

Challenges faced by women of reproductive age (15-49) in accessing family planning services in a post-conflict setting: Case of Northern Uganda.

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CHALLENGES FACED BY WOMEN OF REPRODUCTIVE AGE (15-49) IN ACCESSING FAMILY PLANNING SERVICES IN A POST-CONFLICT SETTING: The Case of Northern Uganda.

A thesis submitted in partial fulfilment of the requirement for the degree of Master in Public Health

By

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Declaration:

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Abstract

Background: Family planning service is a public health problem in Uganda faces numerous challenges; however, the experience of war had made it more challenging for women in Northern Uganda to use and access FP services. Civil unrest has caused a state of poverty, rape, health care disruption, high maternal death and child mortality in the region. Unmet need for family planning is high (12%) in the North, twice the national average of 23% (UDHS, 2006). Women in war-torn zones are susceptible to rape, violence and poverty which exposes them to unwanted pregnancies, unsafe abortions, early marriages for young girls, trauma and death. This among other things undermines women's power to control their fertility.

Method: A literature review to identify barriers leading to the low use of FP services among women 15-49 years of age, in post conflict Northern Uganda. Busza and Lush conceptual framework was adopted to describe and analyse the barriers and impact of war on FP outcomes.

Results: The use of family planning services in post-conflicts is affected by the poor healthcare systems, negative cultural beliefs, gender inequalities and poverty. Countries with similar experience indicate that FP services in war-torn states can be effectively achieved when integrated with other programs. Advocacy, research, partnership' coordination, and governments' commitment of stewardship goes a long way to improve women's reproductive health care services.

Conclusion: The use of family planning is affected by different patterns in conflict settings ascribed in the framework. To address this critical public health problem; it requires every partner to play their role.

Key Words: Family planning, conflict, Northern Uganda, Culture.

List of Acronyms and Abbreviations

| | |
|--------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Anti Retroviral Therapy |
| CPR | Contraceptive Prevalence Rate |
| EC | Emergency Contraceptives |
| FHI | Family Health International |
| FP | Family Planning |
| FPAU | Family Planning Association Uganda |
| GDP | Gross Domestic Product |
| GNP | Gross National Product |
| GOU | Government of Uganda |
| HIV | Human Immuno-deficiency Virus |
| HSSP | Health Sector Strategic Plan |
| IAWG | Inter-Agency working Group |
| ICPD | International Conference on Population and Development |
| IDP | Internally Displaced Peoples' Camps |
| IEC | Information, Education and Communication |
| IMR | Infant Mortality Rate |
| IUCD | Intra Uterine Cervical Device |
| LRA | Lord Resistance Army |
| MCH | Mother Child Health |
| MMR | Maternal Mortality Rate |
| MOH | Ministry of Health |
| MISP | Minimum Initial Service Package |
| NGO | Non Governmental Organisation |
| NUREP | Northern Uganda Rehabilitation Programme |
| NUSAF | Northern Uganda Social Action Fund |
| PHC | Primary Health Care |
| PEPFAR | Presidential Emergency plan of Action |
| PLWHA | People Living With HIV and AIDS |
| PMTCT | Prevention of Mother to Child transmission |
| PRDP | Peace Recovery Development Programme |
| RHU | Reproductive Health Uganda |
| STI | Sexually Transmitted Infections |
| TASO | The AIDS Support Organisation |
| UBOS | Uganda Bureau of Statistics |
| UDHS | Uganda Demographic and Health Survey |
| UNAIDS | United Nation Joint Program on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children Fund |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organisation |

Introduction

Globally over 32.9 million people are displaced due to conflict (UNRCH, 2006) and 80% of these are women and children (UNFPA, 2007). Most of these conflicts occur in developing countries especially in Sub-Saharan Africa (UCDP, 2006; UNRCH, 2006). According to the World Population Report (2005), health care systems are often struggling to meet the needs of people in conflict areas at best times possible. However the situation is quickly overwhelmed by injuries and the increase of infectious diseases.

By 2006, 90% of the population in Northern Uganda was still internally displaced. As of 2008, a total of 70,000 people were estimated to have returned to villages near their original home called resettlement villages/sites (UNOCHA, 2008). Access to basic health care including family planning is a challenge for women in post-conflict Northern Uganda. From my observation, HIV positive women are most affected as they have to walk long distances and sometimes they may not get their treatment due to stock outs. In 2007 TASO Gulu rolled out provision of FP services to HIV positive adults including adolescents but there was low uptake. By June 2008, only 15% of the register women had consented to using contraceptives (TASO performance Report, 2008).

The aim of this thesis is to identify and describe barriers to the use and access of family planning in post-conflict Northern Uganda and seek for good practices elsewhere for improving FP services in the region.

This thesis is organised into six chapters; 1st being background information on Uganda, 2nd is the problem statement, objectives, and methodology, 3rd is about describing FP barriers based on the Busza and Lush (1999) framework, 4th is about practices of family planning implementation, 5th is discussion and 6th conclusions and recommendations.

As working for The AIDS Support Organisation (TASO) as the Assistant Counselling Coordinator for the last 5 years my tasks were supervising a team consisting of 24 counsellors and 1 Day care supervisor and coordinating the child centre activities at TASO Gulu. Counselling and supporting People Leaving with HIV (PLWHA) who are also traumatized as a result of the 20 year old armed conflict motivated me to seek understanding of the barriers to family planning use in conflict settlements. This is developing guidelines for improving and proper integration of services in TASO.

Chapter 1: Uganda – Background Information

In this chapter background information on Uganda, the health sector and family planning situation in the North will be presented.

1.1 Geographical location and administrative structure

Uganda is a land locked country located astride the equator in East Africa. It is bordering Kenya in the east, Tanzania in the south, Rwanda in the southwest, the Democratic Republic of Congo in the west, and Sudan in the north. The country has an area of 241,039 square kilometres and is administratively divided into 80 districts. These districts are further divided into sub-districts, counties, sub-counties, parishes and villages (ocwich, 2005)

1.2 Demographic Profile

Uganda has an estimated population of 29.6 million people with an average fertility rate of 6.7 (UDHS, 2006, UBOS, 2008) and a population growth rate of 3.2% per annum (UNDP, 2008). Uganda has one of the youngest populations in the world. The median age for starting sex is 15 years (Delargy, et al 2008; UDHS, 2006). The population consists of various ethnic groups and 87% of the population lives in rural areas. Table: 1 below is a summary of the key statistics for Northern Uganda verse the rest of the Uganda.

Table: 1 Key Statistics indicators for Northern Uganda and Uganda.

| Item | Indicators for Northern Uganda | Indicators for Uganda |
|--|--------------------------------|-----------------------|
| Total population (millions) (2008) | 1.8 | 31.9 |
| Total fertility rate (2008) | 7.1 | 6.7 |
| % contraceptive prevalence: any method | 12 | 24 |
| % contraceptive prevalence: modern methods | 46 | 18 |
| Maternal mortality ratio (per 100,000 live births) | 700 | 435 |
| Infant mortality total per 1,000 live births | 123 | 76 |
| HIV prevalence rate (%) (15-49) M / F | 8.2 | 6.4 |
| Unmet need for family planning, total (%) | 58 | 41 |

Source: UDHS, 2006 & Uganda Government Annual Health Sector Report 2007

1.3 Economic and poverty situation

Uganda's economy is mainly agricultural based with about 80% of the population depending on agro-based industries and subsistence farming (UBOS, 2008). The GDP per capita is \$300 per annum and the country is ranked 143/177 in human development index (UNDP, 2007). Poverty

levels in Uganda have reduced from 56% in 1992 to 44% in 1997 and in 2000 it reached 35% with the exception of Northern Uganda, where an increase in poverty levels was recorded at 59% to 48% in same period (Okidi, 2002). The period between 2003/2005, Ugandans living below the poverty line reduced to 31% and the rate of unemployment to 1.9% (UBOS, 2006).

1.3 Gender

The 2006 Uganda Demographic and Health Survey indicate that 60% of women and 53% of men have experienced physical violence since the age 15. Furthermore the survey reveals that 40% of women and 11% of men have experienced sexual violence. Thirty six per cent of experienced sexual violence this being forced sexual intercourse (UDHS, 2006). Women in Northern Uganda are the most affected victims of all the forms of violence for instance rape 68.9% for resettlement sites (Ochan, 2007). These gender inequalities are known to affect family planning use among women.

1.4 Literacy situation

The UDHS of 2006 indicates that women in Uganda are less educated than men. In recent years, this gap is seen to be narrowing however differences in between are still large with 19% of women age 15-49 not have been to school as compared to 5% of men it's still a significant margin (UDHS, 2006; UBOS, 2008). According to UDHS, (2006), family planning knowledge is universal for at least one method. Of the men 98% said they know of any FP method as compared to 97% of women (UDHS, 2006). In same survey, it is noted that women in Northern Uganda who said they of any FP method were 87%.

1.5 Orphans and vulnerable children

Uganda has over 2 million orphan's i.e. one in five children are orphaned or vulnerable 21%. Of whom 15% are less than 18 years and have either lost both parents or one and 8% of children less than 18 years are considered vulnerable (UDHS, 2006). And Northern Uganda has majority numbers of orphaned due to war and HIV.

1.6 Health sector

The Ugandan government has worked had towards improving health care services by adopting the Sector Wide Approach (SWAP). The main aim is to improve performance and reduce the administrative burden on the Government health sector. The health sector funding has increased from 9% to 13% of the total national budget (MOPFPED, 2005) however; the government is only remitting 41-65% of the HSSP II as it is funding (MOH, 2007). The country's Health Sector Strategic Plan (HSSPII) has also had a funding shortage. National wide health infrastructure is inadequate, especially in rural areas where majority of the population

lives; 51% of households don't have access to health care (WHO, 2007). Government's failure to remit 15% of the national budget to HSSP as agreed during the 2001 Abuja Agreement (the weekly observer newspaper (Kampala), 2009). Health expenditure on care remains below the expected (MOH, 2007) and family planning programs have had a modest budget if any. For instance, in 2007 the health sector budget was 9.6% of the total GDP (MOH, 2007). The health care budget is dependent on external funding in terms of programs activities. For instance the HIV and AIDS, TB and Malaria programs have had favourable advantages where it receives massive funding of about 85-90% being Global fund, PEPFAR as compared to other programs like family planning (UAC, 2007).

1.6.1 National health policy

At the policy level, provision of health services is guided by the National health policy and the Health Sector Strategic Plan (HSSP) which includes aspects of sexual reproductive health (MOH, 2007). The National Policy set maternal and reproductive health care services as one of the priority areas (Neema 2005) for 2005/2010. These guidelines have been set by the Government of Uganda (GOU) to help health service providers to provide safe motherhood services and reduce the number of maternal-related deaths. Other components of the guidelines include family planning, adolescent sexual and reproductive health, sexually transmitted infections (STIs) including HIV/AIDS, reproductive organ cancer, and gender-based violence.

1.6.2 Health service situation and FP in Northern Uganda

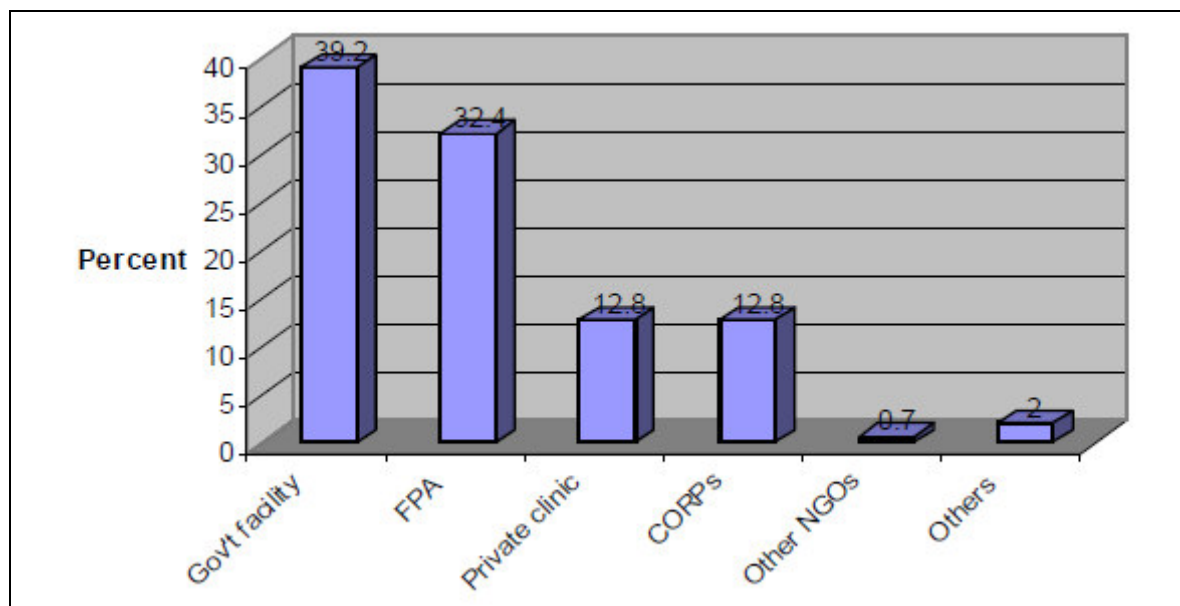
There are 1.8 million people displaced camps as a result of the Lord's Resistance Army rebel activities in Northern Uganda. The conflict which started in 1988 till 2006 has had a negative effect on the population's rights (Lough et al, 2005). Women and children were affected most (Arcel, 1998, Koen, 2006) were sexual violence, rape and rampant killings was experienced (Amnesty International, 2005; Isis- WICCE, 2006a). In the post-conflict state, things have changed since 2006 when government attempted to enter into peace agreement with the rebels. A cessation of hostilities was reached which resulted into relative peace.

During this period, the four functions of health care (stewardship, financing, input and service delivery) are not fully functional (UNFPA, 2007). The Health Sector Strategic Plan (HSSP) which takes responsibility for the health care needs of rural population including IDPs has been constrained by lack of insufficient human resources for health (WHO, 2007). Thirty percent of the population in Northern Uganda lives with 5km radius of a functional health facility (WHO, 2007).

The ultimate goal of improving primary health care has been challenging for districts in the North. The indicators on family planning use and access are still below target. Family planning services as part of primary health care were not prioritized for first and secondary level care as emergencies cases overwhelm the already few service providers in the facilities

The policymakers and national planners support FP/RH programs for the post-war survivors (Prada, et al, 2005). This has been mentioned in the post-war programs and policies; the Peace Recovery Development Program (PRDP), Northern Uganda Rehabilitation Programme (NUREP), Northern Uganda Social Action Fund (NUSAF) and the IDP policy. However, the challenge remains on implementation and budget allocation for FP services (RHU, 2008). The good policies remain on paper and shelve for records and not implementation (UNOCHA, 2008). In the mean time Non-governmental Organizations' such as Marie Stopes, RAISE, Population Council among others take up the lead role of providing family planning services in the region and the Country at large. Figure: 2 below, Presents data from a baseline survey by Family Planning Association of Uganda on ensuring comprehensive RH for Northern Uganda; found that most family planning services are provided by government health centres as summarized in the figure; 2 . The baseline survey findings put the public health facilities as the main source of FP service providers in the region. As this may appears to be ideal, the facilities face regular stock outs and has few contraceptives choices.

Figure: 2. FP in resettlement villages Gulu District



Source: FPAU. 2007 Baseline Survey

Chapter 2: Problem statement

Following the 2006 peace agreement on cessation of hostilities (Amnesty international, 2006) in Northern Uganda, the political situation and civil unrest ended. However, the final peace agreement is not clear and this leaves people doubtful about real peace. This led to over 90% of the population into 132 internally displaced people's camps (IDPs) (UNOCHA, 2005). The returning of peace and as the population is resettling down; they have difficulties in accessing healthcare services in their resettlement sites. On the other hand, the healthcare system faces numerous challenges. The health facilities have the least human resources, inadequate medical supplies, and uneven distribution of the health care facilities to serve people in the region (WHO, 2007; Ochan et al, 2006, UHSBS, 2007).

The process of setting up the health infrastructure, including RH services has not kept pace with the process of resettlement into transit-sites and finally to the original homes. There are not enough health structures in place to address women's reproductive health needs such family planning and STI/HIV. Lack of proper healthcare structures in the resettlement sites places women in a vulnerable situation. For instance lack of access to contraceptives and safe motherhood services expose women to unintended pregnancies which result into unsafe abortions and sometimes death (UNFPA, 2007).

The contraceptive prevalence in the region is 12% which is lower than the national 23% and the unmet need for family planning (women who would like to postponed child bearing or stop but report not to be using any form of contraceptive is 46% as compared to 18% at national level (UDHS, 2006). While similar challenges exist in other parts of Uganda, as shown below, Northern Uganda is the most affected region in Uganda in terms of RH indices (Ochan, 2007). Unmet family planning needs translate into high number of unwanted pregnancies, abortions and eventually maternal deaths. The maternal mortality ratio of 700/100,000 in Northern Uganda is almost double that of the national rate of 370/100,000 (UDHS, 2006). In addition, there is the high teenage pregnancies of 43% in Northern Uganda as compared to 31% National wide (MOH, 2005; UDHS, 2006). High MMR has negative effects not only to children but also to the economy and the National health outcome. Improving family planning and other reproductive health services will help in addressing the high numbers of maternal deaths (UNFPA, 2007).

As Ochan et al, FPAU, point out reproductive health and family planning needs are largely unmet in Northern Uganda. This is also my experience as a counsellor for last 5 years in Northern Uganda. It is important to identify the barriers to access and use of FP services for women in Northern Uganda.

This thesis focuses on barriers to access and use of family planning in post-conflict Northern Uganda. The study findings are meant to inform the Government, policy makers, and community leaders about how to improve family planning services in post conflict Northern Uganda. In order to do this, the following questions would be explored:

2.2 Research questions

- I. What was the situation of family planning services in Northern Uganda before conflict, and what is the situation now?
- II. What are the barriers to family planning access and use in a post-conflict region in Northern Uganda?
- III. What are the good practices of family planning services in regions with similar situations to Northern Uganda?
- IV. How can we promote family planning services in Northern Uganda?

2.3 Research objectives

2.3.1 General objective

To assess the barriers leading to low use and access of FP services among women of (15-49) years in post conflict Northern Uganda with the intention of making recommendations for improving FP services in the area.

2.3.2 Specific objectives

- I. To describe the situation of family planning before, during and after conflict in Northern Uganda.
- II. To identify and describe the barriers to family planning access and use, post conflict in Northern Uganda.
- III. To identify good practices that can be adopted for improving FP utilisation in Northern Uganda.
- IV. To propose recommendations for improving family planning services in Northern Uganda.

2.4 Methodology

This is a literature review and the findings are described using Busza and Lush, 1999 conceptual framework. The framework proposes that improving reproductive health including family planning, there is need to analyse it in three stages; namely before, during and after conflict. This has been used with success in others countries like Rwanda, Cambodia and Sierra Leone that have been in conflict. For details refer to chapter three. Northern Uganda in this paper is solely referring to the war-torn region of Uganda. The author uses her experience of working in the

region for the last 5 years with The AIDS Support Organization (TASO) and lessons learnt during the ICHD course.

Search strategies: Google scholar search engine was used to find both scientific and grey literature; Uganda Ministry of Health, Uganda Bureau of Statistics, Uganda Family Planning Association, Reproductive Health Uganda, Marie Stopes Uganda, to access reports and policy documents. Pub med search was used to find scientific papers and journals published about family planning and conflict. Websites of multilateral agencies such as WHO, UNFPA, FHI, Raise, Pathfinders, Marie Stope International, UNAIDS, UNOCHA, Isis-WICCE, and other NGOs to access policy documents articles, and technical briefs in the field of FP.

Keywords: Family planning, reproductive health, culture, conflict, politics, gender, violence, marriage, access, utilization, Uganda, Africa.

2.5 Study limitations

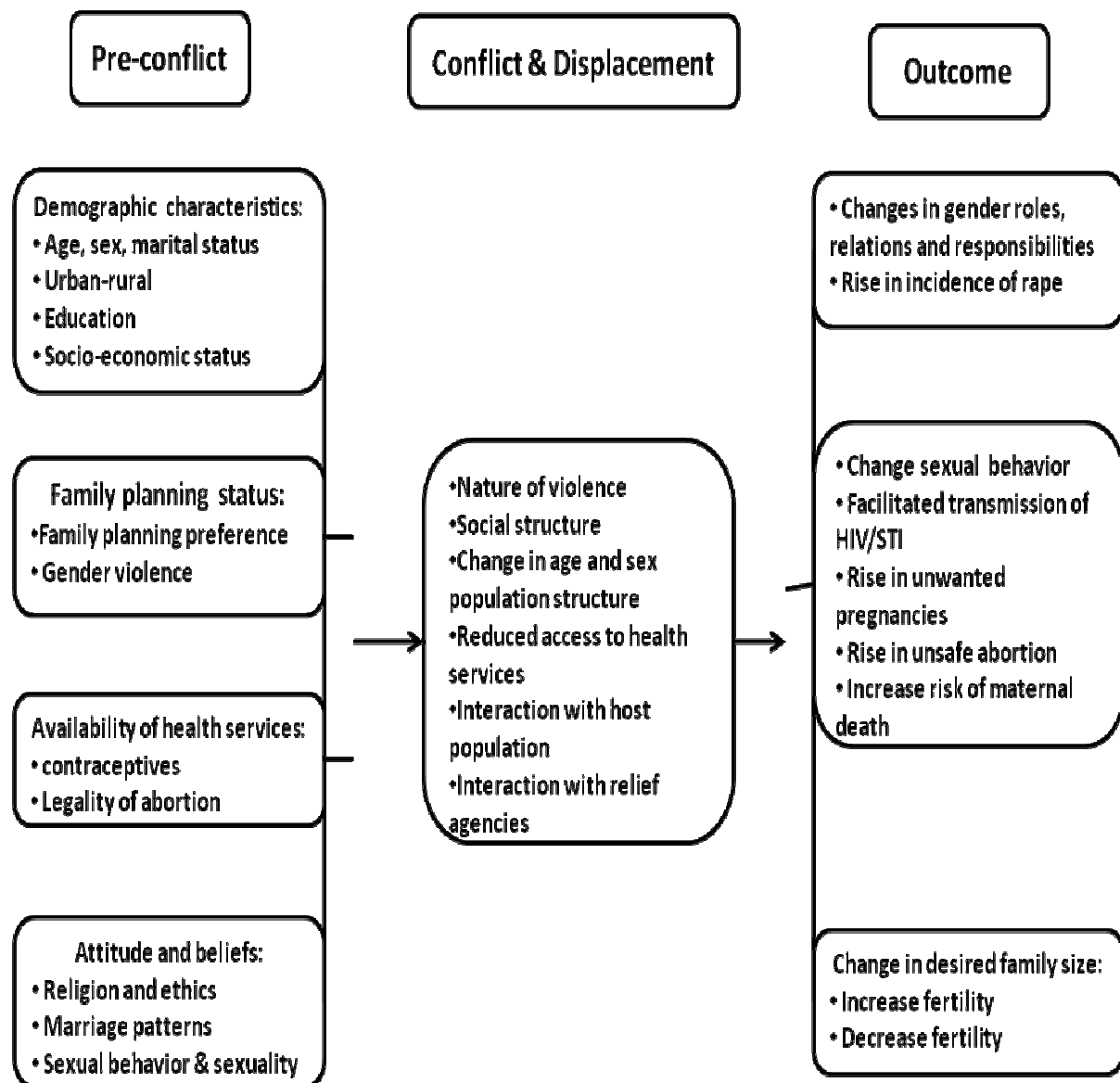
Limited information on family planning use and access before conflict in Northern Uganda made it difficult for comparisons.

2.6 Conceptual framework

The conceptual framework for planning health interventions in crises and post-emergencies is adopted from Busza and Lush, 1999; "impact of conflict on health care services and complex emergencies". The framework outlines three major phases through which reproductive health care needs for conflict populations is assessed. These include, pre-conflict factors, nature of displacement and conflict and possible health outcomes. Like in the case of Rwanda, the three phases were used to assess and plan for FP services after the 1994 genocide. While for Cambodia case it was a complex situation since the country has had a series of conflicts but it worked (Busza and Lush, 1999).

In this study, the framework is used as a guide to describe and assess the barriers and impact of conflict on family planning services for post-war Northern Uganda.

Figure: 3 Busza and Lush, 1999 framework (adopted).



Chapter: 3 Barriers to Family Planning

This chapter is identifying and describing the findings of the literature review on barriers of family planning in a post-conflict situation using Busza and Lush 1999 framework. The framework suggestions that determinates of health for conflict affected populations varies in three phases i.e. pre-conflict, displacement and conflict and post-conflict. These will be used to guide the discussion by answering the above questions and objectives.

3.1 Pre-conflict and during conflict factors

The pre and during conflict situations are used as background for assessing the family planning barrier.

Following Uganda history, pre-conflict in this region refers to the period before independent up to 1980s and conflict started 1986 till 2006. Sometimes it is difficult to draw conclusions to if the region has even been peaceful. Key demographic factors for pre-conflict on the region were not available this is could be due to the long insurgence. For this reason general information on Uganda is used to compare pre-conflict factors.

Four factors are used with reference to the framework i.e. demographic factors, family Planning (FP) health status, available health services and attitudes and beliefs as sub headings. To this effect Total Fertility Rate (TFR) is used as a measure for FP as it is a true indicator for determining the utilisation. Other measures of FP such as Contraceptive prevalence rate (CPR) getting information were challenging.

3.1.1 Demographic

Demographic features such as age, sex, education, place of residence and socio-economic have been found to affect family planning use and access. In a conflict setting these factors are likely to be the same or worse (McGrinn, 2000).

In Northern Uganda girls are usually married and getting pregnant at an early age and are not able to make informed decisions on the use of contraceptives and family planning services. The UDHS of 1995 indicates that there was no difference in age at marriage and age at first pregnancy in Northern Uganda with the rest of the Country during conflict was 17.2 years (UDHS, 1995). In relation to this, total fertility rate (TFR) was estimated at 6.9 births for each woman in her lifetime (UDHS, 1995). A survey done in 2006 showed a similar pattern of 17.6 and that 25% of the adolescent girls (15-19) start child bearing in Uganda (UDHS, 2006). Northern Uganda has the highest rates of early child bearing with 34%

and Internally Displaced Peoples camp (IDPs) at 43.1% (UDHS, 2006). Young people were marrying at early age as 12-15 years. It is very unlikely that they will seek neither family planning services nor think about it (Isis-WICCE, 2004).

Pre and post-conflict Northern Uganda remains predominately rural and the use of family planning services are still low. In 1995, rural women were less informed about FP services and hence high fertility rate (7.2) as compare to the 5% urban (UDHS, 1995). However, even during conflict the fertility rate remained high at 7.1 with low life expectancy (UNICEF, 2004; UDHS, 2006). This could probably be due to lack of information on the available family planning services or the low life expectancy as when life expectance is low people tend to have more children. It has been observed that 55% of the population in Northern Uganda consists of children below 18 years (WHO, 2005). Reasons for this can be lack of sensitization about the available FP services which could be the contribution of low education levels of women.

The education level of women, just like residence and age has been shown to be a contributing barrier to women's access and use of family planning. Lack of education limits women's power to make decisions on their health care (UNFPA, 2006). In many societies of Northern Uganda, education for women was not a priority. This phenomenon continued to deprive women of their right to education and in northern Uganda the conflict made it worse. The region has continued to lag behind other Ugandan regions as the government was promoting girl-child education; this phenomenon reached a peak during the conflict. Subsequently, this has Lead to high school drop outs rates in the region (UNICEF, 2006). With low levels of education, women in the North are less likely to take up FP services. As much as education is important to FP use, the socio-economic status also contributes to the use and access of FP services.

The socio-economic status of women has been shown to improve uptake of family planning services. The UDHS 2006 shows that educated women tend to bear fewer children compared to non educated one. Most important, these women are in position to make independent decisions on the number of children they want and when to have them unlike none educated. In addition these women tend to live an expensive life and will seek FP services to achieve this status. While for the less economically empowered women like in the case of Northern Uganda, most women depend on their male counterparts for survival and this makes it difficult for them to use contraceptives.

From the authors' experience, women in pre-conflict depended entirely on their spouses for economic provisions and were bound by cultural norms to have many children as they could. Unmarried woman with a child were

not socially accepted and were out rightly disowned by their parents. So this kept girls to avoid getting pregnant when not married.

3.1.2 Family planning status

Family planning preferences

In the past, FP use and fertility preferences in Uganda depended on how many children a couple wished to have (UDHS, 1995; Ntozi and Kabera, 1991,). This limited women's use and access to FP services. In addition, preference for a certain sex of the child was common. This too affected the use of contraceptives because if a woman has only children of the same sex she was forced to continue bearing more in search for children of the other sex. As an illustration among the Luo's in Northern Uganda, male children were preferred for the continuity of the clan lineage (Isis-WICCE, 2001). This preference is likely to continue at present in the post-conflict situation. As a result, FP use and access will continue to be less desired in a state where rebuilding their past life is key. In his study on reproductive health in Northern Uganda, Krause (2007) has mixed views on fertility preferences. The study findings show that women want to limit and control childbirth but the men prefer having more children (Krause, 2007). In one of the focus group discussions during Krause's study a woman participant is quoted;

"I have six children and I pray that my husband will understand that I want no more."

"God should be so kind that I can have contraceptives." (Female focus group participants, Mucwini camp as cited in Krause, 2007 pp, 13).

This has a direct implication for gender dimensions in the region. The discussion below looks at how gender dimensions have been affected over time.

Gender Disparities

Gender inequalities have been found to play an important role in the uptake of FP (UNFPA, 2004). The inequality may even be worse for conflict affected women like the case of Northern Uganda. In the past and present times men continue to dominate decisions at all levels including child bearing. The study of Krause (2007) has shown that as much as women want few children, the men continue to demand for more children. It is clear that women have no control over their fertility (Liebling et al, 2008). Culturally and biblically men have been empowered to be more superior to women. Consequently, the notion under mines women's human rights to fully exercise their powers and this in turn affects their decision to services such as FP.

Gender inequalities have shown that men become violent to women in case of any misunderstanding. Study by Kyomuhendo, et al, (2007) and Krause (2007) show that women found using contraceptives by their spouses were accused of extra-marital sex. This results into domestic

violence and sometimes death (Krause, 2007). Fear of violence and the desire for a peaceful marriage, tend to keep woman away from using contraceptives hence having large family size.

During the conflict, young girls in the North were faced with various forms of violence. Women's Commission in 2001 reported that, young girls were raped and sometimes killed in trying to seek refuge (Women's commission, 2001). Consequently, girls were forced to marry their perpetrators who continued to abuse them. In the hands of their abusers these women are unlikely to use or even have access to FP services. Lack of protection for girls has been attributed to the breakdown of traditional courtship as a means of forcing girls into marriage (Women Commission, 2001).

Those violence acts continue to prevail even in the resettlement sites. Another factor contributing to the practice of violence has been listed by Kyomuhedo who underlines that the weak law in the country have failed to protect women against violence (Kyomuhedo et al, 2007). The inequalities in gender and violence associated are possible reasons for low use and access to FP services in the region. Describing these factors alone without looking at the availability of services does not give a good inference to the women's up take of contraceptives. The following headline talks about the available FP services and how they affect uptake.

3.1.3 Availability of health services

In the past, healthcare systems in Northern Uganda were evenly distributed just like any other region. However, during the conflict starting 1995 some of the facilities became non-functional and many health workers moved to urban centres while others left for other regions (WHO, 2007; MOH, 2007). The Family Planning Association of Uganda (FPAU) closed down its services at the peak of conflict in the region (Maseruka, 2006). Reduction in the number of health facilities in the region and shortage in health staff affects access to FP services and as a result adherence to contraceptive is compromised.

The 2006, Uganda MOH assessment exercise on the available health facilities in Northern Uganda, established that there were 167 health facilities for 132 IDPs (MOH, 2006). Fifty percent of the health centres were located within the IDP settings. The facilities were under staffed and were not sufficient to serve the crowding population in the camps (MOH, 2006). Bruce (1990) has noted that poor quality of services affect the health seeking behaviour of individuals and how they use services including FP services. With Only one health centre per IDP, one can imagine how quality of care including FP services would be in such a state.

The findings further, indicate that there was a massive shortage of staff which affected service provision (MOH, 2006). And as a result family planning services were not prioritised for provision and consequently the commodities would expire (MOH, 2006). This is in line with WHO conclusions with respect to post-conflict areas; lack of qualified staff, supervision and family planning services continue to be seen in the post-conflict stage (WHO, 2007).

In addition, a concept paper on health sector recovery in Northern Uganda by UNOCHA 2007 notes that during the conflict, the Ministry Health (MOH) did not dedicate nor play its monitoring and control roles in the emergency response. Underfunding, lack of qualified human resources and weak managerial capability have prevented the Health authorities to exercise their leadership functions well (UFPA, 2007; WHO, 2007). These are some of the challenges that the districts' health team faced in dealing with complex internal and external stakeholders. The World Health Organization (WHO) took the lead in guiding and planning for health care services in Northern Uganda (UNOCHA, 2007).

Contraceptives

The pattern of contraceptive use among the Luo's in Northern Uganda, prior to conflict as mentioned before, was not given any priority. Couples were more interested in having big families other than limiting the number (UDHS, 1995). Even when services would be available it would be unlikely that they would be a change in the desire for more children.

Provision of FP services in Northern Uganda before conflict was mainly through the government hospitals and private providers (WHO, 2007). Distance was a common barrier to most of the women; however, a couple or an individual was motivated to use FP after achieving the desired number of children (UDHS, 1995). During the conflict phase contraceptive use and demand was affected by the break down in the health facilities (UNFPA, 2007).

Distance and transport have been known to affect women's access to FP services. Prior to conflict, women in the North travelled long journeys to access health services including FP (Isis-WICCE, 2001). However, during the conflict health centres were situated within the camps making access easy. Contraceptives have been associated with side effects and myths such as; a person will develop cancer, infertile, painful sexual intercourse among others. Further, contraceptive use in Northern Uganda was mainly affected by; stock-outs of FP commodities, shortage of staff but also the myth surrounding FP (MOH, 2006).

The choice of FP methods is also greatly hampered, an assessment by UNFPA (2006) on sexual reproductive health in Northern Uganda, found

that most NGOs and other health providers concentrated on condom distribution and neglected other contraceptives (UNFPA, 2006).

Since the conflict started, provision of healthcare services in Northern Uganda has been dependent on humanitarian assistance for drugs and other supplies (WHO, 2007). Similarly, for FP services e.g. the provision of condoms, and emergency contraceptives was done through UNFPA partners. Krause and Matthew (2005) highlighted that women were greatly affected by war, they faced difficulties in accessing FP commodities due to; stock-outs, transport, costs and limited supplies (WCRWC, 2003). This is a universal phenomenon for most health care supplies in the region.

Legal status of abortion

Abortion in the past was unheard of and sex before marriage was abominable. In that regard abortion was threat unlike today. Abortions cases are common and a big threat to young girls and women of reproductive age 15-49 in Uganda. The huge numbers of abortion is an indication that due to lack of FP services and unwanted pregnancies occur. Consequently these unwanted pregnancies end up into unsafe abortions since the law does not provide for safe abortions. Legality of abortion is more important in situations where women and girls have been raped. In Uganda, abortion is only accepted when the foetus is a threat to the health of mother or when the foetus is deformed (Neema et al, 2004; FPAU, 2006; section 141 and 212 of the Penal Code Act). The failure to legalise abortion, has made women resorted to unsafe means of terminating the pregnancy. This sometimes led to deaths and affects their fertility. Northern Uganda has been shown to have the highest rates of unsafe abortions (Mirembe et al, 2005). Legalising abortion is politically and religiously contextual hence making it difficult to be legal.

3.1.4 Attitudes and beliefs

Culture

In Northern Uganda polygamy and wife inheritance was commonly practiced. The 1995 UDHS reports that 32% of women in Northern Uganda were living in polygamous families as compared to 11% of men (UDHS, 1995). Mirembe et al, (1998) have highlighted that living in a polygamous relationship exposes an individual to HIV and STIs and high fertility. The practice under mines women in this kind of relationship to seek family planning services even when they are available. In addition the practice promotes competition among women for more children which affects use of FP. Study by Ezeh (1997) shows that in a community where polygamy is practiced it is less likely that the women will use FP services. It is further argued that women who are in monogamous families in a society that supports polygamy are compelled to have more children in

order to protect their marriages. The trend of polygamous families is changing, this could be attributed to HIV prevention messages or it could be due to the economic hardships. The economic hardships continue to prevail at present since they are just starting a new life in their village and this takes time.

Culturally, children are valued as a source of wealth and protection in a marriage (Mirembe et al, 1998). The socio-cultural beliefs among the Luo's in Northern Uganda, have socially ascribed roles for men and women. In a report by Iss-WICCE, (2001) on women's experience with armed conflict argues that, because of the war the strong social structure has been disoriented; affecting the traditional birth control methods among the Luo's; where a woman after giving birth would live with the mother in-law or would go back to her parents till when the child was two years before returning back to her husband.

Religion

Religion is another family planning barrier that has contentious arguments against contraceptive use. In most religious sects, family planning use is believed to defy God's purpose of procreation. In this religious teachings have far reaching influence on women's attitude and acceptance to health care use including FP (Verkuly, 2003). From experience, the region is predominately Catholic and the doctrines do not support modern family planning methods except the natural FP method which has been shown to have high failure rates.

Uganda MOH also recognizes that religious beliefs are one of the barriers it faces in the implementation of FP services. However, in a pilot survey by Reproductive Health Uganda in 2007 found out that religion was not a significant barrier to FP use in the North. However what was significant was the resistance on condom use as a dual method for prevention against pregnancy and HIV. They preferred to promote faithfulness and abstinence messages against the condom (RHU, 2007).

Additionally, most Community based hospitals and health centres in the region are manned by Faith Based organisations (UDHS, 2001). These are more accessible to rural women however, the provision of modern FP services is lacking. This could be a likely contributing barrier to family planning use for women in the region.

Marriage status

In Northern Uganda, it is observed that before conflict marriage was by elopement and there were no criteria on age. A girl was considered ready for marriage when she started developing puberty signs (Isis-WICCE, 2001). The marriage pattern in Uganda has not changed; many girls still marry before 18 years which is a legally accepted age (Mugerwa, 2009). Early marriages promote high fertility because the women will continue to

bear children until late age (Mirembe et al 1998, Neema et al, 2004). The Uganda DHS 2006 estimates that 70% of women in Uganda have their first pregnancy by 19 years a situation that under mines FP use.

The estimates however, may not apply for young girls in Northern Uganda for reason being that they are forced to enter into marriage at an early age. This is in most times against their wish. In the case of abducted girls who have been forced to marry rebels end up with unwanted children who are stigmatized by society referring to them as “the rebels’ children” (UNICEF, 2004). The effect is more on the child-mothers who have to cope after returning from the bush. Worse still is there are no specialized services to handle them not even the youth friendly services available are able to address their needs. In a report by World Vision to UNICEF, on ‘child mothers’¹ noted that young girls who were abducted by the rebels, they were given to the Lord Resistance Army (LRA) commanders as wives being a reward for their actions (UNICEF, 2004). Exposing them to coerced sex, unwanted pregnancies and subsequently they lose the power to control their fertility.

The act of rape, coerced marriage and ending up with unwanted children has forced women and girls to high risky sexual behaviours. Change in sexual behaviours, has results into high HIV prevalence, unsafe abortions and violence. Northern Uganda has high HIV prevalence of 8.2% (UBOS, 2008) and women are more affected. From the authors’ experience at TASO Gulu 75% of the registered clients are women (TASO GULU, 2008). The challenge for when women on Anti Retroviral Therapy (ART) have had an increased desire for children. This is another barrier to family planning use. The situation is made worse with PMTCT interventions which have given hope of having an HIV free child is boost. In the past there worry was STIs which were most times not treated unless it was a threat.

In summary, this chapter indentified some of the key barriers to family planning use among women in Northern Uganda as; early marriage practices, negative cultural beliefs (polygamy, widow inheritance, initiation), lack of FP services and gender violence. The framework used showed the interaction of the commonly known FP barriers and how they are individually affected by conflict. Consequently, how they influence women’s use of FP services in present state of affairs. However, within the framework there is no provision for solutions it only presents the situations.

¹ Child Mothers as categorized by UNICEF means that children below 18 years in the population who are mothers irrespective of where they are.

Chapter: 4 Examples of Family Planning implementation

This chapter is reviewing FP literature from other countries that have been in conflict and identifying good practices for adoption.

4.1 Post- conflict and family planning in other settings

It has been observed from literature that during the emergency and post conflict situations, reproductive health including FP services are not prioritised for intervention (Liebling et al 2007). Organisations that come to provide social services during and after conflict in most times do not support healthcare services, and if they do, it is usually basic health care and during major disease outbreaks. Reproductive health services are not regarded as emergencies. Provision of reproductive health which includes FP services becomes a contentious issue for relief organisations. Consequently, it is often considered last and a long term program. In Chad for example, the main focus was on rehabilitation, development and provision of food, shelter and other basic medical services and FP came in much later (Katie, 2008). Similarly, it is unlikely that provision of youth friendly services will be considered. As it was for the case of Sierra Leone, where youths were not considered for contraceptives unless in companion with the parent (UNAIDS, 2008)

In conflict situations hospital and health facilities are usually the first targets. The result of these targets are looting of drugs and supplies, killing and abduction of health staffs which leads to disruption of services including referrals and communication systems (IAWG, 2004). The implication is that the few remaining resources will be focused towards curative treatment while other services like FP are not immediately considered.

In most instances in a conflict situation, ministries of health are constrained in their health budget especially in planning and coordinating most of their areas of concern like procurement and drug supplies. During conflict public funds are diverted towards defence and resettlement of the people (IAWG, 2000). This affects the health budget and within the health structure itself, funds for reproductive health including family planning is further diverted to for treatment of war wounded people (IAWG, 2000). Study conducted by RHRC and her member organisation (2001) on the reproductive health services for refugees in Angola, found that there was frequent stock-outs especially for the most preferred FP method as a result women were exposed to unwanted pregnancies (McGinn et al, 2001).

Security of the place of residence and the surrounding has an influence on how people will use health services including family planning (WHO, 2007; McGinn et al (2003) have argued that the degree to which

individuals' security of current residence is affected by war (as measured by level of population movement)" influences FP use among the women. Insecurity increases movements and women may find themselves in a situation where they can no longer have access to FP services. In trying to find safety, women may find themselves in a more risky situation than before.

Women in conflict and post-conflict settings are exposed to all forms of violence and abuses (UNFPA, 2007). A study in Sierra Leone estimates that quarter a million of women were raped during the civil war and rebels abused and forced women and girls to be their wives or sex slaves (Human Rights Watch, 2003). These sexual abuse included; rape, physical, socially and psychological violence and early sex for young girls (UNFPA, 2007). All these acts are stigmatising to women and within no time it affected their personality and as a result they shun away from seeking health services including FP. In Bosnia for example, young girls were most affected victims of war which disrupted their sexual and social behaviours. They were exposed not only to stigma but also to HIV/STIs. Due to stigma, women and young girls fear to report the abusers and as a result they miss out on post-exposure prophylaxis for HIV and emergency contraceptive pills (World report, 2008).

Studies have observed that when conflict develops, it disrupts the social, economic, political, and financial and human resources. This in turn affects the use of reproductive health including family planning. The basic human needs for shelter, food, safe water, basic health care and security take primacy over reproductive health needs such as family planning (Zwi & Cabral 1991; Liebling et al, 2008). In a post conflict situation where the political, socio-economical and religious structures are broken down it becomes very hard for one to prioritise sexual reproductive needs more specifically FP services, over other essential primary care services (IPPFARO, 2005).

Northern Uganda, as has been described earlier, reproductive health related morbidity is one of the most important problems facing the population. RH services, including FP services would fulfil a large unmet need, and deserve priority attention. Good practices that have worked in other post- conflict situation would be used as inference for replication for the situation in northern Uganda.

4.2 What others have done in post-conflict (Good practices)

This proposes good practices for improving family planning services in post-conflict situation. FP can be integrated with ongoing services which are more effective and women could easily access the services. A study in Rwanda indicates that after the integration of family planning with prevention of mother to child transmission and voluntary counselling and testing, it increased the acceptability of different FP method. Up to 90% of HIV positive women were offered family planning (Ngendahimana, 2006). The same study however, stresses that family planning counselling must be conducted by a trained health professional in order to achieve good results. Similarly in Guatemala, integration of family planning services with MCH services have indicated an increase in contraceptive use and mother were counselled on the different methods of FP and child up bring (Seiber et al, 2005).

In Uganda, Straight Talk Foundation and UPHOLD (2004) formed youth friendly centres for IDP youths in Northern Uganda where sexual and reproductive health services have been integrated and has been successful with high demand for services (Adong, 2006). In the same spirit, The Family Guidance Association of Ethiopia with support from UNICEF in 2003 started integrating STI diagnosis, treatment and VCT into FP services at selected youth centres which increased the youth knowledge and use of FP services. In both cases, the authors insisted that integration should make privacy a priority.

Privacy is has shown to improve uptake of healthcare including FP services. From experience as counsellor, ensuring clients' safety and privacy builds their confidence in the provider and the care. Kayli et al (2008) in their study in Timor-Leste found that lack of privacy was a barrier for seeking FP services during the mobile clinic. Privacy is an important factor for improving the health seeking behaviour of clients and contributes to the adherence of the treatment. For instance Dejene and Belay (2003) in their study on the use of Intra Uterine Cervical Devise (IUCD), found that provision of IUCD in privacy boosted the use of the method.

Partnership is an important aspect in addressing cross cutting issues such as family planning and HIV/STIs. For instance the coalition of the Acholi Religious Leaders' Peace Initiative has provided psychosocial support to victims of sexual violence which meant working with the police, health care providers and legal sector (UNFPA, 2008). Similarly in Darfur, women have formed "safe zone" where they meet and discuss their experiences on violence, knowledge and health through the support of UNFPA (UNFPA, 2008). In the case of Northern Uganda where this

initiative is has shown that joint partnership programs improve the community's health status and responsiveness.

In Guinea a grassroots programme established a village-level family planning programme in partnership with the local government, traditional and religious leaders. The partnership resulted into a 20% raise of couples using family planning as opposed to the regional of 7% (UNAIDS, 2008). Grassroots programs are viable and can easily yield quick results. There are many development programs at the grassroots that FP can be integrated with and majority are managed by women. In addition, partnership in health care provision can also improve the use of reproductive health including FP services. For example in Afghanistan and Southern Sudan their Governments have contracted NGOs to provide healthcare services including FP services and this has reduced on the pressure where shortage of staff has been common. Non Governmental Organisations are known for quality services and attractive salaries which motivates staffs to work hard (Bayard et al, 2008).

A recent meeting in Bamako by UNAIDS called up on religious leaders from Uganda, Mali, Ghana, Senegal and Mauritania to promote sexual reproductive help so as to improve the health of women in their communities. For example El Hadj Mamadou Traore, a member of Mali's Islamic High Council in 2005 during an advocacy meeting for religious leaders, gave a presentation in support of birth spacing. The five countries represented agreed that family planning and religion are compatible and that they would work to improve reproductive health in their communities as leaders (UNAIDS, 2006). Advocacy is applicable; nevertheless, the religious stakeholders in Northern Uganda should be more vigilant on their commitment to take FP as a solution to development and improved health.

Male involvement in family planning programmes is crucial for increasing women's uptake on contraceptives. For instance in Kenya, a study was done to explore how husband-wife communication would improve contraceptive use. They found that spousal communication had prospects of improving contraceptive use by use of change agents who mainly men (Ashraf and Stan, 1997). Another example from Namibia, men were organised in small community groups to sensitise them on gender issues and family planning use. In 2000, UNFPA established discussion groups and debates on family planning with the aim of improving men's confidence and creating awareness for them. To this they used community educators who went door-to-door to mobilize and educate men about their role in family planning services (UNFPA, 2000).

Research is a good tool that can be used in guiding programmes and solving problems as they come. For example in Guatemala in 1990s, Population Council conducted a research in the Mayan Highlands with the

aim of improving access to a wide range of contraceptive methods (Brambila, 2007). Cultural knowledge is vital in providing FP services in post-conflict situation. Research can be helpful in the documentation of important cultural norms. The observation and findings on the past can then be used to plan for the present situation. Women and girls remain subjects of the traditions. Therefore, investing in family planning research will be important for the region as it is also the beginning of new lifestyle. The region is well placed to do research. The presence of Gulu University has all the advantages for this undertaking.

Chapter: 5 Discussion

The overall objective of the thesis was to assess factors leading to low family planning use in Northern Uganda. First, a description of the pre, during and post conflict situation in this part of Uganda was described and barriers in access to FP identified. Subsequently, good relevant practices from other countries were identified. This chapter presents a discussion where the key findings, are discussed in relation to practices identified for improvement and implementation from other countries. Conclusions and recommendations are then made basing on the discussion and the study questions.

Northern Uganda is currently in the resettlement process after 20 years of IDP life. The population is characterised by young people and early marriages are common. This poses challenges to addressing reproductive health services. Therefore making family planning services accessible, accepted and available to them becomes number priority. However, the big question would be what are the chances that FP will be accepted? Considering the past experiences with the conflict which has eroded their families and the desire to replace is agenda one. Well, convincing such a distorted group with FP services will be challenging but necessary. In the authors' opinion, first we need to appreciate and respect their fertility desires as we build on the information giving on the importance of FP service use.

In view of the fact that this is a common trend for most post-conflict situations as literature has revealed. It is therefore, crucial for development partners to invest in FP services to improve the quality of services. In the first place, when life expectance is low people tend to have more children (UNICEF, 2004). The desire to have many children lowers women's life expectance rate. The absence of family planning services in post-conflict Northern Uganda makes the situation worse. The consequence is high MMR, IMR and low life expectance. To prevent this from occurring, we could borrow a leaf from Darfur, of forming safe zone were women and men come together to discuss about their fertility needs. Given the cultural practices this may fail to work. However, we can increase on the sensitizations.

On the other hand, family planning services as observed by World Health Organisation (2008) are part of the solution to reducing the high maternal mortality ratio and child mortality. This calls for intensive sensitization on FP services and strengthening the primary health care (PHC) systems. This can be done through using political leaders, cultural groups like the popular cultural drama groups, religious leaders and other opinion leaders. The already existing forms of sensitization can be strengthened through radio talk shows, using personal experiences. Given the nature of these political structures, the efforts are bound to fail. Another step would

be to raise the level of education and establish women networks for peer support.

Women need to be educated and empowered to order to recognize their role in family planning service use. Low or not education women have limitations in accessing information. The Government of Uganda has put in place structures to improve women education. More attention should be given to Northern Uganda especially in the resettlement villages where majority of the women live. In the authors' opinion, the level of education for women in Northern could be achieved through the already existing Government systems. For instance, the adult literacy education for women could be rolled out in every resettlement site. In Uganda, adult education has shown to be a powerful tool for empowering women with skills for poverty eradication and development (MGLSD, 2008). Integrating FP information in Adult Literacy Curriculum may improve contraceptive access and use. It is also important to that has got weakness that may not match with the situation in the North. Knowing that the population is dependent on agriculture, and then women may prefer farming than attend school.

The other option would be mobilizing women into micro credit schemes with the aim of improving their economic status. Economically empowered women have relative control of their fertility and have few children. However, this may be applicable for urban educated women than the rural women. The women in rural settings live with their in-laws and are closely monitored so being educated may not save them. In addition, misconceptions about FP services are widespread in the rural than urban. Family planning can also be integrated with the EPI outreach programs. The example of Rwanda has shown that uptake of FP increases when services are integrated. This offers a good opportunity to reach mothers with education and counselling on the importance of family planning at the community level

Reproductive health services are not easily accessed by young people as most healthcare centres do not have specialized services for youths. This could only be a tip of the iceberg to the many challenges young girls face in trying to seek healthcare services including family planning services. For instance adolescent girls are more vulnerable to unwanted pregnancies including STI/HIV (WHO, 2004). These are associated with immoral behaviour and stigma which hinders them from accessing services such as family planning. Youth friend services should be made available and health workers be trained in handling vulnerable youths.

In Gulu one of the Districts in the region have some youth friendly NGOs. These could be as examples to help youths deal with their challenges. Gulu youth Centre, Straight Uganda, Youth Alliance in partnership with Pathfinder International, they have formed youth friendly services for

both in and out of school. These programs have shown to increase youth awareness reproductive health issues most especially HIV/STIs. On the other hand expanding these programs would mean intensive investment in human resources and structures. The adoption of youth friendly services should consider the availability of all services that cater for young people's reproductive health needs. Post-conflict RH and FP programmes should create good environment for young people to feel comfortable in accessing the services. Given the cultural practices, there is likelihood that these programs may fail.

Cultural practices such as preference for a certain sex of the child, widow inheritance, initiation ceremonies present a big barrier in FP using. Community sensitisation and mobilisation of the cultural leaders is necessary for change in traditions and beliefs. There are good examples in Uganda that could be used to facilitate change in negative cultural practices. From the authors' example, the Gishu culture known for male circumcision. Prior to HIV, there was communal sharing of the surgical knife and it took time for people to believe and the change had to start with the traditional leaders. So dealing with cultural aspects is challenging but worth when well handled.

However, the strong belief for male child may defy the use of family planning services (Population report, 2008). More male involvement and education is required. Men can be encouraged to form peer groups to discuss and debate about the RH of their families. Here we could use the experience of Namibia where men were mobilized into small groups to discuss about their role in family planning. The results show that this improved spousal communication and they got involved in the program. The challenge I foresee is many are trying to reorganise themselves and pre-occupied with firming and discussion of sexual matter outside your bedroom is a taboo.

In addition, the mention of it has turned violent so women conceal the information and die silently. The example of Kenya and Namibia could be replicated for Northern Uganda. In case of Kenya, spouse communication showed an improvement of men's approval for their wives to use family planning. While in Namibia men formed small community groups and they were sensitized on family planning and gender issues. Those two examples could be applicable in for Northern Uganda as well, using the existing local leaders meeting and drama which brings men together to rebuild communities. We can also use the social evening gatherings where men come together after a day's work to relax taking the local brew. These strategies are good though it is important to that situations were different and borrowed ideas should start small to build confidence of the few first. This requires patience as it takes time. Involve community change agents that are known to people.

As much as we want to empower men, there remains a gap in gender inequalities. They are socially and culturally engrossed but not static. There is need to promote community participation to recognise the evils of gender violence and raise awareness against violence. The act of violence against women remains the most challenging part to family planning use and access in post-conflict situations. Community initiatives should target men in their programs. To this effect, using the example of Guinea, where reproductive health groups were established and trained refugee women as lay health workers who encouraged and sensitized other women to access and report violent acts (Chen et al, 2008). This example could be replicated for Northern Uganda. Human Right Watch organisation is already involved in sensitising the community about the dangers of violence and advocates for fair trial in the courts of law. The government has also made some efforts in enforcing structural systems to protect women against violence. However, given all the efforts made towards averting violence women continue to be abused and discriminated due to masculinity.

Armed conflicts create a stressful environment where social, political, economical and cultural is disrupted. The disruption goes soar when the healthcare system is down. Reinforcing healthcare through partnership could be a viable option in times of shortage. Taking a leaf from countries like Afghanistan and Southern Sudan, they contracted Non Governmental Organisations to provide Basic Package of Health Care (BPHS) to post-conflict resettlement populations. Northern Uganda has the potentials of replicating this practice. There are many NGO's involved in health care related programs who can be used to improve the health care structures. Healthcare workers on the other hand need to be trained and recruited to fill the missing gaps. The government should be seeking increase funding for the region.

In conclusion, the three processes in which family planning is affected; pre-conflict barriers are barriers that women elsewhere face nonetheless, efforts can be made to overcome them. This may require education, sensitisation of the locals on the importance of FP use. During conflict barriers are specific and require collective efforts to reach out to FP needs of women in time, protection against violence and ensuring that healthcare systems are safe and operational. The Government of Uganda should take the responsibility in ensuring that there is improved health care and is within the reach of the women.

Chapter: 6. Conclusions and recommendations

In this chapter, the author is making recommendations relating to the discussion and proposing the possible answers to the study questions.

6.1 Conclusion

In the post-conflict Northern Uganda, barriers to use and access of family planning services are not as a result of conflict alone. There are other barriers related to health care services, cultural, demographic and individual behaviours. The findings show that post-conflict situation family planning use is made worse as they systems try to get back. Family planning specifically has not been targeted and yet evidence shows that there is demand for contraceptives among post-conflict women in Northern Uganda. The biggest challenge is overwhelming needs that tend to overshadow the importance of FP use.

The examples from elsewhere; have shown promising results. Northern Uganda, is in better placed achieve more. The preventive factor is Government and stakeholder's philosophy on peace recovery forms are not on the same grip.

6.2 Recommendations

6.2.1 To the regional and District Health Management.

Improve contraceptive supplies logistics system and management through staff training, coordination and support supervision. This will enable health managers to effectively supervise and monitor staff absence.

The Regional and Districts should solicit for funding towards capacity building of staff in family planning counselling. As this will improve on the quality of service offered and also capacity of the providers is improved.

There is need to integrate family planning with other services such as VCT and STI, antenatal clinics and at post-natal clinics.

Young girls who have been raped and stigmatized in their society should be supported through trauma counselling and creating health friendly programs. This can be achieved through referrals and forming youth clubs where they can share experiences with others.

6.2.2 To policy makers

Ministry of Health should increase health sector budget for reproductive health (RH) and support for adequate funding at the district level.

Policy making process should include women as a solution to enhance FP use and promote their status in society as they hold the key to this problem.

6.2.3 To Private health providers and Non Governmental Organisations

Relief agencies and health oriented NGOs should integrate family planning services into their programs. For example the "child mothers" programs can integrate family planning counselling into their skills building programs. Adult education with FP this will increase women's power to decision making not only at household level but also at the community level.

There is need to invest in research projects related to family planning use. This helps may indentifying possible barriers and what can be done to improve family planning use.

Awareness raising among the community leaders and most especially men involvement. The author is capable of exploring this through her experience in HIV prevention strategies.

Reference:

Amnesty International 2006. Uganda: Amnesty International Calls for an effective alternative to impunity. AL Index: AFR 59/004/2006 (Public). News Service No: 203, 4th August 2006. [Online] Available at <http://www.amnesty.org/en/library/asset/AFR59/004/2006/en/5d41e5a2-f9d6-11dd-b1b0-c961f7df9c35/afr590042006en.pdf> [accessed on 25th/7/2009]

Ashraf L and Stan B, 1997. Husband-Wife Communication about Family Planning and Contraceptives use in Kenya. *International Family Planning Perspectives*. Vol 23, No 1, march 1997.

Asiimwe. D., Kirombo R, Mastsiko J, (2005) Study of the Integration of Family planning and VCT/PMTCT/ART Programs in Uganda.

Arcel . L. T., 1998. War, Violence, Trauma and the Coping Process: Armed Conflit in Europe and survivor response. IRCT publications. Copenhagen. Denmark.

Blanc A. K. et al 1996. Negotiating Reproductive outcomes in Uganda Calverton, MD, USA: Macro International Institute of Statistics and Applied Economices.

Brambila C, Ottolenghi E, Marin. C, Jane T. Bertrand. 2007. Getting results used: Evidence from reproductive health programmatic research in Guatemala, *Health Policy and Planning* 22(4): 234–245

Bryant Leo. 2008 Evidence to All Party Political Group on Population, Development and Reproductive Health parliamentary hearing into maternal morbidity.

Busza.J. and Lush.L. 1999 Planning Reproductive Health in Conflict: A Conceptual Framework. *Social Science and Medicine* 1999; Vol 49 No 2: 155-71

Chen.M., Roenne.A. V., Souare. Y. Roenne. F., Ekirapa. A., Howard. N., Borchert. M., 2008. Reproductive Health for Refugees in Guinea II: Sexually Transmitted infections. [Online] Available at <http://www.conflictandhealth.com/content/2/1/14>. [accessed on 25th/7/2009]

Dejene, A. and Belay, D. 2003 Reasons for the Low Utilization of IUCDs in Ethiopia. *Pathfinders International/Ethiopia*, Addis Ababa, Ethiopia. Unpublished research findings.

Delargy P. et al, *Humanitarian Response Unit UNFPA*, RHRC Consortium 2003 Reproductive Health from Disaster to Development. In: proceedings

of conference 2003, the international centre for reproductive Health at Ghent University, Brussels, Belgium, October 7-8, 2003. pp. 30. [Online] available at http://www.womenscommission.org/pdf/rh_conf03.pdf. [Accessed on 18th /05/2009]

Ezeh.C. A. and Gora. M. 1997. "Estimates and explanations of gender differentials in contraceptive prevalence rates" *Studies in family planning* Vol 28, No 2: 104-121.

FPAU 2006. *Between two fires: Ensuring comprehensive sexual and reproductive health and rights for people in conflict situations*. Project Proposal.

Gupta, N., Katende,C., and Bessinger. R. 2003 Associations of Mass Media Exposure with family planning Attitudes and practices in Uganda: *studies in family planning*. Vol. 34(1): 19-31.

Human Rights Watch 2003: *Abducted and Abused*. [Online] Available at <http://www.hrw.org/en/node/12306/section/2>. [Accessed on 12th may 2009]

Human Rights Watch, *World Report 2008 - Uganda*, 31 January 2008, [Online] Available at: <http://www.unhcr.org/refworld/docid/47a87c1832.html> [accessed on 10th/8/2009]

Health and Human Rights. *Journal of International Women's Studies* Vol. 8, 4, pp 1-17.

IAWG 2004a. "Inter-agency Global Evaluation of Reproductive Health Services for Refugees and Internally displaced Persons". Geneva: UNHCR. [Online] Available at www.womencommission.org/pdf/IAWGtoc.pdf.

IAWG 2000 *Reproductive Health in Refugee Situation and Consortium: Reproductive Health during Conflict and Displacement: A Guide for Programme managers*.

IAWG 2004b "Reproductive Health Services for Displaced persons: A Decade of Progress". 2004 [Online] Available at http://www.iawg.net/resources/2004_global_eval/. [Accessed on 16th July 2009]

IAWG. 2001. International Planned Parenthood Federation, Africa Regional office. 2005 *Sexual and reproductive health of displaced populations: Refugees and internally displaced persons in Chad and Uganda*. IPPFARO Office. Nairobi, Kenya.

Isis-WICCE: 2006. Medical International Study of war Affected Kitgum District, Uganda: An Isis-WICCE Report with financial support from Medica Mondiale. Isis-WICCE, kampala, Uganda.

Isis-WICCE: 2001 Women's Experience of Armed conflict in Uganda, Gulu District, 1989-1999 Part One. Isis-WICCE research report, Kampala Uganda

Isis-WICCE: 2004. Women, Armed Conflict and Food Security in Uganda: An Exploratory Study of Four District; an Isis-WICCE Research Report 32 Bukoto Street – Kamwokya, Uganda

Isis-WICCE: 2000. Documentation of Teso Women's Experiences of Armed Conflict; 1987-2001 An Isis-WICCE Research Report

Katie. C. 2008. Reproductive Rights and Wrongs in Refugee Emergences: An Evolution of Minimum Initial Service Package (MISP). MA .Human Rights. University of Sussex 2008 [Online] Available at http://www.aidsportal.org/Article_Details.aspx?ID=8840. [Accessed on 20th July 2009]

Kayli. W., Zwi. A. B., Belton. S., Joao. M., Martins. N., Whelan. A., Kelly. M. P. 2008: Conflict and Development: Challenges in Responding to Sexual and Reproductive Health Needs in Timor-Leste [Online] Available at: www.rhmjournal.org.uk. [Accessed on 20 July 2009]

Khan et al (2008) Uganda Further Analysis. Unmet Need and Demand for Family Planning in Uganda: Further Analysis of the Uganda Demographic and Health Surveys 1995-2006

Koen. K. 2006. Claiming Space:, Reconfiguring Women's Roles in Post-Conflict Situations. Institute for Security Studies, 121, February

Krause et al, 2000. Programmatic Responses to Refugees' Reproductive Health Needs. Volume 26, No.4 December 2000

Krause S. 2007. We want birth control: Reproductive health findings in northern Uganda Women's Commission for Refugee Women and Children And United Nations Population Fund June 2007. [Online] available at [http://www.reliefweb.int/rw/RWFiles2007.nsf/FilesByRWDocUnidFilename/TBRL-74EQ92-full_report.pdf/\\$File/full_report.pdf](http://www.reliefweb.int/rw/RWFiles2007.nsf/FilesByRWDocUnidFilename/TBRL-74EQ92-full_report.pdf/$File/full_report.pdf) [Accessed on 22/05/2009]

Krause, S. and Matthews, J. 2005. Assessment of the Minimum Initial Service Package in Tsunami-affected Areas in Indonesia. *Reproductive Health Priorities in an Emergency* (Feb-March).

Liebling-K. H, Marshall. A., Ojiambo-Ochieng.R., Nassozi.M, 2007. Experiences of Women War-Torture Survivors in Uganda: Implications for Liebling-K., Marshall. A., Ojiambo-Ochieng.R., Were.J., Musisi.S., Kinyanda.E., 2008. Violence against Women in Northern Uganda: *The Neglected Health Consequences of War*. Journal of International Women's Studies Vol. 9, 3 may 2008

Long.R and Denholm. E., Amnesty International. 2005. Violence against Women in Northern Uganda

Maseruka, J. "Uganda: Gulu tops abortion list," in *New Vision*. December 15, 2006. [Online] Available at <http://allafrica.com/stories/200612151053.html> [accessed on 14/7.2007]

McGinn. T. 2000. "Reproductive Health of War-affected Populations: What Do We Kown?" *International Family Planning Perspectives*. Vol 26 No 4, 181-187.

McGinn. T 2001. Reproductive Health for Refugees Consortium: Assessment of Reproductive Health for HIV in Angola. [Online] Available at http://www.womenscommission.org/pdf/rh_ang01.pdf [accessed on 8th/7/2009]

McGinn, T., Casey, S., Pudis, S., et al, 2003. *The effects of war on Reproductive Intentions and Behavior: The case of Rwanda*. RHRC Consortium (2003) *Reproductive Health from Disaster to Development*. In: proceedings of conference 2003, the international centre for reproductive Health at Ghent University, Brussels, Belgium, October 7-8, 2003. pp. 120 [Online] available at: http://www.womenscommission.org/pdf/rh_conf03.pdf. [Accessed on 18th/05/2009]

Ministry of Finance, Planning and Economic Development: Social Transformation and Sustainable Development 2008; Population Secretariat

Ministry of Finance Planning and Economic Development, 2004 Population

Ministry of Gender and Social Development, 2007. A Handbook on Sexual Violence. *Sexual and Gender Based Violence Project, Kampala GOU-UNFPA*.

Ministry of Gender Labour and Social Development: National Report: On the Development and State of Adult Learning and Education (ALE) in Uganda 2008.

MOH, Republic of Uganda 2006a. Mapping and Assessment of Health Services Availability of Northern Uganda. April-May, 2006.

MOH 2004. Financing Health Services in Uganda 1998/1999- 2000/2001: National Health Accounts, Ministry of Health, Uganda, June 2004

MOH 2006b. Overview of performance of the concluded first Health strategic Plan (HSSP I, 2000/2001- 2004/2005).

Mugerwa.W.K. 2009 In a statement to the 42nd Session of the Commission on population and development. General debate on "National Experiences in Population Matters". New York, 1st / April/2009. [Online] Available at www.un.org/esa/population/cpd/cpd2009/country_statements/uganda.pdf. [accessed on 25th/7/2009]

Neema, S, Nakanyike, M., Kibombo. R, 2004 Adolescent Sexual and Reproductive Health in Uganda: *A Synthesis of Research Evidence*. [Oline] available at; <http://www.guttmacher.org/pubs/2004/12/20/or14.pdf> Accessed on 6/7/2009

Neema .S. 2005, The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIDS, ECM/WPD-EE/2005/EP.113 November 2005.Ministry of Health [online] Available at website; www.health.go.ug/reproductive [accessed on 21st/3/ 2009]

Nyendahimana and Adong 2006. Linking Reproductive, Family Planning and HIV/AIDS in Africa. UN Conference Center, Addis Abab, Ethiopia October /9-10/ 2006 [Online] Available at http://www.jhsph.edu/gatesinstitute/pdf/policy_practice/FP-HIV/Presentations/Addis_ConfSum.pdf [accessed on 17th/7/2009].

Ochan. W., Nambooze. R., & Mugumya. E. 2006: The Silent Bullet; the Unfought War: HIV/AIDS among People in Conflict Situation.The XVIth International AIDS Conference. Toronto, Canada, August 13-18, 2006.

Ochan.W. 2007. Between two fires: Ensuring comprehensive sexual and reproductive health and rights for people in conflict situations. Project Proposal (Un publicshed).

Ocwich. 2005. Can Uganda's Economy support more districts? The New vision Newspaper 8th /aug/2005 [online] available at <http://www.newvision.co.ug/D/8/26/449320>, [accessed on 5th /4/2009]

Okidi, L. C., and Mugambe, G.K. 2002 An overview of Chronic Poverty and Development Policy in Uganda. CPRC Working Paper no. 11. Manchester: CPRC

Prada. E., Mirembe F, Singh S, Kiggundu C, 2005. The Incidence of Induced Abortion in Uganda. *International Family Planning Perspectives* Vol 31, Nos 4, December 2005

Programs in Africa: An International Conference: UN Conference centre in Ethiopia, October, 9th -10th , 2006. [Online]. Available at www.jhsph.edu/gatesinstitute/CR/FP-HIV. [Accessed on 14/07/2009]

Reproductive Health Uganda (RHU) 2008: [Online] available at www.enteruganda.com/brochures/propulatejulypage06.html. [Accessed on 12/07/2009].

Seiber.E., Hotchkiss.D., and Abesno. N. 2005. Maternal and Child Health and Family Planning Service Utilization in Guatemala: Implication for Social Science and Medicine.

TASO. 2008. Annual Report. TASO Uganda Limited.

The weekly observer (Kampala), 2009: Country on course to achieving MDG goals. [Online], Available at: <http://allafrica.com/stories/200904030684.htm/> : [Accessed on 5th /4/2009- 11.09am]

UNAIDS 2007 .Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators, 2008 reporting. Geneva, UNAIDS.

UAC. 2007. Moving Towards Universal Access: National HIV & AIDS Strategic Plan 2007/08-2011/12. [online] Available at <http://www.aidsuganda.org/nsp.pdf> [accessed on 5th/4/2009]

Uganda Bureau of Statistics UBOS and Macro International Inc.2007. Demographic and Health Survey 2006. Calverton, Maryland, USA: UBOS and Macro International Inc.

UHSBS. 2007 HIV Prevalence in Voluntary Counseling and Testing Centers Compared With National HIV Serosurvey Data in Uganda.

UNICEF and Gulu District Sub-working Group on Sexual and Gender Based Violence 2004. *Suffering in Silence: A study of SGBV in Pabbo camp*. Gulu District.

United Nations Development Program (UNDP). 2006 Human Development Report: Country Fact Sheet-Sierra Leone. Geneva: UNDP. [Online] Available at http://hdr.undp.org/hdr2006/statistics/countries/country_fact_sheets/cty. [Accessed on 20th/ 7/2006]

UNDP. 2008. Human development report 2007/08, Uganda. [Online] Available at <http://hdrstats.undp.org/countries/data> [accessed on 16th/6/2009]

UNFPA 1994 International Conference on Population and Development Programme of Action. [Online] Available at www.unfpa.org/publications/detail.cfm?ID=275. [Accessed on 14/5/2009]

UNFPA 2007a Protecting the Reproductive Health of Communities in crisis. [Online] available at <http://www.unfpa.org/emergencies/overview.htm>. [Accessed on the 12/07/2009].

UNFPA 2006 State of the World Population Report. Kampala, Uganda. United Nations High Commissioner for Refugees (UNHCR) 2006. Refugees by Numbers. Geneva: UNHCR

UNFPA. 2004 State of World Population 2004: The Cairo Consensus at Ten Population, Reproductive Health and the Global Effort to End Poverty. New York, U.S.A

UNHCR 2007. Emergency Reproductive Health Officer, Head of Gulu sub-office, review of draft report, May 2, 2007; Engenderhealth and UNFPA, *Obstetrics Fistula Needs Assessment Report: findings from nine African countries*, p. 79.

UNHCHR 2008. Human Rights in Development. Rights Based Approaches.

United Nations Office for Coordination of Humanitarian Assistance (UNOCHA) 2005. Humanitarian Update: Uganda, Vol VII, Issue I. Kampala, Uganda.

UNOCHA- Uganda: Consolidated Appeal for Uganda 2006 (Revision): UN Office for the Coordination of Humanitarian Affairs. Kampala, 2006

Uppsala Conflict Data Program (UPPCD) 2006. Customized report: Active Conflict in Africa. [Online] available at www.pcr.uu.se/database/CustomizedReport/subset.php. [Accessed on 7th/ august/ 2009]

Verkuyl. 2003. Family Planning as Part of Reproductive Health, including HIV/AIDS Aspects, in Zimbabwe and South Africa, Enschede, The Netherlands.

WHO and T. R. o. U. M. o. Health 2005a. Health and Mortality Survey Among Internally Displaced Persons in Gulu, Kitgum and Pader Districts, Northern Uganda, World Health Organization: page 11.

WHO, 2004 Contraceptive Introduction Reconsidered: A Review and Conceptual framework, Geneva: WHO, 2004

WHO, 2005b. Repositioning Family Planning Guidelines for Advocacy action: 2005-2014. WHO Regional Office for Africa.

WHO, 2007. Health Action in Crisis: Uganda. June 2007. WorldNet Daily. 2006. The New World Disorder: UN Peacekeepers' rape women and children. [Online] Available at http://www.Worldnetdaily.com/news/article.asp?ARTICLE_ID=42088. [Accessed on 20th may 2009]

WHO. 2008. Repositioning Family Planning: Guidelines for Advocacy action. [Online] Available at http://www.who.int/reproductivehealth/publications/family_planning/fp_advocacy_tool/en/index.html [accessed on 25th/7/2009]

Women's Commission for Refugee Women and Children (WCRWC). 2003 "Minimum Initial Service Package Fact Sheet" 2003. [Online] Available at http://www.womenscommission.org/pdf/MISP_fact.pdf. [Accessed on 18th June 2009]

Zwi,A., and Cabral, A., (1991). Identifying 'high risk' situations for preventing AIDS. British Medical Journal 303, 1527-1529.