Reproductive Health in Northern Uganda

Women's Refugee Commission, August 2009

BACKGROUND

In February 2007, the Women's Refugee Commission[1] and the United Nations Population Fund (UNFPA) conducted an assessment of the reproductive health situation in the Kitgum and Pader Districts of northern Uganda. A key finding was the lack of access to family planning services for the Districts' displaced women, men and youth. In June 2008 and in May 2009, Women's Refugee Commission staff followed up on the status of the original assessment report recommendations. The two-year follow-up mission focused primarily on the Acholi sub-region of Kitgum, Pader and Gulu Districts.

CONTEXTUAL UPDATE

After 20 years of civil war, which resulted in the displacement of more than 1.5 million people, a ceasefire agreement was signed in 2007 between the Lord's Resistance Army (LRA), a rebel armed group, and the Government of Uganda. With the stability in the north now improving, displaced persons have begun to return to their parishes of origin. As of May 2009, close to 60 percent of internally displaced persons (IDPs) in the Acholi sub-region were estimated to have returned.[2] The returnee situation has presented new challenges to providing basic health and social services, especially as people are farther away from stationary health facilities and service delivery points.

PROGRESS SINCE 2007

Meetings with service providers and policy makers in Kampala, Kitgum, Pader and Gulu showed that access to antiretroviral treatment for AIDS has improved greatly. More service delivery agencies were providing family planning services. Several international agencies, in partnership with the district Ministries of Health, are providing mobile family planning services for long-term and permanent methods, including implants, tubal ligation and vasectomies. The team also found that the Straight Talk Foundation—a local nongovernmental organization—had established another youth center in Kitgum, offering comprehensive reproductive health services to youth, including treatment for sexually transmitted infections (STIs), a service area which had been previously identified as an overarching area of need.

CHALLENGES

Further funding and support are needed to address the ongoing challenges, including staffing gaps in health centers, drug and equipment shortages and training needs, particularly midwifery skills. Agencies reported limited family planning integration into overall HIV programming, especially in efforts to prevent mother-to-child transmission of HIV. A shortage of drugs that reduce the risk of HIV transmission after sexual assault or occupational exposure—post-exposure prophylaxis (PEP)—was also observed in health facilities due to policy, logistical and provider constraints. Providers lacked the confidence to administer PEP, which has resulted in the expiration of drugs and their consequent recall.

Technicians at a laboratory inside Kitgum Youth Center, one of the few places in the region with its own lab.

PROMISING PRACTICE

The International Rescue Committee (IRC) is working with Kitgum District to ensure ambulance coverage for emergency obstetric care referrals 24 hours a day, seven days a week for the entire district. Such a "step-in" system, where an agency fills the immediate gap and works to integrate the ambulatory service into the district's structures, could potentially be replicated to address the referral gaps in other districts.

The emergency obstetric care (EmOC) referral systems that enable pregnant women experiencing complications to reach health centers or hospitals with higher-level care were found to be particularly problematic, especially in Pader, Gulu and Amuru (the new district adjacent to Gulu). The lack of telecommunications systems to coordinate ambulances and funds for fuel and vehicle repairs presented challenges for the districts to maintain the EmOC referral system.

Platforms to address ongoing challenges—specifically, reproductive health coordination structures that include all stakeholders—appeared to be functioning in Pader. But due to competing priorities, national-level meetings facilitated by the Women's Refugee Commission at the June 2008 Reproductive Health in Emergencies Conference were stalled. Gulu District, however, showed much enthusiasm in convening monthly meetings with key partners.

WHAT IS NEEDED?

To improve reproductive health services and access in northern Uganda, the Women's Refugee Commission recommends:

- **Sustained donor commitment** for existing humanitarian and new development funding schemes to support the districts of northern Uganda as they transition from relief to development. This support will enable returning populations continued access to basic health and social services.
- **Strengthened reproductive health coordination** among policy-makers and organizations providing reproductive health services in the north. Such organization is necessary in order for agencies to use the coordination meetings as a mechanism to problem-solve and strategize around issues such as EmOC referral transport systems and IDP returns.

The Women's Refugee Commission will advocate with the donor and humanitarian communities for the accelerated provision of reproductive health services to crisis-affected populations in the north.

Notes:

[1] Until January 2009, the organization was known as Women's Commission for Refugee Women and Children.

[2] According to the Inter Agency Standing Committee (IASC) in Uganda, approximately 56 percent of IDPs in the Acholi region were estimated to have returned. Roughly 22 percent were living in transit sites. Update on IDPs Movement, IASC, May 2009.

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Since 1989, the Women's Refugee Commission has advocated vigorously for policies and programs to improve the lives of refugee and displaced women, children and young people, including those seeking asylum—bringing about lasting, measurable change.

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