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# Violence against Women in Northern Uganda: The Neglected Health Consequences of War

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## **Violence against Women in Northern Uganda: The Neglected Health Consequences of War**

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### **Abstract**

This article presents a summary of research intervention work carried out in war-affected Northern Uganda by Isis-WICCE, a women's international non-government organisation, in conjunction with the Ugandan Medical Association and funded by Medica Mondiale, a German-based foundation. The findings of this research demonstrate the serious effects of sexual violence and torture experienced on women's physical and psychological health. However, this paper also describes women's key role in trying to bring peace to this region, as well as their resistance and survival strategies. It is recommended that funding is urgently required for the provision of sustainable, gender sensitive physical and psychological health services in this region. Women's campaign for justice for the atrocities they have suffered should be heard by the International Criminal Court. Further recommendations are made with respect to policy changes in line

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with enhancing women's roles and furthering the empowerment of these women war survivors.

*Keywords:* Women, War, Health, Sexual violence, Northern Uganda

### **Introduction and Context**

Northern Uganda has suffered chronic war for the last twenty years with massive violations of the population's human rights. This has led to severe war traumatisation resulting from overwhelming acts of sexual and gender-based violence (Amnesty International, 2005; Isis-WICCE, 2006a). Since 1986 Gulu district in Northern Uganda has been at the centre of civil war between various rebel groups including formerly, the Holy Spirit Movement of Alice Lakwena and currently, the Lord's Resistance Army led by Joseph Kony against the government of Uganda and this conflict is still ongoing. In Teso, (North-Eastern Uganda), there was insurgency between 1987-1992 involving cattle raids by the Karamajong, which the government has failed to curb up to now. In Kitgum, (Northern Uganda), due to the Lord's Resistance Army, the population have been forced into Internally Displaced People's (IDP) Camps. Although there was the signing of the landmark Cessation of Hostilities Agreement in August 2006, the search for durable solutions is ongoing. However, following this agreement, several hundred thousand of internally displaced people's (IDP's) started to return to their original locations, but an estimated 900,000 people still remain internally displaced with limited access to health care, food, water and sanitation (World Health Organisation, 2007).

Coupled with the breakdown in the health infrastructure, Northern Uganda has persistently posted the poorest health indices in the country. Compared to the rest of the country, Northern Uganda has the highest HIV prevalence rate of 10.5% (national average of 6.4%), the lowest rate of contraceptive use at 12% (national average of 23%) and a high rate of abortions and unwanted pregnancies (1 in every 5 pregnant women in Northern Uganda carries out an abortion, while 50% of pregnancies are unwanted (World Health Organisation, 2007). The main health problems faced by the women survivors of the conflict include gynaecological problems, HIV/AIDS, lack of access to safe motherhood services, lack of modern contraceptives and untreated ailments leading to infertility in a society where every woman values motherhood, resulting in a high burden of mental illnesses and trauma (Isis-WICCE, 2001b, 2006a; WHO, 2007). Respondents in a recent survey carried out by the International Centre for Transitional Justice in Northern Uganda said health was their main priority at 45.2% (see ICTJ, 2007).

The most affected by this conflict, as has also been documented worldwide, are the women and children (see Arcel, 1998; Watts and Zimmerman, 2002; Donovan, 2002; Isis-WICCE, 2006a; Koen, 2006). The war in Northern Uganda has included the killing and maiming of thousands of civilians; abductions of over 25,000 children; various forms of sexual and gender-based violence including rape, sexual slavery and forced marriages; physical disfigurement through the cutting of facial and other body parts; gunshots and landmine injuries; destruction of livestock and property; spread of HIV/AIDS; and destruction of moral and social values of the community. These experiences have left the entire population traumatised and in severe poverty.

Isis-Women's International Cross-Cultural Exchange, Isis-WICCE, an international women's non-government organisation, relocated to Kampala, Uganda from Geneva, Switzerland, in 1993 to ensure greater representation of women's voices from developing countries. Since this time, their main focus has been to document women's experiences of war in different regions of the world, including Uganda. This collaborative work with African PsyCare Research Organisation, APRO, started in Luwero District (see Musisi et al., 1999; Liebling and Kiziri-Mayengo, 2002). Since 2000, and in collaboration with the Ugandan Medical Association, Isis-WICCE have carried out documentation and medical interventions in several regions of Northern Uganda, aimed at showing the plight of women in these conflict areas and campaigning to Government and development agencies to prioritise their health needs. Through these studies Isis-WICCE has been able to offer emergency medical and psychological treatment to war-affected communities, to train local health workers and build capacity and to highlight the impact of war on women in these areas (Isis-WICCE, 1999; 2001; 2002). This paper summarises some of the key findings of this work, particularly in relation to the effects of sexual violence on women's psychological and physical health in Northern Uganda. It also makes policy recommendations.

## **Method**

Since early in 2000, Isis-WICCE has been working in Northern Uganda. They have carried out participatory intervention studies in Kitgum, Teso and Gulu, three war-affected regions of Northern Uganda, in order to try and respond to and highlight the needs of women war survivors there. These studies have focused on the documentation of women's experiences as well as providing some medical and psychological interventions (see Isis-WICCE, 2001a; 2001b; 2002a; 2002b). Some of this work has received financial support from Medica Mondiale (see Isis-WICCE, 2006a; 2006b).

## **Methodology and assessments**

A multistage cross-sectional descriptive study was undertaken to document the gynaecological, orthopaedic and general surgical problems, as well as the psychological problems experienced by the women in all three districts. The interventions employed a primary health care approach with alleviation of the most serious health problems of the participants seen. The interventions aimed to build local capacity through training local health workers and camp volunteers, supply of medication and supervision from professionals involved. All persons accessing the Isis-WICCE medical intervention were subject to a screening procedure where trained non-medical interviews initially screened everyone for psychological, gynaecological and surgical complaints. Those found to have symptoms suggestive of psychological and/or medical difficulties were then sent to a second stage diagnostic interview where they were assessed by teams of specialists, which comprised of psychiatrists, psychologists, gynaecologists and surgeons. Four semi-structured questionnaires were designed and pre-tested. These included questions about general camp experiences, gynaecological problems, surgical needs, and psychological difficulties. Referrals were made for surgery and treatment and clients were treated for medical problems and also seen by the mental health team if indicated. They utilised the

ICD-10 PCP diagnostic criteria, CAGE screening assessment for alcohol abuse and DSM-IV diagnostic criteria for post traumatic stress disorder.

### **Gulu**

In July 2001, Isis-WICCE undertook a medical intervention of war survivors in Gulu district. Five hundred and three clients were treated for medical problems and 215 were seen by the mental health team. One hundred and fifty women reported gynaecological difficulties and 138 had surgical needs (Isis-WICCE, 2001b).

### **Teso**

In 2002, Isis-WICCE chronicled the war-related traumatic suffering of the women of Teso region, Eastern Uganda, including the districts of Katakwi, Kumi and Soroti. Those who had a serious medical problem were referred to the regional hospital in Soroti District for further intervention. Eight hundred and twenty-six respondents reported psychological difficulties and the ICD-10 PCP diagnostic criteria were utilised as well as a screening questionnaire, 2012 respondents were screened for medical difficulties and 184 women had gynaecological problems. One hundred and sixty-one participants had surgical needs and of this, 56% were women (Isis-WICCE, 2002b).

### **Kitgum**

In 2005, Isis-WICCE undertook a participatory medical and psychological intervention research study in two IDP camps in Kitgum district, including Mucwini, which has a population of about 15,000 and Padibe which has around 30,000 people. Mucwini is located in Chua County in a North-Westerly direction from Kitgum town and Padibe is in Lamwo County in the North-East from Kitgum town. Eight hundred and ten adults and 182 children were offered screening using a medical questionnaire to identify gynaecological, surgical and mental health problems were identified using the World Health Organisation Self-Report Questionnaire, SRQ-20 (WHO, 1994). Adults who had significant psychiatric problems, a score greater than 6 on the SRQ-20, were also assessed on the MINI International Neuropsychiatric Interview in order to determine a specific diagnosis of their difficulties (Sheehan et al. 1998). Those having significant surgical and gynaecological problems were given treatment. In total 570 women were seen with the majority of women being between 25-44 years of age.

### **Data Analysis**

For all three studies, the questionnaire data was entered into a computer using the Epidemiological package, Epi-info version 6, and then converted for SPSS analysis. Frequencies, frequency tables and means were generated and cross tabulation of study outcomes against the independent variables were undertaken on all of the data sets. The interviews were analysed to look for the main concepts and quotes from the women participants are cited in this paper to illustrate some key themes.

### **Results**

*Experiences of women during war in Northern Uganda*

The studies carried out in Northern Uganda, in line with research worldwide, have concluded that women and children are most vulnerable to the impact of war (see Isis-WICCE, 1998; Isis-WICCE, 2001; Watts and Zimmerman, 2002; IRIN, 2007; Liebling-Kalifani et al. 2007). The first study carried out in Luwero District found that the number of households headed by women had greatly increased by 71 percent following the civil war years (Musisi et al. 1999). Likewise, in Gulu, Isis-WICCE (2001) concluded that the number of children and male adults had considerably declined due to death, abductions, immigration, or recruitment into military services. The presence of women-headed households has impacted on the economic recovery of these war-affected regions and in Gulu (Isis-WICCE, 2001a) and Teso (Isis-WICCE, 2002); where these studies concluded that land tenure disproportionately disadvantaged women. These interventions have also found that the impact of war in the regions of Northern Uganda has affected the education of girls, as most have not even received basic schooling. During the war years children had to commute every night from the IDP camps to towns to avoid being abducted by the Lord's Resistance Army. This activity greatly increases the risk for girls of early sex and prostitution for safe passage, early marriage and increased exposure to HIV/AIDS (Isis-WICCE, 2006a).

The study in Gulu found that men were more likely than women to be subjected to all forms of physical torture (Musisi and Kinyanda, 2001: 127). The same study in Gulu found that sexual torture was predominantly reported by women and supports the previous argument that sexual torture of women is a frequently utilised 'weapon of war' (Paker et al, 1992; McNally, 1992; Arcel, 1998; Donovan, 2002; Watts and Zimmerman, 2002; Amnesty International, 2005; IRIN, 2007; Liebling-Kalifani et al. 2007). Women's reproductive role, which is especially important within this cultural context, is targeted by gender-based violence (e.g. Swiss et al. 1998; McGinn, 2000; Kinyanda and Musisi, 2001; Watts and Zimmerman, 2002; Liebling et al. 2007). More than a quarter of women in Kitgum reported being subjected to various forms of sexual torture. Almost 20% described violent penetrative sexual abuse including rape, gang rape and defilement. Fourteen point six percent suffered sexual abuse including incest, sexual slavery and forced marriages. Other women experienced sexual exploitation for survival or in exchange for gifts and food. These forms of sexual violence against women are typical in war-affected areas all over the world (Watts and Zimmerman, 2002; WorldNet Daily, 2006; IRIN, 2007). Although mostly women experienced sexual violence in Kitgum, it is worth noting that 7.9% of men also reported being sexually abused (Isis-WICCE, 2006a). The shame in reporting sexual abuse in this cultural context is likely to mean these figures are underreported (see Obbo, 1989). In Gulu, women were also brutalised with rampant cases of rape, sexual slavery and other forms of sexual harassment (Isis-WICCE, 2001a). One woman discussing her experiences in Gulu said:

Later all the girls that were abducted and defiled or raped were married off to rebel leaders or used for general sexual services to rebels. Some commanders were reported to have four or five wives while Joseph Kony himself had over thirty wives at any one time (Isis-WICCE, 2001a: 21).

The government army too was accused of sexual abuse as indicated by the following excerpt from another woman in Gulu about the 1986-1988 insurgency operations:

The worst thing about the National Resistance Army soldiers was having forced sex with women one after another....in the evening, the NRA soldiers started sexually abusing the women in the compound. One woman was forced to have sex with six NRA men, and this went on for two days (Isis-WICCE, 2001a: 22, see also Bennett et al. 1995).

The focus of the armed conflict in Teso has been cattle rustling by the Karamajong, dating as far back as the 1950's. Hence, there has been massive displacement especially amongst the Katakwi population. Men, women and children have been moved into IDP camps and women have experienced intimidation, torture, been forced into marriages, gang raped and men have also been subjected to rape. Women interviewed described how breast-feeding women were particularly targeted by the Karamajong. One woman explained:

They never left a breast-feeding woman to go without having been raped. They believed that breast-feeding mother's were free from the HIV virus. They have the belief that a woman with children is not infected with gonorrhoea (Isis-WICCE, 2002a: 65).

Forced prostitution and defilement have also been common. As a result of women's experiences of sexual violence there are many health problems including psychological trauma, gynaecological and surgical complications. Many of these are chronic due to the lack of access to medical treatment and the stigma associated with discussing these experiences. The responsibility of looking after the family has fallen on women as men have taken to heavy drinking and redundancy. In Teso, most health services have collapsed whereas reproduction has continued with 50% of women being pregnant within a five year period hence increasing women's burden of caring for children (Isis-WICCE, 2002a).

The most common forms of torture in Katakwi Internally Displaced People's Camps, were found to be beatings and kicking's (26.9%), loss of property (27.49%) , loss of the nuclear family (11.7%) and sexual trauma (7.6%), due to rape and sexual harassment of women. Sexual torture was suffered by men and women but the percentage of women affected was higher. Sexual violence included rape, gang rape, forced marriage, sexual comforting, defilement, sex in exchange for gifts and food, abduction, 'nakedification,' being forced to walk naked, and sexual humiliation (Isis-WICCE, 2002b).

## **The neglected health consequences of war**

### *General health effects*

The displacement of people from their homes, walking long distances, inadequate food and destruction of the health infrastructure has all taken its toll on the people of Northern Uganda, especially amongst the women and children (Isis-WICCE, 2001b). The



leading cause of ill-health is malaria, with a high prevalence of upper respiratory tract infections (19%), skin diseases and bodily pains (Isis-WICCE, 2001b). Only 53% had received treatment from hospital, 13% obtained local medicines and a third of those interviewed had no treatment at all (Isis-WICCE, 2001b). The war in Northern Uganda has also increased disability of women, men and children in this region. It has also increased the spread of HIV/AIDS as one woman respondent in Gulu describes:

According to me, it is the government which is intentionally spreading AIDS by raping women when they go for firewood. Is raping one of the government weapons to fight the women? (Isis-WICCE, 2001a: 22, see Bennett et al. 1995).

Data from Katakwi, in the Teso region, indicated that malaria, pneumonia, intestinal worms, trauma, skin diseases, diarrhoea, and sexually transmitted diseases including HIV/AIDS are the leading causes of ill health amongst the adults (Isis-WICCE, 2002a). Most women are unable to treat these diseases due to poverty and poor health facilities. The women and children in Teso are therefore in poor health due to a consequence of the prolonged armed conflict. The insurgency plus the relocation to camps have rendered the health care situation very difficult (Isis-WICCE, 2002a).

The severe forms of violence experienced by people in the camps in Kitgum resulted in high levels of psychological and psychiatric suffering as well as general health effects. The factors that were statistically significant, associated with psychological distress scores, were having an alcohol misuse problem, gender- as there was a higher rate amongst women than men in this study, high HIV personal risk assessment, past physical or psychological torture and having a surgical condition. Over 60% of those interviewed in Kitgum had sought assistance from traditional healers, 15.8% self-medicated for their health problems and 18.7% received no treatment at all (Isis-WICCE, 2006a).

#### *Reproductive health complications*

During the Isis-WICCE intervention study in Gulu 150 of the women seen had gynaecological problems as a direct result of sexual violence, including infertility as a result of sexually transmitted diseases, which has been documented in women who have suffered rape in the war-affected regions of Europe (Jasenka Grujic-Koracin, 1998). Other complications included, painful intercourse, unwanted pregnancies, prolapses, genital sores, swelling in the abdomen, chronic pelvic pain, fistula causing leaking of urine and faeces, and vaginal tears (Isis-WICCE, 2001b). A majority of women were unable to work due to these difficulties and 87.3% had not sought medical treatment from a qualified professional due to social factors. During the study Isis-WICCE was able to offer a time-limited medical intervention for women. Although Gulu District has a gynaecologist, several of the war-torn regions of Uganda still lack this facility (see Liebling et al. 2007).

In Teso, most of the women who were seen and treated for gynaecological problems were in the reproductive age group and most were married before the age of eighteen years old. Pregnancy and delivery at an early age is associated with some

gynaecological problems, including fistulae. A large percentage of women had abnormal vaginal discharge and infertility due to untreated sexually transmitted infections, most likely due to the high levels of rape in the region. One woman interviewed described the effects on her health:

But what bothers me is my poor health. From the time I was raped, I get frequent swellings and wounds in my vagina, heavy and painful menstruation periods lasting for about fourteen days. As a result, I spend sleepless nights thinking about my situation. At times, I don't like to meet people, especially those who know me...I went to Atatur Hospital last year. They told me to go back so that my uterus is removed, but I have no money. I'm waiting to die.

(Isis-WICCE, 2002a: 44)

There were also tears and prolapses evident. Sixty-nine percent of the women had sought treatment whilst 20% did nothing and 10.3% went to traditional healers. The study concluded that the health seeking behaviour of women in Teso was slightly better than in Gulu and Luwero where 47% of women went to traditional healers or self-medicated for their ailments (Mirembe et al. 2002). This is largely because Teso has a relatively good health system compared to other war-affected regions of Northern Uganda. However, a limited service was still provided during the study due to lack of access to drugs and expertise in the area. The Isis-WICCE study concluded that the extent of preventable and treatable gynaecological complications amongst the population in Teso is enormous and most women seen had injuries due to the war.

Sixty-six percent of women in Kitgum reported at least one gynaecological problem of which the most commonly found were chronic lower abdominal pain (48.9%), abnormal vaginal discharge (26.9%), abnormal vaginal bleeding (25.5%), swellings in the abdomen (20.9%) infertility (24.8%) and genital sores (23.4%). Other problems included abnormal leaking of urine and faeces, vaginal tears, unwanted pregnancies, and sexual dysfunction. Sexual torture and multiple sexual partners were major contributions to high levels of sexually transmitted infections and chronic pelvic pain. All of these difficulties were attributable to women's experiences of sexual violence during the war. The HIV/AIDS rates in the IDP camps of Northern Uganda are now the highest in the country as are other diseases. A third of women affected were unable to work due to these difficulties and only a few of the women had received treatment, as most of the services were inaccessible for them. The negative impact of the gynaecological difficulties on these women is enormous as they are unable to function in many areas of their lives. This has also affected the health of their family as well as the overall economic development of the community in which they live (Isis-WICCE, 2006a).

### *Surgical and orthopaedic effects*

During the war in Northern Uganda, the population has experienced extensive maiming of their limbs by the warring factions. By 1996 the Gulu Rehabilitation Unit had registered a total of 628 children, 386 women and 147 men as disabled by bullets,

landmines, brutal attacks with machetes, burning and other forms of cruelty (Isis-WICCE, 2001b). Recurrent back pain was the most common complaint especially amongst women and was thought to be due to the strenuous activities they engage in. Other injuries included soft tissue injuries, neglected fractures, arthritis and osteomyelitis. Of the general surgical conditions, hernias were most common, as well as tumours and cancers and intestinal obstruction.

In Teso the majority of patients seen for surgery were women (56%) and many had been injured during insurgency by the Karamajong. There were several gun shot wounds, osteomyelitis, breast cancers, and hernias. The complications treated were common amongst the population due to the armed conflict in the area. The women were more economically disadvantaged than the men. The region has many unattended conditions as listed above (Isis-WICCE, 2002b).

Almost seventy three percent of those screened in Kitgum had surgical problems mostly as a direct result of the war, with women making up 73.3% of the sample. The main complications were fractures and their complications (15%) wounds (11.4%), burns (8.7%) amputations (6.7%) and maiming of body parts (6.2%). More women suffered direct physical trauma, such as cutting of their body parts. Over half of the respondents had sought local treatment, with 20% visiting traditional healers and 18.4% not receiving any treatment. Insecurity, poverty and lack of transport were all factors affecting access to medical care, as well as poor surgical services and breakdown of health care in the area (Isis-WICCE, 2006a).

#### *Mental health effects*

Almost 77% of women in Gulu were found to experience psychological distress, a much higher level than for men in the same region. Having above threshold psychological distress scores was statistically significantly and associated with; having experienced torture, as well as gender-related factors including marital status, having children and gynaecological complaints, all of which affect women's social roles as mothers, wives and providers (Musisi and Kinyanda, 2001).

In Gulu, for those persons who underwent a second stage diagnostic assessment, the psychiatric disorders reported included; 39.9% with post traumatic stress disorder, 18.2% had alcohol abuse disorder, 52.5% had depression and 60.6% suffered panic and anxiety disorders. Somatoform disorders were also common at 72.7% consistent with the study in Luwero and elsewhere in the world where psychiatric problems are a common consequence of torture (see Musisi et al. 2000; McNally, 1992). The study concluded that there existed a presence of severe war trauma with severe psychological effects, which were not being addressed.

In Teso significant psychological distress was reported by 72.6% of respondents with no statistically significant difference between men and women. However, women reported more suicidal thoughts. For those who underwent the second stage diagnostic assessment, the psychiatric disorders amongst women included depression, anxiety, agoraphobia, social phobia, somatisation, post-traumatic stress disorder and alcohol misuse. The most common psychological problem was poor sleep being characterised by nightmares and fear of attack. This study concluded that the constant threat of attacks

together with the poor over-crowded conditions in the camps had led to multiple health problems including psychological difficulties. One woman interviewed told us:

There are people in the camp who have had a mental breakdown because of problems caused by the Karamajong attacks. They are not well. They just wander about saying things that do not make sense to people  
(Isis-WICCE, 2002a: 68).

In the entire region, war trauma has led to a considerable amount of psychiatric difficulties and impairment in function, which is currently not attended to (Isis-WICCE, 2002b).

In the study carried out in Kitgum, 69.4% of women reported psychological distress compared to 60.9% of men. There were clear gender differences in how distress was expressed with women reporting more suicidal and homicidal thinking, whilst men reported more problems with alcohol misuse and completed suicides. In terms of those persons who underwent the second stage diagnostic assessment, the psychiatric disorders reported included epilepsy as most common at 51.8% followed by depression (42.9%), post-traumatic stress disorder (23.2%) and anxiety disorders (8.9%). These disorders are common with similar findings in other war-affected areas of Uganda (see Musisi et al, 1999; Kinyanda and Musisi; 2001). The study found that women and children make up the majority percentage of the population in the camps and also suffer the most physical and psychological trauma. Significantly, the long-term impact on society of chronic sexual violence and degradation of women is significant, as well as the 'uglification' accomplished by burnings, facial and lip cuttings, as one woman from Gulu describes:

I then ran outside rolled on the ground and poured sand on my body. That is what saved my life. I went back inside the house where my child aged two was screaming on seeing me. She started running to me so frightened because I was so much disfigured that she could only recognise me by my voice

(Isis-WICCE, 2001a: 52).

This disfigurement makes women war-survivors often feared and unacceptable in the community (Isis-WICCE, 2006a).

These studies found several effects on women that can be understood as complex post-traumatic stress disorder, PTSD. However, PTSD is a western concept and previous research has proposed an alternative conceptualisation of trauma as a deconstruction of identity (see Liebling, 2005). PTSD as a concept is not gendered and cannot adequately account for the social and cultural reality (e.g. Bracken, 1998), experiences and effects described by the women in this study. Nor can it explain the continuous and long-term traumatisation evident (Summerfield and Toser, 1991). It is argued that war trauma is a 'normal' not 'pathological' response to torture, which requires recognition as 'normal' by others (Agger, 1992; Herman, 1992; Human Rights Watch, 1996; Tal, 1996; Summerfield, 1997; Liebling, 2005). Secondly, war trauma is viewed as a collective/communal destruction of cultural identity (Agger, 1992; Herman, 1992;

Summerfield, 1995). Finally, it is suggested trauma in war is gendered, not in the sense of better or worse for men or women, but in the sense of women's war trauma being differently constituted than men's due to destruction of cultural identity rather than the physical body, equally central to the war project and equally valid as trauma, and therefore deserving of compensation and facilities for recovery, as are provided to mostly male soldiers (Bourdieu, 1984; Human Rights Watch, 1996; Summerfield, 1995; 1997).

### **Women's agency, empowerment and resistance**

Although women have continued to suffer in the war in Northern Uganda, they have demonstrated several survival strategies. They have created women's groups and associations to support each other. They have participated in the public sphere. For instance, the Gulu District Women Development Committee in 1989 has played a crucial role in bringing relative peace to this area by staging peaceful protests and campaigning. The impact of mothers weeping and mourning whilst begging government and rebels to put down their guns and negotiate was very influential and many rebels gave up at this time and the government also saw the need to change their approach. Ms. Bigombe, Resident Minister of State in Gulu has contributed a remarkable amount through organisation of negotiations of peace in 1993. In 1997 Sister Rachele Fassera, Deputy Headmistress of St. Mary's School, Aboke met with the Lord's Resistance Army Commanders in Juba to seek the release of abducted children. Other groups in Northern Uganda have organised around peace building and reconciliation and support for affected people in this region (Isis-WICCE, 2001a).

Commonly as found in other war-affected regions, in Northern Uganda, women have become heads of households. In Katakwi, Teso region, Isis-WICCE found that many women took over the role of protecting their families, organising food for the family, and in particular protecting their children from rape. During the 1987-1992 insurgencies many women played an active role in the resistance and took up arms to fight for their right to peace and to protect their families (Isis-WICCE, 2002a). This has also been the case in other war-affected areas of Uganda where women have taken up arms e.g. Luwero District (see Liebling et al. 2007). One woman war survivor in Gulu lost most of her family but she survived by becoming a rebel. She told us:

In July 1986, I joined the rebels. I could not stand the life of hiding from the NRA soldiers... Government does not appreciate what some of us have done

(Isis-WICCE, 2001a: 56).

Other women became wives of soldiers. Similar to Gulu, women in Teso and Kitgum have carried a heavier burden during the war by continuing their women's roles as well as taking on those traditionally held by men in the family (Isis-WICCE, 2002a). Taking on these additional responsibilities as well as caring for the many orphans also seems to have assisted these women to get on with their lives (see Liebling et al. 2007).

### **Gaining justice? The International Criminal Court.**

The most likely judicial intervention to bring justice to these women may be under the auspices of the International Criminal Court, as the situation in Northern Uganda has been referred to the International Criminal Court (the ICC) by a member state, and investigations have begun. The ICC has requested the surrender of persons, evidentiary material, and permission to conduct investigations within member states, and has sought a co-operation agreement with Sudan (a non-member state). The ICC enjoys jurisdiction over genocide, crimes against humanity, and war crimes (ICC statute: Article 5).

Whereas victims of sexual violence and torture as a result of unrest elsewhere in Uganda have not had access to an international tribunal, women in Northern Uganda can benefit, through the ICC, from the jurisprudence of the International Criminal Tribunal of Yugoslavia. The International Criminal Tribunal of Yugoslavia was the forum for the landmark Trial Chamber judgements, *Furundzija* (10 Dec 1998), in which rape was classified as torture, and *Kunarac, Kovac & Vukovic* (22 Feb 2001), in which three Serbs were convicted of rape, torture, and enslavement of Muslim women in Bosnia-Herzegovina, and for the first time rape was prosecuted as a 'crime against humanity'. The International Criminal Tribunal of Yugoslavia has made an enormous contribution to the statute of the ICC (Robinson, 1999), and Article 7 provides the new ICC definition of 'crimes against humanity'. It consists of 'any act' (contained in an exhaustive list of offences) when committed 'as part of a widespread or systematic attack' against any civilian population (ICC statute: Article 7(1)). An 'attack' is defined as 'a course of conduct' involving multiple crimes (ICC statute: Article 7(2)). The crimes of a sexual nature relevant to the victims in Northern Uganda are contained in Article 7(1) and include rape, sexual slavery, enforced prostitution, forced pregnancy, or 'any other form of sexual violence of comparable gravity'. It is clear that the women of Northern Uganda were subjected to a systematic attack of multiple sexual and violent crimes. It should be relatively straightforward to gather sufficient evidence from the victims for an ICC prosecution of this nature.

What might it take for the victims of these violations to testify at the ICC? Could they be sufficiently protected if they take part in the international court process? The Rules of Procedure & Evidence of the ICC provide some level of protection for victims and witnesses, and include, for example, private 'in camera' proceedings and the protection of the victim's identity (see by comparison Article 22: Statute of the International Criminal Tribunal of Yugoslavia). However, there has been some criticism of the International Tribunals and the ICC implying a dearth of cases concerning female victims and accounts of poor treatment of witnesses (Gunhammar, 2007). It is relatively early in the life of the ICC (which entered into force on 1 July 2002) to make criticisms of a lack of cases, given the length of time a prosecution takes, and the difficulty of bringing a main perpetrator, such as Joseph Kony, head of the Lord's Resistance Army, to trial. It would certainly however be a concern for women in Northern Uganda that there was at least adequate protection from possible retribution if they testify in court (Chinkin, 1997).

It is important for victims that their accounts of these atrocities are heard and recorded, and that perpetrators are seen to be judged and held accountable. In addition,

victims wish for financial claims to be awarded to assist their plight. The ICC is empowered to offer reparation to victims, including restitution, compensation and rehabilitation (ICC Statute: Article 75). This is the first time an international court has been given a mandate to adjudicate claims of this nature, and guidelines are yet to be established on monetary reparation. Uganda, however, should comply with any order made by the Court. Further, Article 79 (ICC Statute) provides for the creation of a trust fund for the benefit of victims and their families. The fund will be managed by a Board of Trustees. This provides a vehicle for claims for compensation to reach the Ugandan government with some international monitoring of the government's response, and legitimate demands may be made on a trust fund equipped to provide reparation at some level.

### **Discussion and recommendations**

This paper summarises the effects of sexual violence and torture on women's physical and psychological health in three areas of war-affected Northern Uganda. This gender-based violence has caused extensive damage to their reproductive and psychological health. Women have been infected with sexually transmitted diseases, HIV/AIDS, and are left with serious reproductive and gynaecological health problems. Some of these are not treatable within the Ugandan health system, and the studies indicate that the majority of women fail to access medical treatment due to a combination of factors including poverty, lack of health care facilities and stigma. Women have also been disfigured through the atrocities carried out in this region. These experiences coupled with the huge stigma of rape within this cultural context have further impacted on the women's identities. Additionally, women's status as Ugandan's displaced within their own country as opposed to having refugee status further compounds their difficulties. As refugees they might be entitled to services. However, their current status does not automatically entitle them to resources, and therefore the inequalities in health care provision are further enhanced.

However notwithstanding this, women in Northern Uganda are not silent victims. They have initiated and engaged in the peace processes, established businesses and income-generating schemes and have made a huge difference to the political processes in this region. This continued strength and resilience should be acknowledged and their current campaign for justice heard (see Wacha, 2007). More than two thirds of respondents in a recent survey carried out in Northern Uganda, stated that it was important to hold accountable those responsible for committing violations of human rights and international humanitarian law in Northern Uganda, including the LRA and the government (see ICTJ, 2007).

Despite all the above studies being carried out and recommendations made, and despite the fact that there is a Ministry of Rehabilitation in Uganda, very few interventions have been established for these war survivors and there is no post-conflict recovery programme for any of the war-affected districts of Uganda (Isis-WICCE, 2006a). The authors recognise the need for multiple strategies in this war-torn area of Uganda, working across different sectors at different levels (see UNIFEM, 2007). Based on the studies' findings and the women's views, the author's make the following recommendations:

1. There should be training and sensitisation programmes for government, local leaders, policy makers and health care workers in Uganda on the gendered effects of war and the services and policy changes that are required. Women should be involved at all stages of decision-making. Whilst women have started to play important roles in conflict-resolution, peace-building and peace-keeping, their voices are still under-represented (see Koen, 2006).
2. The Government should draw up a multi-sectoral and multidisciplinary post-conflict recovery policy to address the psychological, social and physical health problems of women in the war-affected areas of Northern Uganda (Isis-WICCE, 2001b; 2002b; 2006; Liebling-Kalifani et al. 2007; WHO, 2007). Achieving equity in health care provision for women Gomez Gomez (2002) argues, requires a better understanding of gender needs and barriers linked to social structures and health systems and therefore efforts are also needed to improve the status of women and to allocate health resources according to economic ability (e.g. Okojie, 1994) as well as paying attention to social exclusion (WHO, 2005).
3. There is an urgent need to establish funding to develop psychotraumatic treatment centres in all areas of war-torn Northern Uganda to address the massive psychological problems of the population. The Alderman Foundation agreed to fund three mental health clinics in Uganda, including a Trauma Unit in Gulu see <http://www.petercaldermanfoundation.org/>. This and other urgently needed units and services should be fully integrated into the existing primary health care system, and should include training of local health workers in the management of the medical and psychological effects of trauma (Isis-WICCE, 2006b). Evidence indicates that unless these difficulties are addressed, this could lead to serious trans-generational effects with future instabilities in Uganda (Isis-WICCE, 2001b; Isis-WICCE, 2002b; Isis-WICCE, 2006a; Liebling-Kalifani et al. 2007; Musisi and Kinyanda, 2001).
4. There should be a holistic gender-sensitive public health intervention approach to address the physical and mental health needs of women war-survivors in IDP camps in Uganda. This should include provision of free treatment services for women including HIV/AIDS testing and treatment, specialist gynaecologists, obstetricians and women counsellors using a holistic approach and involving women war survivors in all aspects of decision-making. As Koen (2006: 2) argues 'most African governments have failed to integrate women into policy formulation,' as this situation needs to be challenged. The Department for International Development included 'universal access to reproductive health services by 2017' as a priority area for action. Urgent resources are required if this target is to become a reality (DFID, 2000: Doyal, 2000; Isis-WICCE, 2001b; Isis-WICCE, 2006a; Musisi and Kinyanda, 2001; Jewkes, 2007; Liebling-Kalifani et al. 2007; WHO, 2007). Successful health interventions need to be based on long-term sustainable improvements in women's health and social, legal and



political empowerment, rather than on time-limited external assistance. Women war survivors should therefore be involved at all stages of decision making in the planning and provision of these urgently required health services. It is imperative that these services are provided so that these women are able to recover fully and continue to rebuild their lives (see Grown et al. 2005).

5. The investigations of the International Criminal Court should be supported and gender-based violent crimes committed during war perceived as war crimes (see Koen, 2006). In addition, a Truth Commission, to supplement the judicial process and the prosecution of serious war crimes should be established in Northern Uganda, with the purpose of investigating and accurately recording human rights' violations (Isis-WICCE, 2001b). Such Truth Commissions have operated elsewhere (for example, the South African Truth and Reconciliation Commission) to establish the fate of victims and these commissions have given women a voice that they would otherwise not have in the courts. However, Truth Commissions also operate by granting sweeping amnesties (Ratner & Abrams, 1997) and this may not support redress for known victims. Amnesties also can be a barrier to long-term reconciliation within devastated communities. Where a Truth Commission could have particular use is to provide a forum for the many children forcibly abducted and enlisted as rebel commanders by the Lord's Resistance Army (Wacha, 2007). This group may be more readily accepted through the process of reconciliation provided for in a Truth Commission.
6. Another mechanism would be to strengthen and develop the Ugandan Human Rights' Commission and to enable it to deal with human rights' violations that have taken place in the region, through a Ugandan Human Rights' Court (Isis-WICCE, 2002b). A Ugandan Human Rights' Court should be able to move more swiftly than an international court, and could bring public recognition and redress to the victims, although unfortunately the record of the court system in Uganda has been unsympathetic to women and has proved to be reluctant to listen to their witness evidence (Liebling-Kalifani et al. 2007). Hence, in this context the current author's recommend investigation of the atrocities committed against women by the International Criminal Court.
7. Uganda is bound by its legal obligations under the Convention on the Elimination of All Forms of Discrimination against Women treaty (CEDAW, 1979), which requires the government to recognise the specific health care needs of women under Article 12, and to take steps to meet these needs to the maximum extent of their available resources. Although CEDAW does not have a strong enforcement mechanism (there is no 'court'), the recommendations made to the Ugandan government through the CEDAW Committee constitute an added pressure on the government to take note of these concerns, and to make the appropriate policy changes (CEDAW Committee, 2002).

8. Policy changes recommended to the government and also in compliance with CEDAW should include income-generating activities and micro-finance schemes to empower women politically and economically and to enable them to access health services. Poverty reduction strategies in conjunction with specialist health care programmes would improve the health outcomes for these women war-torture survivors (Isis-WICCE, 2001b; OCED, 2005; Isis-WICCE, 2006a; Koen, 2006; Liebling-Kalifani et al. 2007).

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