MEDICAL INTERVENTIONAL STUDY OF WAR AFFECTED KITGUM DISTRICT, UGANDA

AN ISIS – WICCE REPORT

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Abbreviations

APRO	African Psycare Research Organisation
AOGU	Association of Obstetricians and Gynaecologists of Uganda
DSM IV	Diagnostic and Statistical Manual for Mental Disorders Version IV
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immuno-deficiency Syndrome
IDP's	Internally Displaced Person's camp
Isis-WICCE	Isis- Women's International Cross Cultural Exchange
LRA	Lord's Resistance Army
MINI	Mini International Neuropsychiatric Interview
MINI-KID	Mini- International Neuropsychiatric Interview – (Kid) Children's version
MoH	Ministry of Health
NGO	Non-Governmental Organisations
NUPSANA	Northern Uganda Psycho-social Needs Assessment
PTSD	Post Traumatic Stress Disorder
SDQ	Strengths and Difficulties Questionnaire
SGBV	Sexual and Gender based Violence
SRQ-20	Self Report Questionnaire -20
SPSS	Statistical Programme for Social Scientists
STI	Sexually Transmitted Infections
UDHS	Uganda Demographic and Health Survey
UMA	Uganda Medical Association
UPDF	Uganda Peoples Defense Forces
WHO	World Health Organisation

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All the entire Civic Leadership of Kitgum district.

All the women, men & children who benefited from the medical intervention

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Executive Summary

Background: The conflict that has been raging on in Northern Uganda for the last 20 years has led to tremendous suffering of the population impacting almost 8% of the Ugandan population. The most affected being women and the children. The killing and maiming of thousands of civilians; abductions of over 25,000 children; various forms of sexual and gender based violence including, rape, sexual slavery and forced marriages; physical disfigurement through the cutting of facial and other body parts; gunshot and landmine injuries; destruction of property and livestock; spread of HIV/AIDS; destruction and erosion of moral and social values of the community have left entire the populations in traumatic conditions and in severe poverty.

Isis-WICCE in its traditional culture to respond to the post conflict needs of women war survivors undertook to implement a participatory intervention research study about the medical and psychological consequences of the chronic war situation in the two IDP camps of Muwcini and Padibe in Kitgum District.

The objectives of the medical intervention:

i) To document the socio-demographic characteristics, the physical and mental health problems of the people living in the IDP camps.
iii) To provide emergency basic health care services.
iii) To provide specialized psychological, gynaecological, surgical & medical treatment
iv) To create awareness in society both locally and internationally of the negative medical and psychological consequences of chronic war.

Results

Socio-demographics

A total of 992 people were screened, of which 810 were adults and 182 were children. Of the 810 adults, 570 were female, while 240 were male. Of the 182 children, 93 were female and 89 were male.

Torture Experience

Most of the survivors of the conflict that participated in the interventional study had experienced severe forms of violence at least once in their life. Sexual torture was rampant, and was even reported by men. The main trauma perpetrators were

rebels, but even government soldiers, police and prison officers, and the local defence forces were making the local population suffer violent acts including sexual violence.

Psychological problems

The majority of people in the study had significant psychological distress with more women than men. There was a clear gender difference in how this distress was expressed with women reporting more suicide attempts and homicidal thinking while more men had problems with alcohol dependency and completed suicides. Although the majority of respondents had attempted to seek help from the health centres, they were not receiving the appropriate treatment and hence were seeking alternative sources of help such as traditional medicine.

Gynaecological problems

The number of gynaecological problems reported and assessed were extremely high showing that the women in the camps are specifically vulnerable and exposed to numerous gynaecological complications. A third of the women reported being significantly impaired or being completely unable to work. A lot of the women experienced a significant strain on their relationship to their husbands. The use of contraception was extremely low. Although a majority of women with gynaecological problems had tried to seek help from health centres these health units could not provide the required treatment.

Surgical problems

The commonest direct surgical complications seen were fractures, wounds, burns, complications of amputation and cut body parts. The commonest indirect surgical complications reported were backaches and joint pains. Attendance at the regional referral hospital where specialized surgical treatment can be offered was low. The commonest surgical diagnosis encountered at the time of operation included; hernias, benign soft tissue swellings, wounds, post-burn contractures and hydroceles.

Child trauma

More than a quarter of both the girl children and the male children had suffered from physical torture. More girls than boys reported being sexually tortured. Slightly more girls than boys reported being a single parent orphan as a result of war, while more boy children than girl children reported having lost both parents as a result of the war. The numbers of children with very high levels of psychological distress was high.

The lack of facilities to which parents could turn to for assessment and treatment of their children for mental illness was very frustrating.

Recommendations:

The results show that this war torn region in northern Uganda urgently needs more support to tackle the vast health problems. A public health approach which addresses the physical and mental health problems of the people in the IDP-camps is recommended. The planned interventions must be multidisciplinary and take in consideration age and gender balances. Long-term socio-economic development plans must be put in place but should respect local cultures.

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Chapter One

Armed Conflict in Northern Uganda

1.1 Introduction

For the past twenty years there is a forgotten war raging in Northern Uganda between the rebels of the Lords Resistance Army (LRA) and the Uganda People's Defence Forces (UPDF) impacting almost 8% of the Ugandan population (the proportion of the Ugandan population that inhabits this region). As in any war situation, it is the population which suffers the most, and among them the most vulnerable are children and women. Some of the documented results of the war in this region are: the killing and maiming of thousands of civilians; abductions of over 25,000 children; various forms of sexual and gender based violence (SGBV) including, rape, sexual slavery and forced marriages; physical disfigurement through the cutting of facial and other body parts; gunshot and landmine injuries; destruction of property and livestock; spread of HIV/AIDS; destruction and erosion of moral and social values of the community; and severe poverty (Parliament of Uganda, 2004; Isis-WICCE, 2001; The New Vision, 2004a,b,c; Isis-WICCE, 2004a,b). It is estimated that 1.7 million people, 80% of the population in this region, live in internally displaced peoples camps (IDPs)[1] which have been established close to government military camps, but are nevertheless poorly protected and continue to be raided by the LRA.

The twenty years of war have left the region in regard to the economic, education and specifically the health system in a condition way below the Ugandan average. Most people in this area live on subsistence agriculture for survival. The collapsed infrastructure and the constant insecurity make it impossible for development programs to be sustainable and effective. School attendance is the lowest, due to the need for children to help on the fields as well as the fear of abductions. A recent survey

[1] Internally displaced persons are "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border." (Guiding Principles on Internal Displacement). Please refer to http://www.internal-displacement.org/ for more information.

carried out in the districts of Gulu, Kitgum, and Pader by the Uganda Ministry of Health and international organisations show a total excess mortality of 1000 per week, whereby Malaria/fever and AIDS were the top two causes for this mortality, direct violence from the war was the third most frequent cause (MoH, 2003).

All military efforts from the Ugandan government have failed so far and even with increased international attention, the situation for the people living in this region has not improved.

1.2 Previous Isis-WICCE Initiatives in this Area

Previous studies in other war torn places in Uganda documented the extensive medical and psychological health problems people suffer in such situations, especially with a focus on the most vulnerable.

Since 1999, Isis-WICCE has carried out medical interventions aimed at showing the plight of women in situations of armed conflict with the expectation that government and other development agencies would prioritise the area of health in their post-conflict interventions. These interventions were always accompanied by operational studies to document the impact of chronic war on the health of the people living in these areas. In collaboration with local medical professionals from the Ugandan Medical Association (UMA), Isis-WICCE was able to offer emergency medical treatment to the local communities, train resident health workers in the recognition and management of common diseases, especially caused by the violence of war; build institutional capacity for the hospitals and health centres with the provision of drugs and to a limited extent equipment and document the impact of chronic war in these areas to advocate for an ending to war (Isis-WICCE, 1999; Isis-WICCE, 2001; Isis-WICCE, 2002).

Luweero Project (1999)

Luweero district in central Uganda went through protracted civil war between 1980 to 1986 leading to over 100, 000 deaths in this area with many more tortured, maimed or displaced. In 1999, Isis-WICCE documented the war-related torture experiences and the resulting psychological and gynaecological health problems that were still rampant in this region even after 13 years had already passed since the ending of this war.

Most of the war-traumatised survivors were women and children who at that time (1999) were aged 20-45 years old (54%). The majority had no male partners as most men and boys had been killed or relocated elsewhere and were therefore single mothers (61%). The lack of education left most without even primary schooling (94%) and most had had their homes destroyed (70%).

The war-related suffering included sexual violence (60%), beatings (50%), running to hide in the bush (85%) and losing members of their families due to war (40%). The most prevalent psychiatric disorders diagnosed included; post-traumatic stress disorder (55%), depression and anxiety disorders (80%), diffuse chronic aches and pains i.e. somatisations (81%). Over half of the assessed women (55.5%) were diagnosed with gynaecological problems such as sexually transmitted infections (64.7%), urinary tract infections (7.8%), vesico-vaginal fistula (6.0%), infertility (4.3%), fibroids (3.4%), uterine prolapse (4.3%) and cancer of the cervix (3.4%). All women respondents had never accessed any treatment for their war-related psychological and gynaecological problems till Isis-WICCE provided the short term medical intervention.

Gulu Project (2001)

Gulu district in northern Uganda has been the centre of civil war between various rebel groups including formerly the Holy Spirit Movement of Alice Lakwena and currently the Lord's Resistance Movement of Joseph Kony against the government of Uganda, since 1986 and is still ongoing. In July 2001, Isis-WICCE, in collaboration with the African Psycare Research Organisation (APRO), the Association of Obstetricians and Gynecologists of Uganda (AOGU) and the Department of Orthopaedics of Makerere University, undertook a medical intervention that included the documentation of war-related psychological, gynaecological and surgical (orthopaedic) trauma suffered by the women of Gulu district. The findings were similar to those of the Luwero triangle. The major difference was that the war was still raging on in Gulu district and many of the people were forced to live in Internally Displaced People's Camps (IDPCs). Due to the chronic violent situation people suffered higher rates of various diseases, higher alcohol and sexual abuse, and one of the highest rate of HIV/AIDS than in other areas of Uganda.

Teso Project (2002)

In August 2002, in her relentless effort to document the plight of women in situations of war-conflict in this country, again Isis-WICCE chronicled the war-related traumatic suffering of the women of Teso region in Eastern Uganda (including the districts of Katakwi, Kumi and Soroti). This report focused on what happened to women as a result of the 1987-1992 'Teso insurgency' and the centuries old Karamojong cattle raids which governments have failed to curb (up to now). As in the previous studies, war trauma was reported to be rampant with all the respondents who came to access the short term services offered by Isis-WICCE medical intervention reporting having suffered at least one form of torture. As a result, the majority of respondents were suffering from considerable psychological distress, suicidal ideation and homicidal ideations. Gynaecological problems that included; chronic pelvic pain, abnormal vaginal discharge, infertility, vaginal /perineal tears and urinary /rectal fistulae were reported. Surgical problems that included; complications of amputations, chronic wounds, scars, and various other disfigurements and disabilities were also treated. Most of these respondents had previously tried to seek medical treatment from health care facilities in the area but these facilities did not have the appropriate specialised services required.

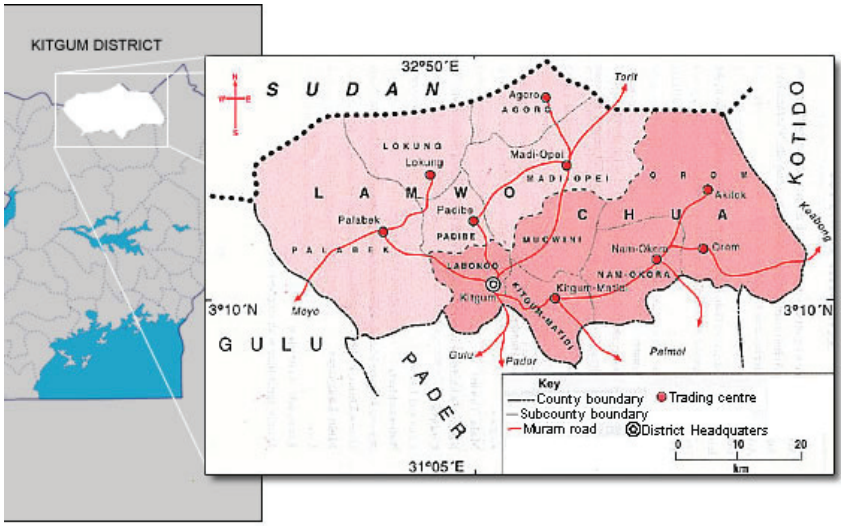
1.3 The Medical Intervention in Kitgum District

1.3.1 Study Site

Kitgum district is located in northern Uganda and borders the Republic of Sudan to the north, Kotido district to the east, Pader district in the south and Gulu district in the southwest. The Town Council is 452 kilometers north of the Ugandan capital Kampala. The district has 9,773.63 sq. km. of land, of which only 3,200 sq. km is for agricultural use. Kitgum district was selected for this intervention because it has been one of the districts most severely affected by the northern insurgency and yet Isis-WICCE had never carried out an intervention there.

The study was undertaken in two IDP Camps in Kitgum district, namely Mucwini (approx. population 15,000) and Padibe IDP Camps (approx. population 30,000) between October and December 2005. Padibe IDP camp is located in Lamwo county in a north easterly direction from Kitgum town, while Mucwini

is located in Chua county in a north westerly direction from Kitgum town. The selection criteria for these study sites were: 1) rural and remote location, 2) high population density, and 3) declaration of poor health infrastructure by district health authorities.



1.3.2 Overall Objective

To implement a participatory intervention research study about the medical and psychological consequences of the chronic war situation in two IDP camps (Mucwini and Padibe) in Kitgum district, Northern Uganda.

1.3.3 Project Purpose

a) To document the socio-demographic characteristics, and the physical and mental health problems of the people.

b) To provide specialized psychological, gynecological, surgical & medical treatment.

c) To create awareness in society both locally and internationally of the negative medical and psychological consequences of chronic war on the population.

d) To revise, field test and update the training manual, "Training notes for health worker's in recognition of war trauma and management of associated medical complications.''

e) To train district based health workers in the detection and treatment of medical and psychological health problems.

f) To train community health people to offer psychological support to both adults and children who are suffering from the psychological sequel of war traumatisation.

g) To propose the establishment a community based psychotrauma rehabilitation service for children in these communities.

1.3.4 Intervention Method and Design

Stage 1: Reconnaince and training

An initial reconnaissance visit was undertaken to the district by a team of health professionals and Isis-WICCE staff to ascertain the feasibility of undertaking the intervention and to work out the practicalities of the intervention (including visiting the two camps & recruitment of research assistants). The reconnaissance team met with the district leadership both civil and those in-charge of health in the district.

Subsequently a training workshop of identified research assistants was held to familiarise them with the data collection tools.

Stage 2: Screening

Screening of both adults (above 18 years) and children (18 years and below) who wanted to access the medical services offered by the intervention. Screening was undertaken using structured questionnaires, one for adults and the other for children. The adult screening questionnaire contained four main sub sections:

- general information on socio-demographics, reproductive health, HIV/AIDS, substances abuse, and trauma experiences related to war.
- screening questions for gynaecological and surgical problems, and for psychiatric problems using the WHO Self Report Questionnaire, also known as SRQ-20 (WHO,1994),
- previous health seeking behaviour for each of these problems.
- questions in regards to a person who had committed suicide over the previous 12 month (name, date/month/year of death, relationship with deceased, age, sex, and circumstances leading to suicide).

The children screening questionnaire contained the same sub sections with slight adaptations to the circumstances of children and while using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) for psychiatric assessment.

Stage 3: Assessment

Adult participants who were found to have significant psychiatric problems (a score of greater than 6 on the SRQ-20 screening questionnaire) were then assessed with a psychiatric diagnostic instrument called the MINI International Neuropsychiatric Interview to determine the specific disorder they were suffering from (Sheehan et al, 1998). Those participants, adults and children, found to have surgical and gynaecological problems were sent to the specialists for further assessment and to determine further treatment. For the children, who had scores of 15 and above on the SDQ, thus showing significant psychological problems, were further assessed using the MINI-KID International Neuropsychiatric Interview (Sheehan et al, 1998).

1.4 Data analysis

The completed questionnaires were entered into the computer using the software program of SPSS version 10. Data was then analysed using the same software to generate frequencies, tables and pie charts. Cross tabulations were also carried out to determine gender trends. For selected variables and their significant relation on study outcomes (having significant psychiatric, surgical and gynaecological problems) logistical regression analysis was carried out.

Chapter Two

Socio-demographics Characteristics

2.1 Introduction

According to the Population and Housing Census (2002), 282,375 people live in a total of 55,973 households in Kitgum district. Of the total population, 139,767 were males and 142,618 were females. Table 1 presents the selected socio-demographic characteristics for Kitgum district in comparison with the national figures. The census results indicated that there were 98 males f or every 100 females in Kitgum. The revealed sex ratio was 3 percentage points higher than the national average of 95 males per 100 females.

Kitgum district exhibited a higher proportion of orphaned children (18.6 percent) and the disabled (7.7 percent) in comparison with the national figures.

Table 1: Selected socio demographic characteristics

Socio-demographics	Kitgum District	Uganda
Percentage out of the total population of Uganda	1.2	100.0
Sex Ratio	1:0.98	1:0.95
Population density	29.3	123.9
Average household Size	5.0	4.7
Growth rate	4.1	3.3
Urbanisation	14.8	12.3
Percentage Under 18 Years	55.1	69.2
Percentage of the youths (18 to 30 Years)	23.6	24.7
Percent orphaned out of total children	18.6	13.1
Percent disabled	7.7	3.5
Total households with at least one death in the last 12 months	5145	270718
Proportion of households within 5 kms from health facility	58.0	73.2
Proportion of households within 5 kms from a primary School	80.9	92.2
Proportion of households accessing water within one km	56.3	72.3

Source: Uganda Bureau of Statistics: 2002 Population and Housing Census Results

2.2 Demographics of Sample Population

A total of 992 people were screened, of which 810 were adults and 182 were children. Of the 810 adults, 570 were females, while 240 were males. Of the 182 children, 93 were females and 89 were males. Table 2 presents the percentage distribution

of adult respondents by socio-demographic characteristics. The majority of the male respondents (58.6%) were aged 45 years and over. Most women in the study (48.3%) were in the age range of between 25 to 44 years. Most of the respondents reported to be married monogamously (52.4 percent). More males (55.7 percent) than females (51.1 percent) were married monogamously. Widowhood was more pronounced for females (8.3 percent) than for males (1.3 percent). A reason could be that men are more likely to re-marry than women.

Table 2: Adult respondents by socio-demographic characteristics

	Male (n= 240)	Female (n= 570)	Total (n= 809)
Broad Age Groups			
Under 18 Years	0.9	1.1	1.0
18 to 24 Years	9.3	10.6	10.2
25 to 44 Years	31.3	48.3	43.4
45 Years and Over	58.6	40.0	45.4
Religion			
Protestant	34.5	37.3	36.5
Catholic	62.2	61.3	61.6
Christian Saved Sect	1.7	0.7	1.0
Moslem	0.0	0.2	0.1
Traditional	0.4	0.2	0.2
Other	1.3	0.4	0.6
Marital Status			
Never	21.3	17.7	18.7
Married/Cohabiting monogamous	55.7	51.1	52.4
Married/Cohabiting polygamous	19.1	19.6	19.5
Widowed	1.3	8.3	6.3
Divorced/ Separated	2.6	3.4	3.1
Highest Level of Education			
No formal	23.4	49.9	42.1
Primary	66.8	45.0	51.4
Senior 1 to 4	8.5	4.4	5.6
Senior 5 to 6	1.3	0.7	0.9
Employment Status			
Peasant Farmer	84.7	90.1	88.5
Fisherman	3.9	4.8	4.6
Professional	1.7	0.9	1.1
Clerical/ Junior Civil Servant	2.6	0.4	1.1
Trader	1.7	0.7	1.0
Artisan	0.4	0.0	0.1
Transport Worker	0.4	0.0	0.1
Unemployed	1.3	1.1	1.1
Other	3.1	2.0	2.3

The majority of men were better educated than women. Almost half of the women (49.9 percent) had no formal education as compared to only a quarter (23.4 percent) of the men.

The adult screening questionnaire elicited information on the employment status of the respondents before the war. The majority of the respondents (88.9 percent) indicated that they were peasant farmers. More females (90.1 percent) than males (84.7 percent) were reported in peasant farming. Other important employment activities for both males and females were fishing, civil service, and trading. Most of the people in Kitgum district live off subsistence agricultural farming, especially since there are no other employment possibilities available due to the underdevelopment of the region. Women therefore mainly work on the farms outside the camps which increases their risk of further violent attack immensely.

2.3 Education of the Children

Almost half of the children had attained primary level of education. About 3% of the male children had attained secondary level of education, while no female children were reported in that category.

Table 3: Child respondents by socio-demographic characteristics

	Male (n= 89)	Female (n= 93)	Both Sexes (n= 182)
Broad Age Groups			
Under 5 Years	32.1	31.9	32.0
6 to 12 Years	45.7	42.9	44.2
13 to 18 Years	22.2	25.3	23.8
Religion			
Protestant	31.8	35.9	33.9
Catholic	68.3	62.0	65.0
Traditional	0.0	1.1	0.6
Other	0.0	1.1	0.6
Highest Level of Education			
No formal	47.1	46.2	46.7
Primary	50.0	53.8	51.9
Senior 1 to 4	2.9	0.0	1.5

2.4 Population by Residence

The majority of the respondents (95.6 percent for children and 91.6 percent for the adults) interviewed indicated that they were from Kitgum district. Further examination of the

respondents by residence, revealed that 4.4 percent of the children and 8.5 percent of the adults had changed the county of residence. This indicates that most respondents joined the IDP camps nearest to their areas of residence.

2.5 Conclusion

The study results confirm earlier findings about the impact of prolonged war on the socio-demographic characteristics of an area. While documenting women's experiences in armed conflict in Gulu, Isis-WICCE (2001) observed that the number of children and male adults declined due to death, abductions, emigration or recruitment into military services. Further more,during the Isis-WICCE study in Luwero (1999), it was noted that as a result of war the number of women headed households increased greatly (71 percent).

The presence of so many female headed households impacted the economic recovery of the region immensely. In the Isis-WICCE study in the Teso region (2002), it was found that in this largely peasant farmer population, more females (7.4 percent) than males (1.2 percent) were earning their livelihood as labourers, indicating that even the land tenure system was affected by war disproportionately not to favour women.

This study also found that the war impacted on the education of the girl child whereby most girl children had not even received basic primary schooling. The necessity for children to commute every night from the IDP camps to towns to avoid abductions by the Lord's Resistance Army increases the risk for girl children for early sex and prostitution (for gifts and safe passage), early marriage with businessmen or soldiers, and the exposure to HIV/AIDS. Such risks do of course impact negatively on the education of the girl children.

It is highly recommended that education planners in this country put in place strategies focusing on the education of children, specifically girl children, in war affected areas.

Chapter Three

Psycho-social Impact of War and the Mental Health Consequences of Torture

3.1 Introduction

Previous research that has been undertaken by Isis-WICCE in other war affected areas of Uganda has documented various direct and indirect experiences of violence that have included: various forms of sexual and gender based violence (SGBV) including rape, sexual slavery and forced marriages; abductions; physical disfigurement (e.g. the cutting of facial and other body parts); killing of loved ones; displacement into IDP camps; gunshot and landmine injuries; destruction of property and livestock (Isis-WICCE, 1999; 2000; 2001). These studies in war affected communities also documented a significant burden of psychiatric problems, most likely as a result of this violent context that included: post traumatic stress disorder (PTSD), depression, anxiety disorders, psychosis, alcohol and substance abuse problems, suicidal behaviour and homicidal ideation towards perceived perpetuators (Musisi et al, 1999; Kinyanda & Musisi, 2001; Kinyanda et al, 2002).

3.2 Results of this Study

Gender differences in the experience of violence and the resulting biopsychosocial problems have been documented in other war torn areas in the world and also in Uganda. Women and children were most vulnerable to the impact of war (Lubanga & Mwaka, 1998; Tumushabe, 2001). Women's reproductive role, especially important within the cultural context of the different ethnic groups in Uganda, was specifically targeted by gender based violence (Kinyanda et al, 2002). As a direct or indirect result, women had significantly more suicidal thoughts than men and were diagnosed more often with panic anxiety disorders (Kinyanda et al, 2002).

Most people participating in the interventional study experienced severe forms of violence at least once in their life. About a half (52.6%) of the residents of Mucwini and Padibe IDP Camps have been subjected to some form of physical torture, including beatings and kickings (31.8%); bayonet and knife cuttings (11.2 %); burnings (15.8%); tying hands and feet behind the victim,

also known as Kandoya (11.6%) or being forced into hard labour (21.2%). While men experienced more beating, kicking, bayonet and knife injuries women were exposed to various sexual forms of violence.

The experience of torture impacted negatively on the people's psychological well being. Most people had their homes and/or livestock destroyed (77.3%), thus loosing a place to live and their only means of surviving. The lack of a means of subsistence added to the already prevalent poverty in this region. Due to the constant threat of attacks, survivors were forced to flee and sleep in the bush (73.4%). The most direct forms of traumatization resulted from having their loved ones/relatives killed (68.6%), being abducted into the ranks of the rebels (43.6%) and being sexually abused (51.3%). Men were more subjected to public violence through arrests and detentions, and experienced the impact of the deprivation of food, water and medicines as more intensively, while women were more subjected to sexual violence.

Table 4: War-related torture experiences of the respondents

Torture Events	Males (n=240)		Females (n=570)		Total (N=810)			
	n	%	n	%	n	%	X^2	P-value
Physical torture								
Beatings & Kickings	84	36.8	164	29.7	248	31.8	3.79	0.005*
Bayonet & Knife injuries	38	16.6	49	8.9	87	11.2	9.62	0.002*
Forced hard labour	56	24.5	109	19.8	165	21.2	2.08	0.15
Severe tying (Kandoya)	33	14.5	57	10.3	90	11.6	2.76	0.09
Burning	29	12.9	93	16.9	122	15.8	1.88	0.17
Psychological torture								
Deprivation of food & water	52	22.9	94	17.1	52	146	18.8	0.06
Deprivation of medicine	48	21.2	62	11.3	48	110	14.2	0.000*
Detained /Arrested	72	31.2	115	20.6	72	187	23.7	0.002*
Forced to sleep in bush	168	72.7	410	73.6	168	578	73.4	0.8
Abduction	97	42.2	246	44.2	97	343	43.6	0.59
Forced recruitment	31	13.4	78	14	31	109	13.8	0.83
Forced to kill	14	6.1	26	4.7	14	40	5.1	0.4
Loved one/ relative killed	145	67.1	323	68.7	145	468	68.2	0.68
Spouse killed	20	10.7	56	13.5	20	76	12.6	0.34
Home/ livestock destroyed	170	73.6	440	78.9	170	610	77.3	0.11
Children killed	56	29.8	95	21.9	56	151	24.3	0.04*

* Statistically significant relationship

Gender violence

More than a quarter of the women (28.6%) reported having been subjected to various forms of sexual torture. Almost

20% of the women described violent penetrative sexual abuse (rape, 3.8%; gang rape, 0.9% and defilement, 15.1%). Others (14.6%) suffered daily sexual abuse such as incest (1.8%), sex slavery (8.3%), and forced marriages (4.5%). Situational sexual exploitation for survival in the form of sexual comforting (3.5%), sex in exchange for gifts (2%) or food (1.6%) is forced upon women and girls due to their desperate situation. These latter types of sexual exploitations are not uncommon in situations of conflict and have been documented in other areas of the world, where soldiers (including UN peacekeepers) are stationed among civilians for long periods of time (WorldNet Daily, 2006; BBC News, 2004; ABC News, 2006; Refugees International, 2006).

Table 5: Sexual violence reported by women (N=570)

Sexual Torture	n	%
Rape (single episode)	21	3.8
Gang rape	5	0.9
Attempted rape	28	5.1
Defilement	83	15.1
Forced incest	10	1.8
Abduction sex slave	45	8.3
Forced marriage	25	4.5
Sexual comforting	19	3.5
Sex in exchange for gifts	11	2
Sex in exchange for food	9	1.6
Total	256	28.6

Even though women experienced most of the sexual violence, it is worthy to note that 7.9% of the men reported being sexually abused. In a culture where homosexuality is so greatly stigmatized, the impact of such violence is aggravated by its cultural context. The shame accompanying sexual violence for both women and men most likely led to an underreporting of these experiences.

Psychological problems

The majority of people in the study had significant psychological distress (SRQ-20 scores of 6 and above), whereby more women (69.4%) than men (60.9%) reported symptoms. There was a clear gender difference in how this distress was expressed. Women reported more suicidal and homicidal thinking and behaviour, while men stated having more problems with alcohol dependency.

The global epidemiological picture of suicidal behaviour whereby more men commit suicide and women attempt suicide, was also observable in the camps. Of the completed suicides, in the one year of study (October 2004 to November 1st 2005), the crude suicide rate[4] for the two camps was 26.67/100,000 of whom 11(91.7%) were males and 1 female (8.3%). The age range of the completed suicides was 18-50 years with a mean of 32.5 years. The circumstances associated with these suicides included death of a child (8.3%), family problems (24.9%), alcohol related problems (25%) and for the rest (41.8%) no cause could be associated with the suicide.

There was a high degree of use of substances of addition in the two camps. The commonest substance of addition used was alcohol (74%). As a result, about a quarter (20.4%) of all the respondents had alcohol dependency (CAGE positive). Proportionally more women (78.9%) than men (64.1%) reported use of alcohol but the reverse picture was observed on alcohol dependency with proportionally more men (24.6%) than women (18.7%) psychologically dependent on alcohol (CAGE positive).

Tobacco was also commonly used by respondents in the two camps by both men and women. Especially in more rural settings in Uganda, it is culturally not very appropriate for women to smoke or drink as supported by national statistics (Kinyanda, 2004). More women in the two camps may have taken to drinking and smoking as a form of coping with their distress.

Table 6: Psychosocial problems among the respondents
Psychiatric disorders

	Males (n= 240)		Females (n= 570)		Total (N= 810)			
	n	%	n	%	n	%	X^2	P-value
Suicidality								
Suicidal ideation	48	21.0	144	25.6	192	24.2	1.89	0.17
Suicidal attempt (life time)	24	10.6	87	15.8	111	14.3	3.53	0.06
Suicidal attempt (last 12 months)	9	4.2	33	7.3	42	6.3	2.32	0.13
Homicidal ideas	22	9.6	64	11.3	86	10.8	0.47	0.49
Use of substances of addiction								
Alcohol	116	64.1	285	78.9	401	74		
Marijuana (Cannabis)	2	1.1	2	0.6	4	0.7		
Khat/Mairungi	7	3.9	10	2.8	17	3.1		
Cigarettes	51	28.2	63	17.5	114	21		
General Psychological distress (SRQ ≥ 6)	131	60.9	383	69.4	514	67	5	0.03*

Due to time, staff limitations and security concerns in the camp at the time of the intervention, it was only possible for the psychiatric team to see 56 people. The commonest psychiatric illnesses were epilepsy (51.8%) followed by depression (42.9%), post-traumatic stress disorder (23.2%) and anxiety disorders including generalised anxiety disorder (8.9%), panic disorder (17.9%) and social phobia (3.6%).

Table 7: Psychiatric disorders found among patients

Psychiatric disorders	n	%
Major depression	24	42.9
Alcohol dependency syndrome	3	5.4
Generalised anxiety disorder	5	8.9
Post traumatic stress disorder	13	23.2
Panic disorder	10	17.9
Phobic disorder	2	3.6
Psychotic disorder	5	8.9
Epilepsy	29	51.8
Total	56	100

* Some respondents had more than one psychiatric disorder

These disorders are a common findings in war-affected populations with similar findings having been observed in all the past studies carried out by Isis-WICCE in various parts of war-torn Uganda (Musisi et al, 1999; Kinyanda & Musisi, 2001; Kinyanda et al, 2002).

Epilepsy is the commonest organic brain neuropsychiatric disorder seen in Uganda. The specifically high occurrence of epilepsy among the survivors of the conflict and the case study below made the psychiatric team wonder as to how much of it was due to injuries sustained from beatings on the head.

> *" X. is a 31 years old woman from Padibe West who was beaten severely in 1990 including on the head by rebels until she was unconscious. A scar on her head is visible as a reminder of that ordeal. Afterwards, she developed loss of hearing in her left ear, then in 1991 she run mad (developed a psychotic breakdown). Since 1993 she has been suffering from epilepsy. At the time of the intervention she had never received any psychiatric treatment for her epilepsy. She was seen by the psychiatric team who diagnosed her to have epilepsy secondary to traumatic brain injury."*

The factors that were found to be associated with psychological distress included; gender (more in females than males), alcohol abuse, high HIV personal risk assessment, past physical torture, past psychological torture and having a surgical condition.

Table 8: Factors associated with psychological distress

Variable	Relative Odd	P-value
Gender	1.48	0.05*
Marital status	1.03	0.75
Alcohol dependency	1.81	0.02*
Attempted suicide (life-time)	0.88	0.64
High HIV risky behaviour	0.74	0.008*
Past physical torture	1.58	0.01*
Past psychological torture	2.59	0.000*
Having a surgical problem	2.77	0.000*

* Statistically significant relationship

All these factors significantly associated with psychological distress in the camps indicate that life in the IDP-camps is intolerable and unliveable especially for females with little hope for future improvement.

Health Seeking Behaviour

Many respondents went to the local health centres and the district hospital (64% and 66.3% respectively). Over 60% sought help from traditional healers (27.4%), self-medicated (15.8%) or received no treatment at all (18.7%). This pattern suggests that although the majority of respondents with psychiatric problems attempted to seek help from the health centres and the district hospital (more than two thirds), they were not getting the appropriate help required and hence were seeking alternative sources of help such as traditional medicine. This is not surprising given that the entire district of Kitgum has only one mental health professional- a psychiatric nurse based at the district hospital.

The relatively high number of visits to the local health centres and the district hospital show the accessibility of health treatment in the two camps and the district hospital in Kitgum town but not the regional referral hospital at Gulu (6.2%) which is equipped with a reasonable number of mental health professionals and service.

Table 9: Help seeking behaviour of respondents for psychiatric problems

Help Sought*	n	%
No treatment	96	18.7
Self treatment / medication	81	15.8
Traditional healer	141	27.4
Local health Centre	332	64.6
District Hospital	283	66.3
Regional Referral hospital (Gulu)	32	6.2
National Referral Hospital (Butabika or Mulago)	0	0

* Some respondents sought treatment from more than one sources

Perpetrators

Most of the trauma perpetrators were rebels (72%), then government soldiers (23.2%). Police officers, prison officers and the Local Defence Forces who are supposed to protect the local citizens in the IDP – Camps accounted for 11% of the traumatisations. No significant gender differences were reported according to perpetrator.

Table 10: Perpetrators of war torture

Perpetrator*	Males (n= 240)		Females (n= 570)		Total (N = 810)			
	n	%	n	%	n	%	X^2	P-value
Rebels (LRA)	158	68.7	409	73.3	567	72	1.71	0.19
Govt. soldiers (UPDF)	48	20.9	134	24.1	182	23.2	0.98	0.32
Police	2	1.6	7	1.8	9	1.7	0.01	0.91
Local Defence Forces	15	6.6	48	8.6	63	8	0.94	0.33
Prison Officers	3	1.3	6	1.1	9	1.2	0.07	0.79
Others	4	2.7	7	3.2	11	3	0.06	0.8

* Some respondents were traumatised by more than one perpetrator group

3.3 Discussion

The severe forms of violence experienced by the people in the camps resulting in a high prevalence of psychological and psychiatric illnesses and problems sheds a light on the suffering which is occurring for the past twenty years among the survivors of the conflict. Perpetrators are not only the LRA rebels, but also UPDF soldiers stationed in the area for protection of the local population. The greatest majority of the surviving victims of this war have been women and children who make up the majority of the residents in the IDP-Camps.

As observed in other previous studies, men and boys are targeted for forced recruitment (e.g. child soldiers) or targeted to be killed if they have become soldiers or paramilitary personnel of the government side. Thus the male gender in the camps is over represented by elderly men.

The women in these camps suffered a lot more physical and psychological trauma. More significantly they were subjected to gender-based violence especially sexual traumatisation in the form of rape, defilement or being abducted for sexual purposes including sex-slaves and forced marriages. Sex for survival was also common as is often seen in *"camp following"* of soldiers by women. In Mucwini and Padibe camps, survival sex being used was in exchange for food, or security, including sexual comforting of soldiers. Sexually transmitted infections (STIs) are common. The HIV/AIDS rates in the IDP-Camps of Northern Uganda are now the highest in the country as are other diseases (MoH, 2003). Therefore, the long-term impact on society of such chronic sexual exploitation, abuse and degradation of women over such a prolonged period of time has to be studied.

Another form of gender-based violence is *"uglification"* as evidenced by burnings, facial and lip cuttings as well as disfigurement. This makes the victim (often women) feared and unacceptable in her community.

Living in camps breaks up families. The sustained and prolonged deculturalisation, dehumanisation, demoralisation and devaluation of the Acholi people in these camps will have a long-term negative socio-cultural impact on Acholi society. Others have argued that it may be a deliberated slow genocide as the death rates in these camps have been reported to be about 1000 deaths per week (Olara Otunu, Monitor Jan. 2006). The camps are often raided by the LRA. Fires are common. People live in fear and their Anxiety levels and Suicide rates are quite high. The question of whether there's any intended *"protection"* of the population in the IDP-Camps, therefore arises.

Despite all the Isis-WICCE intervention efforts and recommendations no systematic government - sponsored interventions have ever been found. Although there's a Ministry of Rehabilitation, there's no stipulated government policy addressing post-conflict recovery problems in any war-affected area in Uganda.

Certainly with the war with Kony's LRA still going on, no special efforts have been put in place by government to address the various physical, mental health and social concerns of the people in these IDP-camps. Yet these have been well documented (NUPSANA, Isis-WICCE). The NGOs found in these camps seem overwhelmed by the magnitude of the physical and mental afflictions of the people in the IDP-Camps. The only available health care in the camps was by the decentralised health care centres but whose services are so poor and rudimentary that over 60% of the people either went to traditional healers, self-medicated themselves or never sought any treatment at all. This was especially so for their psychological problems.

3.4 Recommendations

1. All efforts must be done to stop the war in Northern Uganda and then to disband the IDP-camps whose purpose and usefulness is now very much in question.
2. Government must draw up a multi-sectoral and multi-disciplinary post-conflict recovery policy to address the various physical, psychological and social problems being suffered by the survivors in the affected areas.
3. There's a need to legislate the setting up of Psycho-Traumatic treatment centres in war-torn Northern Uganda to address the massive psychosocial problems being suffered by the survivors of the conflict. There's evidence, from studies elsewhere that if not addressed these could lead to trans-generational effects with future instabilities in Uganda.
4. Human Rights Education, Reconciliation, Conflict Resolution and Peace Building should be taught in all schools, colleges and law-enforcement agencies in Uganda in order to build a sustainable peace.
5. A culture of democratic governance and tolerance of differences needs to be visibly encouraged and demonstrated especially by all those in responsible positions.
6. For now and urgently, a Public Health Approach needs to be adapted to address the physical and mental health problems of the survivors in the IDP-camps through a Primary Health Care approach. The planned interventions must be multidisciplinary and take in consideration age and gender balances.
7. Survivors and especially women must be involved in the long-term socio-economic development planning with respect to local cultures and feelings, and based on Universal Respect of Human Rights.

Chapter Four

Impact of War on the Reproductive Health of Women and Girls

4.1 Introduction

Previous interventions by Isis-WICCE working in collaborations with the Association of Obstetricians and Gynaecologists of Uganda in the war affected communities of Luwero, Gulu and Teso have shown that women are among the most vulnerable to the violence experienced in these areas (Isis-WICCE, 1999; 2001; 2002). Through these previous studies a wide range of gynaecological problems were reported; vaginal tears, chronic leaking of urine and feaces, infertility, chronic pelvic pain, swelling of the abdomen and unwanted pregnancies (Mirembe et al, 2001; Mirembe et al, 1999; Otim et al, 2002). A special issue of concern which these studies raised was the low use of contraception, with rates as low as 7.9% recorded in Awer camp in Gulu (Mirembe et al, 2001). These gynaecological problems incapacitate the health of the women, thereby limiting their important role within the family and community. The majority of the women had never accessed appropriate gynaecological services.

4.2 Results of this Study

4.2.1 Being a Wife and Mother

The identity of a woman in especially rural African areas is determined by being a wife and a mother. Therefore, it is important to find out the context of marriage and motherhood in an area which is enduring chronic violence due to war.

The majority of women in the study, reflecting the overall situation in the camps, were young (67.9%), being still in their reproductive age. Most of them were married (70.9%) with half of them in monogamous marriages, while nearly a quarter reported being in a polygamous marriage. Half of the respondents had no formal education, reflecting not only the breakdown of the educational system in this area, but also that girls still receive less education than boys, due to their work duties.

4.2.2 Age of Marriage

The findings revealed that on average women had married at the age of 19.5. The age at first marriage varied though by age group, with younger women (18 to 24 years) reporting 17.4 years, while the older women (45 years and over) reported being 20.1 years old. The changing tendency of marrying earlier is also reflected in the 2000/1 Uganda Demographic and Health Survey, which recorded the average age at first marriage for women aged 20 to 49 years at 17.8 years.

4.2.3 Number of Marriages

The average number of times adult women were married was 1.3 with a range of 1 to 5. The rate was highest for the 25-44 age group and lowest for the 45 and above age group. This trend has to be understood in the context of the strong pro-marriage tradition still prevalent in Uganda where when a woman dies unmarried it is seen as an embarrassment to her family (Ntozi and Ahimbisibwe, 2001). As a result of this pressure the proportion of women in this country who are widows and divorcees in the highly reproductive ages of 20-34 is very low (ibid). Culture encourages the re-marriage of these women and hence the wide range of the number of times married seen in this study.

4.2.4 Child Birth

Adult women reported delivering their first child on average at the age of 19.5. The youngest being 14 years at the birth of her first child and the oldest being 34 years. The analysis of the age at first birth by age group revealed a similar pattern as shown for the age at first marriage. The average age at first birth both for women in the 20-24 and the 45-49 age bracket in Uganda for the year 1988-89 was reported to be 18.6 not much different from what was observed in this study (Demographic and Health Survey).

On average the women in the study reported 4.8 live births. The number of live births varied from 1 to 12 children. The average fertility rate for Uganda according to the demographic and health surveys for 2000-2005 was 7.1 (Earth Trends, 2003). Only 11 and 23 out of the 456 ever married women reported still births and miscarriages. The average number of still births was 2.1 and the average number of miscarriages was 1.5.

No national figures were available for comparison. The major causes of still births and miscarriages are malaria, sexually transmitted infections, and hard work.

Table 11: Selected variables on women's reproductive health

Broad age group	Age at first marriage	Number of times married	Age at first birth	Number of live births	Number of still births	Number of miscarriages
18 - 24 years						
Mean	17.4	1.3	18.3	2.1	1.5	1.3
25 – 44 years						
Mean	19.0	1.4	18.9	4.3	2.2	1.5
45 > years						
Mean	20.1	1.2	20.3	5.8	2.0	1.6
Overall						
Mean	19.5	1.3	19.5	4.8	2.1	1.5

4.2.5 Contraception

Knowledge about the possibilities of contraception is important since it provides an indication on the awareness of family planning. Of the 570 women in the study, 39.8% were not using any method of contraception. Only 11.1% were using modern methods, while 33.4% were using traditional methods. The low usage of contraceptive methods is responsible for the high fertility rate (7.1 children) which was revealed by the 2000/1 UDHS.

Table 12: Method of contraception used (N=570)

Contraceptive method	n	%
Modern	57	11.1
Traditional	172	33.4
None	205	39.8
Not applicable (no sexual partner)	81	15.7

In order to better understand the context of the use and non-use of contraception in such a congested environment as the IDP camps in northern Uganda, the study team included questions addressing this issue. Some of the reasons given for non-use of modern contraceptives included; desire to still having more children (32.2%), no knowledge about contraceptive use

(31.9%), lack of interest (18.1%) and infertility (9.6%). The high unawareness of women about the possibilities of contraception is a serious concern which could be easily addressed by information campaigns.

Table 13: Reasons for not using contraception

Reasons for not using contraceptives (N= 94)*	n	%
Still need more children	35	32.2
No knowledge	30	31.9
Not interested	17	18.1
Has infertility	9	9.6
Difficult to get	1	1.1
Been spacing naturally	1	1.1

* Results from the 94 women seen by the gynaecologist

4.2.6 Gynaecological Problems

A high number of women (66%) reported at least one gynaecological problem, of which the most commonly reported ones were: chronic lower abdominal pain (48.9%), abnormal vaginal discharge (26.9%), abnormal vaginal bleeding (25.5%), swellings in the abdomen (20.9%), infertility (24.8%) and genital sores (23.4%). Other gynaecological problems reported included; abnormal leaking of urine (13.3%), abnormal leaking feaces (6.6%), vaginal/perineal tear (14.8%), unwanted pregnancy (9.4%), genital laxity/ prolapse (7.3%) and sexual dysfunction (13.3%).

Table 14: Distribution of gynaecological problems (n=570)*

Gynaecological problem	n	%
Chronic lower abdominal pain	280	48.9
Infertility	142	24.8
Abnormal vaginal discharge	154	26.9
Abnormal vaginal bleeding	146	25.5
Swelling in the abdomen	120	20.9
Genital sores	134	23.4
Leaking urine/faeces	114	19.9
Unwanted pregnancy	54	9.4
Sexual dysfunction	76	13.3
Genital laxity/tears	127	22.2

* Some women reported more than one gynaecological problem

4.2.7 Statistical Factors Associated with Having a Gynaecological Problem

The factors that were significantly associated with having a gynaecological problem were; being in the reproductive age group, having attained some formal education having suffered sexual torture having suffered psychological torture and having a surgical problem.

Table 15: Factors associated with having a gynaecological problem (N= 570)

	Gynaecological problem		Odds Ratio	X^2	P-value
	n	%			
Age Group					
Less than 50 years	282	81.7	0.25	46.56	0.000*
≥50 years	86	52.8	0.17-0.37		
Education					
No formal education	173	64.8	2.24	15.92	0.000*
Primary level education and above	202	80.5	1.50-3.34		
Ever suffered sexual torture					
Yes	130	85.0	2.76	17.08	0.000*
No	248	67.2	1.68-4.52		
Ever suffered psychological torture					
Yes	346	75.2	2.85	15.24	0.000*
No	32	51.6	1.66-4.89		
Has a surgical problem					
Present	311	77.2	2.62	20.03	0.000*
Absent	67	56.3	1.71-4.04		

* Statistically significant associations

Table 16 below shows that those with a gynaecological problem had on average been married more frequently (mean=1.3, SD=0.6) than those without gynaecological problems (mean=1.2, SD= 0.5).

Table 16: Relationship between having a gynaecological problem and the number of times married

Presence of a Gynaecological problem	Number of times married		t-test	P-value
	mean	SD		
Present	1.3	0.6	1.95	0.05*
Absent	1.2	0.5		

* Statistically significant associations

4.2.8 Health Seeking Behaviour

Even though 40% of the women in the study reported that they have visited the local health centres in Padibe and Mucwini and

the district hospital in Kitgum town, the number of women who utilised traditional medicine, turned to self medication or sought no treatment at all, is alarming.

Table 17: Health seeking behaviour for gynaecological problems (N=570)*

Health facility	n	%
Local Health centre	240	41.9
District hospital (Kitgum hospital)	238	41.5
To traditional healers	112	19.5
Self medication	43	7.5
Been to regional referral hospital (Gulu)	23	4.0
Not sought treatment	97	16.7

* Multiple answers possible

4.2.9 *Results of the Intervention of the Gynaecological Intervention*

Gynaecological disorders constituted 15% of the total case load of both adults and children seen during the camp based medical treatment phase. For those women referred to the gynaecologist, more than half (57.3%) of them had pelvic inflammatory disease while 40.9 % had secondary infertility. About a quarter (23.6%) had primary infertility and 6.4% had chronic pelvic pain. The other gynaecological disorders identified included; uterine prolapse (4.5%), sexually transmitted infections (3.6%), candidiasis (4.5%), vesico-vaginal fistula (1.8%), uterine fibroids (0.9%), recurrent abortions (0.9%), and urinary tract infection in pregnancy (0.9%).

Table 18: Gynaecological diagnoses of referred women (N= 110)*

Diagnoses	n	%
Pelvic inflammatory disease	63	57.3
Secondary infertility	45	40.9
Primary infertility	26	23.6
Chronic pelvic pain	7	6.4
Uterine prolapse	5	4.5
Sexually transmitted infection	4	3.6
Candidiasis	5	4.5
Vesico-vaginal fistula	2	1.8
Uterine fibroids	1	0.9
Recurrent abortions	1	0.9
Urinary tract infection in pregnancy	1	0.9

* Some women had more than one gynaecological disorder

4.2.10 Impact of Gynaecological Disorders

The immense impact of the gynaecological disease on the women's lives can be shown clearly through how often they reported the negative effects. A third (34.2%) of the women reported being significantly impaired or being completely unable to work. Nearly half (49.5%) of the women reported being unable to have children because of the disorder. 45% of the women reported significant strain on the relationship with their husband because of the disorder. Lastly, having a gynaecological disorder significantly affected the self esteem of 41.1% of the women.

Table 19: Impact of gynaecological disorder on ability to function(N= 110)

	n	%
Effect on work		
Minimal/ Not there	38	34.2
A little	30	27.0
A lot	34	30.6
Completely unable to work	4	3.6
Ability to have children		
Minimal/ Not there	36	32.4
A little	14	12.6
A lot	33	29.7
Completely unable	22	19.8
Effect on marriage		
Minimal/Not there	36	32.4
A little	19	17.1
A lot	39	35.1
Completely unable	11	9.9
Effect on self esteem		
Minimum/ Not there	31	27.9
A little	29	26.1
A lot	39	35.1
Completely low	7	6.3

4.2.11 Results of the Gynaecological Surgeries

In total 116 operations were carried out and of these 8(6.8%) were specifically gynaecological. The most common gynaecological disorder was cancer of the cervix (37.5%) which turned out to be in advanced stages after careful examination. Other gynaecological disorders that could be operated upon included; post menopausal bleeding, stress incontinency, grand multiparity and uterine prolapse.

Doctors operating a patient with a gynaecological problem

Table 20: Diagnoses and procedures carried out (N= 8)

Table 20: Diagnoses and procedures carried out (N=	n	%
Diagnosis		
Cancer of the cervix	3	37.5
Post menopausal bleeding	1	12.5
Stress incontinency	1	12.5
Grand multiparity	1	12.5
Uterine prolapse	1	12.5
Pyosalpinx	1	12.5
Procedure		
Hysterectomy	2	25.0
Examination under anaesthesia	3	37.5
Anterior colporrhaphy	1	12.5
Caesarean section	1	12.5
Laparatomy + drainage of pyosalpinx	1	12.5

The case story below illustrates the extent of war trauma that the women of Kitgum district have experienced, the resultant gynaecological complications and the ray of hope provided by the Isis-WICCE short- term medical intervention:

> *"S. is a twenty five year old woman from Padibe camp who was abducted when she was fourteen years old and "married off" to one of the Lords Resistance Army (LRA) commanders as a fourth wife. Six months later the husband was killed in battle. She was again "married off" to another LRA commander who had two other wives. One year later she*

became pregnant and carried the pregnancy for 9 months. She had a difficult labour in the bush in Sudan. The labour took two days and she delivered a dead baby. She was unable to walk for two weeks and had severe lower abdominal pain and pus discharging from her genital part. She was treated with traditional drugs with no improvement. Later she was given capsules and other tablets and she improved. She escaped from LRA six years ago. Two years later she was got married to a civilian in the IDP camp of Padibe. She was unable to conceive and constantly felt severe lower abdominal pain, which was worst during her menstruation period. She later separated from her husband because she could not conceive. She was treated by the gynaecological team who at surgery found her to have accumulated pus in both fallopian tubes (oviduct). Pus was removed from both tubes during the operation. She now has no chance of conceiving naturally."

4.3 Discussion

The above results demonstrate the magnitude of the war/armed conflict on the reproductive health of women, demonstrating the elevated risk for women during war.

The major gynaecological complications found were sexually related. Sexual torture, multiple sexual partners and polygamous marriages, are some of the major contributors to sexually transmitted infections. Even for those who are not raped, women in a war situation have no possibility of negotiating for condom use or other protective barriers and hence run a very high risk of acquiring sexually transmitted infections including HIV. According to this study sexual torture appears to be rampant in northern Uganda. About two thirds of the women who had chronic abdominal pain had experienced sexual torture. The other common gynecological problems were infertility, abnormal vaginal discharge and having genital sores. The major cause of infertility in this socio-economic environment is tubal blockage which in most times results from untreated or poorly treated sexually transmitted infections. As shown elsewhere sexually transmitted infections are quite common in war situations (Jasenka Grujic-Koracan, 1998; Libby Tata Acel, 1998).

Only few women who had gynaecological problems had ever accessed specialist care at the regional referral hospital in Gulu. This is not surprising given that the nearest specialist gynecological services are only available at the regional hospital

in Gulu which is hundreds of kilometers away. These services are therefore not accessible to the majority of women who cannot afford the transport and lodging costs of going to Gulu. Use of other reproductive services particularly Family planning was also poor. Only 11.1% of the women used modern family planning methods with a third using traditional methods (33.4%) while another third (39.8%) used no method at all. Again this may be a reflection of poor access to services in a war situation, but very low levels of formal education among women as observed in this study may have a big influence on the uptake of family planning services. The picture of limited health services, lack of access to drugs and specialized services is similar to what has been observed in previous studies carried out by Isis-WICCE in the war affected areas of Luwero, Gulu and Soroti in Uganda (Mirembe et al, 2001; Mirembe et al, 1999; Otim et al, 2002).

The negative impact of the gynaecological disorders on the ability of women to function is significant. Those who reported significant negative effect on their ability to; work were 34.2%, effect on ability to have children were 49.5%, effect on marriage were 45% and self esteem were 34.4%. This negative consequence on the women's ability to function in various areas cannot be ignored. By virtue of their reproductive roles women are traditionally the guardians of the health of family members. If they are unable to function this will reflect negatively not only on the health of the family but also on the overall economic development of the community in which they live. Therefore the provision of gynaecological services for women in situations of conflict not only will greatly improve the quality of life of the women and the overall health of the communities but will also contribute to the economic recovery and development of these communities.

4.4 Recommendations

1. There is need to provide reproductive health services to war affected communities. These services need to be built into the entire referral system serving these war affected communities.
2. The district hospital of Kitgum given the extent of the burden of gynaecological problems facing the population should be equipped with a gynaecological unit with a resident gynaecologist.
3. There is need to have health education campaigns targetting women in this district to increase awareness of reproductive health issues and to increase access to these services.

Chapter Five

Surgical Complications in War

5.1 Introduction

In war torn areas health problems resulting from untreated injuries caused by beatings, bullets, landmines, fire and knife cuts are common. Due to the breakdown of health delivery systems in such regions, injuries have been inadequately managed leading to chronic wounds, ugly hypertrophy scars, deformities and functional disabilities.

The common surgical diseases, usually easily treatable, become chronic and constitute a major health burden due to the absence of skilled surgical service. Previous Isis-WICCE medical interventions in the districts of Gulu and Teso have attested to the magnitude of the surgical problems and the associated disability in war affected communities (Beyeza, Naddumba, Buwembo, 2001; Kirya, Epodoi, Buwembo, 2002).

5.2 Results of this Study

813 persons from the two camps were screened, of which 591(72.7%) had at least one surgical problem with females constituting 73.3% while males were 26.7%. Those found to have surgical complaints were referred to medical workers for further assessment and possible treatment. The surgical team that was based at Kitgum hospital performed surgery on 117 people during the intervention.

5.2.1 Main Injuries and Surgical Complaints

The physical health complications of war can be divided into the direct effects of war such as injuries caused by the violence experienced and indirect physical complaints and health problems which are caused independently, due to living under harsh conditions characterised by inadequate health services.

The main direct health problems which were identified among the survivors were injuries such as fractures and their complications (15.0%), wounds and their complications (11.4%), burns (8.7%), amputations (6.7%) and cut of body parts (6.2%). More women than men showed direct physical trauma such as cut body parts.

Table 21: Distribution of injuries and surgical problems

	Females (n= 573)		Males (n= 240)		Total (N = 813)			
	n	%	n	%	n	%	X^2	P-value
Injuries								
Fractures	74	13.9	40	17.8	114	15.0	1.91	0.17
Severe wound	58	10.9	29	12.7	87	11.4	0.52	0.47
Lost limp	34	6.3	17	7.5	51	6.7	0.34	0.56
Burn	48	9.0	18	7.9	66	8.7	0.23	0.63
Body parts cut	33	6.2	14	6.1	47	6.2	0.00	0.99
Surgical complaints								
Back ache	357	66.5	127	56.7	484	63.4	6.89	0.09
Joint pains	327	61	107	47.3	434	57	12.10	0.001*
Swelling of limbs	164	30.5	68	30.2	232	30.4	0.01	0.93
Swelling in groin/abdomen	94	17.5	39	17.1	133	17.4	0.02	0.89

* Statistically significant difference

Fractures were often old and the fact that they were not treated resulted into complications such as shortening of the limb, malunion (an incorrectly united fracture) or deformity.

Wounds were caused by gunshots or bomb blasts. Some wounds healed with large hypertrophic[2] scars, others were still dirty and chronically discharging. The discharging wounds were treated whereby foreign bodies were removed and all wounds were skin grafted[3] to enhance healing.

[2] Hypertrophic scars – skin scars that grow beyond the skin level of a particular body part

[3] Skin grafting is the surgical procedure where skin obtained from other areas of the body is used to cover a deficient area

Loss of limbs was attributed to crush injuries caused by gunshots, landmines, and grenades. Others had their limps deliberately amputated as part of torture. All surgeries were carried out successfully without any major complications. An additional survey of amputees would highlight and explore this problem properly so that artificial limbs could be provided.

Ears, noses, lips, fingers, forearm and breast were the mainly cut body parts in nearly equal proportions in both gender. The plastic surgeons were able to reconstruct only ears, noses and lips.

Survivors reported as their main physical complaints, backaches (63.4%) and joint pains (57%) with both these conditions reported more by women than men. The reason for these complaints included; living under harsh conditions such as carrying heavy loads, walking long distances and poor diets, exposing the body to excessive strain and wasting of the body's muscular-skeletal system.

Dr. Kitara checking on a patient after operation

5.3 Surgical Diagnoses

The surgical diagnoses of the survivors are presented in Table 22. These are divided into the ones which were directly caused by the violence experienced in a conflict situation and those which were indirectly caused by the conflict.

Table 22: Distribution of surgical diagnoses (N=117)

Diagnosis	n	%
Indirectly caused		
Herniorhaphy	31	35.2
Soft tissue Lump excisions and biopsies	26	29.5
Hydrocelectomy	13	14.7
Herniotomy	4	4.5
Knee Athrotomy	4	4.5
Thyrodectomy	3	3.4
Extradigit excision	2	2.3
Knee Aspiration	2	2.3
Eye evisceration	1	1.1
Undescended testes	1	1.1
Parotid cyst Excision	1	1.1
Directly caused		
Wound debridement	14	48.3
Contracture release	11	37.9
Laparotomy	1	3.4
Internal fixation facture	1	3.4
Skin grafting	1	3.4
Wound exploration(discharging sinus)	1	3.4

Eight (6.4%) of the patients were not treated due to lack of the necessary equipment. The diagnoses of those surgical cases were:

- Goitre (2 patients)
- Imperforate anus with colostomy (joining of two sections of intestines)
- Lymhoedema of scrotum
- Avascular necrosis of head of femur
- Benign prostatic enlargement
- Malunion tibio-fibular fracture
- Severe backache (did not need operation)

5.4 Health Seeking Behaviour for Surgical Problems

More than half of the respondents (56.3%) had sought treatment from the local health centers for their surgical problems. A considerable number of patients visited traditional healers (20.3%), and some survivors had never sought any treatment (18.4%). Only 3.6% of them went to the regional referral hospital where specialized surgical treatment can be offered. The reasons for the low attendance at the regional hospital included the still prevailing insecurity and the lack of transport money to undertake the journey.

Table 23: Health seeking behaviour for surgical problems (n=591)*

Treatment possibilities	n	%
Local Health Center	333	56.3
District Hospital	303	51.3
Traditional Healer	121	20.3
Not sought any treatment	108	18.4
Self medication	62	10.5
Gulu Referral Hospital	21	3.6

*Some respondents had tried more than one method.

This pattern of health seeking behavior reflects the poor surgical services in the region due to the ongoing war. Essential surgical treatment and care is hindered through the lack of skilled man-power, a destroyed infrastructure, unavailability and inadequacy of equipment and medication.

5.5 Training and Additional Support

Besides the surgical treatment, the surgical team was also able to give the following support

- Training local staff in surgical techniques which were not commonly done.
- An anaesthetic machine was repaired and the anaesthesiologist of the intervention team trained the local staff in how to maintain it properly.
- There were pulse oximeters in the theatre but they were not being used. The anaesthesiologist taught the anaesthetic officers how to use the machine.
- The anaesthetic officers were also taught how to use a T-piece for paediatric anaesthesia. The T- pieces were donated to the hospital by the anaesthesiologist.
- 14 victims injured in an ambush by armed men were brought at around 7pm when the team was still present. One victim was brought in severe shock due to intense bleeding. He was successfully resuscitated and the following day the intervention team assisted the local doctors in the

5.6 Conclusion

Most of the patients who received surgical treatment had diseases which were caused either directly or indirectly by the prolonged war in northern Uganda. Though 70 people were selected for surgery, an additional 55 people arrived for treatment indicating that there is still a large number of the population living in the camps in need of medical help. Most of the people are not able

to access health care because of the breakdown of the health system and limited financial resources.

The large number of people with surgical problems living in the camps shows a great need for sustainable medical interventions in this region. The lack of a functioning and accessible health system prevents the management of treatable diseases and therefore causes prolonged suffering.

Chapter Six

Impact of War on the Mental Health of Children

6.1 Introduction

Children in northern Uganda have been worst affected by the 20 year old conflict that has been raging in the region. As a result 25,000 children have been abducted into a life of forced brutality against their communities, forced to fight as child soldiers, sex slavery, forced marriage, forced impregnation, mutilation, porters and early death (Parliament of Uganda, 2004; Austrian Development Cooperation, 2004-2005; Isis-WICCE, 2004).

For fear of abduction, many of the children in the region have resorted to trekking every evening to the relative secure towns leading to the phenomena of the *''night commuters''*. Outside the protection of their families who have to remain in the IDP camps these children have fallen prey to rape, sexual seduction by adults and soldiers, HIV/AIDS infection and alcohol and drug abuse (The Monitor, 2004a; The New Vision, 2004a,c). However, at the time of the intervention the phenomenon of the *'night commuters'* in Kitgum town had gone down.

Trauma and insecurity in children damages their sense of the world around them and their sense of self (Pfefferbaum et al, 1997; Kocijan-Hercigonja et al, 1998a). The children and adolescents in Northern Uganda are now a whole generation of traumatized Ugandans (Derluyn et al, 2004). Traumatized children have a foreshortened sense of the future and because of this, are often unable to focus and plan for their future, often living one day at a time (Pfefferbaum et al, 1997). The memories and emotions associated with the conflict and trauma often lead to poor school performance (ibid).

Long-term exposure to trauma like that in Northern Uganda, often leads to behavioural problems like aggression, opposition, anxiety and depression among children and adolescents (Pfefferbaum et al, 1997; Kocijan-Hercigonja et al, 1998a; Kocijan-Hercigonja et al, 1998b). Since they are on a large scale, these may decrease the productivity of the community and increase violence.

The children that came for the intervention were often brought by their parents or guardians. They came for a variety of reasons ranging from mental retardation, which we were not able to do much about but give advice; uncontrolled epilepsy, infections and behavioural and emotional difficulties. Children more than often had more than one complaint. Most children and their parents interviewed had not been given a chance to tell their stories. They had suffered silently the devastating effects of the war on their health, having nowhere to turn to.

6.2 Methods

Children were initially screened by previously trained health workers. The Strength and Difficulties Questionnaire, a simple screening tool for psychological distress was used (Goodman, 2001). Children who were then suspected to have severe neuropsychiatric problems or behavioural problems (score of at least 15 on the Strength and Difficulties Questionnaire) were then seen by a psychiatrist for a more in depth interview and administration of a diagnostic semi-structured questionnaire, the Mini International Inventory for Children (Sheehan et al, 1998).

6.3 Results

Results of the psychiatric evaluation of the children were based on data from 183 children who were self referred following announcements that a team of doctors were coming to the camps. Twelve percent of these children had been abducted by rebels at some point in their lives. Female former abductees made up 54.5% of the abducted children.

All children regardless of their reason for coming for treatment were screened for psychological distress. Those found with symptoms suggestive of psychological distress were then assessed by a psychiatrist using a semi-structured diagnostic interview.

6.3.1 Experiences of Violence

Twelve percent of these children had been abducted by rebels at some point in their lives. Most children had experienced the violent death of a relative. Female former abductees made up 54.5% of the abducted children.

Table 24: Torture experiences of children

	Female (n= 89)		Male (n= 93)		Total (N= 182)	
	n	%	n	%	n	%
One Parent Killed	15	16.0	10	11.2	25	13.7
Both Parents Killed	2	2.1	4	4.5	6	3.3
Relative killed	71	54.2	60	45.8	131	71.6
Ever suffered from physical torture	27	28.7	23	25.8	50	27.3
Ever suffered from Psychological torture	36	38.3	30	33.7	66	36.1
Ever suffered from sexual torture	5	5.3	3	3.4	8	4.4

6.3.2 Gender

Even though of tender age, children in Mucwini and Padibe camps had not been spared torture. 28.7 % of the girl children had suffered from Physical torture compared to 25.8% of the males. Additionally, the girl child was more likely to have suffered psychological torture than the boy child. It should be pointed out that in the war in Northern Uganda, while children of both sexes are targets for rebel abductions, the girl child is more vulnerable and a bigger prize catch for the rebels than the boy child. Hence the likelihood for easier torture. Both sexes had been exposed to sexual torture. This is a very important finding. In many interventions for sexual violence in war areas, there is often a bias towards assessment of only the girl child. These findings show us that though the girl child is more sexually tortured (5.3%), the boys too are sexually tortured by rebels and need to be asked questions related to sexual torture.

Dr. Kizza interviewing a mother whose child has a mental problem

Table 25: Psychiatric and Other Psychosocial Problems among children.

	Female		Male		Total			
	n	%	n	%	n	%	X^2	p-value
Use of Substances of addiction Cigarettes	0	0.0	2	2.2	2	1.1		
Alcohol	6	6.4	8	9.0	14	7.7		
Khat/Mairungi	1	1.1	2	2.2	3	1.6	3.1	0.38
Non- users	87	92.6	77	86.5	164	89.6		
Alcohol dependent	2	2.1	2	2.2	4	2.2		
Lifetime Suicide Attempt	2	2.1	2	2.2	4	2.2	0.003	0.96
Has SDQ scores above 15	85	90.4	79	88.8	164	89.6	0.14	0.71

Substance use in the screened sample was high for the average age group. The most commonly used substance of abuse being alcohol. Alcohol is widely available in the camps. It is locally brewed and often takes the form of a potent poorly distilled spirit. Though culturally it is the men who often take a lot of alcohol, with the breakdown of cultural norms and social structures in the setting of a camp, it is evident that the girl child in this environment has become more vulnerable to alcohol and other substances of abuse. Indeed, for all substances of abuse except cigarettes, there was no difference in rates of use between the males and females.

The numbers of children with very high levels of psychological distress was staggering with 89.6% of the children having abnormal scores on the Strength and Difficulties Questionnaire. Although the sample was self referred, this could only partly explain the high frequency of those with abnormal scores. The psychological distress scores observed among these child survivors were a lot higher than even those seen in a sample of sick hospitalised children (Kizza, 2004). High rates of psychological distress have been documented in children in other conflict areas in the world. What is unique about these children in the camps is that the on going war, the uncertainty of peace and the gross disruption of the social structure by the crowded life of a camp make it almost impossible to have a semblance of normalcy. This in turn impairs the families' abilities to cope with the emotional and behavioural problems of the children as shown in table 26.

Table 26: Impairment as a result of psychological distress

	Not at all		Only a little		Quite a lot		A great deal	
	n	%	n	%	n	%	n	%
Psychological difficulties hurt or distress the child	13	7.9	17	10.4	59	36.0	11	6.7
Difficulties interfere with home life	9	5.5	21	12.8	33	20.1	35	21.3
Difficulties interfere with friendships	8	4.9	18	11.0	19	11.6	28	17.1
Difficulties interfere with classroom learning	8	4.9	6	3.7	12	7.3	26	15.9
Difficulties interfere with leisure activities	8	4.9	7	4.3	14	8.5	23	14.0
Difficulties put a burden on the family	10	6.1	17	10.4	25	15.2	45	27.4

This study also found that the psychological distress greatly affects the children's life, their learning and the functioning of their families. 41.4% of children had their difficulties interfering with their life at home while in 42.6% of respondents, the child's illness put a burden on the family. It can therefore be seen that the children's psychological distress has far reaching implications for the family and community as a whole. It puts a strain on the family and community's meagre resources. The lack of facilities to which parents could take the children for different services like mental health assessments and treatment was experienced by most parents as a very frustrating condition.

Children lining to see psychiatrist

6.3.3 Surgical and Gynaecological Problems

Of the 94 females screened, 13.8% had some form of gynaecological complaint. Common complaints included chronic lower abdominal pain, genital sores, vaginal/perineal tears and abnormal vaginal discharge. The complaints of chronic lower abdominal pain were mostly found in children that had been formally abducted. Surgical complaints were more common in the male children. However, joint pains and broken bones were more common among the girls. The reasons for markedly higher numbers of the girl child with more fractures and more joint pain were not explored in this intervention. It was notable that some children had had parts of their bodies forcefully cut. This was done especially as part of physical torture when they were abducted.

Table 27: Relat ionship between psychological distress and socio-demographic factors

	Cases		Non-cases			
	n	%	n	%	X^2	p-value
Gender Female	85	90.4	9	9.6	0.14	0.17
Male Age Group	79	88.8	10	11.2		
Under 5 5-9 10-14 15-18	38 59 40 18	92.7 92.2 83.3 94.7	3 5 8 1	7.3 7.8 16.7 5.3	3.55	0.32
Marital Status Never Married Married/Co-habiting Monogamous	156 8	90.2 80.0	17 2	9.8 20.0	1.05	0.31
Highest Educational Attainment No formal education Primary Level Senior 1-4	58 60 2	92.1 85.7 100.0	5 10 0	7.9 14.3 0.0	1.16	0.45

None of the socio-demographic factors was **statistically significantly** associated with psychological distress.

Table 28: Relationship between psychological distress and other psychosocial factors

	Cases		Non-cases			
	n	%	n	%	X^2	p-value
Use of Substances of abuse						
Cigarettes	2	100.0	0	0.0		
Alcohol	13	92.9	1	7.1		
Khat/Mairungi	2	66.7	1	33.3	2.09	0.55
Non- users	147	89.6	17	10.4		
Alcohol dependent (CAGE positive)	3	75.0	1	25.0	0.94	0.33
Lifetime Suicide Attempt[t]	4	100.0	0	0.0		1.00
One Parent killed	23	92.0	2	8.0	0.81	0.67
Both parents killed[t]	6	100.0	0	0.0		1.00
Ever suffered physical torture	44	88.0	6	12.0	0.19	0.66
Ever suffered psychological torture	64	97.0	2	3.0	6.00	0.01
Ever suffered sexual torture[w]	6	75.0	2	25.0	1.92	0.17
At least one surgical complaint	55	85.9	9	14.1	1.43	0.23
At least one gynaecological complaint.	11	84.6	2	15.4	0.59	0.44

[t] *Fischer's exact test used.*
[w] *Analysed only for the girl child.*

The only factor found to be significantly associated with psychological distress among this group of children was having suffered psychological torture.

Fifty one children were reviewed by the psychiatrist during the intervention. These were children whom the trained health workers found to have severe behavioural health problems that were disruptive to the community and families.

Table 29: Diagnoses of Children seen by Psychiatrist. N=50

Disorder	n	%
Emotional Disorder following trauma(Unclassified)	25	49
Mental Retardation	13	25.5
Choreoathetosis	1	2.0
Major Depressive Disorder	2	3.9
Suicide risk	2	3.9
Post Traumatic Stress Disorder	2	3.9
Conduct Disorder	2	3.9
Psychotic Disorder	2	3.9
Generalised Anxiety Disorder	1	2.0

Forty nine percent of children seen by the psychiatrist had non specific emotional reactions to trauma. Most of these children had a mixture of a variety of symptoms that did not meet specific DSM-IV criteria but were sufficient to disrupt a child's functioning. Such symptoms have also been described in other children affected by long standing war trauma including in Northern Uganda (Kocijan-Hercigonja et al, 1998a; Kocijan-Hercigonja et al, 1998b; Derluyn et al, 2004). Children who fear for their own personal safety and that of their family, who experience the loss of a loved one, whose house or other property such as livestock and crops are destroyed, witness a death or a dead body, and who have been injured or raped during the war are at an increasingly higher risk for developing PTSD and other emotional disorders(Kocijan-Hercigonja et al, 1998a; Kocijan-Hercigonja et al, 1998b). The children in these camps still live in fear of all these possibilities. Hence we see very high numbers of children with various non-specific emotional and behavioral difficulties and definite psychiatric diagnoses.

The high numbers of children with mental retardation were of particular concern. Most of the developmental delay had been as a result of preventable or easily treatable conditions like malaria and epilepsy. However, due to the paucity of health services in these camps, these often went untreated resulting in permanent brain damage to the children.

A young child with a natural retardation

6.3.5 Previous Health Seeking Behaviour

Only 1.8 percent of those that had significant psychological distress had not sought treatment or services for the child's illness. 40.9% had been to the camp health center in search of help. Unfortunately, the camp health centres do not have any one with the skills to recognise or help especially women and children that have been traumatised. The health centres also do not have any mental or psychological health services. About thirty percent had been to traditional healers and another thirty percent to the district hospital. Only 3 percent had been to the regional referral hospital which is the only place with mental health services at the moment. Many parents had sought help from several of these sources to no avail.

6.4 Recommendations

1. Given that many survivors seek help from the health centres and referral hospitals, specialised services for trauma need to be developed at these centres. These would provide more long term interventions to the communities.

2. Training of trainers needs to be done for local child counsellors and gender sensitive trauma counsellors.

3. An easy to use, culturally appropriate and child friendly method of trauma counselling should be taught to some members of the community to help children who have experienced torture and other forms of trauma. Such children would be easily identified by family/community members referred to a community resource person(counsellor) for early intervention.

4. Reproductive health services for children need to be established within the internally displaced people's camps.

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Appendix: Definition of Terms

1. *Torture*

The World Medical Association's Tokyo Declaration of 1975, defined Torture as "the deliberate systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession or for any other reason" (IRCT/RRCTV, 1995).

2. *War Trauma*

A life threatening experience to one's life or the life of a loved one in a situation of armed conflict. This experience may lead to negative physical, psychological and social consequences (Arcel, 1998).

3. *Purpose of torture*

In earlier times the main purpose of torture was to get information or a confession, to punish or to terrorise (IRCT/RRCTV, 1995). Today, particularly in low income countries, including Sub-Saharan Africa, the purpose of torture is political; to destroy the individual or to break them spiritually and then use the broken person as an example to spread terror throughout the rest of the community (Zwi et al, 1989 and IRCT/RRCTV, 1995).

4. *Methods of torture*

The methods of torture are either physical or psychological. It is however, worth noting that the physical methods of torture oftentimes lead to psychological sequelae. The methods of torture are predominantly similar throughout the world with some regional differences. The physical methods include systematic beating and kicking, rape, burning, bayonet injuries, forced hard labour, deprivation of food, water and medicine (Musisi et.al,1999 and 2000).

The psychological methods of torture are primarily aimed at the mind of the victim and include verbal threats, attempted rape, interrogations, mock executions, detention, being forced to flee and live in the bush or in displacement, false accusation, abductions, forced to witness the killing or torture of others and destruction and or stealing of property (Musisi, et al, 1999 and 2000).

In Uganda the regional specific methods of torture include a severe form of tying called the "Kandoya" which is used in the Great Lakes Region (Musisi et.al, 2000 and Kinyanda et.al,

2000). In the "Kandoya" method of tying, the arms are flexed at the elbow, are tied behind the victims' back with the ropes going through the mid arm section and tightened until the elbows meet. This physical form of torture results in neuromuscular damage of the arms, anterior chest wall, and forearms with the victim later unable to use their hands (Musisi & Kinyanda, et. al, 2000).

5. Psychological Consequences (Squeal) of Torture.

Torture leads to psychological and physical disorders (Musisi et. al. 1999; Skylv 1992; McNally, 1992 and Kadenic, 1998). The most commonly recognised psychological disorder of torture is the Post Traumatic Stress Disorder or (P.T.S.D) (Tomb, 1994; American Psychiatric Association, 2000). P.T.S.D. follows a traumatic event that is characterised by actual or threatened death or serious injury or a threat to the physical integrity of self or others. The person's response to this traumatic event usually involves intense fear, helplessness or horror.

6. Psychiatric diagnoses most commonly found in war torn areas

Post Traumatic Stress Disorder (PTSD)

Posttraumatic stress disorder is characterised by three clusters of symptoms namely:

Symptoms of persistently RE-EXPERIENCING of the traumatic event in form of flashbacks, (film of the event), recurrent distressing dreams of the event (nightmares) and psychological distress at reminders of the trauma (e.g. soldier's uniform).

The second clusters of symptoms are persistent AVOIDANCE of stimuli associated with those of the trauma. This may take the form of avoidance of thoughts, places and activities that are reminders of the traumatic event.

Lastly, there is the cluster of symptoms of persistently INCREASED PHYSIOLOGICAL AROUSAL, which may take the form of difficulty falling asleep, irritability or out-bursts of anger, difficulty concentrating, exaggerated startle response and hyper vigilance (Tomb, 1994; American Psychiatric Association; 2000).

Like many psychiatric disorders posttraumatic stress disorder commonly presents in conjunction with other disorders (McNally, 1992). The most common co-morbid psychiatric disorders associated with P.T.S.D. are; depression, the anxiety disorders, alcohol abuse, somatoform disorder and personality changes (Musisi et al, 1999; Kinyanda et al, 2000; McNally, 1992; Tomb, 1994).

Depression

Depression is a psychiatric disorder that is characterised by the following symptoms: sad mood, reduced interest in formerly pleasurable activities, poor sleep, loss of energy, feelings of worthlessness, feeling excessively or inappropriately guilty, poor concentration, recurrent thoughts of death or suicidal plans or even suicidal attempts (DSM IV-TR American Psychiatric Association, 2000).

Anxiety Disorders

This is a group of disorders that are characterised by symptoms of excessive apprehensive expectation, worry – with person's experiencing difficulty controlling the worry, symptoms of restlessness, feeling on the edge, being easily fatigued, difficulty in concentrating, being irritable, muscle tension and sleep disturbance. The anxiety disorders include generalised anxiety disorder, panic disorder, social phobia, and agoraphobia (DSM IV-TR American Psychiatric Association, 2000 and United Nations High Commissioner for Human Rights, 1999).

Generalised Anxiety Disorder

In generalised anxiety disorder, the above symptoms under anxiety are persistently experienced.
Experiencing these symptoms is not restricted to particular social events or environments (DSM IV-TR American Psychiatric Association, 2000 and United Nation High Commissioner for Human Rights, 1999).

Panic Disorder

In panic disorder the individual experiences the above anxiety symptoms in sudden attacks. The anxiety symptoms in panic anxiety build up quickly and suddenly in the individual creating a fear of a catastrophic outcome. The patient gets rapid over breathing resulting in dizziness, ringing sounds in the ear, headaches, feeling weak and tingling sensation in the feet and arms and discomfort in the heart region of the chest. The individual usually interprets the latter sign as an impending "heart attack". These symptoms usually resolve much more slowly within an hour with the individual being symptom free in between attacks (DSM IV-TR American Psychiatric Association, 2000 and United Nation High Commissioner for Human Rights, 1999).

Social Phobia

In this disorder, anxiety symptoms are experienced in situations in which a person may be observed and criticized such as going to restaurants, parties and community meeting. Social phobic people tend to avoid such situations with anticipation of going to such places capable of provoking anxiety symptoms (DSM IV-TR American Psychiatric Association, 2000 and United Nation High Commissioner for Human Rights, 1999).

Agoraphobia

Persons with this disorder experience anxiety symptoms when they are away from home, in crowds or in situations in which then cannot easily leave. Such anxiety provoking situations include being on buses, trains, places that cannot be left suddenly such as crowded markets, and supermarkets. In these circumstances, the symptoms experienced are similar to those of other anxiety disorders. As this condition progresses, the individuals become confined to their homes and become house bound (DSM IV-TR American Psychiatric Association, 2000 and United Nation High Commissioner for Human Rights, 1999).

Somatoform Disorder

This disorder is characterised by multiple physical complaints suggesting a physical disorder but for which there is no demonstrable organic basis. For example, a person who was subject to multiple rapes by her torturers may report continuous lower abdominal pain despite not having any evidence on examination of any gynaecological problem. The underlying problem in somatoform disorder is psychological. The somatoform symptoms reported in the A.C.T.V. Ugandan study included; chronic headaches, musculo-skeletal aches, pains and fatigue, recurrent "fever" complaints, chronic lower abdominal pain (Musisi, et al, 2000).

Alcohol Abuse

This refers to any mental, physical or social harm resulting from excessive alcohol consumption. The physical problems that may result from alcohol abuse include liver disease such as cirrhosis, cardiac disease and diseases of the nerves. The mental illnesses that may result from excessive alcohol consumption include psychosis (madness) delirium and amnesia (black outs). Excessive alcohol abuse may also result in social problems such as – neglect of family, impaired occupational functioning and domestic violence (American Psychiatric Association, 2000 and United Nations High Commissioner for Human Rights, 1999).

Alcohol abuse disorders are known to be associated with post-traumatic stress disorder (McNally, 1992).

Psychosis

This is a mental disorder characterised by hearing voices or seeing things from without. Often the patients don't make sense in their speech and their behaviour and self-care is grossly disturbed.

7. Gender and the Psychological (Consequences) of Torture

Gender has an important bearing on torture phenomenology. The female gender appears to determine the methods of torture used and later the psychological complications experienced by the victims of torture (Paker, et al, 1992; Allodi, 1990). Physical torture in women is frequently directed at their sexuality in form of rape (Paker et al, 1992; Allodi, 1990). Women also tend to be subjected to the more psychological methods of torture as compared to men (Pakeret al, 1992; and Allodi et al, 1990). The psychological methods of torture to which women are subject to often take the form of sexual humiliation and abuse – short of rape per se (IRCT/RRCTV, 1995) e.g. nakedification (i.e. being stripped naked in public).

The psychological complications reported by women also differ from those reported by men, with women suffering from a wider range of psychosomatic problems (somatisations) and sexual dysfunction (Paker et al, 1992; and Allodi et al, 1990).

8. Co-morbidity

This is the occurrence of one psychiatric disorder in combination with another.

The co-morbid psychiatric disorders associated with post-traumatic stress disorder tend to differ between the sexes (McNally, 1992 and Paker et al, 1992). In women, the most common psychiatric disorders are depression, generalised anxiety disorder, alcohol abuse and panic disorder, (McNally, 1992). In men the most common comorbid disorders are alcohol abuse depression and generalised anxiety disorder and antisocial personality disorder, (McNally, 1992).

9. Perpetrator

This is the individual who carries out the traumatisation itself including the collaborator in the torture.