

## REPORT ON THE CLINICAL MANGEMENT OF RAPE ASSESSMENT FOR NORTHER AND NORTH EASTERN UGANDA

### Introduction and Background

The IASC gender-based violence sub-cluster undertook an assessment on clinical management of rape in order to identify existing GBV health response related capacities and gaps. The clinical management of rape assessment was organised and carried out with the intention that the findings would inform recovery and development priorities and planning processes for 2009-2010. And, in addition the report will further inform decision makers on additional next steps / action needed to improve and strengthen access to life saving clinical care for survivors of sexual violence; thereby decreasing the chances of spreading HIV/AIDs, other STIs, reducing the chances of unwanted pregnancies as well as minimizing health and psychosocial consequences often faced by survivors of sexual violence.

GBV health related response gaps have been highlighted in Acholi sub-region and in Moroto District, including service providing NGOs, district health officials, UN agencies and related stakeholders on the ground. For the past one or more years, a number of concerns have been noted by GBV sub cluster members - some of which included absence or shortage of trained medical personnel on clinical management of rape, absence/shortage of drugs and equipment for GBV survivors, lack of confidence by trained medical personnel to implement the skills learnt in the clinical management of rape training, lack of knowledge of available medical services by GBV survivors thereby minimizing utilization of the available medical services by GBV survivors and - last but not least - a lack of clarity among medical personnel related to authorized or recognized medical personnel in filling out Police Form 3 (the form that is used to document medical findings that are tendered as evidence in a court of law.)

Recently during CAP 2009 planning, multi-sectoral actors were again reminded of the lack of data and information available on clinical management of rape resources/supplies and services in Acholi sub-region and in Moroto district. These assessments were therefore undertaken with a purpose of assessing realities on drugs and supplies; the quality of health services available to survivors of sexual violence; as well as the capacity of health workers in following clinical management of rape protocols and procedures at district and sub county levels. The assessments looked at protocols, personnel, furniture setting, supplies, drugs and administrative supplies considered to be the minimum care for rape survivors in low resource settings.

UNFPA took the lead to conduct these assessments to determine the gaps and capacities that exist and make recommendations for improving this service in 2009. The assessment was also necessitated by the need to measure the indicator that the GBV sub cluster has included in CAP 2009 which captures the percentage of GBV survivors reporting for post rape care / medical services at health facilities that successfully receive post rape care. The information collected on this assessment will therefore supplement the baseline data that already exists for this indicator.

## **I. Objectives of the Assessment**

1. To assess and understand the status of the available minimum care health services for survivors of sexual and gender based violence.
2. Based on the health situation findings (capacities and gaps) make recommendations for improving the situation

## **II. Methodology**

Staff members from UNFPA, WHO, CARE, the district gender officers and health staff from the District health Offices went up as teams to health centres to conduct the assessment. The health centres were randomly and focused on health centre II and III. The questionnaire that was administered is the WHO Questionnaire on Assessment of clinical management of rape survivors for low resource settings. The assessment teams conducted interviews with health workers at the health centres. They also made observations on filing systems and set up for the examination rooms. As in all assessments this assessment had its limitations. The main limitation of this assessment was that it could not go to all health centres in the districts but relied on a sample to come up with general findings and recommendations. Although this was an inter agency activity the final report was compiled and finalized by technical staff of UNFPA.

## **III. Scope of the Assessment**

In **Amuru** District a total of 7 health centres were assessed. These are:

1. Awer HC II,
2. Kaladima HC III,
3. Anaka Hospital,
4. Purongo HCIII,
5. Alero HCII,
6. Langol HC II,
7. Pabbo HCIII

In **Gulu** a total of 13 health centres were assessed. These are as follows:

1. Palenga HC II
2. Bardege HC III
3. Pabwor HCIII
4. Ocit HC III
5. Lalogi HV IV
6. Bobi HC III
7. Koro Abili HCII
8. Labworomor HC
9. Patiko HC III

10. Awach HC IV
11. Gwero HC III
12. Kal AL HC II
13. Unyama HC 11

### **Kitgum**

Kitgum district has about 19 sub-counties; the assessment was conducted in 17 sub counties. The Health centers included:

1. Ogili Health Center iii
2. Palabek Kal Health Center iii
3. Palabek Gem Health Center iii
4. Payimo Health Center iii
5. Okidi
6. Lokung Health Center iii
7. Padibe Health Center iv
8. Madi Opei Health Center iv
9. Mucwini Health Center
10. N-Health Center iv
11. Lagoro Health Center iii
12. O-Nyima Health Center iii
13. K-Matidi Health Center iii
14. Lobo-rom Health Center iii
15. Agoro Health Center iii
16. Paloga Health Center iii

### **Pader**

Pader has 19 sub-counties with 46 functional health centers. Out of them 13% of the health centers were provided with PEP. The assessment was conducted only in 6 health facilities: Pajule Health center IV, Atanga Health center III, Awere Health center III, Patongo Health center III, Kalongo hospital, and Puranga health center III.

## **Moroto**

The assessment was carried out in 7 health units, including Moroto Hospital, Matany Hospital, Nadunget HC III, Kangole HC III, Irir HC III, Lorengecora HC III and Moroto DHHs HC II, representing 37% of the total of 19 health units in the district.

### **IV. Findings**

#### **a. Protocol**

**Amuru:** 57% did not have written protocol while 43% did have written protocols in the language of the provider.

**Gulu:** 46% had protocol written in language of provider.

**Kitgum:** 31% of the health centers (Ilo-Ilo, Palabek Kal, Palabek Gem, Padibe West and East, Agoro, IRC supported) had a written medical protocol in the language of provider.

**Pader:** None of the six health centers had a protocol for handling the survivors of GBV. The main doctor in Pajule was planning to develop one for the health staff.

**Moroto:** None of the HCs visited had a written protocol in language of the provider. The DHO also reinforced this finding in saying that all other HCs in the district lacked on this.

#### **b. Personnel**

**Amuru:** 43% of the health centres did not have any trained staff while 57% have trained staff on call 24 hours a day.

**Gulu:** 77% have trained staff on call 24 hours. The number of staff ranges from 1 to 8 trained professionals. 1 out of the 13 HC trained staff was transferred. 2 out of 13 or 15% completely had no trained staff.

**Kitgum:** 15% health care providers in the 16 health centers assessed had received training in clinical management of rape all trained by IRC.

**Pader:** 100% had at least one trained health worker trained on CMR. However most of the health workers confessed to having little confidence or practical knowledge in administration of PEP. And all the health centers have a staff 24hours on call, though not specifically for survivors, but can help to coordinate with in -charges in case a survivor is brought for medical attention, unless the health worker in charge is not around.

**Moroto:** Other than the two hospitals of Moroto and Matany, and 2 HCs III, which had less than 3 trained health care professionals on call 24 hours a day (not specific to handle rape cases), the rest of

the HCs had generally no trained health care professionals. The situation is even worse in HCs II. All over the district, information available in DHO reveals as few as 10 health professionals trained on administration of PEP (by IRC).

### c. Furniture/Setting

**Amuru:** 86% health centers had over 90% of the required furniture and settings, while only 14% had less than 50% of the required furniture.

**Gulu:** 77% of the health centres have adequate furniture required, while 23% do not have. Noteworthy is the fact that the health centres who responded that they have the lighting required relied on natural light more than the fixed one.

**Kitgum:** 11 out of 16 (69%) health centers reported having a private room where they could meet to provide the survivor counseling and any other information while 12/16 (75%) reported having an examination table.

Regarding furniture/setting only Agoro Sub County out of the 16 had the whole set as per the check list. Five health facilities out of 16 (31%) had lighting system in form of a torch or lamp. Regarding access to autoclave to sterilize equipment, only 9/16 (56%) had access. The remaining of the health centers said they lacked either paraffin or a stove to sterilize the equipment.

**Pader:** All (100% of) the health centers carry out the examination of survivors in the maternity ward and use the maternity equipments like examination table, room, and light, sterilizers, weighing scales and height chart for children. None of the health centers have magnifying glasses and no private toilets for survivors. Atanga health center lacks reliable power source.

**Moroto:** All HCs III carry out the examination of survivors in the maternity ward and use maternity ward equipment, including examination table, touches and autoclave. All other HCs however lack these equipments save only the two hospitals.

### d. Supplies

**Amuru:** 6 out of 7 or (86%) did not have supplies while only one (14%) had more than half of the supplies.

**Gulu:** investigations were made on the availability of such supplies as rape kits, speculum, tape measures, replacement clothes, needles and syringes, gown/cloth to cover survivor during examination, sanitary supplies, and resuscitation equipment for anaphylactic reactions and supplies for universal precautions. 7 out of 13 or 54% of the health centres had 50% or more of the required supplies. 6 out of 13 or 46% have less than half of the supplies required.

**Kitgum:** 33% of the 16 health centers assessed had some of the supplies included on the rape kit. None of the health center had a complete set; Paloga had 9 out of 10, followed by Agoro 8 out of 10 of the supplies. The rest of the health centers either had only one or two items as indicated on the checklist.

**Pader:** Most of the health centers lack most of the supplies in a rape kit. 90% of the health centers lack items like glass slides, combs, and speculum (plastic), paper bags for debris, tape measures, paper bag for collecting evidence, paper tape for sealing, cotton-tipped swap, and laboratory container for transportation of swaps.

**Moroto:** Supplies were generally lacking in all the HCs visited. PEP kits were not available in any of the HCs visited, save only in the two hospitals of Moroto and Matany. Sanitary supplies, supplies for universal precautions, rape kit for collection of forensic evidence and resuscitation equipment were not available.

**e. Drugs** *The drugs investigated are for treatment of STI, PEP, emergency contraceptive pills and or IUD, for pain relief, local anesthetic for suturing and antibiotic for wound care*

**Amuru:** PEP: 4 out of 7 (57%) had PEP while 3 out of 7 (43%) did not have PEP. Other drugs: 100% of the health centres had more than 90% of the other drugs

**Gulu:** All the health centres 100% reported that they had the listed drugs. In 46% of the health centres it was reported that the PEP they had had expired while 3 out of 13 or 23% reported that they did not have PEP.

**Kitgum:** 5 out of 16 (31%) (Paloga, Agoro, Lobo Rom, Ogili, Palabek Gem) health centers had all the drugs as per the check list. 9/16 health centers had PEP (56%) where as 8 out of 16 (50%) had ECP/IUD. 15 out of 16 had pain relief dugs (94%) while 12 out of 16 (75%) had local anesthetic for suturing. Only four of the health centers reported to be out of stock for antibiotics.

**Pader:** 50% of the health centers had PEP out of stock (Pajule, Atanga and Patongo), however when they had PEP, survivors were accessing it; they have to now refer to health centers with PEP like Kalongo hospital. 33% of the health center had PEP but no laboratory assistant/Officer to help in pre-testing of the survivors before administration of PEP (Puranga and Awere) and Awere health unit had expired PEP due to Lack of laboratory assistants in the unit.

**Moroto:** None of the HCs visited had PEP kits/drugs, apart from only Moroto Hospital which had few. Only 50% of the HCs III had a few drugs for treatment of STIs, emergency contraceptive pills, antibiotics for wound care, and pain relief drugs.

**f. Administrative Supplies** *the availability of medical charts with pictograms, consent forms; information pamphlet for post rape care and safe lockable filing cabinets for record keeping that was asked for.*

**Amuru:** 0% of the health centres assessed had the required administrative supplies.

**Gulu:** 3 out of 13 (23%) reported that they had more than three quarters of the required administrative supplies while 77% of the health centres had less than half of the required supplies

**Kitgum:** 2 out of 16 (12%) reported having a whole range of administrative supplies as per check list while 7 out of 16 (44%) of the health centers had none. 5 out of 16 (31%) had some aspects.

## V. Summary of findings

1. An average of 26% of the health centres (Gulu, Amuru, Pader, Kitgum and Moroto) have a written protocol on handling GBV survivors
2. An average of 50% of the health centres have at least one person trained on clinical management of rape. The worst case is in Moroto where only four health centres had trained staff.
3. On furniture and settings required almost all health centers assessed had the basic minimum of required furniture
4. An average of 70% of the health centres that were assessed lacked the drugs required to respond to sexual violence in a low resource setting (PEP, emergency contraceptive, antibiotic, drugs for treatment of STI, dressing for wounds etc)
5. An average of 74% of the health centres assessed did not have the administrative supplies required.

## VI. Major challenges Faced by the health centers.

1. Most survivors are brought to the health center after 72 hours (too late for PEP drugs to prevent unwanted pregnancy or HIV/AIDs and other STIs). The major reason is that most parents do not understand the health risks of rape. They prefer pursuing the legal justice or traditional courts where the parents can demand for compensation. Health centers are usually accessed when the negotiations at the family level fail, or when they have spent a lot of time with going up and down the police stations.

2. Transportation of evidence from health centers to police or courts is a challenge. There is a real fear by survivors that evidence is tampered with. There have been cases where allegations have been made that police tamper with evidence when bribed by accused persons.

3. There is a serious shortage of staff who are trained on clinical management of rape. Where staff have been trained they do not stay for long at the health centers as they get transferred or move to other better duty stations. In the absence of the trained staff, it becomes difficult to help the survivor, and she has to be referred to other health center with trained staff, resulting in delays in accessing the life saving drugs.

4. In some health centers it was reported that PEP expired due to low utilization by rape survivors, while in other cases the health staff confessed that they were not confident enough to conduct the examination, document the findings and administer PEP. In other cases it was fear of getting involved in lengthy and complicated legal processes that reportedly prevented the health staff from helping rape survivors.

5. Another complication is that where the law requires a competent/qualified health professional to collect and document evidence of sexual violence on a rape survivor, this has been generally taken to mean only a doctor can carry out this process. The reality on the ground however is that most health centers do not have doctors and in the case of Pader, there is only one doctor for the whole district. In Pader like most in most health centers it is difficult to get a health staff member at the health center, resulting in delayed access to PEP for survivors.

6. In all the cases reported no follow up services was provided on the survivor on PEP to ensure adherence to taking of medication. It was also reported in all the health centers that survivors generally do not come back to the health centre after initial consultation so there is no way to determine the effectiveness of PEP.

7. There is no proper record keeping by health centers of the GBV cases they attend to, in this assessment it was not immediately available how many cases each health centre had handled for the year and they pointed out that they had no system in place to monitor.

8. Communities still lack knowledge of the health services available. They opt for legal services (traditional or formal) where they can be able to get some compensation for the harm suffered.

## **VII. Summary of Conclusions and recommendations**

1. It is evident that from the sample of health centers assessed there is a major gap in terms of availability of drugs, supplies and equipment in most health centers in Northern Uganda and Moroto. Given that the drugs are supposed to be life saving the erratic way in which they are found at the health centers is unacceptable. There is therefore need to ensure the basic or minimum package for managing rape is available at every health centre (Level II upwards). Partners need to come in to fill in this gap working closely with district health officers to identify the health centers most in need and then distribute jointly with them. The District needs to be firmly on board in the monitoring of equipment and supplies, and should work with partners to ensure that the stock out situations is minimized.
2. Secondly the shortage of trained staff and their retention presents a big problem for clinical management of rape. The issue of unauthorized absence from the duty station

by some health staff members is also of big concern. While contributions to training and capacity building of health care staff to provide this service, Government needs to be continually engaged on strategies for the retention of staff based in Northern Uganda.

3. Capacity building of health staff on clinical management of rape needs to address issues of lack of confidence that is reported by health staff. Training needs to address the challenges that health care providers face in examination, and documentation of sexual violence findings and assist them to overcome these.
4. Civil society partners need to continuously engage with policy makers for the issuance of clear practice guidelines by Ministry of Health and Ministry of Justice to do away with current confusion which reigns on who is authorized to examine a rape survivor and give evidence in court. While some districts have gone ahead and sought district specific guidance, it is still imperative to get intervention and guidance at the national level in order to get consistency in the application of the law. Partners who participate in the JLOS forums need to highlight this issue with their counterparts while UN agencies need to engage in high level discussions with the Ministries concerned for a resolution of this area of uncertainty. It is also highly recommended that the level of personnel authorized to conduct an examination on a rape survivor and testify in court should be reviewed and take into account the challenges that exist on the ground, especially in the north where a whole district can have one doctor only, as in the case of Pader. This effectively denies survivors access to justice because it is virtually impossible to get one doctor to attend to survivors of sexual violence. In this regard lessons learnt from other countries in the region like Kenya and Zambia can be referred to for persuasion (where clinical officers and midwives trained on clinical management of rape are allowed to conduct the examination and document the findings)
5. Members of the public still lack appreciation and knowledge on why a survivor of rape or defilement needs to get medical attention as fast as possible. This is evidenced by the discrepancy that exists between the number of cases reported for defilement/rape in a district and the number of cases actually accessing PEP. Civil society partners working with communities therefore need to ensure that when they engage with the communities they bring this message on board and encourage them to support survivors by taking them for medical care with no delay.
6. Support for PEP to the health centers need to be closely tied in with capacity strengthening for documentation and record keeping. The partners supporting CMR need to agree with the DHOs of their respective districts on a system to be used by health centers for documenting all cases of gender based violence, especially sexual violence, that come to them for health care.

7. Last but not least the issue of adherence to taking PEP medication needs to be addressed. Currently there is no system of support to those survivors taking medication, so adherence challenges remain unaddressed. A system of support (possibly by social workers already working with GBV survivors) needs to be put in place to provide the support and follow up of survivors. This way actors can be certain to some extent that the provision of PEP is making a difference in the lives of the survivors.

#### **Annex A: Assessment Team Members**

Kitgum: a team of 4 -members from, Kitgum District Local Government, UNFPA and KIWEPI participated in the exercise. The assessment was conducted 5-12 September 2008.

Pader: a team of 4 - from the World Health Organization, District Health Officers, District Gender Officer and UNFPA.

Gulu and Amuru: a team of four from UNFPA, CARE, and the DHV seconded by the office of the DHO to the team

Moroto; Information not available

In Moroto, the assessment was carried out jointly with the DHO, WHO, DGO and UNFPA.

#### **Annex B: World Health Organization Minimum Care for Rape Survivors in Low Resource Settings – Checklist of Supplies**