ACCESS AND UTILIZATION OF HEALTH SECTOR RESPONSES TO SEXUAL VIOLENCE IN CONFLICT AND POST-CONFLICT SETTINGS: THE CASE OF NORTHERN UGANDA

PAPER PRESENTED AT THE SVRI FORUM 2009,
6-9 JULY, JOHANNESBERG, SOUTH AFRICA

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Introduction

The conflict in Northern Uganda that raged on for almost 20 years increased women's vulnerability and strengthened social, cultural and personal factors that perpetuate gender-based violence particularly sexual violence.

Recent studies show that both women, girls, men and boys are vulnerable to sexual violence in conflict situations, but the vast majority of victims of this form of violence are women and girls (MoH, May 2007:1).

Methodology

- Data presented in this paper was extracted from mainly 6 studies done on GBV by different institutions. These include:
- 1. A baseline study on possible interventions to address Gender-based Violence in Pader district in Northern Uganda, done between June-July 2008 by Concern Worldwide (U)
- 2. Sexual and Gender-based Violence in War Affected Communities in Northern Uganda, by Ministry of Health, May 2007
- 3. Health Services for Survivors of Gender-Based Violence in Northern Uganda: A qualitative Study, July 2006

- 4. Rapid Assessment of Sexual and Reproductive Health in Northern Uganda, UNFPA, September 2006
- 5. Gender-Based Violence in Camps, Transit and Return Areas of Northern Uganda, Report of an Inter Agency Rapid Assessment, UNFPA, 2009
- 6. Assessment on clinical management of rape in North & North Eastern Uganda,IASC on GBV, 2008

- The methodology used in the studies that have been reviewed to develop this paper comprised of household surveys, key informant interviews, focus group discussions and documentary review.
- The geographical areas that the studies reviewed covered include: Gulu, Pader, Kitgum Lira, Apac, Amuru, Amolatar

Most common acts of Sexual Violence in conflict and post-conflict settings

The most common acts of sexual violence in armed conflict include defilement, rape /gang rape, marital rape, forced/early marriages, sexual exploitation, prostitution and child trafficking.

Conflict Setting

- Defilement
- Rape/Gang rape
- Marital rape
- Prostitution
- Sexual exploitation
- Early marriages

Post-Conflict Setting

- Defilement
- Marital rape
- Early marriages
- Prostitution

Focus of the Paper

- The paper will focus on defilement, rape/gang rape as these are the most commonly reported to health units. Victims of other acts like prostitution, early marriages and marital rape may seek services when they develop a complication but will not disclose the cause.

Effects of Sexual Violence

- The effects of sexual violence are enormous and multi-edged: physical, psychological, legal and economic and are realised at various levels: individual (by both victim and perpetrator) family, community and national levels.

The Health Related Effects Arising from Sexual Violence include:

- Death, injuries, gynecological disorders, unwanted pregnancy, adverse pregnancy outcomes, sexually transmitted infections, including HIV and mental distress ie fear, shame and anxiety.
- All these require medical responses.

What Health Services do Survivors of Sexual Violence Require?

- Basic clinical Management of bruises, tears and wound care
- Management of complications ie fistulas
- Prevention of tetanus
- Hepatitis B
- Prevention of HIV transmission (PEP)
- Screening for STIs
- Pregnancy tests
- Emergency contraception

- Psychosocial counseling
- Forensic evidence collection
- Medication - Follow-up care of the survivors (two week and six-week month follow)
- Special care for child survivors
- Referral to support groups
- Elective abortion

- Post-abortion care (PAC)
- Treatment of abortion complications
- Hygiene supply including pads

Understanding Access and Utilisation of services

Access

- The ability of a person to receive health care, which is a function of: availability of personnel and supplies, ability to pay for services, and to reach services ie physical accessibility
- Gaining entry into.

Utilisation

- Use of a service
- The extent to which a given group uses a particular service.
- The state of having been made use of.
- The pattern of use of a service.

Accessibility to health services by survivors

- There was limited access to health sector responses by survivors of sexual violence in conflict and post-conflict settings in Uganda

- The services were more accessible to survivors living in IDP camps than those living in transitional settings and returnee villages.

Factors that hinder access to health services by survivors

- Returnee sites lack servces because government agencies like LCs (Camp leaders) and Police are based within camps and most CSOs tend to concetrate in the camps (Concern Worldwide-U, 2008: 39).
- Proximity to health services. Health centers III and IV are largely not accessible (some are approximately 20 km away).
- Health centres are not opened regularly.

- Lack of effective referral and follow up services for patients with severe cut wounds or vaginal fistulae due to rape ie transport, limited medical personnel in referral centers.
- Accessibility in terms of referral services was limited: few Health units at level III and II had any had a functional means of transport for referring cases at all.

- Ogar health center in Lira district is 26 km from Lira hospital and it does not have functional means of transport for referral cases.
- Many health workers are not aware of the availability of counseling services in private health units and hence fail to refer survivors.

- The majority of the health units lacked basic services for management of the health effects of sexual violence (MoH, May 2007: 31, Concern Worldwide-U, 2008: 30). In the camps health centres cannot afford gloves, cotton wool syrunges and neddles among others (MoH, May 2007: pg 36-37). Between 3% and 9% of health facilities in Gulu, Pader, and Kitgum provide the full package required for clinical management of sexual violence (MoH, May 2007: pg 37).

- Shortage of qualified health personnel (limited number of medical officers). In Kitgum (9%) and Pader (21%) of the health centre II and none of Health Cetre III and IV met the HSSP I staffing norms.
- The doctor to district population ratio was 1 doctor to 11318 (Gulu), 21519 (Kitgum) and 53291(Pader). MoH May 2007, pg 35

- Ratio of nurses and midwives to population was 1 to 1246 (Gulu), 2339 (Kitgum) and 5829 (Pader) MoH May 2007, pg 35

Utilization of Health Services by Survivors of Sexual Violence

- An analysis of data presented in the studies reviewed indicated that there is low utilization of health sector responses by survivors of sexual violence (Henttonen et al, 2008: pg 126; MoH, May 2007: 36-37; concern Worldwide-U, 2008, UNFPA 2006, UNFPA, 2009 and IASC,2008).
- As security situation improves, utilisation of existing services also increases but defilement and rape cases are reducing as well.

Factors that limit Utilization of Health Services by Survivors

- Late reporting of cases hinders utilization of critical services. Survivors fear consequences; social stigma, having to testify in court, retribution by the offender, abandonment by husbands and loosing out on livelihood resources.
- Most survivors go to health units as a police requirement to fill out form 3 but not seek medical care. Community perceives referral to health units vital in collection of forensic evidence and not treatment of survivors.

- Failure to identify some acts as abuse by the law and community (Ugandan law does not recognise marital rape as a crime, community does not view early marriage as abuse).
- Self-blame by the survivors and ignorance about their sexual rights ie those raped at night during discos run away from helath units (MoH, May 2007: pg 32).

- Besides medical doctors, the majority of other health workers lack the skills for the management of rape/defilement ie skills in talking to survivors, preserving evidence at time of seeing a survivor and recording using police form 3.
- Health personnel find it difficult to identify survivors unless they request for information on legal services.

- Survivors seek general medical redress and do not disclose violence.
- Most health workers are not adequately trained to identify survivors, filling out Police Form 3 and giving evidence in courts of law (MoH,May 2007: pg 34).
- Integration of services affect utilization of services by survivors.

- Utilization of health services is affected by poverty some do not have money to buy items like gloves, syringes/neddles, speculum, drugs and diagnostic tests ie STD test, X-ray or ultrasound examinations. In some instances, supplies and drugs are out of stock for about a month in health units (UNFPA, 2006: pg 41).

- Some health workers are hesitant to fill in Police Form 3 for fear of the repercussions and long court processes if called upon to give evidence (court cases are unpredictable and court officials do not respect their time: Medical Superitendant of Gulu Referral Hospital, MoH, May 2007: pg 34). This creates delays in submitting Police Form 3 and survivors lose interest in the cases

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- Health effects of some acts like early marriages, marital rape are underestimated. In case defilement results into marriage, survivor will not seek health services.
- Limited awareness about management of sexual violence by communities (participation of community in health management of services)

- The introduction of the hotline using mobile phones in some districts like Pader has increased access to and utilization of health services by survivors.

Conclusions

- Sexual violence is a fundamental abuse of human rights and has serious consequences for women and girls, their families and the recovery and reconstruction process in post-conflict settings.

- The health sector in Uganda lacked the capacity to address sexual violence during conflict and post-conflict period.
- The factors that hinder access to and utilisation of health sector services by survivors of sexual violence are at : individual, community and institutional levels.

- Addressing gender-based violence is not regarded as a priority in war affected areas by leaders both at national and local levels.

The level of utilization of health care responses has an influence on the ability of the survivor to successfully utilize other services ie legal redress and psychosocial counseling

- Limited access to and low level of utilization of health services by survivors constrains the legal redress mechanism and hinders women's access to justice.

Effective management of sexual violence in war affected communities requires a multi-sectoral approach.

- Health sector responses are a key component of the redress mechanism and therefore the sector should be accorded the importance it deserves in gender-based violence programming.

Recommendations

- Health workers need to be trained adequately on the redress protocol to respond to the needs of survivors irrespective of where they report. Should services be compartmentalised or integrated in various units in the health facility?)
- Train lower cadres such as nurses and midwives to respond to cases of sexual violence to overcome the shortage of qualified health personnel. They legal system should recognise them as competent to fill out police form 3 and give evidence in court.

- Increase avenues for sharing information and knowledge of available services to improve management of sexual violence.
- Leaders at both national and local levels should be sensitised about the public health implications of sexual violence and its consequences on the reintegration process.

- PEP should be available in all health centres ie starting at health centre III (Sub-county level).

References

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