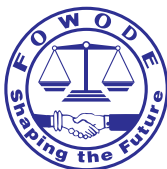




Gender Transformation & Empowerment

REPRODUCTIVE RIGHTS | Survey Report





REPRODUCTIVE RIGHTS

Survey Report

Acknowledgement

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Acronyms

RR	REPRODUCTIVE Rights
ART	Anti-Retroviral Therapy
EALA	East African Legislative Assembly
FEMRITE	The Uganda Women's Writers' Association
FGM/C	Female Genital Mutilation/Cutting
FP	family planning
GBV	Gender Based Violence
IDPs	internally displaced people's camps
IUD	intrauterine device
JCRC	Joint Clinical Research Centre
LRA	Lord's Resistance Army
MDGs	Millennium Development Goals
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NAPW	National Action Plan on Women
NMS	National Medical Stores
PRDP	Peace, Recovery and Development Plan
RDC	Resident District Commissioner
STDs	sexually transmitted diseases
TERREWODE	The Association for the Re-orientation and Rehabilitation of Women for Development
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demography and Health Survey
UDN	Uganda Debt Network
UPE	Universal Primary Education(
WHO	World Health Organisation
WHO	World Health Organization

1.0 INTRODUCTION

1.1 Definition:

REPRODUCTIVE Rights (RR) are a basic freedom. They are part and parcel of Reproductive Health, which is a fundamental Human Right. Reproductive Rights are basic for gender equality in the society which encompasses a state of complete physical, mental and social well-being and not merely the absence of infirmity or disease, in all matters relating to the reproductive system, its functions and processes.

Based on the definition, it implies that for people to enjoy their RR, they should have a safe and satisfying sex life, the freedom to reproduce and to decide when, and how often to get the number of children they want. They have a right to be informed and have access to safe, effective, affordable and acceptable method of family planning, and/or any other methods of choice that is not illegal for regulating their family.

Also, they have the right to appropriate labour services that do not prejudice safe pregnancy, child birth and enable the couple to have healthy infants. RR also ensures access to health care services in family planning, pregnancy, confinement and the post-natal period. There is need to provide this access freely to the poor of society where possible, especially as found in the rural areas.

Overall, RR presumes the women's right to exercise these rights. It is enshrined in the United Nations Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) ratified in 1985 and also captured in the Beijing Declaration of 1995 and, most recently, the African Union Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2003 (The Maputo Protocol).

These are reinforced by the Millennium Development Goals (MDGs) 3, 4, 5 and 6. While Goal 3 advocates for the promotion of gender equality and empowerment of women and eliminating gender disparity in primary and secondary education at all levels by 2015, Goal 4 provides for the reduction of child mortality by two-third of the mortality rate among children less than 5

years of age. Goal 5 supports improving maternal health, reducing by three-fourths the maternal mortality ratio by 2015. And Goal 6 aims at combating HIV/AIDS, malaria, and other diseases by halting and beginning to reverse the spread of HIV/AIDS. These international agreements are actively promoting the expansion and improvement reproductive health and charging the national leaders to honour their commitment to these international obligations.

By invoking the gender equality, the committee on CEDAW advocates that the promotion of rights to reproductive freedom, primarily take into account access to specific information related to: appropriate health services; the well-being of families; advice on family planning; counseling; contraception; maternal mortality; HIV/AIDS and other sexually-related complications; domestic violence; and, including the attendant factors.

At the ICPD in Cairo, there was invoking of a policy to “match the population growth to the available national resources over time in order to improve the well-being and the quality of life of the individual, the family and the nation as a whole.” It required that subsequent policies be developed and implemented through a collaborative process involving stakeholders from both public and private sectors, including non-governmental and community-based organizations. The ICPD emphasized raising awareness among decision makers and development planners about the effect that population change can have on social, economic development and the benefits of lowering fertility.

ICPD recognizes that population increase is putting greater pressure on natural resources and warns that the degradation of the nation’s soils, water sources, and forests will constrain the country’s ability to produce food and guarantee acceptable health and economic standards. It implies a responsibility within the population and health sectors to deal with environmental issues and lays the foundation for population-health-environment cross-sectoral collaboration.

There are many forms of RR violations but these survey investigated the following: The availability and supply of ARV, access to quality ARVs by women of reproductive age, teenage pregnancy, Quality and availability of Female Genital mutilation, Availability and access to Family Planning services, Abortion, obstetric Fistula, availability and access to Post Exposure Prophylaxis, Antenatal care services, Gender based Violence.

2.0 REPRODUCTIVE RIGHTS-ACUTE SHORTAGE OF ARVS IN UGANDA, WOMEN OF REPRODUCTIVE AGE MOST AFFECTED

Uganda is one of the very few countries around the world that is recorded to have brought the generalized epidemic under control, now between 6.3 and 6.7%, a lot is still desired. It is estimated that 180,000 individuals are currently on ART, according to the Uganda Aids Commission (UAC) 2010. However, this is only a fraction of the estimated 360,000 people in need of the life-saving drug.

There have been reports that Uganda was running out of AIDS drugs, and some major service providers closed down outlets, leaving many people living with HIV/AIDS stranded.

The two biggest providers, the Joint Clinical Research Centre (JCRC) and Mildmay Uganda, scaled back services - closing some treatment centers. There were also cases of deaths related to this situation reported in 2010. More frustrating however, there is no gender breakdown of these deaths, and even where it is available, it is still difficult to establish the number of positive mothers who died. A number of centers stopped registering all people who test positive for HIV due to limited funds.

This is because many donors like Pfeifer, a company manufacturing drugs, the Global Fund and others, who have been providing ARVs, reduced the assistance because of the credit crunch that hit mainly the Western world.

Ugandans have previously worried about the fact that an HIV-positive woman cannot exercise her reproductive rights. Today, with the improvement in science and technology, these worries are no more. Such a woman can now produce a healthy baby and remain strong and alive if she adheres to the treatment.

The Ministry of Health has however assured Ugandans that there are enough AIDS drugs for the whole country to last for six months (October 2011 to March, 2012). The drugs were procured using the cash received late last year from the Global Fund.

Case study 1

Adongo Pricilla (not her real name), 20, is an HIV positive mother and is six months pregnant. She has been commuting from Olilim village in Katakwi district, which is 30km away, to go to Katakwi General Hospital to get her monthly dose of Anti-retroviral (ARVs) drugs. The last time she went for the drugs was in October, 2011 and by the time of this survey she had given up.

The visibly frustrated mother of two complains that her going to the hospital is a waste of time because on a number of occasions she failed to get her medication due to drug shortages.

“I first went to collect my drugs in June when I was four months pregnant and I was given only Septrin. The second time was in August when I received only ARVs yet I’m supposed to take both Septrin and ARVs,” Adongo complains.

She says the third time she returned to the hospital she came back empty handed due to shortage of drugs. It was more frustrating for me to be parting with about UGX 20,000 on each visit and return home without medication.

Micheal Akeria, the Coordinator Katakwi Network of People Living with HIV and AIDS, says “From October, 2010 to-date(time of the survey), the district received sufficient drug supply as opposed to the past when had insufficient supply of drugs.”

He noted that lack of or inconsistency in accessing HIV drugs during pregnancy exposes such a woman to opportunistic infections like anemia, and if she is not cared for at a health facility during child birth, she is susceptible to death during delivery. “It can also expose the baby to not only the HIV virus but other infections,” he says.

Florence Nagawa, the National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU) says pregnancy is known to reduce immunity but it gets worse for an HIV positive woman.

“When a woman is HIV positive and pregnant, her immunity is twice lowered as opposed to an expectant mother who is healthy. Lack of or inconsistent use of anti-retroviral therapy (ART) drugs endangers both the life of the mother and that of her baby, Nagawa explains.

She asserts that an HIV-positive woman has the right to reproduce, a right to be served by health providers and it is her responsibility to access the health services that are relevant to her condition. “If she decides that she needed these services and finds that they are lacking, it means her right to be served has been violated.”

Dr. Elizabeth Namagala, the Coordinator in the ART Division at the Health Ministry has assured Ugandans that with the Support recieved from the Global Fund in 2010, quoting an estimated 4.25 million US dollars which the ministry used to buy around six months worth of anti-retroviral drugs for the whole country.

“Those drugs have already come in. Some of it came in before Christmas and others came in at the beginning of January. So, we have enough drugs at the National Medical Stores (NMS), and people can order for supply,” she stressed.

2.1 Continuity of the Supply of ARTs

Also, other ART issues reported include eligible people living with HIV/AIDS, who cannot be enrolled on ART, limited or no CD4 count machines in parts of the country, inconsistent supply and distribution by NMS, lack of nutrition and ART adherence and illegal charges by health workers.

Namagala, however, says the ministry had the capacity to avert a crisis. The demand for ARVs has been rising in Uganda, creating pressure on limited resources. The number of people in immediate need of the drugs had risen from about 225,000 in 2006 to 312,000, according to Health Ministry estimates. On average, 1,500 patients are enrolled on ART every month.

An estimated 1.1 million Ugandans are living with the virus that causes AIDS. Currently, 130,000 patients, including 10,000 children, are receiving ARVs. This is about 42% of the total number of people in urgent need of ARVs. This percentage is one of the highest in Africa. The shortage also came in at a time when Uganda has started producing ARVs. Quality Chemical Industries, a pharmaceutical company based in the Luzira Industrial Area, started full scale production of ARVs last year.

NAFOPHANU, being the umbrella organization for all people living with HIV/AIDS in the country, has come up with recommendations, calling upon the government to meet the commitment of universal access by 2010 so that all people living with HIV/AIDS receive free ARVs.

“We also say that there should be transparency in the distribution and supply chain, misallocation of funds for ARVs and corruption in the AIDS industry should stop, and government should provide CD4 count machines in every district in the country,” says. Dr. Stephen Watiti, chairperson, NAFOPHANU.

Amidst the postive responsive to avert the crisis, some sources say that the ministry could down playing the crisis. But HIV/AIDS activists in the country under the leadership of NAPHOPHANU revealed that stock out of ARVs is still a problem.

“In most districts, Katakwi inclusive, there is just one or a few health facilities accredited to give HIV/AIDS treatment and people go home miserably waiting for death as there are no drugs,” said an activist who preferred to remain anonymous.

2.2 Specific Recommendations

Government, development partners and Civil Society to get more involved in designing Monitoring and Evaluation (M&E) mechanism for tracking progress on ARTs particularly among pregnant positive rural women.

Government, development partners and Civil Society to get involved and contact the NMS to establish the quantity of drugs available, when it was bought and for how long is it going to last.

Government, development partners and Civil Society to advocate for the accreditation of health center III to give out ARVs or HIV/AIDS treatment in general.

For meaningful intervention, Government, development partners and Civil Society should conduct research countrywide to establish the number of positive pregnant women who are dying simply because of lack of or inconsistency in the use of ARVs.

3.0 TEENAGE PREGNANCIES, CHILD MOTHERS ON THE INCREASE

3.1 Communities ironically promoting the rights of children, and forcing teenage girls into early motherhood

Analysis

YOU could have heard of cases where children have produced children, but you may not appreciate the ordeal the mother of that child -turned mother goes through while taking care of her, especially if the mother herself also has a breast feeding baby.

Uganda has the highest teenage pregnancy rate in sub-Saharan Africa, with half of its girls giving birth before the age of 18. Some give birth to healthy children, but for many, pregnancy was

unplanned, birth comes too early and the experience is one of fear and pain. Many times girls marry and start their families before ending their own childhood.

The median age for women to marry is below the age of consent (17.8 years) as many experience their first sexual intercourse at 16.6 years, compared to 18.1 for men, according to the 2006 Demographic and Health Survey. The Constitution of the Republic of Uganda 1995, defines any body below 18 years as a child who conceives is a victim of abuse and violations of Reproductive Rights. According to the World Health Organisation (WHO) 2007 Report, adolescent girls face health risk during pregnancy and childbirth, accounting for 15% of the global burden of disease for maternal conditions and 13% of all maternal deaths.

Adolescent mothers are twice as likely as older mothers to die during childbirth. Only 41% of births are attended by skilled personnel. For poor young mothers, aged 14 and under, the risk is highest because they have the lowest access to prenatal care, hence, more likely to deliver at home than in hospitals, experts say. The Ministry of Health 2006 Survey data show also that fertility varies markedly with the education and economic status of the mother. Uneducated mothers have almost twice as many children as women with secondary or higher education's (7.7 children compared with 4.4).

Similarly, women in the poor households have more than twice as many children as women in the wealthy households (8 children versus 4.3 children).

Teenage pregnancies increase school dropout rates, dependency, early marriages, poverty and risks of contracting sexually transmitted diseases (STDs). According to the Annual Learning Assessment Report, Uganda 2010, major gender differences in reading is skewed in favour of boys in the upper Primary classes (P6-7). Educating the Girl-Child is therefore one of the national strategies adopted to fight teenage pregnancies. Even with Universal Primary Education (UPE), dropout rates for girls remain higher than those of their male counterparts as 50% of the girls leave school. According to records from Alero Primary, a rural school in northern Uganda, out of the 13 pupils who failed to sit the 2008 Primary Leaving Examinations, nine were girls hindered by early marriages and unwanted pregnancies.

Moreover, maternal complications are more likely to affect not only the poor, but also girls who are not in school. For instance, Mulago Hospital records show that 70% of women attending post-maternal complication clinics are below 30 years, 77% of whom are primary school dropouts. "It

is usually girls from poor settings who come here. There are also very few secondary dropouts. In any case I have never seen any girls from the university. Most of them are primary dropouts. There are also a high number of those who have never been to school.

“They (school dropouts) are also the same people who do not seek antinatal care or even if they did so, find difficulties in accessing it because of logistical problems,” Baragain says. “The more educated a woman is, the higher her chances and those of her child to survive,” says Dr. Sam Okuonzi, a research fellow with the African Centre for Global Health and Social Transformation. “International studies have shown that a girl studying just up to primary seven reduces maternal and child mortality by 50%, he says”

“Pregnant adolescents are in a dark void of helplessness and hopelessness, waiting to be rescued,” “For some, their need dates back to their infancy, when their families were unable to give them access to education, nutrition and survival skills,” says Dr. Olive Ssentumbwe Mugisa, the WHO advisor on family and population health. Dr. Anthony Mbonye, the in-charge of reproductive health in the Ministry of Health, says for every young woman who dies in childbirth, on average 40 others are left with an injury (or incapacitated to fend for themselves). “Young mothers are more likely to have low birth-weight babies, at the risk of malnourishment, poor development or death,” adds Mbonye.

Case studies

In Akwiya Woro village in Acaba Sub-county, Oyam district, a 32 year old Manjeri Akot, last August had twins while her 15 year-old second-born was also nursing a two-weeks old baby. The twins were Akot’s 9th pregnancy.

An investigation into the issue of teenage pregnancy in Oyam district revealed that in just one parish in Acaba Sub-county, seven child mothers were registered in the year, with the majority of them falling under the age of 15 years.

According to Lillian Emuna, the Child Protection Community Member in Acaba, the situation in other sub-counties is not any different from that of Acaba. She described the rate of teenage pregnancies as worrisome and regretted that little attention is being directed towards understanding the plight of teenage mothers as a human rights development concern.

“Being pregnant at a teenage age, these children need a lot of love, care and attention and their bodies need enough, balanced diet and nutritious food, enough rest and psychological support for proper growth of both the teenage mother and her baby,” she says.

She adds; “Most parents do not provide this requirement not necessarily that they cannot afford, or that they are ignorant about the rights of the child but more so because they assume that conception has turned their teenage daughters into adults ready to embrace motherhood.”

As a result, Emuna says, most parents turn violent on learning about the pregnancy of their teenage daughters, often harassing them to the extent of chasing them from their homes to join the men responsible for the pregnancy and yet in most cases, those men will have fled the village in fear of taking responsibility and facing the law on defilement.

Reminiscing on her ordeal, the 15 year Lucy Ajok, says she was defiled by a S.4 boy from a neighboring school. When she broke the news to him that she was pregnant, he did not respond but instead fled the village, leaving her with a three- month’s old baby, apart from making her a P.7 drop out and being harassed by her parents.

Unlike most women in her condition who would have a choice to ask or get whatever they wished to eat during pregnancy, Ajok did not have that chance to even ask her parents in fear of being reprimanded. “I had fear and I did not want my parents to know I was pregnant. I had no chance to ask for what I wanted to eat because each time I did, I was told it should serve as a lesson for me and I was never given.”

For Nane Akullo, 14, she was in P.4 when she was defiled. Her experience is no different from that of Ajok. Her abuser fled the village leaving her at the mercy of her impoverished parents who were hostile about her dropping out of school. Her baby is six months old but she is still unable to go back to school because there is none to leave the baby with. “During pregnancy, I used to throw up a lot. The only meal I loved to eat was meat but it was never available. Whenever I asked for it, my mother would rebuke me saying I deserved it.”

Lucy Atim, also 14, and a mother of a seven-month old baby was totally oblivious about the importance of antenatal care services, until her pregnancy turned 6 months; that is when she chanced to get information from a member of the Child Protection Committee in her village.

There are more shocking experiences of a number of Reproductive Rights violations suffered by many of these children forced into early motherhood, but the general consensus is to protest the

rampant abuse and violations of their rights to decide when to start a family. They also advocate against discrimination and stigma they are subjected to by members of their community because of their plight.

They need information about pregnancy, delivery and post delivery services and care like how to breastfeed, how many times to bathe a baby, the sleeping position for the baby, take care of a sick baby, care of oneself after birth among others.

“My major challenge is finding a person to take care of my baby so that I can return to school. I will also need financial support to staff income generating activity to raise funds for both my upkeep and for the baby,” says one of the child mothers, a view that is echoed by others in her situation.

POLICY PRACTICES

“Infant and child mortality is highest among children of adolescent mothers. Girls who give birth miss school and opportunities for employment. There is a risk of the cycle repeating itself.”

Unwanted and early pregnancy reflects a failure to provide a safe environment that supports girls to reach adulthood with education, prospects and hope. In Uganda, many teenage pregnancies are not merely unplanned, but also unwanted, contributing significantly to an estimated 297,000 stealthy abortions annually. Because they are less likely to have access to legal and safe abortion, the unwanted and unsafe pregnancies occur disproportionately among the poor rural women when compared to their urban fellow women.

The North and Eastern regions that have borne the brunt of fighting for more than 20 years, between the Lord’s Resistance Army (LRA) of Joseph Kony and the Government, has the highest incidence of poverty in women, put at 71%. And the occurrence of abortions was high as most of these women were confined to the internally displaced people’s camps (IDPs).

This creates a circular factor. Poor and illiterate or semi-illiterate women have less control over their sexuality and they are often victims of defilement or rape. In this case the violation of their Reproductive Rights and the reason for unwanted pregnancy is that these victims are school girls.

It stands to reason that policy-makers will help avert unintended pregnancies that make women choose abortion and risk death, or from complications of pregnancy and childbirth. They are the most influential public group. They can either change policies and programmes directly or influence those who can.

Some policy-makers also reach the general public through their public speeches and statements. Policy-makers' support is key to ensuring commitment, adequate resources, and, ultimately assurance of these children's Reproductive Rights. Policy-makers include top political leaders, high-level officials in various ministries and directorates (e.g., health, finance, planning, education, and youth), Parliamentarians and other legislators, national religious leaders, and heads of national non-governmental organizations (NGOs) and media institutions.

In Oyam however, the different stakeholders are approaching the intervention in different ways. For instance, Daniel Okulu, the Executive Director for the Development Pathway for Transformation, in Oxfam, says the organization is supporting poor and vulnerable children households to engage profitably in agriculture.

3.3 Recommendations

Family life education has to be provided in schools. The need for Reproductive Health information cannot be over-emphasized especially in the Northern and Eastern regions that have recently come out of a war situation.

Promote involvement of a wide spectrum of concerned Ugandans: policy makers; religious leaders; educators; journalists; health professionals and planners; women legal advocates for increased awareness enactment and advocacy on issue.

Deliberate interventions need to be designed and implemented to help victims. Uganda cannot continue to pretend that it's not faced with the burden of child mothers whose reproductive rights have been violated.

Providing financial information to enable members from the poor household access loans and utilize them more profitably to increase household incomes and ensure food security is critical in reducing incidences of teenage pregnancies.

Ensuring effective enforcement of laws protecting Women and children against rape and defilement is key.

4.0 FEMALE GENITAL MUTILATION/CUTTING IS STILL PRACTICED IN MOROTO DISTRICT IN KARAMOJA REGION

4.1 POLICY PRACTICES

Female Genital Mutilation/Cutting (FGM/C) or female circumcision is the most extreme form of sexual-based violence (SBV). WHO defines it as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.”

FGM/ C is carried out on girls from a few days old to puberty. It is usually performed, without anesthesia by a traditional circumciser using a knife, razor, or scissors. In Uganda FGM/C is still being practiced in Karamoja by the Pokot and Tepein ethnic groups. WHO estimates that up to 140 million women and girls around the world have experienced the procedure, including 92 million in Africa.

In Uganda today, the concentration of the practice is found in the eastern part of the country among the Sabiny of Kapchorwa and Bukwo districts; and Pokot and Tepein, Karamoja region. It has spread to other parts of the country, notably Bugiri District inhabited by Sabiny settlers, and in Kampala, within the Somali and Nubian communities

4.2 Case Studies

Study 1

AGRIPHINE Munyesi, 26, is from Moroto District. She is a Karimojong, and her culture requires that she undergoes female genital mutilation (FGM) as pre-requisite for progression into adulthood; but she is not.

In 1989, her father visited her in her secondary school to inform her of her impending circumcision alongside their neighbour's daughters. On hearing this, she burst into tears and could not stop until her friends advised her to escape. Munyesi went home and established that preparations to circumcise her were complete.

She confided in her mother about her situation. She was afraid of the ordeal and particularly its

immediate effect of transforming her into early marriage as it is the case with most victims of FGM in her community. The mother was touched by her daughter's pleas, and borrowed some money and helped her to escape to her aunt's place in Kapchorwa, a neighboring district.

The father tracked her from her hideout in Kapchorwa saying her daughter's refusal to be circumcised would bring shame and embarrassment to the family. On realizing this, the aunt immediately relocated Munyesi to stay with a friend in a distant sub-county in Jinja district. Her father returned to Moroto after failing to locate her.

In 1999, oblivious to her father, she managed to get to St. Michael Girls' SS in Kapchorwa to continue with her education in Senior Two but she did not have anybody to pay her school fees.

At the opportune time Mrs. Jane Frances Kuka, then minister of State for Gender and Culture visited the school in the company of the Americans Mr. and Mrs. Chamberlain. At a general assembly, the visitors addressed students on the effects of Female Genital Mutilation (FGM) and revealed that they were sponsoring some girls who had said "NO" to FGM. Munyesi found out that the visitors had come to take the girls they had sponsored to other schools in Kampala and she was among them.

Today, 12 years down the lane, Munyesi has a degree in Adult and Community Education from Kyambogo University. She is sure her future prospects are bright and believes this would not have been possible if she had succumbed to the cultural demands to be circumcised in 1998.

She is among very few lucky Tepeth girls in Karamoja and Sabinyi girls in Kapchorwa who have escaped the effects of FGM, a primitive and outdated cultural practice which should not be practiced in the modern world. It is believed to be a way of preserving female chastity and in Karamoja, it is performed to girls aged 15 years.

Study 2

Kuka, now the Resident District Commissioner (RDC) for Kapchorwa has been struggling against FGM/C since childhood. In 1988, when as Principal of Kapchorwa Teachers' College, she spoke out against the practice. Then, the Kapchorwa District Council had declared circumcision compulsory in order, according to them, to strengthen the Sabiny culture. That is when she acted. She contacted the Minister of Gender, then, Mrs. Joyce Mpanga, who communicated the situation to the President Yoweri Museveni. Mrs. Mpanga went to Kapchorwa and met the Council and sensitized it about the dangers related to the practice.

After a long discussion the Council agreed to change the compulsory requirement for circumcision to optional. From that success Kuka has championed the fight against FGM/C until in 2009; in the gallery of Parliament she witnessed the passing of the FGM Bill into law.

What actions have been taken

The Uganda Women's Writers' Association (FEMRITE), has recently published a 156-page anthology of prose and poems entitled "Beyond the Dance", which according to Mrs. Dora Byamukama, a Member of Parliament in the East African Legislative Assembly (EALA), who wrote the forward, is "breaking the silence and recording voices of women that have been stifled for ages" about the practice of FGM/C.

The Government is using a multi-pronged approach to fast track the abandonment of the practice. Government is working with Civil Society Organizations and Faith-based Organizations in the practicing communities to build capacity of the communities to abandon the practice. The process of abandonment is challenging however, since FGM/C is rooted in cultural expressions of marriage, womanhood and standing in society. Government appointed a full minister for Karamoja Region who has prioritized farming, agriculture, health and education sectors.

The Ministry of Gender Labour and Social Development and its partners, including UNICEF and UNFPA, have chosen to expose the damage done to women and girls as a result of this practice, and these organizations are disseminating the information to the various stakeholders with a view to effecting behavioral change.

The ultimate goal of UNFPA support is to have in place institutional mechanisms and socio-cultural practices which promote the rights of boys, girls and women and protect them against sexual and gender based violence and other harmful practices such as FGM/C and to advance gender equity and equality. One of the critical areas of emphasis is to intervene using culturally sensitive approaches in handling harmful traditional practices such as FGM/C.

But perhaps the enactment of the Female Genital Mutilation (FGM) Private Members Bill into law in 2009 imposed tough penalties the Pokot and the Tepeth, the peoples involved. The law provides that a person who carries out FGM shall be liable to 10 years imprisonment. A person who carries out FGM on herself is also liable to imprisonment for 10 years. Attempts to carry out FGM or supporting it are also crimes, each carrying five years of imprisonment and the consent of the victim to FGM is immaterial and shall not be a defense under the law.

According to Julius Kapwepwe, a development worker in Karamoja, there are legal frame works for Tackling FGM/C but the success will depend on implementation approaches.

Some of the community members the consultant interacted with agree that an integrated approach be adopted into a holistic programme for transforming Karamoja region.

It is also important that the voices of girls and those of the adult women be heard on the issue, said a social worker who requested anonymity. “The programmers should adopt their ideas into the specific cultural and social contexts,: she said.

Other commitments: The Minister State for Gender, Rukia Nakadama, called for a widespread ban, for the whole of Africa to stop the practice FGM. She said Uganda enacted the anti-FGM law which should be enforced to eliminate the practice in communities where it is still rampant.

4.3 Recommendations Nationally

Government, Civil Society and Development Partners to link up with local activists in Moroto to establish effective techniques, strategies; psycho-social and physical support systems for responding to Issue.

Facilitate processes that support community ownership and harmonize their community values with universal principles of human rights and define all forms of FGM/C as a violation of Human Rights.

Help community members create an environment that is conducive to change and sustainability.

Provide care, support and protection for especially girls & women affected by FGM/C.

Mobilize the community through support groups to create safe spaces for discussion such as; women, girls and male youth and engage them to identify problems, existing structures and appropriate solutions.

5.0 MUBENDE FAMILY PLANNING SERVICES REFLECT A NATIONAL INADEQUACY

5.1 Women empowerment to take charge of their Reproductive Rights

If she is not pregnant, she is breast feeding, or she is both pregnant and breast feeding at the same time. This sounds to be a mere exaggeration but it is a true picture of how fertile a rural Mubende woman is.

FP is the combined “comprehensive medical or social activities which enable individual women, including minors, to determine freely when to have children and the use of birth control and other techniques to implement such plans. This involves the range of contraceptive methods. These can be: sterilization, implants or injection with progestagen under the skin or forearm, oral contraceptive pill, intrauterine device (IUD), diaphragm or condom.

According to Center for Reproductive Rights 2007 report, it is important to note that stock out and lack of supplies are barriers that women encounter in seeking to space their pregnancies. Despite that FP provides additional societal benefits, including: healthier women who are better able to contribute economically to their families and communities; a reduction in neonatal deaths, deaths among children under 5, and children orphaned by maternal mortality; a reduced burden on public health and social welfare systems; and a reduction in abortions.

The documentation established that in Mubende, there was lack of comprehensive and understandable information with regard to availability and accessibility of especially the modern FP methods that is currently being preferred by rural women.

According to the District Director of Health Services for Mubende, Dr. Wilson Mubiru, the district fertility rate stands at 7.3 children per woman, far above the national average fertility rate of 6.9. He regrets that male involvement in FP, availability and accessibility to FP services remains low.

The Mubende district senior health educator Scholastica Matovu says in spite of the fact that the antenatal attendance is high above 80% for 1st time visits; this has not been translated into reduced fertility rate due to a number of reasons.

5.2 Case Studies

Study 1

Susan Muwonge 29, has just had her fourth baby. She is lying in the maternity ward at Mubende Regional Referral Hospital, on seemingly unhappy and regretting why conception took place this time. She on a number of times visited the Hospital with her husband trying to access depovera, a modern family planning (FP) method, in vain.

Muwonga is not alone; hundreds of Mubende women have tried to access these services unsuccessfully as some of them are made to wait for a month or so. The wall in the nurse's room is awash with tags bearing telephone contacts of over 50 clients on the waiting list to be contacted once the services are delivered to the hospital.

There is constant shortage/supply of the most preferred FP methods such as diprovera, implants etc, by women in Mubende. This is coupled by the long distances travelled to accredited health facilities that provide these services free and the inaccessible roads. The situation is worsened by the fact that there are a few players that provide these services in Mubende namely; United Nations Fund for Population Activities, and Mildmay.

Allen Joyce Nakato, a mid wife at the Hospital, stresses that limited availability and inconsistency supply of modern contraceptives is the most frustrating fact in improving utilization of FP services especially in the rural Mubende. "For a month now, we have registered 100 women who want either depovera, or implant but all of them are out of stock for two months.

The fact that there are so many women who leave their contacts behind to be contacted is mere indication for how desperate the situation is.

The negative attitude of the local has to also a larger extent discouraged the service providers and other stakeholders in the district to invest more time and prioritize making the services available at all times even to those living in hard to reach areas of Madudu, Nabingola, Kasambya sub-counties.

Community responses to why family planning?

We should not discourage our women from producing more children because President Yoweri Museveni is already taking care of them through Universal Primary Education(UPE) and Universal Secondary Education(USE), remarked a taxi driver in Mubende town.

A pedestrian hailing from Nabingola Sub-county also had this to say in regard to FP. “We still have a lot of unused land. If we do not encourage our women to produce more children, who will occupy the land?”

Other residents have also observed that the issue of FP is only a political move intended by the political leaders to grab land belonging to the local and give it away to foreigners in the name of investors.

FP one of comprehensive medical or social activities which enables individual women, including minors, to determine freely when to have children and the use of birth control and other techniques to implement such plans.

Other techniques commonly used include sexuality education, prevention and management of sexually transmitted infections, pre-conception counseling and management infertility management.

FP is sometimes used wrongly as a synonym for birth control though it often includes more. It is usually applied to a couple who wish to limit the number of children they have and/or to space children. Family planning may encompass sterilization and abortion

6.0 Opportunities

FP allows for healthy spacing and timing of pregnancies and limits the number of unintended pregnancies, both of which are essential components of comprehensive safe motherhood strategies, according to the WHO 2009 Report. Through integration of family planning and safe motherhood programmes, women can limit their overall fertility and reduce the number of times they are at risk for maternal death; space births, thereby allowing their bodies to recover from previous pregnancies; and time their pregnancies.

Investing in reproductive health not only advances the human rights and improves the health and well-being of individual women and their families but also benefits society and the national economies. Despite the emphasis placed by various policies and agencies on the specific needs of women, gender parity in the provision of services and encouraging women’s participation in the community are limited.

The participation of women in the health initiatives would help couples have the number of children they want as well as address the high “unmet needs” for family planning services. It

would also help to diversify contraceptive options by ensuring availability to the most rural populations. The involvement of women would further support the government to increase contraceptive prevalence.

Female education and empowerment are critical determinants of fertility and providing girls with access to education. Nevertheless these rights continue to be either disregarded or even deliberately violated.

At the ICPD in Cairo representatives of over 180 nations agreed that women needed to be empowered to take charge of their reproductive lives, that unsafe abortion is a public health concern, and that forced sterilization has no place in family planning efforts. This was a precursor to the 1995 World Conference on Women in Beijing, governments pledged to guarantee reproductive rights for all women.

The United Nations Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) ratified in 1985 was a precursor to the Beijing Declaration and, most recently, the African Union Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2003 (The Maputo Protocol). These are reinforced by the Millennium Development Goals (MDGs) .5.

The UN and regional human rights bodies started to urge governments to respect and ensure women's reproductive rights. Women in Africa and those with disabilities, meanwhile, won crucial recognition of their rights to control their reproductive lives and to live healthy lives in two new human rights agreements, the 2008 UN Disability Rights Convention and the 2005 Protocol on the Right of Women in Africa. These gains set the stage for legal breakthroughs that would expand women's access to reproductive healthcare.

Now, both men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.

6.1 Recommendations.

In order to mitigate the unmet need for FP services, government, civil society and development partners will need to undertake a number of actions to supplement the current interventions that have been started by the Mubende districts authorities. This included setting up FP committees

and training them to correctly provide data on the need for FP services and ensuring timely submissions of reports to the DDH for effective planning and coordination of the services. Also there are staffing and equipping of especially health center II. The staffing level of especially the lower cadre medical personnel has improved to 75% in 2010 from 48% in 2009 but more efforts are required to continuously lobby and advocate for the staffing levels to increased to meet the need of rural mothers.

Government, civil society and development partners will need to conduct targeted advocacy and information sharing sessions with policymakers and policy implementers about the needs of especially HIV-positive women and men with regard to improving access to quality contraception to help them have the number of children they want.

The Mubende community have already identified their challenges in addressing HIV pandemic and thus government, civil society and development partners will need to work with them on implementation of HIV/AIDS and FP services that currently need to be harmonized to enhance joint planning and inter-service coordination and take advantage of synergies among the programs.

Currently, ART providers, most of whom have received training from TASO, take it upon themselves to provide FP counseling; however, there is no system to ensure that these counselors and service providers have on FP use among HIV-positive clients. Counseling and training can be further integrated and strengthened, with standard guidelines from MOH, an activity that will inevitably require government, civil society and development partners to take lead for greater impact.

Despite the near universal knowledge of family planning among PLHAs, many still hold several misconceptions about contraceptive methods. There is a need to develop targeted messages specifically addressing these misconceptions.

7.0 ABORTION, THE SALIENT KILLER OF WOMEN: IN UGANDA IT IS UNSAFE, UNSANITARY, DONE BY UNSKILLED AND DISPROPORTIONATE RISKY PREGNANCIES AMONG THE POOR RURAL WOMEN AND URBAN FELLOW WOMEN

7.1 Analysis

Abortion is the termination of an unplanned or unintended pregnancy. Usually the pregnancy has been occasioned by a variety of reasons such that it is unwanted. Women, who do not want to become pregnant but do not use contraception, resort to abortion whether it is legal or not. This brings in health risks thus making abortion unsafe.

WHO defines unsafe abortion as when it is performed by persons “lacking the necessary skills or in an environment lacking the minimal medical standards, or both”. This is particularly pertinent to Uganda.

7.2 Uganda’s Case

Most abortions in Uganda are unsafe because they are performed in unsanitary conditions or by unskilled providers. In a 2008 study, the New York Guttmacher Institute, an NGO that pushes for advancing sexual and reproductive rights globally, estimated the number of abortions at 297,000 from 775,000 unwanted or unintended pregnancies, of the total of 1.83 million pregnancies, yearly. This translates to 54 abortions per 1000 pregnancies occurring in the 15-49 age brackets. This is the most update information currently. These figures are not spread uniformly in Uganda’s 34.5 million populations.

Women in poor rural areas suffer more. The north and eastern regions that have borne the brunt of fighting for more than 20 years, between the Lord’s Resistance Army (LRA) of Joseph Kony and the Government, has the highest incidence of poverty in women, put at 71%. And the occurrence of abortions was high as most of these women were confined to the internally displaced people’s camps (IDPs), Where they were vulnalable to suffer Sexual violence such s rape and defilement.

This creates a circular factor. Poor and illiterate or semi-illiterate women have less control over their sexuality. They have little say on when to marry, have children or how many to produce,

thus proliferating unwanted pregnancies which in turn lead to unsafe abortions. There are many reasons why a pregnancy is unwanted or unintended.

It may be poverty which leads to lack of family planning; the couple's reluctance to have more children because the number is already too high; they maybe school girls or unmarried; the pregnancy maybe a result of rape; a result of violent conjugal relationships; or, the pregnancy was unintended conception.

Overall, Ugandan poor women account for 49% of the population; and this figure is more stilted when you compare rural to urban women. Only 2% of women live in urban areas. Thus unwanted and unsafe pregnancies occur disproportionately among the poor rural women when compared to their urban fellow women.

7.2 Case Studies

"ABORTION is real and we leave with it in our community's especially in rural areas. I recently handled two cases of attempted abortion by two former school girls. When they got here, they were emergency cases," Kalisto Tile, the Clinical Medical Officer, Anyeke Heath Center IV, Oyam District, shares his experience on abortion.

"One of them came when her cervix was open, the product of conception was already at the survival oath-meaning the foetus was already dead and the placenta was already detached. If she did not access quick medical intervention she would have died of severe hemorrhage.

"If she had survived, she would have suffered sepsis that could have caused her secondary infertility. After my intervention, she returned to her husband and they now have a baby. Whether we like it or not, abortion is on the increase. Women only report to the health facilities when its almost too late to save their lives."

Whereas Dr. Tile's scenario ends happily with life saved, Ageno Harriet's of ASBs scenario ends on a sad note. Two of her OGs attempted abortion using crude traditional methods. One of them died and the other survived but suffered infertility. ASB is a German charity working to develop former Internally Displaced Persons (IDPs) in the greater northern Uganda.

The main cause of abortions is the rampant defilement and rape in Oyam, attributed by the local authorities to high consumption of alcohol, high levels of household poverty and moral decadence that have been fueled by the 21 years LRA insurgency in the greater northern Uganda.

According to Gira Chris Otim, the Community Development Officer, Oyam District, cases of defilement and rape are on the increase and are especially more pronounced in S/C such as Mina Akulu formerly IDP camps. “The long period of camp life destroyed the strong cultural systems of Lango. People today have little or no respect for one another and the vulnerable population particularly the females at high risk of suffering abuse and violations of their Reproductive Rights,” he said.

Coupled with the fact that the districts is one with the population growth rates currently standing at 3.6% far above the national average rate of 3.2%.

7.4 Socio-Cultural Factors

Many Ugandan social groups abhor abortion. According to Dr. Ellis Mutabazi of the Alive Medical Services, “abortion is considered a selfish act”. Significantly, more than 80% of Ugandans are Christian and view abortion from the religious point of view as “evil”. A 1997 survey done in Kampala found that 6 out of ten people believed that it was mainly prostitutes who practiced abortion. Because it is associated thus, most unmarried women will do all possible to conceal their abortions. This may lead to avoidance of medical care resulting in maternal complications.

Even the Ugandan laws are not clear on the “termination of pregnancy”, despite the fact that the 1995 Constitution does not prohibit abortion, stating that abortion has to be “authorized by law”; and there are many sections of the Penal Code Act dealing with this.

As a result abortion is largely stigmatized by the majority of society; and because of this clandestine nature, it causes to women to perform unsafe abortions leading to a high incidents of maternal deaths and morbidities. The Stigma also discourages women from gaining to access to life-saving interventions such as pre-abortion contraceptives or post-abortion care (PAC).

According to WHO unsafe abortions are characterized by the provider’s inadequate skills, unsanitary facilities and use of hazardous techniques that have brought risks such as: infection, haemorrhage, sepsis, shock and abdominal injury. Eventually, the women may develop chronic problems such as: pelvis infections, ectopic pregnancies and infertility.

7.5 Tendencies

Ten years ago the average number of children produced by a Ugandan woman was 6.9, a figure which was less than previously. But there is now a tendency for women to give birth to a fewer

number of children. And even more, the ideal number of children desired by women in 2000 was 4.8. The debate now is the pressure caused by the ever worsening economic conditions for supporting a large family, and especially educating the children. Most women want to educate their children now beyond the rudimentary primary, or even secondary school level up to university, yet the resources are dwindling. The high cost of living and educating children makes the families want to reduce the number of children.

7.6 Contraception and unmet need

Where family planning services are introduced and promoted, abortion-related deaths decline as contraceptive use rises. This means that women must spend a considerable number of years trying to avoid producing children. If the sexually active lifespan of a woman is between 20 to 45 years; and if she wants four children and spaced over the time, a tabulation of data from a 2001 Uganda Demographic and Health Survey found that women will spend about 14 years avoiding pregnancy.

Unless women practice contraception over this period of time, it becomes difficult avoiding unintended pregnancies. But the use of contraception by the Ugandan women is very low. The Uganda Bureau of Statistics (UBOS) put the figures of an average at 23% among married women of child-bearing age – 14% of these were using modern methods while 6% used traditional methods.

Among unmarried women the figures were considerably higher at: 38% on modern methods while 6% were on traditional ones. The ratio of use was higher in urban areas than in the rural areas in the 15-49 years bracket. And in the poorer Northern region the ration for married women of child bearing age was even smaller at only 6% as compared to for instance, to the more affluent Central region at 26%.

Unmet need for the proportion of sexually active women of child-bearing age who do not use contraceptives and do not want a child is at 33%; among the poor rural women it goes as high as 38%. The unmet need is for several reasons. Many women either do not trust contraceptive methods because of fear of side effects or that they were inconvenient to use; there are those whose partners do not want them to use the family planning methods, such as the use of condoms, or because of their religion's opposition to it; and even some who do not know where to access the family planning methods, not to mention inadequacy in supply of family planning service.

This says a good deal about the lack of accurate information given out on contraception and also that the country lacks a conceivable family planning programme with adequate budget,

allocation. Thus gender inequality, sexual violence etc all, congregate to contribute to the extent contraceptives are used or not.

7.7 Legal and policy framework

Uganda is a signatory to many international conventions and agreements on reproductive rights. One of the significant ones is the protocol on the African Charter on Human Rights and the Rights of Women in Africa (2003) in which Uganda guarantees to “provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas”. However, the challenge is to transform these ideals into practice.

Many of the policy and programme commitments remain on paper. The translation of this into practice is lacking because the country’s resources are low and even now still diminishing creating a serious shortage in funding; the health centres including hospitals lack facilities, medicines and personnel and are in a state of continuing disrepair.

A Uganda Debt Network (UDN) survey found out that “inadequate funding, shortage of trained health personnel, inadequate network of functional health infrastructure and a serious shortage of drug supplies are the highest challenge in the health sector”. This has brought in some of the problems as:

Women lack proper health care during child birth; and there are inadequate mechanisms supporting provision of EmOC; poor management of contraceptives; weak management of human resources at the health centres; cultural norms that negate gender equality; and, Myths and male disrespect of women on contraceptive use.

7.8 Case study

Acute shortage of midwifery staff impacts of Reproductive Rights.

Apio Manjeri, 25, is due to deliver. She arrives at the Ongongoja Health center III in Katakwi in time. Unfortunately, she finds the only midwife attending to an emergency case of a mother who requires Caesarian birth, which is only performed in Katakwi General Hospital.

As she prepares to make referral, Apios condition turns unbearable as also she requires emergency attention as a result of having developed hypertension (Eclampsia) condition. Suddenly, she sees a

mother who delivered at home with the assistance of a TBA being supported on a bicycle to the maternity ward also for her attention. This only midwife is in a state of confusion under such circumstances.

This is the delay experience at Ongongoja health center, caused majorly by lack of adequate staffing. With only one midwife assisted by a nursing aid in a facility that is supposed to have six midwives, you can imagine the plight of mothers in the community served by the health center.

The DHO, Katakwi, Apio was referred to Katakwi general hospital for a C-section when her condition had deteriorated. She had developed hypertension from Ongongoja health facility and by the time she arrived, we only performed the C-section to save the life of the baby because it was too late to save both the life of the mother and her baby.

He says the woman had delayed to go for antenatal care and also delayed to get to the health center where she was then referred for the operation. According to the expert, she should have attended antenatal care at least four times for the medical officers to diagnose her condition and advice accordingly.

Generally, in Katakwi district, there are only two midwives out of six that are needed in each sub-county. The staffing situation of medical staff and particularly midwives and doctors is just about the same in other health facilities.

Situation Analysis

Although the maternal maternity rates have dropped to 200 women per 100,000 live births from 400 in the previous years, the current rate is still high by Ugandan standards in order to achieve the MDG5 by half in 2015. Statistics show that only 240,000 out of 800,000 pregnancies are attended to by midwives every year. The rest (about 500,000 women) are being assisted by the TBAs, according to the State of the World's Midwifery Report, 2011.

It also shows discrepancies and unequal distribution of midwives between regions, rural and urban areas. The recently published MidWifery report states that even if a number of midwifery carders appear sufficient, a big challenge resides in the uneven distribution of those midwifery skills.

The gap in position filled by midwives is wider in rural compared with urban setting as well as in lower level health centers compared with referral health facilities such as general hospital.

A significant discrepancy is also seen in positions filled by midwifery personnel in rural (1,533 or 42%) compared with urban government health facilities (431 or 22%). From the above women in rural Uganda are the worst affected as only 37% have access to skilled assisted deliveries. It is therefore logical that most rural women deliver at home.

7.9 Recommendations

Government, civil society and development partners will need to rally the support of policy makers at all levels to promote family planning. Getting Policy-makers on board will help to save women's lives, averting unintended pregnancies that make women choose abortion and risk death, or from complications of pregnancy and childbirth. Of all the groups that can help promote family planning, high-level policy-makers are among the most influential. They can either change policies and programmes directly or influence those who can.

Government, civil society and development partners should consolidate the efforts of the Oyam district leaders to increase awareness on the dangers of abortion while emphasizing strategies for prevention of unwanted pregnancies. It is one of the facilitating factors of the current high death rate among women of reproductive age. Efforts must be put to deal with current widespread child marriages, rape and defilement and promote the Reproductive Rights of victims, most of who are still children.

Specific efforts also need to be put to increase awareness on interventions such as PEP, CRP and its linkages to the violations of the Reproductive Rights of victims.

Improving the staffing levels of medical personnel especially the midwives from the lower Health Centers and building their capacity to respond to the wide spread RR violations in a timely manner is critical. Abortion places a burden on Ugandan society, thus a greater attention be paid in the issue of unintended pregnancies. It may be important that Government, civil society and development partners review the legal precepts under which abortion can be performed safely and provides the health professionals with relevant information such that the women can be educated to make informed choices on their sexuality.

Involvement of a wide spectrum of concerned Ugandans: policy makers; religious leaders; educators; journalists; health professionals and planners; women legal advocates, and, and above all getting active involvement of the male population on issues of abortion and safe motherhood generally is critical.

The involvement of Government, NGOs and other groups to raise the standards of Post Abortion Care(PAC) services for women..Training should be undertaken for the women's obstetric needs and appropriate methods should be designed to reach out to all categories of women including the rural women who are most hit by this form of RR violation or abuse.

Government, civil society and development partners should spearhead Family life education to be provided in schools. The need for reproductive rights information cannot be over-emphasized especially in the Northern region that has recently come out of a war situation, especially as these acts as long term preventive measure.

8.0 THE MISSING LINK IN THE CURRENT EFFORTS TO ELIMINATE GBV

8.1 Analysis

Obstetric fistulas are the result of a long, obstructed labor when the head of the baby cannot pass through the mother's pelvis, according to National fistula Strategy 2010/2011. Constant pressure from the baby's head on the mother's bladder or, less commonly, the rectum, limits the blood flow to these tissues and results in a small hole, or fistula, between the bladder or rectum and the vagina. The consequence is near constant leakage of urine or feces. In the vast majority of cases, the fetus dies of asphyxia. Risk factors for obstructed labor and obstetric fistula include low socio-economic status of women, malnutrition, illiteracy and lack of formal education, early and forced marriage, childbearing before pelvic growth is complete, and lack of access to quality maternity care.

An obstetric fistula is considered the most debilitating of all pregnancy related morbidities according to 2006 WHO Obstetric Fistula Report. While it is estimated that 200,000 women in Uganda suffer from an unrepaired obstetric fistula with 1,900 new cases each year National Fistula Strategy 2010/2011, the exact prevalence is hard to estimate because so many affected women live in rural, impoverished areas and because of underreporting due to the stigma involved.

According to the the International Journal of Gynaecology and Obstetrics, November 2007, preventing Fistula is part of a larger goal of safe childbirth--safe for the mother , and safe for the child. Fistula is considered a "disease" of poverty, a clear marker of the failure of political, social and health systems to protect and promote women's health and their reproductive rights. In developed countries with strong medical infrastructure and social support for prenatal care, labor and delivery, fistula is only seen as a complication of hysterectomy or other pelvic surgery, or of radiation for cervical cancer.

The prevention of fistula is ultimately linked to prevention of maternal mortality from all causes, and also linked to prevention of infant and child mortality. domestic fistula is largely seen in poor countries and regions where access to appropriate prenatal and obstetric care and family

planning are limited, including rural areas and dense population centers marked by extreme poverty (Hinrichsd D. 2004).

Globally, at least 2 million women and as many as 3.5 million are living with obstetric fistula and there are between 50,000 to 100,000 new cases every year. With this kind of volume of need, and an affordable surgical treatment that we know is 90% effective, you would be shocked at how few women get treated. Only 10,000, according to UNFPA, 2011 Brochure. These women are spread to the far corners of the developing world. The problem is biggest in the most remote places. Even in places where they can be counted, many women with fistula are so ashamed of their condition that they do not want to come forward.

The Association for the Re-orientation and Rehabilitation of Women for Development (TERREWODE) , a lead fistula CSO in Uganda has for the past 10 years mobilized, supported for treatment over 600 women survivors out of which only 50 hailed from the neighboring sub-regions of Karamoja. Fistula is not just not a Karamoja issue but one of Uganda's development concerns and indeed a global problem.

8.2 Case study; Until a Police woman trained by TERREWODE discovered it, the authorities were baffled by GBV

FOR the last three years, Sylvia Icowunai (not real name), 21 had knocked at the doors of law enforcement authorities over the endless domestic fights with her husband in vain. She has interfaced with the Family Court, the Local Councils (LCs) and Police but she still could not get justice. Her only trouble was concealing the root cause of their domestic disagreements.

Icowunai, who was actually suffering from fistula, a debilitating child birth injury which leaves the victim leaking urine, faeces or both uncontrollably from her vagina, was downplaying her problem to the authorities. She would tell some of them that her husband had merely turned violent against her without any proper explanation; or that her husband was persecuting her because she had refused to relocate to their village; while to others, she would say she had rejected her husband's desire to marry a second wife.

But privately both Icowunai and her husband knew the naked truth of the matter. The man had stigmatized the woman because of her condition and therefore he wanted to get rid of her. For the woman, she was experiencing self-stigmatization and therefore expected to get compassion and support from her husband.

It was only with the intervention of a Police woman in charge of Child and Family, who had been trained by the Association for Re-orientation and Rehabilitation of Women for Development (TERREWODE) on the causes, treatment and management of obstetric fistula and its linkages to Reproductive rights violations and Gender Based Violence (GBV), in particular, who saved the situation.

Judging by the way Icowunai was dressed (wrapping her whole body with more than one lesu, and the smell emanating from her, the Police woman was in no doubt certain that Icowunai must be living with fistula. She asked her to escort her into a private place for a tete-a-tete talk, where eventually Icowunai owned to her fistula condition. The Police woman then counseled her about her condition. She referred her to TERREWODE to seek appropriate advice and treatment. At the same time she assured her of the legal action to be taken against her husband for the domestic violence against her.

Florence Adongo, the in-charge of Child and family at Soroti police station says incidences of fistula related violence are common where she has worked in the department for three years. Adongo has handled over five cases of this nature in Soroti where she has worked in the department for 3 years.

Adongo, a beneficiary of TERREWODE fistula empowerment activities, says that since her training in 2009 she has referred 5 women with fistula cases of domestic violence for treatment. She said fistula was both cause and result domestic violence women suffered. She says in all cases, the victims never volunteered to disclose their status but when she applied her knowledge of fistula she discovered and assisted them by referring them to TERREWODE for treatment while she dealt with the legal aspect of the matter.

According to the 2010 Annual Fistula Report by TERREWODE, 95% of women living with fistula are separated by their husbands because of the condition. The separation takes effect within the first six months of experiencing the problem. In most separations, the victims are subjected to all forms of violence.

According to the World Health Organization (WHO) Report on Violence and Health, the type of violence suffered by Icowunai is frequently invisible since it happens behind closed doors, which effectively the legal systems and cultural norms do not treat as a crime, but rather as a “private” family matter, or a normal part of life.

The fistula surgeon for the Eastern Sub-region, Dr. Fred Kirya, says the prevalence of fistula in Karamoja and Moroto, in particular, is not known but because it is based on the fact that most

women in Karamoja deliver at home with the traditional birth attendant (TBAs), the problem is “hidden” yet it is common knowledge. “Given the nature of the communities in Karamoja, (pastoralists, less informed and impoverished) even when you make radio announcement calling upon these women to come for treatment, the turn-up is always underwhelming,” Dr. Kirya says. He advises that to improve access to treatment of fistula patients and reduce the incidences of domestic violence, stakeholders need to design holistic strategies that are relevant to the people in these communities.

8.3 Recommendations

Government, civil society and development partners together with her partners should commission a more comprehensive study to document the linkages between obstetric fistula and GBV in particular and generally violations of human rights..

Government, civil society and development partners to identify and coordinate CSOs, individuals and institution focusing on fistula and maternal health interventions in order to effectively address the problem. There are already some best practices /Efforts such as TERREOWDES’ that can be mapped out and promoted for scale up to eliminate fistula and reduce on the GBV incidences resulting from it.

Government, civil society and development partners should prioritize prevention of fistula as catalysts to promote RR. From the medical and public health point of view, prevention or mitigation of disease reduces the overall burden of pain and suffering not just to the patient herself, but to her family and to the entire community.

Prioritizations of interventions that seek to transform systems such as the health and cultural systems are critical. In many parts of the world, history has shown that improvements in systematic functionality reduce the incidence of maternal death and disability. Systemic improvements also address interlocking social and economic inequities such as the low status of women, lack of education for girls, early marriage and pregnancy, malnutrition, poverty, inadequate health and transportation infrastructure and harmful traditional practices such as female genital mutilation/ cutting (“FGM/C”) (Barot, 2010).

To increase awareness at all levels about the fact that “Safe Motherhood” and the systems that support it can be considered to be a RR concern of women, according to International Society of Obstetric Surgions 2010. It can also be considered as an economic policy and as an element of security strategy and thus, an important development concern to the country.

9.0 WHERE MEN USE HIV/AIDS TO JUSTIFY VIOLENCE GAINS

9.1 Analysis

Violence is propagated by improper methodologies that deny women their sexuality choices.

The Uganda Demography and Health Survey (UDHS) 2006 reveals that 60% of Ugandan women aged 15-49 have experienced some form of gender based violence (GBV). Most of the GBV is committed by a husband or an intimate partner. Overall 16% of the women experienced physical violence while pregnant says the report.

Women with three or more children were more likely to have experienced physical violence than women with 1-2 children or no children; and this was especially among poor rural women with lower education levels or no education at all. In the Central region, where Mubende is, 53% of the women have experienced GBV.

GBV is any harmful act perpetrated against a person's will, based on social cultural identities such as roles, expectations, limitations, status and myths. Women, men, boys and girls can be victims and perpetrators. Women and girls are primary victims due to unequal power relations. GBV involves the abuse of power, it is characterized by lack of informed consent and it is a violation of human rights. The types of GBV that are prevalent in Uganda include physical violence, psychological/emotional/mental violence, sexual violence, economic violence and harmful traditional practices.

Abas says discordance should not cause divorce and even GBV as it is the case in our community today. "With intensive counseling and psychosocial support, an HIV positive man can support his HIV negative wife by remaining faithful and practicing safer sex. They can even be guided by the health workers to conceive and deliver their baby in that state," he noted.

According to the Journal of the International AIDS Society which has had its members take intensive studies on the situation in Uganda, 14% of the HIV/AIDS infections were caused by mother-to-child transmission. Of the estimated 1.34 million pregnancies leading to live births, 102 800 pregnancies were HIV positive and led to 19 600 vertical infections, corresponding to 1.47% of all births. The planned expansion to 80% PMTCT coverage prevent 13 000 infections, lowering the neonatal HIV prevalence. The existing ART programme, covering an estimated 27 500 women of reproductive age.

9.2 Case Studies

MELISA Nalumanzi, 27, a mother of three was oblivious of her HIV positive status until she conceived her fourth baby and subsequently visited Mubende Regional Referrals hospital for antenatal care services. She is seven month's pregnant. After undergoing counseling by a midwife, she accepted to undergo an HIV test which revealed she was HIV positive.

Nalumanzi was enrolled in the same health facility for Anti-retroviral Therapy (ART). Like Nalumanzi, Joseph Baguma, a boda boda rider in Mubende town did not know his HIV status until he impregnated his girl friend who also went for antenatal care and she was told she was HIV positive. Her HIV positive status prompted Baguma also to go for HIV Testing which revealed he was also HIV positive.

Like Melisa and Baguma's scenario, many boda boda riders do not know their HIV status until their sexual partners are enrolled for ARTs during antenatal visits. "If you asked any of the boda boda riders in Mubende town about the best way to know their HIV status, they will tell you is through making your wife pregnant and encouraging her to go for antenatal visits in government hospitals," says Miriamu Nagawa, the assistant Community Development Officer for Mubende district.

9.3 Statistics

Mubende is one of the district that has the highest HIV/AIDS prevalence rate at 7.4 % above the national prevalence rate of 6.3%, with the women population being the most affected. The prevalence is highest among the urban set up and town centers; attributed to the erratic behavior of the soldiers in the barracks within Mubende and neighboring the district.

Nationally, however, Uganda is viewed today as a model of success in HIV/AIDS prevention, and litmus test of what more can be achieved by hard-hit African nations battling AIDS. In 1992, 16 percent of Ugandan adults were estimated to be HIV-positive; by 1996, that number had fallen by half, and 6.1% by 2001.

The latest statistics however show a rise again in the prevalence. Of this HIV researcher Peter Mugenyi noted, "The current HIV rate is unacceptably high and appalling and would constitute a state of emergency in developed countries."

One million Ugandans are infected by HIV, and they have limited access to antiretroviral medicines. Mugenyi predicted, “New infections will continue to spread from the huge infection reservoir, most of who do not know their serostatus.” That includes a large number of women who are passing HIV on to their offspring”.

9.4 Legal and policy framework

However, the Ministry of Gender, Labour and Social Development which is responsible for promoting gender equality and women empowerment is mandated to coordinate all efforts towards the prevention and response to GBV. Prevention is characterized by development of policies and enactment of specific GBV laws, mass media campaigns, advocacy, awareness creation and initiatives such as community dialogue, while response involves providing services and support to reduce the harmful effects of GBV and prevent further injury, trauma and harm.

GBV can be addressed through legal action. A GBV victim should report to the nearest authorities, like the village chairperson, immediately, if there is no police station or police post. If the offender is identified he must be taken to a doctor for examination. The police must act very quickly in case of sexual abuse because the evidence is usually destroyed very quickly. After the whole due process of law, a report must be made. This report is very important as it connects the offender with the crime.

Law: Some of the legal framework which include; the Penal Code Act, the Domestic Violence (DV) Act and the Female Genital Mutilation (FGM) Act. The DV Act and the FGM Act have been passed by Parliament and assented to by the President.

Policies: The policies in place to address the broader aspect of Gender-based Violence (GBV) includes the Uganda Gender Policy and the Health Policy among others.

The GBV prevention and response strategies have also been integrated in the National Development Plan; the Health Sector Investment Plan II; the Education Sector Investment Plan; the Justice, Law and Order Sector Investment Plan; the Local Government Sector Investment Plan; the Social Development Sector Investment Plan; the Peace, Recovery and Development Plan (PRDP) for Northern Uganda and the National Action Plan on Women (NAPW).

The NAPW has a priority area of Peace Building, Conflict Resolution and Freedom from Violence. The strategies under this include influencing change in attitudes and practices that affect the well-being and dignity of women, building community and institutional capacity to handle all forms of violence against women and the Girl Child.

The international legal instruments include: the Convention on the Rights of the Child and Optional Protocols; and, the Protocol to Prevent Suppress and Punish Trafficking in Persons which supplements the UN Convention against Transnational Organized Crime. Other anti-GBV instruments to which Uganda is bound include: the Vienna Declaration and Programme of Action; the Programme of Action of the International Conference on Population and Development; the Beijing Declaration and Platform for Action and the outcome document of the 23rd Session of the General Assembly entitled, “Women 2000:

Gender Equality Development and Peace for the Twenty-first Century. Others include; the UN General Assembly Security Council Resolution 1325 (2000) on Women, Peace and Security; the Commission on Human Rights Resolution; and the Elimination of Violence against Women, Resolution 2005/41

Addressing GBV through MDD at community level contributes to improving couple counseling as a proxy indicator for positive behavioral change in the fight against HIV transmission.

The problem of GBV and women’s exposure/ risk for HIV has been addressed by both National and international bodies such as the World Health Organization and UNAIDS mainly calling for action to ensure that the perpetration of violence among women if unattended to will continue to fuel the HIV/AIDS epidemic. A clear and direct link has been implied in Uganda between gender-based violence and HIV/AIDS. In addition to a relationship between violence and positive status, fear of gender-based violence can keep a girl or woman from negotiating safer sex, seeking HCT, PMTCT, and even use of antiretroviral drugs (ARVs).

9.5 Government intervention and actions

The government last year announced a major national program for the prevention of mother-to-child transmission (PMTCT) of HIV using anti-HIV drugs like AZT and nevirapine and says it offers all pregnant women attending government clinics a comprehensive package of voluntary HIV counseling and testing (VCT), maternal care and STD prevention, and for those who test HIV-positive, a PMTCT regimen.

With this in the picture Mubende District hopes that the enrolment of these women would be good news as it would drastically promote PMTCT and generally wipe HIV/AIDS in the district. However, in Mubende, this move only brings along with it domestic violence in most households, according to Sophie Wasagalali a nurse at the Mudende Health 111 Rehabilitation Center.

“It is very common to get mothers reporting cases of domestic violence resulting from disclosure of their HIV positive status”, she says. Wasagalali says out of three women who test HIV positive during antenatal care visits, at least one of them has reported experiencing domestic violence. Most discordant men do not want to use condoms which also contribute to domestic violence.

According to Abas Ismael, the center's health assistant says the center has registered a total of 80 discordant couples in two clubs established in Mubende and Ntungamo barracks. He says the center receives about 100 clients every month but 20% of the clients would be discordant couples reporting Gender Based Violence.

9.6 Limitations

Jackson Odia, the health educator at the ART clinic in this health center interjects: “Most infected soldiers say it's better to die with their partners”. He says while counseling plays a big role in minimizing HIV/AIDS related domestic violence especially among discordant couples, we continue to register cases where women report that their partners refuse to adhere to use of safer sex. “For a woman who insists him using protected sex, she would be threatened either with divorce order or a beating until she surrenders,” he says.

In Mubende the stigma is so well pronounced that some men even encourage their partners to register for ARVs in two different treatment centers such that they get drugs on their behalf without their presences, according to Odia.

However, Nicholas Kwesiga, coordinator MUDNET blames the violence on improper methodologies that deny pregnant women the choices to choose to or not to disclose their HIV positive status. He says stigma associated with HIV/AIDS also hinders the success of the PMTCT efforts.

He noted that there is a high dropout rate of women enrolled for PMTCT who resort to seeking services of Traditional Birth Attendants (TBA) or private clinics due to the lack of confidentiality in accessing ART services. “The way ART services are administered especially during antenatal

visits for example confining positive expectant women in a sacred place, leveling their meeting places with HIV slogans and giving them particular dates for visits, there is no way confidentiality can be concealed,” he says.

The fact that HIV positive mothers would opt not to breastfeed as a way of reducing chances of infecting their newborn baby, this would also deprive them their right to confidentiality as this would socially attract community to raise eyebrows to a non –breast feeding mother.

Kwesiga however notes that although the government has made great strides in combating HIV/AIDS epidemic by making available ARTs from national to grassroots, lack of active male involvement specifically in HIV/AIDS particularly and reproductive rights in general, is a major contributing factor to slowing down the progress.

“While male involvement is generally wanting in the HIV/AIDS fight, it’s even much harder to get their support in issues to do with promotion of reproductive Rights of HIV positive women,” he asserts. The legal officer for FIDA Mubende attributes the problem to weak laws and their inadequate enforcement, saying if passed, irretrievable breakdown of marriage is ground for divorce under the new Marriage and Divorce Bill.

9.7 Recommendations /What has been done

- Awareness programmes focusing on positive living with HIV/AIDS and the issues of positive mothers are today being sponsored by the district. Government, civil society and development partners need to get involved to determined content.
- Provision of counseling services to victims is critical.
- Keeping at risk women especially positive pregnant mothers in temporal shelters FIDA being done by need to be sustained to protect them from Domestic violence by their husbands.
- While the staffing level is slowly improving, Government, civil society and development partners there a need to lead advocacy to build their capacity to specifically handle HIV/AIDS related GBV, and also ensure staffing ceiling are met.
- Mubende being a district with diverse cultures, it is important that Government, civil society and development partners works with it to scale RR services across all cultures and right from the districts to the villages.

- Government, civil society and development partners to work with districts to ensure women are empowered to be aware of their RR and engage their partners by way of demanding for their active participation on the issue.
- HIV-positive pregnant women and their spouses have been supported to form family support groups (FSGs) and facilitated to engage in peer counseling. An increase from 222 to 1,837 of women being tested and counseled together was reported in areas where local music, dance and drama (MDD) troupes had conducted community mobilization. FGDs revealed that inclusion of males in FSGs improved male involvement in PMTCT services and spousal disclosure of sero-status.
- These are great steps but need to be monitored and evaluated by UWONET. The Uganda Programme for Human and Holistic Development (UPHOLD), a USAID-funded Bi-lateral programme has supported GBV prevention initiatives through CSO partners as one way of increasing uptake of PMTCT services. The focus of the training for the CSO representatives on approaches to preventing gender-based violence and skills in integrating gender-based violence prevention into their programme activities.
- Overall, 32 representatives from seven CSOs were trained in GBV prevention promotion at community level. This was followed by a cascade of trainings at community level. In addition, 220 local groups from 20 districts were trained and supported on MDD content and methods. Coverage/Community level out puts 53,000 people in all are estimated to have attended the various drama and community dialogue sessions. (NB: there are no statistics of those reached through the radio programs as this was difficult to quantify).
- Further, UPHOLD provided support supervision to the CSOs in the implementation of GBV prevention and utilization of PMTCT services. In addition to these initiatives, UPHOLD supported HIV positive pregnant women and their spouses to form Family Support Groups (FSGs), trained them and equipped them with skills in peer counseling, and community mobilization on PMTCT services and referrals.
- Two Lot Quality Assurance Sampling (LQAS) surveys conducted by UPHOLD in 2005 and 2006 within the programme's Monitoring and Evaluation plan. In both surveys, more than 15000 adults were interviewed on various reproductive health behaviour. Data drawn from the surveys covers 6 intervention districts where GBV and PMTCT interventions were implemented concurrently. In the 6 districts-Kyenjojo, Kitgum, Luweero, Rakai, Bugiri and Mbarara, the program took a

two pronged approach, where GBV interventions combined community dialogue and MDD. It is therefore expected that the impact of GBV interventions was greater in the six districts than in the rest of the 14 districts.

1. The Ministry of Gender commends various actors for their role in preventing and responding to GBV and urges more actors to acquaint themselves with the relevant instruments against GBV and join in the fight against all kinds of violence against women, men, girls and boys. Foster state commitment and accountability by developing and enforcing policies, laws and programmes to integrate GBV abandonment into development programmes.
2. With vertical public health programs for HIV and family planning, even if policies are integrated, the programs and services must be linked or integrated, which requires attention to policy implementation to surmount the current organization of programs that are under different lines of authority in the MOH. For example, harmonized (and greatly strengthened) logistics systems would help avoid having no medicine stock, which were reported to be a huge issue, particularly in the public sector provision HIV/AIDS services. Human resource allocations should be jointly determined.

Opportunities

- A focal point for PMTCT is laudable. Such focal points should be appointed across the programs to help ensure integration. A coordination unit could be established by Government, civil society and development partners to supervise the integration process.
- The ART policy was found most lacking in addressing HIV-positive concerns, there is should lobby Policymakers address this gap from gender perspective and provide adequate guidance to service providers on PMTCT provision for clients.
- Given the current constraints in coverage, staffing, range of FP services, and space in HIV/AIDS settings, it is likely that HIV/AIDS facilities will continue referring clients who require body invasive contraceptive methods (clinical methods such as the intrauterine device and male and female sterilization) to specialized FP clinics. Consequently, FP providers need to be sensitized to serving HIV-positive clients without judgment. HIV-positive clients should not feel that they are being discouraged from having sex or using contraception.

- Data on fertility preferences suggest that female people living with HIV/AIDS (PLHAs) are likely to come under pressure from their male partners to produce more children—since males generally prefer larger numbers of children. Their is should pay closer attention to sensitizing men to the need for and the benefits of family planning and to meeting their needs. At the same time, there is a need to increase women’s access to female controlled methods.

10.0 MANY WOMEN ARE UNAWARE OF POST EXPOSURE PROPHYLAXIS; PEP UNDER UTILIZED, AS EVEN MEDICAL WORKERS ARE IGNORANT OF IT

PEP is an emergency medical treatment meant to reduce the likelihood of HIV infection after exposure, either occupationally or through sexual abuse, or any other form of accident. This treatment should be administered as soon as possible within 72 hours of the incident.

10.1 Analysis

PEP was introduced after the realization that sexual violence is a serious public health, human rights and a key development concern. Studies and surveys carried out in Uganda and around the world confirm that sexual violence has significant consequences, especially for girls and women, as well as implications for the economic and social well being of families and communities in Uganda. Despite the various efforts to address rape and defilement, they continue to be serious problems that affect many people in Uganda.

According to the Uganda Police Crime Report of 2008, a total 10171 cases were reported to police stations (8,635 cases of defilement and 1,536 cases of rape). Yet it is highly recognized that many cases go unreported at Police Stations. Studies show that acts of rape increase women’s risks of HIV infection .

The 2007 National Policy Guidelines on HIV, Hepatitis B and Hepatitis C indicate that sexual assault through rape and defilement is considered high risk for HIV infection since it is likely to involve exchange of semen and vaginal fluids as well as blood. Though women and girls and the biggest survivors, men and boys can also be survivors of rape. The Ministry of Health recognizes that survivors of rape and defilement should receive HIV PEP as a way of minimizing risks of HIV infection. Despite the fact that an HIV PEP Policy is in place, many survivors of rape cannot get PEP services because they are s not easily accessible at many government health facilities

country wide.

At a national level, the HIV PEP Coalition was formed to create a forum for building synergies to influence and share strategies by different stakeholders to influence Ministry of Health to provide free HIV PEP for survivors of rape and defilement. The coalition was created last year and it is headed by Center for Domestic Violence Prevention (CEDOVIP).

10.2 Case study

DEMETERINAH Abalo (Not her real name), 11, of Eastern Ward in Oyam District, is one of the hundreds unlucky victims of defilement who was not able to access Post Exposure Prophylaxis (PEP) at the time it mattered most - to save her from getting the HIV virus.

To many rural dwellers in Oyam district, the vital health intervention of PEP does not ring a bell. Surprisingly, even some health workers express little knowledge about the procedure for administering the treatment. For the few who are aware, referral procedure is still a night mare to the detriment of those who would be saved by PEP.

Abalo is one of the hundreds of victims of defilement and rape who is unlikely to benefit from this procedure. According to Lucy Awino, a Community Health Worker in Akai Debe Eastern Ward, Abalo was defiled by her HIV positive uncle three months ago in August 2011. She was forced to keep it a secret after receiving death threats from him until three days later when a community volunteer noticed her unusual walking style and demanded to know what befell her.

Abalo then confided in her on condition that she safeguards her from the consequences of her revelation of the facts considering that her grandmother, who was fully aware of her condition, had resorted to massaging her for fear of exposing her son-Abalos' abuser.

After a number of meetings and negotiations with Abalo's family including her abuser, which lasted over three months, Awino says the perpetrator an HIV/AIDS positive middle aged man was arrested but it was too late to get the victim to benefit from PEP, making her susceptible to the HIV virus.

PEP can be life-saving as a means of surviving from contracting the HIV virus. Studies suggest that when initiated within 12, 24, or even 36 hours after exposure to HIV, PEP is more effective than after that. It is not effective when administered after more than 72 hours following the exposure. Then a month's course of drug therapy appears to be more effective than courses one and half weeks.

Oyam District Health Educators' Orech John Bosco says defilement/rape is on the increase especially in sub-counties like Minakulu, Ngai, Otual and Acaba. Police data in the district confirms this fact for instance in Ocele, three cases of defilement and two incidences of child marriages were recorded in just one week during the month of October.

"Reporting of cases of defilement and rape is increasing but still many of them are being concealed at the community levels because of the stigma and legal actions taken against the abuser," Orech observes.

"PEP is being underutilized also because the rape and defilement cases are reported to police when it is late to administer it. For PEP to effectively work, it has to be given within 72 hours," he noted.

According to Kalisto Tile, Clinical Medical officer Anyeke Health Center (HC) IV, Oyam district, the major causes of delay in accessing PEP is the decision making that is required by the victim or her guardian.

Medically, a victim who is 12 years and above is required to consent to receive PEP. If the victim declines, the policy allows their guardian to do so on their behalf.

"Short of these, we are not in a position to even carry out a medical examination. I recently handled a case of a 13 year old girl who was defiled. She refused to consent and we did not examine her," he stressed.

In 2005, a study of PEP in 400 cases in Uganda, of possible sexual exposure to HIV/AIDS by the Centers for Disease Control (CDC) in Atlanta, Georgia in the USA, revealed that all the cases had survived being infected with HIV/AIDS. CDC reviewed information on PEP and concluded that it should also be available for use after HIV exposures that are not work-related. People can be exposed to HIV during unsafe sexual activity, when a condom breaks during sex, or if they share needles for injecting drugs. Infants can also be exposed if they drink breast milk from an infected mother or woman.

The PEP exists in the hospital countywide. The doctors will determine whether there is need for the PEP or not. PEP will not be given before an HIV test is taken; and for the women or girls a pregnant test must also be taken. If an HIV test is negative the PEP is then administered. This treatment is not given to people who are already HIV positive.

The medication has some side effects that can make it difficult to finish the dose. Some of these include; diarrhoea, nausea, headache and fatigue. If someone discontinues treatment, the treatment is not effective.

Because of ignorance of its availability, many who would have benefited from PEP services are consequently left to the mercy of God or the chance that the defiler or the rapists is free from HIV infection. The HIV/AIDS prevalence rate stands at 9% with women being the most affected.

10.3 Recommendations

Oyam community has attained a certain level of awareness about the dangers of defilement and rape but this awareness has not yet been translated into promotions of the rights of the vulnerable groups. Government and civil society needs to recognize that achieving positive behavior change is a long term investment in terms of resources and commitment and thus designing a five to ten years education program is critical.

Government and civil society to clarify the procedure for accessing PEP. Massive mass media campaign in local languages on the basics such as what, when, who, how why etc about PEP to guide service providers and the victims is important at this time. There is a lot of confusion about the procedure for administering PEP especially among the top districts technocrats and policy makers.

Building the capacity of the masses at the community level to demand for PEP services for the victims or even as the ambassadors of the campaign against sexual violence while protecting the rights of victims by increasing utilization of PEP is ultimately the best strategy that UWONET can invest in.

Conclusion

Investing in reproductive health not only advances the human rights and improves the health and well-being of individual women and their families but also benefits society and the national economies. At the ICPD in Cairo representatives of over 180 nations agreed that women needed to be empowered to take charge of their reproductive lives, this was a precursor to the 1995 World Conference on Women in Beijing, governments pledged to guarantee reproductive rights for all women.

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