WOMEN'S COMMISSION
for refugee women & children

UNFPA

# We Want Birth Control

## Reproductive Health Findings in Northern Uganda

Women's Commission for Refugee Women and Children
and
United Nations Population Fund

**June 2007**



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ISBN: 1-58030-060-X

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# CONTENTS

# ACRONYMS & ABBREVIATIONS

| | |
|---|---|
| ABC | Abstinence, Be faithful and use Condoms |
| AMREF | African Medical and Research Foundation |
| ANC | Antenatal care |
| ARV | Antiretroviral |
| BCC | Behavior change communication |
| CAO | Chief administrative officer |
| CBD | Community-based distribution |
| CBDA | Community-based distribution agent |
| CHW | Community health worker |
| COC | Combined oral contraceptive |
| CORP | Community-owned resource person |
| CRHW | Community reproductive health worker |
| DRC | Democratic Republic of Congo |
| EC | Emergency contraception |
| EmOC | Emergency obstetric care |
| GBV | Gender-based violence |
| GYC | Gulu Youth Center |
| HIV/AIDS | Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome |
| IASC | Inter-agency Standing Committee |
| IDP | Internally displaced person |
| IEC | Information, education and communication |
| IOM | International Organization for Migration |
| IRC | International Rescue Committee |
| IUD | Intrauterine device |
| LRA | Lord's Resistance Army |
| MoH | Ministry of Health |
| MVA | Manual vacuum aspiration |
| NGO | Nongovernmental organization |
| PAC | Post-abortion care |
| PEP | Post-exposure prophylaxis |
| PMTCT | Prevention of mother-to-child transmission |
| PNC | Post-natal care |
| POP | Progestin-only pill |
| RH | Reproductive health |
| SAE | Sexual abuse and exploitation |
| SAM | Services availability mapping |
| SRH | Sexual and reproductive health |
| STI | Sexually transmitted infection |
| TASO | The AIDS Support Organization |
| TBA | Traditional birth attendant |
| UDHS | Uganda Demographic and Health Survey |
| UHSBS | Uganda HIV/AIDS Sero-Behavioral Survey |
| UHSSP | Ugandan Health Sector Strategic Plan |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UPDF | Uganda People's Defense Forces |
| USAID | US Agency for International Development |
| VCT | Voluntary counseling and testing |
| VHT | Village health team |
| WHO | World Health Organization |

# ACKNOWLEDGEMENTS

This report was written and researched by Sandra Krause, director, reproductive health program and Laetitia Bader, intern, Women's Commission for Refugee Women and Children. The report was reviewed by Primo Madra, Rachel Goldstein and Grace Latigi from UNFPA Uganda; Sophie Read-Hamilton, UNICEF Uganda; Wilma Doedens, UNFPA; and William Oloya, AMREF Uganda. The report was edited by Sarah Chynoweth, Mihoko Tanabe and Diana Quick of the Women's Commission and designed by Diana Quick. However, this project would not have been possible without the participation of the internally displaced women, men and youth in northern Uganda whose insight, stories, time and advice are invaluable.

The Women's Commission is also grateful to the United Nations Population Fund (UNFPA) for its essential support and participation in this assessment and our advocacy initiative to promote key recommendations in the report. In particular we would like to thank Denise Ogwang for her time and experienced input in both organizing and participating in the assessment mission.

This assessment was made possible by the generous support of an anonymous donor, the Bill and Melinda Gates and Hewlett Foundations and UNFPA.

Photographs by Sandra Krause and Wilma Doedens.

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# MISSION STATEMENTS

## THE WOMEN'S COMMISSION FOR REFUGEE WOMEN AND CHILDREN

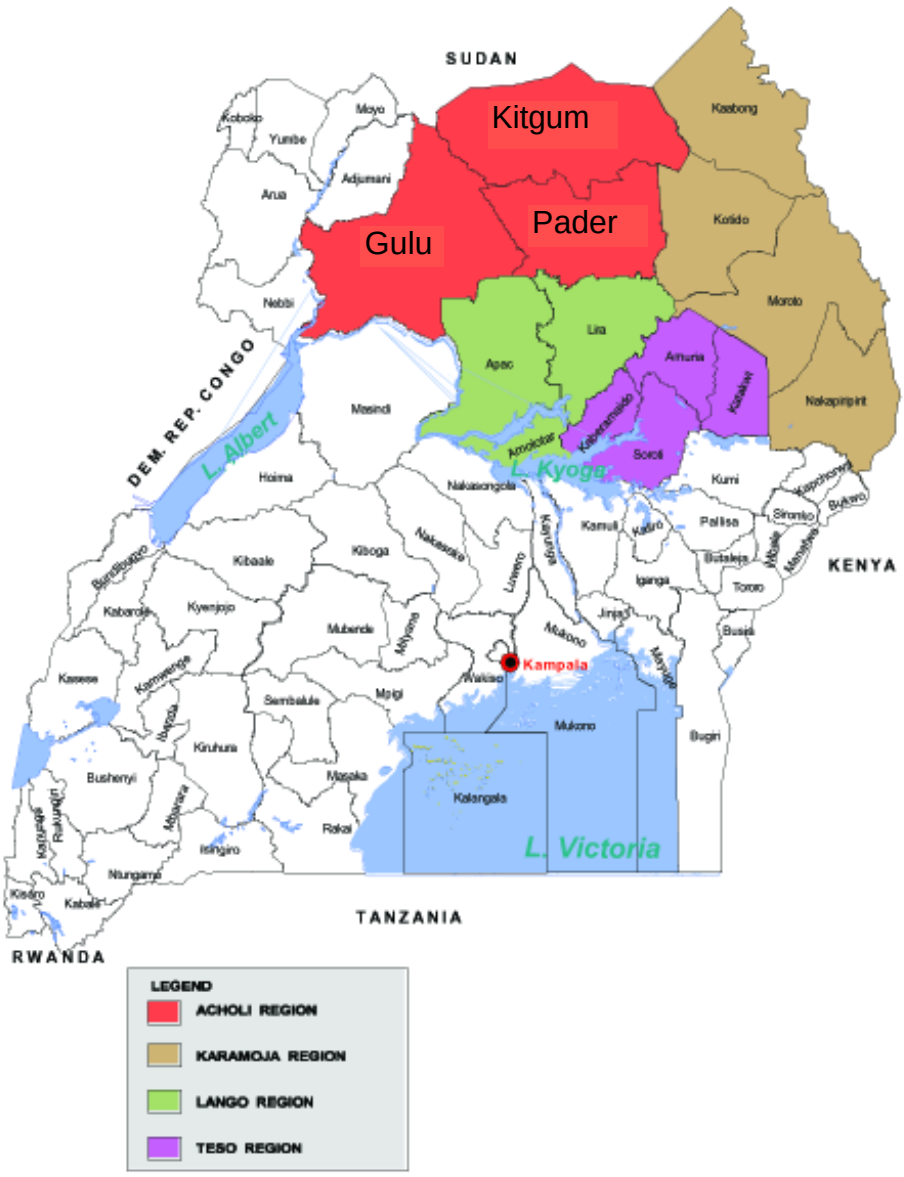
The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women, youth and children. The Women's Commission works in consultation with refugee women, youth and children. Through our advocacy, we ensure that their voices are heard in the halls of power and taken into account in the decision-making process. Our work contributes to long-term solutions, thereby lessening the likelihood of continuing cycles of conflict and displacement.

The Women's Commission is legally part of the International Rescue Committee (IRC), a non-profit 501(c)(3) organization. The Women's Commission receives no direct financial support from the IRC.

## THE UNITED NATIONS POPULATION FUND

UNFPA is the world's largest multilateral source of population assistance. Since it became operational in 1969, UNFPA has provided close to $6 billion to developing countries to meet reproductive health needs and support sustainable development issues. The Fund helps ensure that women displaced by natural disasters or armed conflicts have life-saving services such as assisted delivery and prenatal and post-partum care. It also works to reduce their vulnerability to HIV infection, sexual exploitation and violence.

# MAP OF UGANDA




Eleven new districts were created in July 2006 which are not included in this map.

# I. EXECUTIVE SUMMARY

## OVERVIEW

The Women's Commission for Refugee Women and Children (Women's Commission) and the United Nations Population Fund (UNFPA) conducted a reproductive health (RH) assessment among the conflict-affected populations of northern Uganda in February 2007. Northern Uganda has been embroiled in a civil war for almost 20 years, resulting in the displacement of approximately 1.5 million people. The assessment team visited the districts of Kitgum and Pader and also visited a youth center and clinic in Gulu. In general, the findings revealed that although some basic services were in place, many were sorely lacking.

## SPECIFIC FINDINGS

Although the World Health Organization (WHO) leads the health cluster in the cluster approach aimed to enhance coordination and accountability at the field level and works collaboratively with UNFPA and the UN Children's Fund (UNICEF), there is a lack of adequate overall coordination for RH. Specifically, RH coordination meetings are not in place at the national level and RH is reportedly buried in health coordination meetings that primarily address infectious disease control. However, RH coordination meetings were established in Gulu district approximately one year ago though the meetings reportedly lack vigorous activities and some direction for them would be helpful. In addition, in Pader district a sub-sector working group was established for child and reproductive health though no information about the group was obtained.

The overall environment for RH programming is made worse by a significant gap in the coverage of health facilities and a dearth of qualified health care workers, resulting in fair to poor RH services in the settings visited. In addition, although Ministry of Health (MoH) protocols for the delivery of comprehensive RH services are developed and were observed at the WHO, they are not used at the facility level.

Overall antenatal care coverage was good, although supply gaps were found. Most deliveries take place at home with traditional birth attendants (TBAs). Although UN agencies and non-governmental organizations (NGOs) had undertaken some training of health workers in life-saving emergency obstetric care for women suffering from complications of pregnancy and delivery, essential materials and supplies were not available in some cases and there were gaps in training follow-up. In addition, most health workers did not have access to telephones or transportation options to facilitate timely referrals to higher level facilities and hospitals.

Gaps in health workers' knowledge and practice of universal precautions to prevent transmission of infections were significant. Although sexually transmitted infections (STIs) were reportedly common, standardized protocols for syndromic treatment were unavailable.

Many focus group participants appeared to have knowledge about HIV/AIDS and generally good access to HIV/AIDS prevention, treatment and care, perhaps reflecting the success of political will and funding. However, female condoms were not available and some men wanted to use male condoms but did not know how to use them. In addition, there were stock-outs of nevirapine to prevent mother-to-child transmission (PMTCT), post-exposure prophylaxis (PEP) for women and girls surviving rape and a shortage of anti-retroviral treatment drugs in government centers.

Family planning services were very weak and women were desperate to access birth control. Yet many men wanted large families and did not recognize the benefits of birth control; others suspected that their wives were planning affairs if they accessed birth control, resulting in significant discord and some domestic violence. Further, although some family planning supplies were available, women often did not know how to access them.

Sexual abuse and exploitation were reportedly very widespread and appeared to be accepted as a distressing outcome of the poverty associated with war. Rape and domestic violence were also perva-

sive. Practices relating to gender-based violence (GBV) such as marrying girls to perpetrators, encouraging girls to engage in sexual relationships with men in positions of economic and other power, and domestic violence are entrenched in cultural norms and exacerbated by conflict. Services for youth were generally lacking, although a particularly good initiative that combined recreational and educational programs with high quality service delivery was identified in Gulu district.

## ASSESSMENT METHODOLOGY

The assessment was undertaken by the Women's Commission's executive director, RH program director and three board members and a UNFPA technical advisor. The team conducted structured interviews and meetings with representatives of local and international NGOs, including RH coordinators and UN agencies, as well as members of the MoH and district level health officials. The assessment also included 10 focus groups with 80 men and 140 women and youth displaced by the conflict. In addition, the team visited local and district level health facilities.

## RECOMMENDATIONS

### Funding

- Donors should prioritize support to the MoH for reproductive health when they provide support to the Ministry of Finance.
- MoH should increase the health sector budget for RH and support adequate funding at the district level.
- MoH, UN agencies, national and international NGOs and donors should scale up support for information, education and communication about family planning and emergency contraception, particularly among internally displaced men, as well as the community-based distribution of contraceptives in all camps.

### Coordination

- MoH, WHO and UNFPA should strengthen RH coordination by establishing monthly RH coordination meetings in Kampala and in the districts of Kitgum and Pader while revitalizing the existing working group in Gulu.
- MoH, WHO, UNFPA and national and international NGOs should ensure MoH standard protocols are reviewed and/or new protocols developed and that these are implemented by health providers to ensure the delivery of quality RH services.

### Health Facilities and Staffing

- MoH, UN agencies, national and international NGOs should continue to renovate, upgrade and strengthen nonfunctional facilities and establish Health Center IIs and IIIs in addition to staff housing in northern Uganda.
- MoH should fully implement its planned incentive package to address the acute shortage of health workers in northern Uganda.
- MoH, UN agencies and additional national and international NGOs should consider recruiting qualified health staff by offering scholarship opportunities for health worker training with reciprocal commitments to work in northern Uganda for a designated number of years.
- Wealthier governments such as the US government should not recruit trained health staff from Uganda and should provide increased financial support to the Uganda health sector to support employment of Ugandan health professionals.

### Training

- MoH, UN agencies, national and international NGOs should provide refresher training in the practice of universal precautions and ensure appropriate medical waste disposal systems are functioning.
- MoH, UN agencies and national and international NGOs should collaboratively plan to provide refresher training for health workers in family planning and basic emergency obstetric care at all Health Center IIs and IIIs.
- MoH and UN agencies and national and international NGOs should provide refresher training for health workers on clinical management of rape survivors, using standard protocols and according to an agreed upon curriculum.
- MoH, UN agencies and national and international NGOs should provide refresher training for health workers in medication administration

and logistics systems management.

- MoH should train health workers in professional behavior and integrate community evaluation of health workers' ethical and respectful behavior with patients in its new management performance review system while all agencies should hold health workers accountable for misbehavior.

### Reproductive Health Equipment and Supplies

- MoH should require that health workers order a minimum requisition of medicines and supplies, including contraceptive commodities such as female condoms.
- MoH, UN agencies and national and international NGOs should ensure that clean delivery supplies and syphilis testing are available to all pregnant women.
- Health centers should be equipped with cell phones and transportation to support the immediate referral of women suffering from complications of pregnancy and delivery to health centers where basic emergency obstetric care (EmOC) is available and further referral as needed for comprehensive EmOC.

### Safe Motherhood

- Community-owned resource persons (CORPs) and traditional birth attendants (TBAs) should educate pregnant women and their families about the danger signs of pregnancy and the immediate referral of women to health facilities.
- Rapid syphilis tests to screen antenatal care (ANC) clients should be widely available and staff trained in their use.
- Health workers should discuss with all pregnant women receiving antenatal care their plans for delivery and transport to health facilities in the event they suffer complications of pregnancy and delivery.

### Family Planning

- MoH, UN agencies and national and international NGOs should train community health workers such as CORPs and TBAs about family planning and contraceptives, including male and female condoms.
- CORPs and TBAs should provide training to community members on community-based distribution of contraceptives, including male and female condoms.

### STIs including HIV/AIDS

- MoH, UN agencies, national and international NGOs should encourage voluntary counseling and testing for couples as a component of antenatal care.
- MoH, UN agencies, national and international NGOs should support comprehensive care for HIV-positive internally displaced persons, including consistent antibiotic prophylaxis and access to antiretrovirals as appropriate.

### Gender-based Violence

- Donors should provide immediate support to WFP for adequate food distributions with kilocalories that meet international standards.
- MoH, UN agencies, national and international NGOs should support women's and girls' safe access to their basic needs, including water, food, fuel and sanitation.
- MoH, UN agencies and national and international NGOs working in the direct provision of health services should all be competent to directly provide comprehensive clinical care, including post-exposure prophylaxis, emergency contraception, prophylactic antibiotics and other care as needed, to women and girls surviving rape. This training should be closely monitored and supervised with regard to both the competency and the professionalism of providers and the availability of appropriate drugs and supplies. All medicines in the post-rape treatment protocol, including post-exposure prophylaxis, should be available for women, girls, boys and men surviving rape.
- UN agencies and national and international NGOs should increase viable and appropriate income generation activities for women and girls to alleviate acute poverty and women's vulnerability to sexual abuse and exploitation.

### Youth

- MoH, donors, including UN agencies, and

national and international NGOs should support both the continuation and expansion of the youth-friendly services provided by the Gulu Youth Center to more camps in the district and replicate the Gulu Youth Center model in Kitgum and Pader districts.

- MoH, UN agencies and NGOs should advocate to community members, including parents, teachers and other authorities, to allow and encourage pregnant girls to remain in school for the duration of their pregnancy and to return to school to continue their education after delivery.

### NEXT STEPS

The Women's Commission will:

- develop a basic synopsis of the report, translate it and send it to internally displaced persons participating in the assessment;
- disseminate the report widely with some individual cover letters to representatives of governments, UN agencies, donors and NGOs;
- give presentations on the assessment findings and recommendations to government, UN, NGO and donor representatives;
- meet with UN representatives (particularly UNFPA and UNICEF) and NGO representatives to discuss the assessment findings and to promote the report's recommendations;
- address the assessment findings with the media where there are appropriate opportunities; and
- follow up with UNFPA Kampala in six months and one year to determine progress on the report recommendations.

# II. INTRODUCTION

In 1986, the Lord's Resistance Army (LRA), a rebel group claiming to represent the ethnic Acholi minority from northern Uganda, formed in order to overthrow the government and rule the country along the lines of the Biblical Ten Commandments. The resulting conflict between the LRA and the national army, the Uganda People's Defense Forces (UPDF), has lasted for almost 20 years and has led to the displacement of over 1.5 million people, approximately 90 percent of the Acholi population.[1] Their displacement has been provoked by the violence inflicted on them by both the LRA and government operations, notably the relocation of the civilian population to "protection camps" under UPDF control. The LRA have persistently targeted civilians in northern Uganda subjecting them to indiscriminate killings and abuse, including the abduction of more than 30,000 children to serve in the rebel forces as soldiers, sex slaves and porters.[2] Soldiers of the UPDF deployed to the internally displaced persons' (IDP) camps have also committed abuses, including rape and killing, and have largely been given impunity.[3]

In August 2006 an agreement for cessation of hostilities was signed between the Ugandan government and the LRA. Pressing issues, however, remain unresolved, notably the question of the pending arrest warrants issued by the International Criminal Court against LRA leaders and the continued marginalization of the Alcholi by the central government.[4] Since the ceasefire, the government has been encouraging the internally displaced population in certain districts to relocate to decongestion camps or to return home. Some IDPs have sought to move to the less congested sites in the hope of gaining access to land; others have moved out while keeping their spots in the main camps. In theory the government's relatively comprehensive IDP Policy supports voluntary return and a range of governmental structures have been set up to deal with the issue.[5] However, in practice, the government and the army often determine whether or not IDPs can return home.[6] Furthermore, not all IDPs are keen to return: insecurity remains widespread, infrastructure in places of return is in disrepair and at times non-existent and some of the younger IDPs have become accustomed to living in a more urban environment.[7]

# III. REPRODUCTIVE HEALTH BACKGROUND

## NATIONAL REPRODUCTIVE HEALTH CONTEXT

Uganda has one of the fastest growing populations in Eastern Africa (3.2%)[8] and a high maternal death rate. Although the Ugandan Ministry of Health (MoH) has developed numerous policies and guidelines promoting sexual and reproductive health (SRH), these have brought limited change, primarily in the area of HIV/AIDS. It has only been in the past year that the MoH specifically prioritized RH and it remains less than one percent of the entire health sector budget[9] with most RH programming financed by international donors.[10]

Clear disparities exist regarding the RH status between urban, rural and conflict-affected populations in Uganda. Available resources are unequally distributed: most of the health and RH funding is funneled to urban hospitals that are inaccessible to a large portion of the population. Trained health care providers are often unwilling to work in remote areas and to work with certain populations, notably the ethnic Acholi in the north. As a result, morale is low among service providers working in these neglected areas as they are both poorly remunerated and under-trained.[11]

Nationwide, the use of contraception remains very low according to the 2006 Uganda Demographic and Health Survey, with a combined national prevalence rate of 23 percent.[12] There is a clear discrepancy between urban (41%) and rural (21%) contraceptive usage.[13] Abortion is banned, except to save a woman's life. As a result women are likely to seek unsafe abortions, and even women who receive the help of a trained practitioner face unsanitary conditions and complications.[14] Fees and stigmatization from health providers prevent many from receiving essential post-abortion care.[15]

Overall, the proportion of deliveries taking place in health facilities is low. Women who experience unforeseen complications during pregnancy and childbirth are unlikely to receive emergency obstetric care (EmOC)[16] as accessing care is challenging, expensive and access to transport is limited.[17] In addition, giving birth at home is a valued practice and TBAs, who are still very popular, are often reluctant to refer women to health facilities. As a result, women often only go to health facilities when they are already in a desperate condition.[18]

The RH status of adolescent girls is particularly dismal. Uganda has one of the highest levels of adolescent pregnancy in sub-Saharan Africa, primarily as a result of inadequate information on sexual and reproductive health for adolescents, lack of adolescent-friendly services, early marriage, early sexual activity and low contraceptive use.[19] HIV/AIDS infection rates among young women (15 to 24 years of age) are more than double those of their male counterparts.[20]

Violence against women, including rape, is a significant problem.[21] Domestic violence is particularly high and law enforcement officials rarely intervene in such cases.[22] Women rarely report such cases although there has been a significant increase in the number of women and girls coming forward since the latter half of 2006 due to the establishment of GBV prevention and response programs.[23] Early forced marriages remain common particularly in rural areas. According to a report by Human Rights Watch, intimidation, threat and violence by partners have been shown to prevent women from gaining access to HIV/AIDS services.[24] The government has recently set up a task force on infant and maternal mortality that includes within its mandate addressing sexual violence.[25]

A large proportion of SRH government spending is targeted for HIV/AIDS programming. In the 1990s high-level political commitment to this issue succeeded in reducing overall HIV prevalence from 18 percent to the current rate of 6.4 percent; however, a new abstinence-only policy, driven by funding imperatives set forth by the U.S. government, has negatively impacted this trend. Condoms continue to be used and promoted as an HIV/AIDS protection rather than as a form of contraception. According to the Ugandan AIDS Commission, married couples are the group most at risk and women are disproportionately affected.[26]

| REPRODUCTIVE HEALTH INDICATORS | |
|---|---|
| | **NATIONAL** |
| Maternal Mortality Ratio: maternal deaths per 100,000 live births | 435 (UDHS2006) |
| Total fertility rate | 6.7 (UDHS 2006) / 7.11( 2006 World Pop Report) |
| Age specific fertility rate per 1000 women, 15-19 | 203 (World Pop Report) (UDHS 2006) |
| Contraceptive Prevalence (all methods) (%) | 23 (UDHS 2006) |
| Unmet need for family planning, total (%) | 41 (UDHS 2006) |
| Births attended by trained personnel (%) | 41 (UDHS 2006) |
| Adult HIV prevalence (%) | 6.4 (Uganda HIV Sero-Behavioral Survey 2004-05) |
| People living with HIV/AIDS | 1,000,000 (UNAIDS 2005) |

Sources: 2004-05 Uganda HIV/AIDS Sero-Behavioral Survey (UHSBS); UNFPA Uganda Profile http://www.unfpa.org/profile/uganda.cfm; UNAIDS/WHO Global HIV/AIDS Online Database, figure from 2005; Uganda Demographic and Health Survey 2006 (note the UDHS findings are preliminary); State of the World Population 2006, UNFPA; Uganda Country Health System Fact Sheet 2006, WHO

## REPRODUCTIVE HEALTH IN NORTHERN UGANDA

The conflict has clearly had a very negative impact on basic health services in northern Uganda. The infrastructure has been damaged and many facilities and agencies, including the Family Planning Association of Uganda, were forced to shut down as the conflict intensified.[27] The ongoing insecurity has thwarted improvements to RH services and facilities in the camps.[28] As a result, health care units in the camps are often overwhelmed and managed by predominately unqualified staff. Access to the better equipped district hospitals is severely limited for many people living in the camps, due to lack of transport, restricted freedom of movement and curfews.[29]

According to current indicators the level of RH in northern Uganda has fallen dramatically below national averages. A recent United Nations Population Fund (UNFPA) assessment highlights the fact that many of the international NGOs and agencies providing health care in the camps have limited sexual and RH programs.[30] The programs that are in place tend to focus on condom distribution and largely neglect other aspects of sexual and reproductive health. The MoH with the World Health Organization (WHO) and other partners conducted a comprehensive health Services Availability Mapping (SAM) in camps and health facilities in Gulu, Kitgum and Pader districts in 2006 (see Appendix II).


*Group of children outside Padibe Health Centre IV.*

| REPRODUCTIVE HEALTH INDICATORS IN NORTHERN UGANDA | |
|---|---|
| Contraceptive prevalence (all methods) (%) | 11 (Northern Region) / 12 (IDP camps) |
| Unmet need for family planning, total (%) | 58 (UDHS 2006) |
| Births attended by trained personnel (%) | 35 (UDHS 2006) |
| HIV adult prevalence in the conflict-affected regions (%) | 8.2 (UDHS 2004-05) |

Source: Uganda Demographic and Health Survey (UDHS) 2006 (note the findings are preliminary)

# IV. ASSESSMENT METHODOLOGY

The RH assessment was carried out in cooperation with UNFPA from February 8-22, 2007. It was undertaken by the Women's Commission for Refugee Women and Children's executive director, reproductive health program director and three board members, and a UNFPA technical advisor. The team assessed the conflict-affected districts of Kitgum and Pader and a short trip was also taken to Gulu to visit an acclaimed youth center and one health facility operated by a nongovernmental organization (NGO). The team visited Padibe and Mucwini camps in Kitgum, with populations of 41,260 and 25,434, respectively, and in Pader the team visited Omot and Patongo camps, with populations of 8,465 and 40,335, respectively.

## FOCUS GROUP DISCUSSIONS

The team conducted focus group discussions in each of the camps with women, men and youth using structured questionnaires. In preparation for the focus groups, an assessment team member requested that community leaders organize the voluntary non-random selection of male, female and youth participants from each section of the camp in advance of the team's arrival. Four (three female and one male) focus groups were arranged in Kitgum district and six (three female and three male, including one male youth and one female youth) focus groups were arranged in Pader district. The questionnaires were reviewed prior to use with the team's two local female translators. Prior to the start of the focus groups, participants were informed about the content of the questionnaires and discussion, the purpose of collecting the information and how the information would be used with full respect for confidentiality. Focus group participants were also guided to respond to the questions based on their understanding of the situation in general versus their own personal experiences, informed about the importance of confidentiality among participants and the assessment team's confidential use of the information, as well as their right to refuse to participate and to remain silent. Approximately 220 community members, including 140 females, 80 males and 20 youth, participated in the 10 focus groups.

## STRUCTURED INTERVIEWS AND DIRECT OBSERVATION VISITS

The assessment team also conducted structured interviews and meetings with representatives of international NGOs, including RH coordinators and UN agencies, as well as members of the MoH and district level health officials. In addition, the team visited and conducted direct observations in five health facilities in Kitgum and Pader districts and two health facilities in Gulu district.

### LIMITATIONS

The main constraints for this assessment were time limitations preventing both visits to additional camps and follow-up meetings or debriefings with some agency representatives, and the difficulty of conducting more focus groups with youth who were generally in school. The team heard from several representatives of NGOs, UN agencies and the MoH about the dire situation, extremely poor health indicators and desperate needs among IDPs, particularly women and children, in the Karamoja region of northern Uganda, but was unable to visit the region. In addition, as focus group participants were not randomly selected, the findings cannot be construed to represent the male, female or youth populations as a whole in the camps visited. The assessment is therefore limited to a "snapshot" of the situation in several health facilities and important voices of women, men and youth from the IDP community in Kitgum, Pader and, to a very limited extent, Gulu districts.

# V. FINDINGS

### GENERAL

Several key informants described the needs in northern Uganda as a major challenge both from a development and a humanitarian perspective. A UNICEF representative claimed that over the past two years the international community's response has been one for developing countries, but with an emergency response component. The long-term nature of the conflict requires a development approach, yet survival needs remain great and the gamut of basic services must also be established in new "decongestion camps" where IDPs have started to relocate.[31] Humanitarian and development actors must balance priority needs in both existing and new camps with interventions that support long-term development.

The peace talks between the government and the LRA appeared to be unraveling at the time of the assessment.[32] Reports of insecurity during the assessment mission were associated with the Karamoja region where a few cattle rustlers crossed into the sub-Acholi region and seven civilians were killed. According to one government official, government forces retaliated, killing 42 others.[33]

In Padibe and Patongo camps, female focus group participants said that their most pressing concerns were inadequate supplies of food and non-food items such as cooking utensils, tarpaulins and bedding; overcrowded schools largely lacking in teachers; and insufficient health services.

Two-thirds of male focus group participants in Padibe camp used government health facilities while one-third used private health facilities managed by Catholic missionaries. Those attending private health facilities wanted to avoid waiting for up to two days at government facilities, which they said were only open from 8:00 a.m. to 2:00 p.m. They noted that private facilities have more effective laboratory testing and are open 24 hours per day, seven days per week but they must pay for services. In addition, women said that there is always a shortage of drugs at government health facilities and illnesses drag on because the full dose of treatment is usually unavailable.

The district chair person in Pader identified lack of water, limited road access and an acute shortage of personnel in health centers and schools as the most serious problems facing the district. He said that according to government regulations, there should be five doctors in Pader but there are only three doctors, one of whom is a dentist. He stated that doctors are not motivated to work in Pader because there are no libraries, insufficient staff housing and inadequate facilities. For example, the hospital was built in 1938 and has never been renovated.

The chair person also gave examples of the consequences of the dire circumstances in Pader: one woman said to him:

"I am sleeping every night with a hungry stomach. I choose to sleep with a soldier who is HIV-positive who provides me with food. I know eventually I would contract HIV but at least I continue to live another few years with food in my stomach."

Another tragic example he gave was that of a disabled man who, having lost his wife, would no longer allow his eight-year-old daughter to continue school so that she could care for the family.[34]

Female focus group participants in both camps that the assessment team visited in Pader district said that their greatest problem was finding an economic activity to support themselves and their children. Male focus group participants said that their main concern was insecurity: a man had been shot dead that very day and they had been hearing gun shots that they feared were being fired by men from the Karamoja region. They were also concerned that the main camp would split into satellite decongestion camps without water, health facilities or teachers.

## REPRODUCTIVE HEALTH

Among the most significant problems identified, and possibly the least difficult to rectify, is the inadequate RH coordination for IDP populations in northern Uganda at the national, district and local levels. While working groups are reportedly established for the health sector in general and for gender-based violence (GBV) and HIV at all levels, this was not the case for RH (which was said to be unaddressed or "buried" in the general health sector). This gap is clearly a missed opportunity for important health information sharing and collaboration among government, UN and other humanitarian and development actors on numerous significant components of the health sector, including services to address safe motherhood, family planning and sexually transmitted infections (STIs) with the exception of HIV.

Fortunately, UNFPA has recently significantly increased their staffing coverage in Kampala to address RH in northern Uganda and has plans to continue to increase staff in Gulu district to cover the sub-Acholi region, aiding their capacity to work with the MoH and WHO to host regular RH meetings at all levels.

An immediate and long-term challenge, repeatedly voiced in key interviews, is the significant dearth of qualified health workers practicing in northern Uganda. Indeed, the Services Availability Mapping shows that staffing needs do not meet the Health Sector Strategic Plan (HSSP) I recommendations in Health Center IIIs or IVs and there is less than 21 percent staffing coverage for Health Center IIs.[35] The African Medical & Research Foundation (AMREF) also reports that currently only 25 to 50 percent of staffing needs are filled in Health Center IIIs and IVs. "In Health Center IVs, where there should be 46 staff, there are 23 and in Health Center IIIs, where there should be eight staff, there are two."[36] In addition to the lack of care caused by this gap, some health workers such as nursing aides provide health care beyond their training. One assessment team member heard reports from two IDPs of highly unethical behavior by nurses and midwives:

"When my brother's wife, who is 16 years old, delivered, she was frightened with her first baby and would not open her legs so they just cut her legs to force them open."
Jacqueline Amono

"When the wife of my cousin arrived at the hospital for delivery they told her to undress and because she had not prepared herself by shaving, they told her she was a very dirty woman and slapped her for not being prepared."
Josephine Amecho

A host of factors were reported to contribute to the lack of adequate numbers of qualified health workers in northern Uganda, including inadequate government pay; health workers' preference to

work in districts where they come from and lack of interest in settings with the most needs; delays in the recruitment process; death of some health workers; fear of living in an insecure setting; lack of staff housing; no hardship-post incentives; and lack of girls' basic education particularly in the sciences to qualify them for professional training. This is compounded by the emigration of health workers to other countries, caused by attractive recruitment offers from rich countries, and the MoH's lack of employment of and incentives for available trained Ugandan professional nurses. The Uganda diaspora in other countries provides significant income support to families in Uganda.


*From the Daily Monitor*

The MoH is reportedly developing an incentive package for staff to work in northern Uganda and WHO is planning to work with the MoH to develop a management performance review system using a team approach (senior midwives, obstetrician, medical officers, etc.). In addition, some NGOs are working to improve existing health worker capacity, including at the community level, and staff housing.

BEST PRACTICE: To address the health worker shortage, one NGO offers training programs and scholarship opportunities for health workers from northern Uganda, such as medical officers, nurses/midwives and laboratory workers; it provided 24 scholarships for this year alone.

Health center stock-outs of medicine, contraceptive commodities and other supplies were also reported by focus group participants and observed at health facilities. MoH interviewees explained that the decentralized health care system requires districts to requisition essential drugs, including those for EmOC and birth control supplies. If health workers at the community level do not know or choose not to request these medicines and commodities, the district will not secure them from the national medical store, resulting in supply stock-outs and shortages. This problem is exacerbated by high staff turnover, with newcomers ill-equipped to manage the supply chain.

According to a WHO representative, all supervisors in charge at the health units were trained two years ago to forecast/request drugs from sub-district to district to the national medical store. Two internally displaced women also said they believe that government health workers smuggle drugs to a private clinic—then when they are out of the drug, they tell the patient to go to a private clinic that the health worker owns or is associated with and where patients will have to pay for the drugs.

In addition to the problem of health workers not completing consumption reports and making their requests, there are big problems with the delayed distribution of supplies from the national/central level resulting in delays that may last months and sometimes in a notice that the item requested is unavailable. Several MoH staff reported that they had re-ordered supplies on time, but they were told the supplies were "held up" in distribution centers at the district level.

## SAFE MOTHERHOOD

### Antenatal Care

Antenatal care (ANC) services appear fair to good at the health facilities visited, although in Omot camp women must walk nine miles for this care. Delivery kits, bed nets, malaria prophylaxis, folic acid, tetanus toxoid, syphilis testing, voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT), including nevirapine prophylaxis, were generally routine components of care. However, syphilis testing was not available in two sites and supply stock-outs of folic acid and nevirapine were noted. Clean delivery kits were not always provided to pregnant women.

*Focus group discussion with Antenatal Care Clients, Padibe Maternity Unit.*

Health workers reported that partners of pregnant women do not come for VCT. Men consider that getting tested and dealing with the risks of HIV/AIDS for pregnant women is a woman's problem.

### Delivery

In Padibe and Mucwini camps in Kitgum district, health workers and focus group participants report that the majority of women deliver at the health center or hospital, though a large number of women also deliver at home with a TBA. Some TBAs have been trained to assist midwives in the maternity unit. The use of partographs to monitor labor and delivery at health centers was varied. In Patongo camp in Pader district some women have their babies at the hospital and some at home with TBAs. In Omot camp in Pader district all deliveries reportedly take place at home. The TBAs in Omot had been trained by two international NGOs but reported they received no clean delivery supplies. One TBA reported re-using her razor blade and that she did not have soap or gloves.

### Emergency Obstetric Care

According to UNFPA, EmOC is nearly non-existent and the number of skilled deliveries in the northern districts is the lowest in the country.[37] An MoH EmOC needs assessment conducted in 2003 to 2004 showed the met need for EmOC nationally was 24 percent while the recent SAM showed met need in the Acholi sub-region was only 14 percent. The very serious problem of poor family planning coverage and self-induced abortions compound this critical lack of EmOC and leads to additional morbidity and mortality.

> "Many women have died because of complications. They die on the way to town typically." Focus group participant, Mucwini camp.

Most focus group participants in all camps reported there had been anywhere from one to several women and many more infants who died as a result of complications of pregnancy and delivery in the past year. However, male focus group participants in Patongo camp said that approximately 45 women and too many babies to count have died over the past year. The assessment team members discussed checking these reports with the numbers at the local health facility but the men insisted they would not have an accurate count since many women do not make it to a facility.

Focus group participants in Kitgum and Pader districts report that they transport women from home by bicycle—with a stretcher attached if available—to health facilities. Health workers in Kitgum and Pader districts refer women suffering from complications of pregnancy and delivery to the Kitgum and Patongo hospitals, respectively. In one setting an NGO provided a mobile telephone to the clinic and in another the clinical officer uses his own mobile telephone to call an ambulance. However, the ambulance will not travel to at least one setting at night due to security issues. In addition, in one of two settings, vital medications such as oxytocic drugs to prevent hemorrhage and magnesium sulphate for seizures were not available to stabilize a

*Non-functioning bicycle ambulance: it has a flat tire and the bicycle is gone. It is only used to move dead bodies and supplies. Omot IDP camp, Health Centre II.*

patient. Health worker training in post-abortion care (PAC) and the availability of manual vacuum aspiration (MVA) was also mixed.

"What is killing our mothers are simple things that can be stopped."

Dr. Keith Mugarurua, Canadian Physicians for Aid and Relief.

UNFPA has supported the provision of equipment and supplies to 115 health facilities and PAC training for health workers via its partners. They have also procured 30 ambulances although these have been held up for months at the national level awaiting administrative clearances.

### Post-natal care

Post-natal care (PNC) services for women are limited. According to a UNFPA representative, even where PNC services exist there appears to be a lack of information about the importance of PNC at the community level.[38] Some health workers provide routine neonatal and cord care and education on breastfeeding. Generally, according to health workers, PNC services are not available and clients are simply advised to come back in the event that the woman experiences complications. There are many examples of the results of this lack of care; one case in the Padibe camp was particularly poignant. A three-week-old malnourished baby was in the therapeutic feeding center because the mother had been sent home from the clinic immediately after delivery and had died at home three days later. The mother's sister now looks after her own four children and four of the dead woman's children.

The overwhelming majority of women reported immediate breastfeeding of their infants up to two years while several women said they waited three to five days to breastfeed, giving their babies sugar water in the meantime. Some women also said that if a mother weans the baby earlier it often means she is pregnant. A second problem associated with PNC reported in Mucwini camp is that in January, five of the 13 mothers who delivered in the clinic were HIV positive. Health workers were trained by an international NGO and the MoH to train HIV-positive mothers on the important choice to bottle feed or breastfeed. However, mothers who decided to forego breastfeeding after counseling were not provided with formula milk.[39]

Health workers identified training needs in vacuum extraction and a need for supplies, including: bicycles for TBAs and midwives to attend home deliveries; resuscitation kit for newborn babies; furniture and supplies (for clinic rooms); mobile telephones with batteries and chargers; and MVA kits. Humanitarian actors reported the need for more training, equipment and follow-up. UNFPA and other organizations have conducted a variety of trainings on EmOC, including PAC and MVA. However, in some cases the equipment was provided but there was no follow-up; in other situations the training did not include the provision of MVA equipment. Fortunately UNFPA, UNICEF, WHO and Marie Stopes International, with its partners through the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative,[40] are planning to significantly scale up support for maternity units and EmOC.

## Family planning

Family planning use is poor in the conflict-affected districts. According to the 2006 Uganda Demographic and Health Survey (UDHS), the northern districts have the lowest contraceptive prevalence rates in the entire country.[41] This is the result of limited availability of contraception and widely held misconceptions about family planning.[42] The unmet need for family planning is reflected in the rates of abortion, which are reportedly the highest in the country.[43] Several NGO representatives said that women and girls attempt to induce abortion with pills, twigs and traditional herbs. The Kitgum district chair person said that as a result of a lack of access to family planning there are too many children who are malnourished and do not go to school.[44]

The most popular method of birth control is Depo Provera. Norplant is also in demand at one health center; if a client requests Norplant, she is referred to the government hospital in Kitgum. Contraceptive use is low. Among 17 clients in one health center in Kitgum in January, 16 of them were new users and only one a continuing user.

Many female focus group participants in both districts reported they wanted birth control. In a Mucwini camp female focus group, a show of hands indicated that more than half of all partici-

pants wanted access to birth control. Contraceptive methods were available at the health facility in Mucwini camp but women were not aware they were available. Although some women said they still wanted up to six children, they also mentioned that they would have wanted more before the war and that it was too difficult now. Most female focus group participants could identify contraceptive methods such as injection (Depo Provera), pills, condoms and Norplant. The overwhelming majority of focus group participants were not aware of emergency contraception (EC). Some of the female focus group participants had never heard of female condoms while others had and were interested in trying them. Focus group participants said that there was a real need for general sensitization, particularly among married men, on family planning in the camps and suggested going house to house to discuss the issue as very few practice family planning.

*Women returning from the market. Like her elders, the little girl is carrying a small baby on her back, protected from the sun by half a calabash shell, Mucwini camp.*

One of the main barriers to family planning repeatedly mentioned by female focus group participants is that men will not allow women to use contraception. Indeed, male focus group participants, particularly older men, repeatedly said that they wanted up to 12 children, one even said he wanted 20 children, or as many as a woman can produce from marriage to menopause. Some men also viewed women's interest in using contraception a signal of planned infidelity. However, in Omot camp some men thought women needed to be sensitized about family planning and a few younger men in male focus group meetings said that they wanted two to four children because it is easier to feed and educate children if there are only a few. According to female focus group participants in Omot camp, discussion of family planning is not allowed and men always have the final say. In Patongo camp men said, "Since the war is finished women should replace children" and, "If you married a woman she should produce until menopause."

> "I have six children and I pray that my husband will understand that I want no more."
>
> "God should be so kind that I can have contraceptives."
> Female focus group participants, Mucwini camp.

The general differences between women's interest in birth spacing and men's interest in having as many children as possible are evidenced in the many reports the assessment team heard in focus group discussions with both women and men about how women seek birth control without informing their husbands. They said that women secretly receive Depo Provera injections or take pills; a man may realize his wife is taking birth control when she experiences bleeding from the side effects of Depo Provera or when she stops menstruating but is not pregnant. When men do find out that their wives are using contraception, they often become very angry and may beat them.[45] In Patongo camp female focus group participants said that the free government hospital expects a woman's husband to attend the clinic with his wife so that he would be more supportive of buying contraceptives from the clinic.

Another barrier to family planning expressed by focus group participants and others was the lack of privacy at health facilities for family planning counseling. If neighbors and relatives see a woman seeking family planning, they spread rumors about her and report it to her husband.

MoH guidelines are available for comprehensive family planning programs and include a wide array of temporary and permanent methods of contraception. EC was introduced in Uganda five years ago and was widely promoted in the media, result-

ing in significant resistance and opposition by local groups. The MoH has recently acquired the dedicated EC product Postinor which is available in the national medical store. The MoH is currently planning to integrate EC with family planning programs, including community-based distribution (CBD), and will avoid a media campaign. They plan to reach people by promoting it as a component of standard family planning programs.

"All methods of contraception are available in the national medical store but they don't reach where they are supposed to go because we have problems of ignorance, negligence and mismanagement. We are dealing with a pull system where supplies must be ordered from the health centers and some people order medicines instead of contraception or do not know how to request them. Training in logistics management is also needed." Dr. Olive, World Health Organization, Kampala.

In the health facilities in both Kitgum and Pader districts, the methods of contraception include: combined oral contraceptives (COCs), Progestin-only pills (POP), Depo Provera (injectable) and male condoms. In most of the Health Center IIs the team visited, expired supplies and stock-outs of one or more of these methods, in particular of COCs and POP, were noted. Uptake of family planning is generally very low, with not more than 10 to 20 clients in each of the settings.

Health workers reported that female condoms are not available and said clients are asking for them. According to the MoH RH focal point in Kitgum district, the MoH introduced female condoms in 2004 and the district received a carton of 1,000 condoms.[46] At first there was a negative reception to the condoms as people complained that they made a lot of noise and were expensive. However, over time some men said the female condom narrows the vagina and others said that the plastic conducts heat, which increases pleasure. They eventually grew to like the female condom but when the carton was finished, replacements were not available.[47]

Several interviewees explained that paying more attention to family planning and making services available increases demand. One interviewee said that in addition to the need for more information, education and communication (IEC) about family planning, contraceptive logistics management is also a problem.

"When commodities are there the uptake goes up. Tubal ligation is available occasionally and the providers work around the clock. Donors must provide more resources and practitioners must put in more work. With enough human and financial resources it can be done."

Nestor Owomuhangi, UNFPA Focal point RH northern Uganda

According to UNFPA, the National Medical Stores deliver commodities to district headquarters and hospital levels; it is the district's responsibility to distribute these commodities to the health centers. Many districts fail to do this and commodities remain in the district stores when facilities have stock-outs for extended periods. The districts then claim a lack of resources.[48]

UNFPA has undertaken trainings on CBD of family planning, training 675 CBD agents and equipping 200 of them with kits of contraceptive supplies. A UNFPA representative reported that CBD is expensive and requires more resources for training, kits, transport, such as bicycles, and good monitoring and evaluation. UNPFA plans to further address CBD through village health teams with its NGO partners in northern Uganda.[49]

"I need help with family planning. No organization has ever come to me to offer help with family planning."

RH focal point, MoH, Kitgum District.

BEST PRACTICE: An NGO in Gulu district sends mobile outreach teams including a physician and a nurse, to Gulu, Kitgum and Pader districts. The mobile clinics offer comprehensive contraception, including condoms, pills, Depo Provera, IUDs, Norplant, tubal ligation and vasectomy. The mobile teams work with trained community mobilizers and visit more than 20 camps, assisting 150 clients per month to access birth control.

### STIs, INCLUDING HIV/AIDS

The practice of infection control by health workers in health facilities was reported by the MoH and observed to be very poor. In the observed Kitgum health facilities, which were all supported by international NGOs, supplies such as needles, syringes and gloves were available but not in abundance, and health workers expressed concern they would run out of these supplies. Disposal systems such as boxes for sharp materials, incinerators to burn sharps and fenced-off waste pits were established, though in one setting the system had broken. There were autoclaves in the health facilities but not a consistent supply of charcoal or paraffin to use them. In addition, there were no written instructions on how to use the autoclaves.

*Unfenced medical waste pit, Health Centre II, Omot IDP camp.*

In one facility the health worker was knowledgeable about how to use the autoclave, yet in another the health worker did not understand the protocol for its use. Adequate water tanks were available in one facility, but not in another. Soap was generally available.

*Dressing room at Omot IDP camp HC II. All equipment and instruments are kept and cleaned in kidney dishes on the floor as the room does not have a table.*

The system for universal precautions to prevent disease transmission was less acceptable in health facilities in Pader district than in Kitgum. Needles, syringes and other supplies were available but the disposal systems were not well established. Water and hand soap were available in one facility but there was no soap in the other; autoclaves were not used in either facility. In one dressing room without furniture, some instruments that had been washed with iodine were on the floor. Health workers requested supplies such as hand soap, jerry cans and basins for hand washing.

Male focus group participants in Padibe camp were familiar with syphilis and gonorrhea and said that they are aware of the symptoms of STIs. They were also aware that treatment should be available at the government clinic, although they must pay for drugs at a private clinic when they are not available at the government clinic. The men also said that some men will visit a traditional specialist for herbs for STI treatment.[50] Male focus group participants in Omot camp said there is no medical treatment for STIs, just herbal remedies, which can have bad results.

According to a UNICEF representative, services to address STIs apart from HIV are unavailable. In

one facility in Kitgum district the clinical officer reported seeing many cases of genital ulcers, urethral discharge and vaginal discharge. He thinks he has seen a few cases of neonatal syphilis. In another health facility in Kitgum district the clinical officer said that he sees a few cases of urethral discharge but believes most men go to private "clinics" (pharmacies) to buy antibiotics. The clinic manager at a health facility in Gulu district where laboratory services are available reported the main STIs included syphilis, gonorrhea and candidiasis.[51]

The health workers at facilities in Kitgum and Pader districts reported following standard STI protocols but no protocols or wall charts were identified. In one facility in Pader district the patient registration book showed that many cases of STIs were diagnosed and the treatment prescribed for infection is an indiscriminate use of antibiotics versus following specific treatment protocols. Male condoms were available for free in one facility but not in stock in another and could also be purchased at markets and "pharmacies."

Focus group participants were very aware and knowledgeable about HIV/AIDS with a few misconceptions. Male focus group participants in Padibe camp said AIDS is common, not curable and kills. Women in this camp said that many people in the community had become sick from AIDS and died. These women blamed the problem on men because they have many partners and women are unable to refuse sex. Most participants could describe what causes the transmission of HIV (sex, accidents causing exposure to blood, blood transfusions and sharps) and how to prevent and treat HIV/AIDS. The majority of participants also had experience with the availability of free voluntary counseling and testing (VCT), including ANC through government facilities and mobile VCT programs. One misconception expressed in a female focus group in Patongo camp was that you can tell by appearances if a person has HIV. The women said, "We don't like people being given medicines because it makes them fat and then you don't know who has AIDS."


*Gulu Youth Center Counselors.*

Focus group participants reported mixed availability of treatment and care for people testing HIV positive. In Omot camp male focus group participants said 15 doses of the prophylactic antibiotic Septrim (co-trimoxazole) were provided to HIV-positive patients by an NGO and they did not return. Antiretroviral (ARV) therapy was reportedly unavailable even for PMTCT.[52] Yet in the same setting, female focus group participants said women could obtain ARV and continue ARV therapy following PMTCT at Patongo hospital.[53] In Mucwini camp women said that PMTCT was not available, but that HIV-positive pregnant women could get Septrim and additional food, and were counseled on positive living. A woman also said she heard that ARVs were available at St. Joseph's Hospital in Kitgum. Men and women in Patongo camp said that ARVs were available if the CD4 count is low.

The medical coordinator of an NGO who supports an HC III in Pader district reported that they have 300 clients, of whom 90 are on ARVs. Ninety percent of all children admitted to the Therapeutic Feeding Centre are HIV-positive. The coordinator says there is a shortage of ARVs in the district. The NGO has sufficient ARVs for their own clients and lends some supplies to other MoH centers in the district to ensure continued treatment of HIV-positive patients. However, they see no improvement in reliable ARV supplies from MoH.

> "My sister is sick with HIV. Her CD4 count is below 50. I think she will die before she gets the drugs. I would pay for her but I can't afford."
>
> Individual interview with IDP woman, Kitgum District.

Male condoms are generally available at public health facilities for free, although in one setting youth reported they were required to pay for them. A recent HIV/AIDS mapping exercise carried out by the International Organization for Migration (IOM) found that although condom distribution was high, it was not enough. Insufficient condom supplies were also a problem.[54] Male focus group participants in Padibe camp said Catholic missionaries do not provide condoms. A box of male condoms is reportedly distributed with VCT in Omot camp; the men complained that while they had the condoms in their huts they did not know how to use them. Men in Patongo camp also said that men do not know how to use condoms and some are afraid to use them while others just don't like them. These men also suggested that there should be more door-to-door services to teach men how to use a condom. One group of women reported that men are responsible for condoms and they do not use condoms with their wives (who number two to four usually), but will use them socially. Other women said men just do not want to use them.

Many women had heard of female condoms and most had never seen them but were interested to learn more about them. Female focus group participants in Patongo camp had heard that female condoms were expensive.

In Padibe camp in Kitgum district, VCT, first-line ARV treatment and antibiotic prophylaxis with Co-trimoxazole were available at the health facility visited. Records showed 25 patients receiving ARVs and 87 patients receiving antibiotics. The clinical officer in Padibe camp requested second-line ARV drugs, explaining that three patients on first-line treatment had died over the past month. In Mucwini camp HIV-positive patients are referred to Kitgum hospital. Several NGOs in Gulu district collaborate to provide community VCT and HIV-positive clients are referred to The AIDS Support Organization (TASO) or a Gulu public health facility.

At one NGO health facility in Gulu district the most common STIs seen are syphilis, gonorrhea and candidiasis. Health workers said they need more antibiotics (ampicillin, chloramphenicol, flagyl, and gentamycin) and second-line ARV drugs.

## GENDER-BASED VIOLENCE

Desk research shows that high levels of alcohol consumption and other problems such as widespread unemployment, idleness and restricted freedom of movement, as well as a break-down of traditional social structures and values and a sense of "emasculation" amongst the male IDP population, contribute to gender-based violence (GBV) in and around the camps.[55]

Most focus group participants reported that rape, sexual abuse and exploitation (SAE) and domestic violence are common. An internally displaced woman said that before the war rape was very rare and that war has exacerbated the problem.[56] In Mucwini camp female focus group participants said that women and girls are most at risk of rape when they collect firewood and water. In Padibe camp women said that women were less at risk of rape associated with the collection of firewood and water in recent times. In Patongo camp women said rape happens a lot, including to children, and usually by UPDF soldiers but also by Karamojong when women are collecting firewood. However, there have been relatively few reported cases of rape by Karamojong with the vast majority of reported rapes perpetrated by community members.[57] Women in Kitgum said that young women are raped at night clubs or by their husbands and that women generally avoid reporting it.

Male focus group participants in Omot camp said that a woman was recently raped by a soldier and when the husband reported it to the authorities the soldier killed him; as a result, other people are afraid to report rape. Similarly, male focus group participants in Padibe camps said that if a civilian man is caught for rape he will be arrested, but if a soldier is reported he will not be arrested. However, it is noted that military are not accountable under civilian law and therefore would not be "arrested" by the police; such cases are addressed through military procedures.[58] In addition, if any girl under the age of 18 years suffers sexual violence, parents settle things at home instead of reporting it. Traditionally, these cases would be adjudicated through customary settlement systems where the perpetrator marries the girl. Others said that the man's or boy's family pays money to the police to drop the case.[59] However, according to the GBV project officer with UNICEF, they are just as likely to pay money to the victim's family as compensation as per traditional adjudication.

There is a level of police corruption because "defilement" (statutory rape) in Uganda is defined as any sexual intercourse with a girl under 18 (even if it is consenting) and is punishable by death.[60] Focus group participants said that if a woman is badly hurt, the police will be called and the man will be put in prison.[61]

Most focus group participants stated that a woman or girl should report rape to the police and that women who are raped also need medical care. Focus group participants in several settings understood this was to prevent the transmission of HIV[62] but they did not mention the opportunity to prevent pregnancy with EC, while others did not understand why medical care was important at all.[63]

Exploitative sex is widespread as women and girls seek a means of survival and soldiers are seen as a source of protection.[64] Female focus group participants in Mucwini camp reported that many women have sex for money especially with soldiers and generally at discos. Men in Patongo camp said sex for survival was common as a result of hardship; yet, they hope it will improve with their return home. Women and girls who had been abducted by the LRA are often ostracized by their communities and appear to be particularly vulnerable to sexual harassment and exploitation.[65]

Domestic violence is frequent and often condoned by the community according to research carried out by Columbia University.[66] Male focus group participants in Omot camp reported that domestic violence is rampant and that these are "disciplinary beatings" because women go off with soldiers or arrive home late without an explanation about where they have been. In addition, there were multiple reports by focus group participants that alcohol abuse contributes to domestic violence.[67] Female focus group participants in Patongo camp said that although people try to help one another, they will not interfere at night if they think the wife is refusing to have sex with her husband. There were no observed systems in place to monitor incidence of GBV other than rape.

"There is a lot of forced early marriage in the North. You end up getting children bearing children"

Bibiane Nyiramana, GBV Advisor, Christian Children's Fund Inc.

UNICEF leads the GBV sub-cluster for northern Uganda and supported the development of a comprehensive GBV Strategy in 2006 and an Interagency Action Plan with designated responsible parties to address GBV in 2007. The strategy outlines interventions at structural, systemic and operative levels to protect women and girls from GBV. Structural activities are considered as primary prevention and include activities that support international, statutory and traditional laws and policies that protect women and girls from violence. Interventions at the systemic level address secondary prevention and focus on monitoring and responding to violations of their rights, including ensuring systems are in place to address health, protection, social welfare and justice needs. Finally, tertiary protection includes activities to ensure direct services to meet the needs of individual GBV survivors. The GBV sub-cluster strategy objectives support the Inter-agency Standing Committee (IASC) minimum interventions to prevent and respond to sexual violence and promote the transition from humanitarian to development actors. Other key activities to achieve the objectives include: coordination at all levels; assessment with data collection and monitoring; and humanitarian action to support protection.[68] [69]

At the time of the assessment, WHO reported that clinical protocols for survivors of sexual violence and post-exposure prophylaxis (PEP) protocols were "going to print" while they are also developing user-friendly "desk aid" guidelines to support the clinical care of rape survivors.

At four of the five health facilities visited by the team in Kitgum and Pader districts an NGO or MoH/WHO had provided training of the MoH staff on clinical care of rape survivors, even though clinical protocols for rape survivors were not available. Health center staff, including midwives and clinical officers, were trained to counsel and to prescribe EC (combined oral contraceptives) and PEP to reduce the risk of HIV infection, and to provide STI presumptive treatment. All supplies, with the noteworthy exception of PEP, were available in all four settings. However, it is important to note that there are concerns about the quality of some of this training and the lack of follow-up and supervision post-training relating to human resource capacity, medicines and attitudes of the health workers, with one senior health worker reportedly engaged in privately humiliating rape survivors.

In one case the clinical officer was not aware that EC can be given to women and girls up to five days[70] after the incident. Staff reported that survivors can come to the clinic without a police form and that sometimes police bring survivors with the form for medical-legal examination by a clinical officer. Staff reported treating one to eight rape survivors per month. In one setting there were no standard forms for recording history, examination and care. At one Health Center II in Pader district—although staff were aware of two women who were raped in the camp the previous month—no one was trained in the clinical management of rape survivors and there were no supplies. One NGO with its own functioning health facilities reported that they refer survivors of sexual violence to another NGO to provide clinical care such as EC, PEP and STI treatment.

An NGO representative said that her organization advocates a holistic family approach to protection of children by promoting an understanding of women's and girls' rights and linking child protection responsibility to parents. She also recommends adult literacy training combined with information to make decisions about their bodies and their lives. Income generation opportunities were also deemed important by this representative to empowering internally displaced women.[71]

## YOUNG PEOPLE

More than one-third of the population in Uganda are 10 to 24 years old[72] and their sexual and RH needs have been particularly neglected. Young people face specific barriers when obtaining contraception, in part due to the fact that several operational health units are run by religious organizations reluctant to offer young people family planning support and methods.[73] Young girls are particularly at risk for GBV, notably at night when they leave their parents' huts or when sleeping in the bush and also as a result of a breakdown in traditional courtship practices, which has led to an increase in rape as a means of forcing girls into marriage.[74]

One NGO representative explained that the overall situation of youth is extremely difficult, with some children born in the camps and missing out on education for 18 years. In addition, she said some youth have lost their parents and do not understand their rights and what they are entitled to. Poverty is so severe that young girls do not have clothes to wear to school, causing them to be too self-conscious and embarrassed to attend. With regard to services, the interviewee said that the attitude of middle-aged health workers to youth is poor and they have not received refresher training on youth needs and issues. Youth need positive role models, support for their dignity and opportunities to increase their self-esteem.

Young people face high sexual and reproductive health risk in northern Uganda, including: early sexual debut (as early as eight years) with the mean age between 15 and 16 years, with more than one-third of girls having experienced their first sexual debut as a result of rape and more than half of boys and girls reporting multiple partners; higher HIV prevalence than in the South; and low acceptance of condoms and contraceptives.[75]

Both male and female adult focus group participants reported that young men and women have sex before they are married. Some said that teenage girls provide sex to men in exchange for food and protection.[76] Many male and female focus group participants said girls have unwanted pregnancies, are forced to leave school and are abandoned by the men. Young girls also attempt unsafe abortions and some have died.[77] [78]


*Gulu Youth Center Schedule of current events.*

Young school girls participating in a focus group in Omot camp said that soldiers approach them wanting sex and will attack them if they refuse. In addition, girls are at risk of sexual violence from boys who do not go to school. They said that girls who are raped are taken to the hospital for med-

ication to prevent HIV. Although girls are allowed back in school some are too ashamed to go back. The girls also said that some girls have sex with men for money and they have heard that some boys visit commercial sex workers. In addition, the girls said domestic violence is endemic and they feel it has increased in the camps.

All of the school girls participating in the Omot camp focus group wanted to continue their education but were worried they would not have the money to attend. The school girls said some girls do not attend school because their parents will stop their daughters who perform poorly in school from continuing and tell them to cultivate the garden; boys, on the other hand, are allowed to continue regardless of their results. They also said there were generally more boys than girls in their class. The girls reported that they were taught in special classes for girls and in co-ed science class about menstruation, pregnancy prevention and HIV. They said they could prevent HIV by using condoms, ensuring a new razor blade for any cutting and abstaining from sexual intercourse.

According to the girls in the Omot focus group, boys will not marry until after they finish school. The girls also said that young people marry between 18 and 24 and that this was a safer age to give birth. In addition, some marriages are arranged by the parents at birth and, if a girl refuses, her parents will disown her.

Boys aged 11 to 16 in a focus group in Omot said that the conflict itself was their main concern. They also said that the majority of young people attending school are boys but they think it is because girls develop a relationship and drop out of school around 12 to 15 years of age whereas boys do not start a relationship until 18 years of age. According to them, girls marry at around 14 years of age and boys at 18 years. They said some parents do not allow their children to attend school so they can cultivate crops, make bricks and herd animals.

The young boys in Omot camp explained that they did get some health information at school about changes in their body and that they could get health information from CHWs who move around the camp. If they had a concern about their SRH they would travel to the hospital in Patongo because the local clinic lacked supplies. Boys said that a girl can get pregnant the first time she has sex if she has started menstruating and they do not think most of their male friends protect their sexual partners from pregnancy. They said if a girl becomes pregnant and does not want to have the child she will abort it by taking drugs. The boys had heard of HIV and were worried about getting it. They said it is transmitted by sex and piercing.

Health facilities do not provide much privacy for youth to attend. The assessment team heard of only two youth-friendly clinics, one implemented by an international NGO and the other by a local NGO; only the latter was visited.

> "Reproductive health services for young people are a big, big gap!"
>
> Dr. Abeja Apunyo, Country Representative, Pathfinder International.

*Gulu Youth Center Entertainment.*

In 2006, the GYC provided VCT to 7,631 young people, of whom approximately 70 percent were in the static Gulu center and the remainder were in camps. Approximately 48 percent of clients were female and 52 percent were males, ranging in age from 10 to 25 years with the majority (97 percent) 15 to 24. Of the 7,446 young people taking the test, 310 (4 percent) tested positive for HIV, with 2.7 percent of boys and more than double (5.7 percent) the number of girls testing positive, reflecting the great gender disparity in HIV infection rates. GYC refers young people who test

BEST PRACTICE: Recognizing the sexual and reproductive health (SRH) needs of young people, the national NGO Straight Talk Foundation established the Gulu Youth Center (GYC) with support from the U.S. Agency for International Development's (USAID) UPHOLD program. The Center's male and female peer education counselors conduct outreach to five IDP camps in the area to establish youth clubs and to train peer educators on SRH.[79] Staffed by a director, peer education counselors, a full-time nurse and clinical officer, among others, the multi-purpose GYC offers recreation such as volleyball, netball, basketball and football; entertainment with music and dancing; health education opportunities through its library, films, daily health talks and Saturday radio programs; free SRH services including VCT, condom distribution and referral for treatment and care; and testing and treatment for STIs and family planning through its static clinic in Gulu.

positive to TASO, NGOs and the government health services for treatment and care. Stigma and lack of youth-friendly approaches at the referral facilities are identified problems; however, the Center itself is reluctant to establish ARV treatment because it does not want to become too medical. The GYC also finds more uptake of services by young people in school than out of school.

The GYC works with the police section on the legal aspect of girls and women surviving rape. The GYC center manager reports it as a challenge because the parents of the survivor and the perpetrator negotiate to resolve the case. According to the center manager, rape survivors arrive in the Center too late for medical care, although there appeared to be a gap in knowledge and preparedness for addressing clinical care for rape survivors at this facility. In one situation, a girl came to the Center after she was raped in the Karamoja region and specifically requested HIV testing and treatment and abortion services and received VCT and was further counseled to keep the pregnancy.[80]

Some of the challenges faced by the GYC include: motivation and retention of peer educators and maintenance of their free bicycles; conflicting messages on the approach to addressing HIV prevention, that is, "Abstinence, Be faithful to one partner, use a Condom" (ABC) approach; the negative influence of poverty; insecurity and lack of parental guidance on SAE; idleness among young people; the lack of relevance of abstinence and virginity messages for some formerly abducted children and among formerly abducted girls and women who are pregnant and have children. Some of the lessons identified by the GYC include the importance of youth-friendly services to increasing young people's use of health services; collaboration with local authorities, groups and referral networks; and recognition and support for the particular needs of displaced youth.[81]

An NGO in Gulu also collaborates with other NGOs to host live radio programs with debates on RH issues.

### MALE INVOLVEMENT

Some community sensitization has been undertaken by UNICEF, but otherwise there was minimal mention of male involvement.

# VI. CONCLUSION

While some components of RH have been addressed by the MoH, UN agencies and NGOs, RH coverage appears ad hoc. Regular RH working group meetings for coordination and collaboration at the national or district levels are weak or nonexistant. Without regular meetings following an established terms of reference, important opportunities are missed to share and discuss RH protocols and to improve effectiveness and efficiencies in training health workers on MoH protocols to ensure that comprehensive RH services are available to women, men and young people.

The delivery of RH services are seriously thwarted by an insufficient number of functioning health facilities, particularly Health Center IIs and IIIs in Kitgum and Pader districts and an acute shortage of qualified health workers. While some UN agencies and NGOs are working to improve existing health worker capacity—including at the community level—and staff housing, the number of qualified staff remains grossly insufficient. Further, the existing staff are overburdened and lack supervision and accountability, resulting in sub-standard RH care for IDPs in northern Uganda.

A lack of medicines and family planning commodities and expiration of medicines at health facilities were observed and reported by focus group participants. For example, PEP was consistently unavailable and there were stock-outs of oxytocic medicines, magnesium sulfate, nevirapine and folic acid, and some family planning supplies were also expired.

Antenatal services are quite well established, though some components such as routine syphilis testing and the participation of men in VCT for HIV are problematic and clean delivery supplies were not consistently available to pregnant women. Critical gaps exist in health worker competence, equipment, supplies, means of communication and transportation to support women's access to EmOC, resulting in the death and disability of an unknown number of women and infants.

Internally displaced women and MoH staff expressed a dire need for family planning support. In addition, women did not appear to be aware of the availability of birth control at health facilities when it was observed to be in stock. In contrast, most internally displaced men were either opposed to or not aware of the benefits of family planning. Further, focus group participants had never heard of EC and while they had heard of and were interested in female condoms, they were generally not available.

Universal precautions against the transmission of infection in health facilities were poorly practiced by health workers, particularly in Pader district.

Health workers reported following syndromic management of STIs but no protocols were available and the treatment of patients was questionable in some settings.

There appeared to be a significant contrast in knowledge about HIV/AIDS as compared to family planning among internally displaced men and women, possibly reflecting global political and financial support for HIV/AIDS. VCT opportunities were common and focus group participants were often knowledgeable about the care they should receive though it was not consistently available. One key issue is that some men did not know how to use condoms. In addition, there was poor quality of care for some HIV-positive patients in particular with regard to co-trimoxazole prophylaxis for opportunistic infections and the availability of first-line ARV drugs. There was a request to consider the availability of second-line ARV drugs.

RH services for young people and male involvement in RH services are extremely limited. While there is at least one model RH program for youth and another one reportedly supported by an international NGO, these services are generally not available. Male involvement is also an important gap while there were clear needs for men's participation in family planning, the prevention and treatment of STIs in general and HIV specifically, including PMTCT.

# VII. APPENDICES

## APPENDIX I

### BACKGROUND ON THE CONFLICT IN NORTHERN UGANDA

Uganda is located in East Africa and shares borders with Sudan, Kenya, Tanzania, Rwanda and the Democratic Republic of the Congo (DRC). It has a population of over 28 million, 50 percent of which is under the age of 15.[82] The official language is English; Swahili and Luganda are also widely spoken.[83] Sixty-six percent of the population is Christian; 18 percent hold indigenous beliefs and the remainder are Muslims.[84] Kampala is the capital. The country is divided into 80 districts; conflict has mainly affected three districts in the north of the country: Gulu, Kitgum and Pader.[85] However the districts of Amuru, Lira, Apac, Oyam, Dokolo and Amolatoar in Lango sub-region and Adjumani in Madi sub-region were also affected at some time during the insurgency.

Upon gaining independence from Britain in 1962, Uganda experienced 10 years of multi-party democracy under the increasingly authoritarian president Milton Obote.[86] In 1971, Ugandan General Idi Amin led a coup that successfully ousted Obote and established a severely repressive military regime. Under Amin, more than 300,000 people, particularly Ugandans from the northern region with the same ethnic origin as Obote, were killed or "disappeared,"[87] and Uganda's mercantile South Asian populations were expelled from the country, devastating the country's economy. Obote returned to power in 1980 and Uganda witnessed the death of another 100,000 people due to widespread human rights abuses under his rule.[88] The current president, Yoweri Museveni, came to power in 1986 and installed a no-party government system.[89]

In 1986, the Lord's Resistance Army (LRA), a rebel group claiming to represent the ethnic Acholi minority from northern Uganda, formed in order to overthrow the government and rule the country along the lines of the Biblical Ten Commandments. The resulting conflict between the LRA and the national army, the Uganda People's Defense Forces (UPDF), has lasted for almost 20 years and has led to the displacement of over 1.5 million people, approximately 90 percent of the Acholi population.[90] Their displacement has been provoked by the violence inflicted on them by both the LRA and government operations, notably the relocation of the civilian population to "protection camps" under UPDF control. The LRA have persistently targeted civilians in northern Uganda, subjecting them to indiscriminate killings and abuse, including the abduction of more than 30,000 children to serve in the rebel forces as soldiers, sex slaves and porters.[91] Soldiers of the UPDF deployed to the internally displaced person's camps have also committed abuses, including rape and killing, and have largely been given impunity.[92]

In August 2006 an agreement for cessation of hostilities was signed between the Ugandan government and the LRA. Pressing issues, however, remain unresolved, notably the question of the pending arrest warrants issued by the International Criminal Court against LRA leaders and the continued marginalization of the Alcholi by the central government.[93] Since the ceasefire, the government has been encouraging the internally displaced population in certain districts to relocate to decongestion camps or to return home. Some IDPs have sought to move to the less congested sites in the hope of gaining access to land; others have moved out while keeping their spots in the main camps. In theory the government's relatively comprehensive IDP Policy supports voluntary return and a range of governmental structures have been set up to deal with the issue.[94] However, in practice, the government and the army often determine whether or not IDPs can return home.[95] Furthermore, not all IDPs are keen to return: insecurity remains widespread, infrastructure in places of return is in disrepair and at times non-existent and some of the younger IDPs have become accustomed to living in a more urban environment.[96]

## APPENDIX II

## SERVICES AVAILABILITY MAPPING

The Ugandan Ministry of Health (MoH), with the World Health Organization (WHO) and other partners, conducted a comprehensive health Services Availability Mapping (SAM) in camps and health facilities in Gulu, Kitgum and Pader districts in 2006. This thorough mapping documents the following: number, distribution and accessibility of internally displaced person (IDP) camps; availability, functionality and distribution of health facilities and services, including reproductive health (RH) and community-based services; availability of functional medical and laboratory equipment and specific drugs in health facilities; availability and distribution of human resources and amenities in health facilities and the community; and the national and international partners delivering services.

The SAM reports the projected (based on projections from 2002 with a growth rate of 3.4%) populations of Gulu, Kitgum and Pader are 543,26, 322,78 and 373,035 respectively. Approximately, 90 percent of the population of the Acholi sub-region have been internally displaced to camps. In total there are 132 IDP camps in the Acholi sub-region and 167 health facilities. In Kitgum, 22 (56%) of the 39 health facilities are functional and in Pader, 32 (82%) of the 39 facilities are functional. Most non-functional health facilities are located in areas from where the population has fled: Kitgum and Pader districts have 39 health facilities each, and in both districts approximately 50 percent of the facilities are located inside camps while the other half are based outside of camp settings.[97]

The Ugandan Health Sector Strategic Plan (HSSP) I recommends that there be one hospital or Health Center IV[98] in all counties of Uganda, and the SAM shows this coverage is met in the Acholi sub-region. Kitgum district has two hospitals, one private and one public, and three level IV Health Centers; Pader district has one general hospital and one level IV Health Center.

However, the HSSP I also indicates there should be one Health Center III[99] per every 20,000 population and one Heath Center II[100] for every 5,000 people. In Kitgum, there are nine functioning level III health facilities versus the recommended 16, representing approximately 56 percent coverage. In addition, only eight functioning level II health facilities versus the recommended 64—representing only 12 percent coverage of Health Center II's—are set up in Kitgum district. In Pader district 17 out of 19 level III health facilities are functional, representing 89 percent coverage and 13 of the recommended 75 level II health facilities are functional, representing 17 percent coverage.

Finally, the health services structure also includes community-based[101] interventions through village health teams (VHTs) comprised of community-owned resource persons (CORPs). According to the SAM, the emergency needs for CORPs are met in Pader district but not in Kitgum district.[102]

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100. The 2006 Ugandan National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights define a Health Center II as providing the following functions: preventive, promotional and curative SRH services; maternity care including basic EmOC; offer basic family planning services; implement gender-sensitive and rights-based SRH services; supervise and work with VHTs and other SRH CORPs including TBAs; refer clients to Health Center IVs or district hospitals; provide IEC/BCC; promote community participation and involvement in SRH services.
101. In line with the Health Policy, community participation is key to the success and sustainability of the SRH program. There are different resource persons at the community level. These include the TBAs, Community-based Distribution Agents (CBDAs), Community RH workers (CRHWs), VHTs, peer providers, herbalists, families and individuals whose roles should be to mobilize people for SRH services and mobilize resources.
102. Ministry of Health Republic of Uganda. *Mapping and Assessment of Health Services Availability of Northern Uganda.* April-May 2006.

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