hospital-based study conducted to quantitatively describe GBV, its various prevalences and associated factors among adult residents of a rural municipality in Uganda during the CPLC.

The prevalence of recent GBV described as having experienced any type of GBV in the last one month prior to data collection was 42 per cent with the majority of victims being women, which is more than double the previously reported highest

Table 2: Description of the various types of GBV

Variable	Male (N=151)	Female (N=188)	Overall (N=339)		
	n (%)	n (%)	n (%)	95% CI	P-value
Lifetime GBV***	63 (41.72)	82 (43.62)	145 (42.77)	37.48–48.07	0.0000*
One type	47 (31.13)	52 (27.66)	99 (29.20)	24.34–34.07	-
Multiple types	16 (10.60)	30 (15.96)	46 (13.57)	9.90–17.23	-
Recent GBV	61 (40.40)	81 (43.09)	142 (41.89)	36.61–47.17	0.0000*
Past GBV	41 (28.28)	63 (43.45)	104 (71.72)	64.31–79.14	0.87
GBV victim and/or survivor	43 (68.25)	67 (81.71)	110 (75.86)	68.81–82.91	0.43
Domestic GBV	29 (19.21)	41 (21.81)	70 (20.65)	16.32–24.98	0.0000*
Physical GBV	7 (4.64)	15 (7.98)	22 (6.49)	3.85–9.13	0.0000*
Psychological GBV	42 (27.81)	49 (26.06)	91 (26.84)	22.10–31.58	0.0000*
Social GBV	3 (1.99)	10 (5.32)	13 (3.83)	1.78–5.89	0.0000*
Sexual GBV	3 (1.99)	7 (3.72)	10 (2.95)	1.14–4.76	0.0000*
Marital GBV	2 (1.32)	1 (0.53)	3 (0.88)	-0.12–1.89	0.0005**
Human trafficking GBV	1 (0.66)	2 (1.06)	3 (0.88)	-0.12–1.89	0.01**

*P-value is statistically significant (P-value<0.05); **Confounding detected; ***Reference variable

Table 3: Frequency of past and recent GBV

GBV past frequency	Male (N=41)	Female (N=63)	Overall (N=104)	95% CI	P-value = 0.39
Daily	1 (2.44)	3 (4.76)	4 (3.85)	0.09–7.60	-
Weekly	9 (21.95)	16 (25.40)	25 (24.04)	15.69–32.39	-
Biweekly	18 (45.00)	17 (26.98)	35 (33.65)	24.42–42.89	-
Monthly	13 (31.71)	27 (42.86)	40 (38.46)	28.95–47.97	-
GBV recent frequency	(N=61)	(N=81)	(N=142)		P-value = 0.05
Daily	8 (13.11)	14 (17.28)	22 (15.49)	9.47–21.52	-
Weekly	17 (27.87)	25 (30.86)	42 (29.58)	21.98–37.18	-
Biweekly	19 (31.15)	23 (28.40)	42 (29.58)	21.98–37.18	-
Monthly	17 (27.87)	19 (23.46)	36 (25.35)	18.11–32.59	-

*P-value is statistically significant (P-value<0.05); **Confounding detected; ***Reference variable

prevalence in the region of 19.1 per cent (Rottach et al, 2018). This uptick and the female preponderance was in line with our hypothesis and consistent with a number of studies and reports authored about the effects of the CPLC on the prevalence of GBV in a general population as well as their gendered differences (Mittal and Singh, 2020; UN, 2020a; UNFPA, 2020b; Sharma et al, 2021). The possible explanations for this finding include movement restrictions, socioeconomic impact of the CPLC, limited access to available GBV services and protective social support networks, and perpetrators exploiting the restrictions associated with the CPLC as a means of controlling, exploiting and manipulating their victims, especially women (UN, 2020a; WHO, 2020d).

Among victims of recent GBV, 72 per cent reported having experienced GBV in the past and women were again affected the most (63%). These findings were similar

Table 4: Reasons for GBV and the perpetrators of the various types of GBV

Reason for GBV	Male (N=63)	Female (N=82)	Overall (N=145)		
	n (%)	n (%)	n (%)	95% CI	P-value
Poverty-related stress	34 (53.97)	47 (57.32)	81 (55.86)	47.68–64.04	0.24
Economic inequality	9 (14.29)	16 (19.51)	25 (17.24)	11.02–23.46	0.02*
Economic insecurity	8 (12.70)	14 (17.07)	22 (15.17)	9.26–21.08	0.01*
COVID-19 related quarantine and social isolation	35 (55.56)	44 (53.66)	79 (54.48)	46.28–62.69	0.03*
COVID-19 related unrest and instability	6 (9.52)	8 (9.76)	14 (9.66)	4.79–14.52	0.0007*
Reduced health service availability	6 (9.52)	7 (8.54)	13 (8.97)	4.26–13.67	0.59
Other reasons	3 (4.76)	0 (0.00)	3 (2.07)	-0.28–4.41	0.19
Perpetrator of GBV	Male (N=43)	Female (N= 67)		Overall (N=110)	
Father	15 (34.88)	12 (17.91)	27 (24.55)	16.38–32.72	0.14
Mother	9 (20.93)	7 (10.45)	16 (14.55)	7.85–21.24	0.00*
Guardian/step parent	4 (9.30)	10 (14.93)	14 (12.73)	6.40–19.05	0.46
Sibling	4 (9.30)	0 (0.00)	4 (3.64)	0.08–7.19	0.19
Spouse	1 (2.33)	3 (4.48)	4 (3.64)	0.08–7.19	0.38
Adults living with their parents or guardians	10 (23.26)	9 (13.43)	19 (17.27)	10.10–24.45	0.04*
Non-family members	21 (48.84)	38 (56.72)	59 (53.64)	44.17–63.10	0.07

*P-value is statistically significant (P-value<0.05); **Confounding detected; ***Reference variable

to those of several studies and a report published prior to the pandemic (Lundin et al, 2020; Mubangizi, 2020; Rodriguez-Jimenez et al, 2020; Stark et al, 2020; UNFPA, 2020b; Yaker and Erskine, 2020; Dlamini, 2021). These trends were also similar to findings showing increments in GBV over the past years (UBOS, 2019).

Female participants were most affected by majority of the various types of lifetime GBV. This is in line with the findings of several published surveys and reports (Lundin et al, 2020; Rodriguez-Jimenez et al, 2020; Stark et al, 2020; WHO, 2020a; UN, 2020b; Yaker and Erskine, 2020; Dlamini, 2021) with a plethora of adverse consequences (UNFPA, 2020a; Mundt, 2021). This finding could be attributed to the prevailing inequitable gender norms and roles as well as the inherent inequalities in the socioeconomic and healthcare systems that were revealed by this pandemic (UN, 2020a; John et al, 2020). Manifestations of gender inequalities affecting women the most during the pandemic included unrelenting demands for sex, exacerbated financial dependences and monitoring as well as controlling victims' phone and internet use (WHO, 2020a).

The most common type of lifetime GBV was psychological followed by domestic and physical GBV with a disproportionate number of women affected mostly as victims or survivors. This finding was similar to the assertions of a recently published joint statement on GBV and COVID-19 (UNFPA, 2020b). However, this finding differed from most of the previously conducted studies (Oladepo et al, 2011;

Table 5: Factors associated with GBV (N=145)

Variable	n (%)	UOR (95% CI)	P-value	AOR (95% CI)	P-value
Tribe					
Native (Munyankole)	224 (66.08)	1.654 (1.039–2.634)	0.03*	1.126 (0.593–2.141)	0.72
Non-native (Others)	115 (33.92)	1.000	-	1.000	-
Marital status					
Single	87 (25.66)	0.569 (0.285–1.136)	0.11	1.000	-
Married	185 (54.57)	1.892 (1.067–3.357)	0.03*	2.277 (1.078–4.808)	0.03*
Cohabiting	67 (19.76)	1.000	-	1.000	-
Marital type					
Monogamy	184 (80.35)	0.334 (0.165–0.677)	0.00*	0.347 (0.158–0.763)	0.01*
Polygamy	45 (19.65)	1.000	-	1.000	-
Education level					
None	25 (7.37)	0.867 (0.350–2.148)	0.76	0.467 (0.109–2.001)	0.31
Primary	77 (22.71)	1.993 (1.136–3.496)	0.02*	1.451 (0.623–3.383)	0.39
Secondary	92 (27.14)	1.843 (1.083–3.138)	0.02*	1.157 (0.546–2.452)	0.70
Tertiary	145 (42.77)	1.000	-	1.000	-
Frequency of income					
Monthly salary	93 (27.43)	1.034 (0.587–1.823)	0.91	0.833 (0.336–2.065)	0.69
Daily wage	132 (38.94)	1.821 (1.092–3.037)	0.02*	1.124 (0.524–2.414)	0.76
Others	114 (33.63)	1.000	-	1.000	-
No Financial liabilities	83 (24.48)	0.306 (0.174–0.540)	0.00*	0.254 (0.107–0.605)	0.00*
No Substance use	231 (68.14)	0.393 (0.246–0.628)	0.00*	0.472 (0.254–0.879)	0.02*
Lack of Social contact	88 (25.96)	0.465 (0.276–0.783)	0.00*	0.501 (0.244–1.028)	0.06

*P-value<0.05; **Confounding detected

Stark and Ager, 2011; Wirtz et al, 2013; True, 2015; Undie et al, 2016; Rottach et al, 2018; Guloba et al, 2018). This discrepancy could be due to the advent of novel types of GBV that are engendered by perpetrators taking advantage of the CPLC and they tend to manifest mostly with psychological features (Pfitzner et al, 2020).

A significant proportion of participants attributed the different types of lifetime GBV to the CPLC, quarantines and social isolation whereas the majority identified poverty-related stress as the reason for GBV. This finding was similar to the findings of several international non-governmental organisations' reports (Guloba et al, 2018; UNHCR, 2019; Asia-Foundation, 2020; UN, 2020a; UNFPA, 2020b; UNODC, 2020; WHO, 2020a).

In terms of being victimised within a domestic setting, fathers were more likely to perpetrate lifetime GBV and males living with their parents or guardians were more likely to be victimised. The second finding was contradictory to that of most of the studies reviewed (Mittal and Singh, 2020; Dlamini, 2021; Katana et al, 2021; Ouma et al, 2021). A plausible explanation for the first finding could be the patriarchal nature of the society that predisposes more women to lifetime GBV victimhood (Gardsbane, Bukuluki, and Musuya, 2022). The possible reason for the second finding is that culturally determined systems of punishment tend to be more punitive towards males (Oladepo et al, 2011; Mootz et al, 2017).

Lifetime GBV was directly proportion to the number of household members. This was in line with previous studies and a published report (Morrison and Orlando, 2004; Jewkes et al, 2017; Pfitzner et al, 2020; WHO, 2020d). The possible explanation is overcrowding leads to competition for scarcely available resources (UN, 2020a) causing increased tensions within the household (UNODC, 2018).

The other risk factor for lifetime GBV was being married however this risk was significantly curtailed by being in a monogamous marriage. This finding was similar to that of a study conducted in Nigeria (Oladepo et al, 2011). The probable explanation for this finding is that being married within the cultural context of gender inequality (John et al, 2020) will predispose one to GBV especially when there is more than one marriage partner (True, 2015).

Participants who didn't use substances of abuse were less likely to experience lifetime GBV which was similar to what was demonstrated by several previous studies (Oladepo et al, 2011; Rees et al, 2011; Walsh et al, 2015; Gilbert et al, 2015; Leddy et al, 2018; Fitz-Gibbon et al, 2020). This reduced risk could be attributed to substance use being among the recognised risks of GBV. Therefore, not partaking will result in a lower risk of GBV (UNODC, 2020).

The other protective factor against lifetime GBV was not having financial liabilities. This was in line with the findings of a previous study conducted in the region and a World Health Organisation report (Peterman et al, 2020; WHO, 2020a). The possible justification for this finding is that economic inequalities resulting from being indebted lead to poverty and indulgence in substance use which in turn create a perfectly unstable environment for GBV occurrences. Additionally, women who are most affected by GBV are more dependent on men for their livelihood (Rees et al, 2011; Walsh et al, 2015; Leddy et al, 2018; UNODC, 2020).

Our findings should be interpreted in view of these limitations. Most people aren't willing to talk about GBV because it's a sensitive subject in most cultures and societies. Hence, there could be issues of recall bias, confirmatory bias, implicit biases in self-reporting and, stigma and associated discrimination in relation to the information that we collected from our participants (UN, 2020a). To minimise these effects, participants were given adequate time to respond to questions about the past and they were also reassured of the inherent mandatory privacy and confidentiality during data collection. Cultural constraints were also anticipated as revealed by reports from Nigeria and the Gambia which found that a significant proportion of women perceived certain types of recognised GBV as culturally normal and justified (UN, 2020a; UNFPA, 2020c). This limitation was mitigated for by designing and conducting the study in accordance with the current guidelines for conducting GBV-related research (WHO, 2020e).

In conclusion, this study revealed that GBV had skyrocketed in rural areas of Uganda during the COVID-19 pandemic. It also found that the CPLC significantly increased the prevalence of the different types of GBV, with women being more disproportionately affected.

Conducting this research, albeit implicitly beneficial, wasn't without inherent risks. These included the prospect of the research team and study participants contracting COVID-19, the exacerbation of GBV and lack of access to other GBV-related services other than healthcare-related services due to the CPLC. Nevertheless, the implicit benefits of conducting this study included the research team being trained in the identification and management of GBV as well as acquiring an insight into the

burden of GBV. The other benefits were that the participants got a rare opportunity to be screened for GBV, to access the necessary healthcare services which were made available to them, and the concerned policymakers were provided with data that could inform their policymaking process. The findings of this study could also be utilised by other countries especially low-income countries to better understand, prepare for and manage pandemics akin to and including the COVID-19 pandemic while considering the consequences of the strategies chosen to mitigate these pandemics on the burden of GBV. This study could also provide a basis and an opportunity for governments in countries across the globe affected by this pandemic to scientifically challenge the increments in GBV at the individual, family, community, national and international levels.

Prospective studies and longitudinal surveillance programmes are required to design and develop accessible, cost-effective, customisable and locally adaptable evidence-based strategies and interventions that utilise current, relevant and insightful scientifically sourced information like that ascertained by this study. These customised strategies and interventions such as targeted behavioural change communication strategies (Morrison, Ellsberg, and Bott, 2007; Verma et al, 2008) which have already been proven to be effective in combating and mitigating GBV during public health crises are urgently needed both now and in the future (Fraser, 2020; WHO, 2020e). Last but not least, the findings of this study are generalisable to other adult general populations of all genders and ethnicities living under similar circumstances, whether in low-, middle- or high-income countries.

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Author contributions

JBF, JK, and RS were responsible for the conception and design of this study as well as the initial contact with the local authorities. JBF and JK (the principal investigators) developed the study site operational protocols and were responsible for training the members of the research team. JBF, JK, BA, MN, NG and SA were responsible for adapting and validating the data collection tool during the pilot phase of this study in order to determine and select the most appropriate, reliable and valid assessment items for inclusion in the final version of the study tool used. All authors contributed to data acquisition, quality control and adherence to the prerequisite site operational protocols as well as the recommended ethical considerations. JBF, JK and RS were responsible for the conduction of this study, including the coordination of data collection and associated logistics. JBF and JK were in charge of statistical analyses and the drafting of the results section. All authors contributed to the interpretation of the analysed data. The first draft of the manuscript that culminated

in this published article was written by JBF. SA critically reviewed the initial and subsequent versions of the drafts of the proposal and manuscript that resulted in this published article. All authors approved the final version of the manuscript intended for publication and accepted accountability for the resultant literary work published in this article.

Abbreviations

COVID-19: Coronavirus disease 2019

CPL: COVID-19 Pandemic-related lockdown

CPLC: COVID-19 Pandemic-related lockdown and curfew

GBV: Gender-based violence

KIUTH: Kampala International University Teaching Hospital

Data availability

The data utilised in this study are freely available for download in a deidentified format from the corresponding author on reasonable request.

Conflict of interest

The authors declare that there is no conflict of interest.

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