

“Obstacles for survivors of Gender Based Violence in accessing Health Care and Legal Redress²”

1. Introduction

Despite the efforts from the Ministry of Health, MoGLSD and the broader humanitarian community, survivors of GBV continue to have their rights violated not only during the incident itself but thereafter while seeking medical care and access to justice. According to the Uganda Demographic Health Survey of 2006, over 60% of women aged 15-49 years experienced physical violence, 39% experienced sexual violence and 16% experienced violence during pregnancy. Amongst ever married women, 48% were physically violated by their husband or former husband. In Gulu, service providers received approximately 880 cases of gender-based violence in ten months. In Pader, service providers received approximately 960 cases in the same period. While this document focuses on the situation in Northern Uganda, many of the issues raised also apply to the country as a whole.

In selected districts in Northern Uganda GBV service provision has drastically increased³. Despite the progress, women and girls who suffer GBV are still facing numerous overwhelming obstacles hampering or denying them their basic rights. Whereas sustained advocacy efforts and initiatives by the humanitarian community have taken place in various districts in Northern Uganda with senior and technical district officials, including law enforcement and health officers; many district officials and service providers are themselves requesting clarification on processes and procedures linked to GBV cases.

Sovereign states have a responsibility to protect their own citizens from avoidable catastrophe, which includes sexual and gender-based violence. Therefore, it is critical that the relevant State authorities provide rights-based clarifications and guidance to all districts and sub-districts that survivors of gender-based violence receive free and timely medical services and legal redress as outlined in national and international law and policies.⁴

This background note outlines a number of key issues and selected recommendations. This list is not exhaustive, but highlights a number of prime concerns. The recommendations have been aligned with the Peace, Recovery and Development Plan for Northern Uganda (PRDP) 2007-2011; in order to facilitate further discussion of these recommendations in the context of the PRDP operational plans.

¹ The GBV sub-cluster has not restricted membership and since mid-2006 has engaged all key humanitarian partners, including the Government of Uganda. There is active membership of all relevant UN agencies in the cluster (UNICEF, UNHCR, OHCHR, UNFPA, WHO, UNIFEM, UNDP, WFP), International Organisations (ICRC, IOM), as well as all international and national NGOs implementing GBV or GBV-related projects including CARE, CRS, IRC, ARC, CCF, COOPI, NRC, MSF (Holland, Spain, Swiss and France), ACORD, War Child Holland and Canada, Save the Children in Uganda, World Vision, AVSI, JRS, FIDA, Marie Stopes, Hope After Rape, KICWA, CPA, JPC, Caritas, CCF (Pader), CPAR, HIDO, URCS, YSA. The Ministries of Health and Gender, Labour and Social Development participate in coordination at national and district level and representatives of the Uganda Police Force are involved in coordination meetings and cluster initiatives at district level.

² The following note is based on reports from multi-sectoral service providers and relevant agencies and in consultation with government counterparts and community members themselves.

³ The CAP 2008 reports the following figures for the percentage of sub-counties with functional service delivery systems for GBV survivors : Amuru 75%, Gulu 63%, Kitgum 47%, Pader 31% and Lira 21%.

⁴ "The African Charter on Human and Peoples' Rights," Articles 16 and 18, ratified by Uganda on 21 October 1986; "the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa," Articles 4, 5, 8, 11, and 14, signed 18 December 2003 (not ratified); "Convention on the Rights of the Child," Articles 3, 4, 19, 36, 39, ratified 16 September 1990 ; "Convention on the Elimination of All Forms of Discrimination against Women," Article 14(2)b, 21 August 1985; "Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power," Articles 4 and 14, adopted by UN General Assembly 29 November 1985, "the Constitution of Uganda," Articles 44 and 50, 8 October 1995. Article 33 (6) of the constitution of the republic of Uganda: Laws, cultures, customs or traditions which are against the dignity, welfare or interest of women or which undermine their status are prohibited. Article 2 (f) of the Convention of the Elimination of Discrimination against Women: To take all appropriate measures including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

2. Key issues

While there are many obstacles faced by GBV survivors country-wide, below are a number of key considerations, as documented by GBV sub-cluster members, community members and service providers in Northern Uganda.

I. Lack of police and medical services

The first obstacle often encountered by GBV survivors is a lack of essential legal and medical services.

Police form 3 unavailable

Police Form 3 is crucial for a GBV survivor since it gives access to legal redress as well as medical services. However, it is still systematically reported that the vast majority of police outposts do not have copies of PF3; despite the fact that the humanitarian community distributed thousands of PF3 forms (in Gulu, Kitgum and Amuru).

PEP unavailable

Toward the end of 2007, the situation was slightly improved with the MoH training of clinical officers in Kitgum, Pader, Lira and Gulu (incl admin of PEP). Followed by distribution of PEP to (GBV sub cluster service provision members please fill in ...) HOWEVER ...

Lack of trained medical personnel

To date only a very limited number of medical personnel have been trained on WHO MoH clinical management of rape survivors. Moreover, previously trained medical staff are either not known to other service providers or are no longer working in that area. There have even been many cases of PEP being procured and stored, which eventually expired because there were no trained medical providers to administer the PEP.

Neglect and denial of medical treatment and care

Survivors are systematically being denied medical care and treatment in case they have not filled PF3 when arriving at the health centre. Moreover, oftentimes PF3 is deemed as the most important issue following a case of rape and/or defilement; treatment is considered secondary if deemed important at all. Because PF3 needs to be filled within 48 hours to be able to hold the perpetrator/suspect in prison; police and survivors end up spending most of their time trying to get the form filled, while the first 72 hours are crucial for preventing HIV infection and/or unwanted pregnancy amongst survivors of rape. In this way GBV survivors are being denied life-saving medical care.

II. Access to justice and medical treatment: who fills PF3?

Who fills PF3: lack of authorised individuals

There is no clarity amongst the public, duty bearers and service providers on who has the legal authority to complete Police Form 3. It has been mentioned that there is a practice guideline on this issue, but this is not accessible and unknown to the relevant stakeholders. There is also inconsistency (within and across districts) of interpretation and understanding of who is entitled to fill out PF3. In practice, courts will generally only recognize (government) medical doctors to provide evidence. However, there are very few medical doctors, particularly government medical doctors, in the Northern districts. For example, in Kitgum there is only 1 medical doctor, 1 in Lira, and 3 in Pader that are authorised, available and willing. If these doctors are not available or willing, the result is that (as documented in some cases) the perpetrator is released by the police as the procedural evidence is lacking.

Provision of medical testimony accepted in Court

Currently, the practice is that the highest medical ranking official in an 'area' is the only person authorised to provide medical testimony accepted by the court. Some cases have been dismissed as the medical officer who intended to provide evidence, was not of the highest rank in the 'area'. Furthermore, it was found that doctors do not want to testify in court as they are generally not paid for it.

- Check the status of the precedent of a TBA who testified in a court GBV case: Kitgum

III. Rights violations of GBV survivors: carrying the costs

Where services are available, the rights of survivors are violated in the way they are treated, made to pay for services that are free, and are denied access to medical services if the PF3 form is not filled out by persons deemed to have authority to do so.

Police form 3 and international human rights standards

The questions and language on the PF3 are unethical and out of line with internationally recognized standards for the treatment of survivors.

Charges by the police for PF3 and other services

Furthermore the victims are made to pay for receiving a service that should be free of charge. At the end of October 2007 – the average fee requested ranged between 2,000 and 5,000 UGX have been asked from survivors of GBV to obtain PF3 forms. Survivors are often requested by police to pay for transportation of the perpetrator; e.g. 25,000 – 30,000 UGX; for his accommodation e.g. 2,000 UGX, for arrest warrant e.g. 5,000 UGX, or for the transport of the police officer to investigate.

Payment for medical examination and treatment

In addition, medical officers and doctors are requesting for services that should be free of charge. There is a budget in JLOS given to Ministry of Internal Affairs which allegedly has not reached the district/or has not been made available for the intended purpose at the district level. Doctors are certainly aware they are entitled to the compensation and the case in Kitgum was cited whereby the Doctor has pushed consultations on GBV after 5pm so as to receive clients in private clinic where fees can be charged. Doctors ask approximately 5,000 UGX for medical treatment for survivors of GBV, while a government Doctor in Gulu and Amuru (who is always consulted by the police) reportedly charged 20,000 Ush for the medical examination necessary to fill PF3.

3. Key Recommendations

Below are a number of key recommendations related to the main issues raised.

I. To improve the capacity of the police and ensure availability of PF3

In line with the PRDP Police Enhancement Program, it is recommended that the capacity of the police is strengthened and the numbers of police officers increased. Crucial measures in this respect are ensuring that staff are equipped and trained to function and execute their jobs well, as well as strengthening community policing, which includes family protection, the promotion of human rights and dealing with domestic violence. Specifically, the Ministry of Internal and Constitutional Affairs should avail the resources to ensure sufficient PF3 forms; continuous monitoring and follow-up. In addition, PF3 should not be an obstacle in obtaining medical care and treatment as is currently often the case. In this regard, decisions and actions should take place to create a procedure/protocol that allows survivors of rape or defilement to receive life saving medical treatment as a matter of immediate priority; and the PF3 form being secondary.

II. To train more medical personnel and ensure the availability of PEP

As outlined in the PRPD, the quality of existing health facilities and services needs to be improved. Specifically, to address the medical needs of GBV survivors the following measures are needed. A comprehensive training and capacity building strategy from the MoH is needed which is fully resourced in order to ensure timely life saving medical service provision (clinical management of rape) including PEP as a critical procedure in preventing the transmission of HIV. The training and capacity building strategy must be linked to provision and distribution of PEP; covering all sub countries. Ongoing procurement of PEP is incumbent upon the State's medical authorities. Moreover, distribution of PEP and dissemination plans need to be effectively widely disseminated and there must be supervision and monitoring of administration of PEP.

III. To provide clarity on who is authorised to provide medical evidence (PF3) and ensure their number is large enough to provide timely services to GBV survivors in all areas.

Clear directives are needed from the office of the Inspector general of Police outlining authorised persons to fill out PF3 per District. This information must be widely communicated and known throughout Uganda. If existent, the Practice Guidelines from the Principal Judge or Chief of Justice should also be disseminated widely. Measures should be put in place that ensure sufficient number of trained medical providers are authorised to fill in the PF3 form in districts and sub districts, and be officially authorised to provide testimony in court that will be upheld by the courts. [Link to the status of the precedent of a TBA who testified in a court GBV case](#)

IV. To ensure the human rights to survivors: survivor friendly services, access to medical care at any stage, and free of charge

A consultation process should be started to discuss ways to make PF3 survivor friendly, and in line with internationally recognised standards. The MoH medical forms can be a reference point in this process. In the mean time, clarification is needed on the procedures around the MoH medical-legal forms, for example: are they sufficient to provide evidence in court hearings, and who is authorised to fill out MOH medical-legal forms?

Measures need to be put in place to ensure that police officers and medical personnel do not charge for services which are supposed to be free. Punitive measures should be taken where these regulations are violated.

Noting the numerous discrepancies regarding PF3, it is also recommended that a Guideline is developed and disseminated to all stakeholders and duty bearers which includes all of the above mentioned aspects; from providing free of charge to using it as legal evidence in court; (throughout the entire process). The implementation of these guidelines should be monitored and where necessary taking punitive action should be taken toward stakeholders breaching the guidelines.

V. To address and plan for improving access to justice and medical care and treatment for GBV survivors in the PRDP operational plans and related budget

The Government of Uganda's Peace Recovery and Development operational plans and related budget should include explicitly rights-based linkages and commitments to strengthening protection from gender-based violence and improving response services: notably - the police enhancement program; judicial enhancement program; and health infrastructure and service improvement.

The members of the IASC Gender Based Violence Sub Cluster would be pleased to provide more information and technical guidance in the process of strengthening the government's gender-based violence prevention and response efforts.